When staying home isn’t safe: Australian practitioner experiences of responding to intimate partner violence during COVID-19 restrictions

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Times of crisis are associated with increased violence against women, often with reduced access to support services. COVID-19 is no exception with public health control measures restricting people’s movements and confining many women and children to homes with their abusers. Recognising the safety risks posed by lockdowns the United Nations declared violence against women ‘the shadow pandemic’ in April 2020. In the Australian state of Victoria, residents spent over a third of 2020 in strict lockdown. Based on an online survey of 166 Victorian practitioners between April and May 2020 using rating scales and open-ended questions, our study revealed that women’s experiences of intimate partner violence (IPV) intensified during lockdown. COVID-19 restrictions created new barriers to help-seeking and necessitated the rapid transition to remote service delivery models during a time of heightened risk. This article provides insights into how practitioners innovated and adapted their practices to provide continued support during a high demand. Our study exposed the significant toll responding to IPV during the pandemic is having on practitioners. We explore the impact of remote service delivery on practitioner mental health and wellbeing and the quality of care provided.

Key words shadow pandemic • intimate partner violence • pandemic • innovation

Key messages
• Online capacities and service innovations implemented in crisis-mode during the COVID-19 pandemic should inform the development of responsive services systems to help prevent gender-based violence post-COVID and in future crises.
• Policymakers should resource and prioritise intimate partner violence as well as other forms of gender-based violence within emergency planning and disaster response frameworks and inter-agency coordination.
• This study emphasises the importance of better supporting the violence against women workforce. There is a need to increase flexible, surge support for the mental health and wellbeing of practitioners working to support victim-survivors during times of emergency.
Introduction

Internationally the COVID-19 pandemic control measures have exacerbated women’s experiences of all forms of gender-based violence, including intimate partner violence—the most prevalent form of violence against women. Forecast modelling released in late April 2020 by the UN Population Fund (UNFPA, 2020) predicted that for every three months that government-enforced COVID-19 restrictions continue, an additional 15 million cases of intimate partner violence will occur worldwide. Research by the United Nations shows that the ‘home’ is the most likely place for women to be killed and where the threat to their personal safety looms the largest (UNODC, 2019). With the World Health Organisation (WHO) and many countries issuing ‘stay home, stay safe’ directives to reduce community spread of COVID-19, concerns have been raised about the heightened risk to the safety of women and children at a time when access to support services was significantly reduced (UN Women, 2020). Recognising safety risks associated with lockdowns in April 2020 the United Nations labelled violence against women the ‘shadow pandemic’ (UN Women, 2020).

At least initially, Australian experience of the pandemic has differed from many of its counterparts. Australian states and territories, unlike many countries, have largely pursued an elimination strategy seeking to maintain zero COVID cases. They have mainly relied on strict lockdown periods and other heavy restrictions on personal freedoms and movement. Australia does not differ in relation to the impact of the pandemic on women’s freedom from violence. A study conducted by the Australian Institute of Criminology in May 2020 revealed that of 15,000 Australian women surveyed about their experiences of intimate partner violence during the initial national lockdown, one in 20 women had experienced physical or sexual violence in the three months prior and one in ten had experienced emotional abuse, harassment or controlling behaviour by a current or former cohabiting partner (Boxall et al, 2020). These findings confirm fears held by Australian experts and specialist services that the pandemic would increase the risk of intimate partner violence.

The reported increased violence against women in Australia during the 2020 COVID-19 restrictions heightened an already significant problem affecting the wellbeing and safety of women and children. In 2015 intimate partner violence was declared a national emergency in Australia (Victorian Government, 2015). Each week, on average, one woman is killed by male violence, most commonly by a current or former intimate partner (Cussen and Bryant, 2015). While there has been significant political attention and reform activity in this area over the last decade (see, inter alia, Victorian Special Taskforce, 2015; RCFV, 2016), intimate partner violence remains an issue of national concern. Evidence of intensified violence against women and children during the pandemic, and in particular during lockdown has been a pressing concern for many practitioners, academics, advocates and policymakers.
This article examines the impact of COVID-19 and related lockdowns on Australian women’s experiences of violence and responses to their help-seeking. To do so, it draws on the findings from an online survey conducted with intimate partner violence practitioners in the Australian state of Victoria between April to May 2020, as the state experienced its first six-week lockdown. Drawing from the professional experience and expertise of specialist intimate partner violence practitioners, the article explores the degree to which the nature and frequency of violence changed during lockdown, the degree to which women’s help-seeking needs altered over this period, including their ability to access services. Focusing on the practitioner perspective we explore how services innovated and adapted their practices to ensure continued support for intimate partner violence victims during this high demand. Our findings increase understanding of the impact of lockdowns on women’s safety and help-seeking behaviours and on the wellbeing of practitioners of providing remote support. This study contributes to the growing evidence that the pandemic has increased the perpetration of violence against women (see, inter alia, Carrington et al, 2020; Piquero et al, 2020; Polishchuk and Fay, 2020; True et al, 2020; Cortis et al, 2021). As background, we begin by examining what is known about the occurrence of intimate partner violence during times of crises and disasters.

Violence against during global crises and disaster

The interconnections between financial crises, disasters and increased intimate partner violence is well researched (Hozic and True, 2016; Kinnvall and Rydstrom, 2019). We have seen the compounding impact of disasters and financial crises on social isolation, a common tactic used by abusers to distance victim-survivors from their support networks (Stark, 2007). Such isolation has been linked to higher incidences of intimate partner violence (Renzetti and Larkin, 2009). Previous research has also shown that women’s more precarious social and economic standing increases their vulnerability to violence during economic downturns and disasters (True, 2012; Schneider et al, 2016). For example, research following the 2008 Global Financial Crisis (UNICRI, 2015; Schneider et al, 2016) and natural disasters (Fisher, 2010; Parkinson and Zara, 2013) in several countries has consistently demonstrated the heightened risk of intimate partner violence post-crisis (see also, Thornton and Voigt, 2007; Jenkins and Phillips, 2008). In the two weeks following the 2011 Christchurch earthquake in New Zealand police reports of intimate partner violence rose by one fifth. Service providers attributed this to stress, alcohol consumption and noted that the subsequent provision of safe shelter expedited decisions to leave situations of intimate partner violence (True, 2012: 166). This escalation of violence is recognised as occurring at a time when access to services is impeded.

Times of crisis and natural disaster as well as increasing violence against women, often lead to reduced access to support services (Erskine, 2020; IASC, 2020; Lauve-Moon and Ferreira, 2017; Parkinson and Zara, 2013; True, 2013; UNICRI, 2015; UN Women, 2020; UNFPA, 2020; Peterman et al, 2020). Evidence demonstrates that services offering support and protection to women and children experiencing violence can disappear entirely during disasters. Hotlines, access to legal help and shelter availability, for example, can all be disrupted.

Since the beginning of the pandemic evidence has emerged that its economic impacts and related control measures have exacerbated existing gendered inequalities
(see, inter alia, John et al, 2020; Lewis, 2020; Morse and Anderson, 2020). For example, the increased care burden carried by many women during the pandemic has led commentators to describe women as the ‘shock absorbers’ of the pandemic explaining that they are now performing a ‘double double shift’ or ‘third shift’ (Atabakhsh, 2020; Daniel, 2020; John et al, 2020; Sandberg and Thomas, 2020). One US study observed that between February and April 2020 mothers with young children reduced their work hours four to five times more than fathers and as a result, the gender gap in work hours grew by between 20 to 50 per cent (Collins et al, 2020).

These increases in women’s caring responsibilities have coincided with their increased economic vulnerability. Women are more likely to be employed in sectors hardest hit by the coronavirus restrictions, such as accommodation and food services, and are also more likely to be employed in low/paid casualised roles with limited leave entitlements (Barns et al, 2009; Batchelor, 2020). One global study found that women’s jobs are at 1.8 times more vulnerable during the pandemic than men’s jobs (Madgavkar et al, 2020). These findings resonate in Australia, where in Victoria as of August 2020 women had lost their jobs at a higher rate than men, and women’s unemployment levels were at an historical high (Batchelor, 2020). Victorian data from the first lockdowns in early 2020 further support this, revealing that women were more likely to experience less secure and lower paid work than men and forecasting that Australia’s early access to superannuation policy introduced during COVID-19 would further compound the economic impact of the pandemic on women (Batchelor, 2020).

Research design

This article presents the findings from our survey of practitioners responding to IPV during the pandemic from the Australian state of Victoria. The anonymous online survey combined a series of short demographic questions with rating scale and open-ended questions. Respondents could choose to answer some or all of the survey questions which invited practitioners to reflect on the impact of COVID-19 restrictions on women’s experiences of IPV and their own experience of providing support during lockdown, including practice changes and service adaptations. Questions about the perceptions of the impact of the pandemic on the prevalence and nature of violence were measured using scale variables where 1 to 2 represented a decrease, 3 – no change and 4 to 5 an increase. The survey ran for a four-week period during April and May 2020. Information about the study was distributed on social media outlets (including Twitter and LinkedIn), through the Monash Gender and Family Violence Prevention Centre network, and by providing information about the survey directly to relevant Victorian organisations.

Ethical data collection methods that prioritise victim-survivor safety and support when contributing to research, such as face-to-face interviews, were not possible during Victoria’s lockdown as many victim-survivors were sheltering in homes with their abusers and there were heavy restrictions on people’s movement. There was a real risk that if a perpetrator became aware that a victim-survivor was sharing their experiences with the research team it may place them at greater risk and/or escalate the violence they were experiencing. This was of particular concern given reports of increased perpetrator monitoring of communication devices. Guided by the principle of doing no harm, we sought to understand women’s experiences of violence during this time through the reflections and observations of key informants – frontline
intimate partner violence practitioners and service providers. Ethics approval was received through the Monash University Human Research Ethics Committee.

One hundred and sixty-six Victorian practitioners completed the survey. Over two thirds of those worked in child and family services (33%, n=48) and specialist family and sexual violence services (29%, n= 42) (see Figure 1 for further details). Practitioners’ experience working with IPV clients ranged from less than one year to 37 years, with an average experience of 2.9 years and a median of 6.5 years (n= 119). They worked across 49 local government areas in Victoria, including non-metropolitan locations. All survey participants were assured anonymity as part of the consent process. Therefore, we did not collect information on specific organisations employing participants.

The quantitative survey data was analysed descriptively in Excel. Univariate analyses explored overall trends in the nature and frequency of IPV during the COVID-19 lockdown. Qualitative survey data were thematically analysed to develop a rich description of practitioners’ perspectives of the impact of pandemic restrictions on women’s experiences of violence and practitioners’ experiences of remotely providing support to victims. Drawing on Bazeley (2013) and Miles and Huberman (1994), we engaged in a two-stage coding process using NVivo 12. First level coding involved descriptive coding labelling passages of data with codes that summarised the data segments (Miles and Huberman, 1994; Bazeley, 2013). Second-level coding built on these summaries, refining, interpreting and grouping them into smaller analytical categories, themes or constructs (Miles and Huberman, 1994; Bazeley, 2013). This phase explored the interrelatedness of data within and across themes to construct meaningful explanations (Bazeley, 2013). This two-stage coding process is cyclical with researchers constantly moving from data to description to analysis (Bazeley, 2013; Miles and Huberman, 1994).

Findings

Our survey data revealed that women’s experiences of violence intensified during the pandemic with practitioners reporting an increase in the prevalence and severity of violence. COVID-19 restrictions and rapid transition to remote service delivery models created new barriers to help-seeking for women experiencing IPV. Working from home mandates had significant wellbeing implications for practitioners doing trauma work. These findings are presented here in four sections: women’s experiences of violence during COVID-19, barriers to help-seeking during COVID-19, remotely responding to violence during the pandemic, and remote work and practitioners’ wellbeing in lockdown.

Women’s experiences of intimate partner violence during COVID-19

Over half of the practitioners surveyed reported that the pandemic had led to an increase in the frequency (59 per cent, n=94) and severity of IPV (50 per cent, n=102). Just under half of the practitioners surveyed (42 per cent, n=105) reported that the pandemic had resulted in an increase in women reporting IPV to specialist support services for the first time. Most notably, three quarters of practitioners (86 per cent, n=103) said that the pandemic had increased the complexity of women’s needs with 55 per cent reporting a significant increase in complexity. As one practitioner explained:
With families being stuck at home, with even the playgrounds in our area roped off, this has been a tinder box in many households and has made the circumstances for many women unbearable.

In addition to intensifying violence experienced by women, practitioners reported that the pandemic had provided new opportunities for perpetrators to exert power and control over women. Practitioners reported that perpetrators are using the COVID-19 restrictions and threat of infection to restrict women’s movements, to gain access to women’s residences and to coerce women into residing with them if they usually reside separately. For example, one practitioner commented that:

Demanding women to wash their hands and body excessively to a point [where] women’s skin starts to bleed and become badly irritated; spreading a vicious rumour she’s got COVID-19 so nobody would come near her or help her; taking children away saying she is likely to have/get COVID-19 and is a risk to children.

Other practitioners reported new forms of abuse commenting that:

[Perpetrators are] using COVID-19 as a reason to keep women isolated. For example, not letting them out of the home to ‘protect them’ from COVID-19.

Ex-partners are using COVID restrictions as an excuse as to why they have to stay with ex-partners, and not giving them any other options.

Monitoring of internet use, removal of mobile phones and using Fitbits and hidden downloaded phone [apps], monitoring movements. We also have cases of car usage being monitored via new technology in computerised vehicles.

Several practitioners reported that perpetrators were using children and the restrictions as a pretext to gain access to women. This was more common among families with shared care arrangements or who were involved in the family law system at the time of the initial outbreak in Victoria. Practitioners said:

Victims who have escaped but who have children with the perpetrator are reporting perpetrators are using COVID-19 as an extra weapon in their arsenal, fearing that the family law system will be hard-pressed to protect them.

Increase in wanting to control them more around custody arrangements especially as children not going to school… threatening to call police if they don’t let them have the child for more days. Ex-partner demanding to move into the client’s home.

Research has repeatedly identified that children growing up in households with intimate partner violence experience abuse in various ways, which has detrimental effects on their safety, development and wellbeing (Hester, 2007; Campo, 2015; McTavish et al, 2016). Further, perpetrators commonly use children to coerce and control their victims (Campo, 2015; Holt, 2017; Katz et al, 2020). Our findings show
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how COVID-19 restrictions have facilitated an increase in coercive and controlling forms of intimate partner violence post-separation and substantially affected women and children’s lives during the pandemic.

The practitioners’ stories demonstrate how perpetrators ‘weaponised’ the pandemic and utilised restrictions to exert further control over women’s movements and decision-making. Given that coercion and control are recognised as high-risk features of abusive relationships (see further Stark 2007), increased opportunities for perpetrators to control their victims during lockdown raises grave concerns. In Australia (Domestic Violence Death Review Team, 2020), and internationally (Myhill and Hohl, 2019), coercive control is increasingly recognised as a precursor to intimate partner femicide. At a time of acknowledged higher risk for women experiencing violence it is a significant issue that governments’ primary method for suppressing the spread of the virus, namely through ‘stay safe, stay home’ restrictions, placed women at higher risk of victimisation.

**Barriers to help-seeking during COVID-19**

The barriers to help-seeking experienced by women IPV victims are well documented, including stigma, shame, fear of being disbelieved and the presence of children (Meyer, 2011). This research provides insight into the ways in which the COVID-19 lockdown restrictions heightened existing barriers and introduced new obstacles to help-seeking and accessing support for victim-survivors. Practitioners reported that an increase in surveillance of communication devices and online activities by perpetrators limited women’s ability to use phone line support services. As one practitioner highlighted:

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Partners who are monitoring phone use now have an increased amount of power and control in this domain as the phone is now quite literally the only connection with the outside world.
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Consequently, many practitioners noted that reduced privacy in homes severely restricted women’s ability to use their communication devices to call support services:

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Women have been very concerned about their phone calls being overheard and not having a safe space to speak freely.

Women have often ended phone calls, changed the topic or called back later when it is safe to talk.
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Practitioners emphasised that in lockdown there is ‘no assumption of confidentiality’ as all client contact is by phone and perpetrators may be physically present or using tracking/personal monitoring technology. They explained that restrictions facilitated perpetrators’ isolation of women experiencing violence. As one practitioner noted:

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It has been much easier for the perpetrator to get the victim-survivor to isolate from friends and family.
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The impacts of isolation and the barriers identified by practitioners were evident in IPV services provided data during the first Victorian lockdown. One state-wide
The first COVID lockdown in Victoria in early 2020 prompted a rapid transition to remote service delivery models for intimate partner violence services. Practitioners reported that they adapted their traditionally in-person face-to-face service response to phone, web, video and message-based services. Victoria had entered its first lockdown as data collection commenced and practitioners were at different stages in transition to remote-service delivery. Some of the remote service practices that were reported in this study were developed specifically for the pandemic, while others utilised and expanded existing remote-service models.

Many practitioners reported that their organisations sought to integrate IPV responses into permitted essential services, including general medical practice clinics, Centrelink (state income support services) and childcare. Practitioners recognised that these services offered potentially useful ways to access women and children experiencing violence but who would otherwise be unable to seek help. As one practitioner described their service integration:

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

Several practitioners reported that their organisations created new alert systems for women to signal when they need support. These alerts included the use of code words in telephone and text communication as well as physical signals. These findings mirror those reported internationally during the first wave of the virus and represent a broader shift towards offering IPV referrals through other services. A rapid review of alternative entry-points and service models to address gender-based violence during COVID-19 noted that services, such as 24/7 phone hotlines, and web-based service delivery models, such as telecounselling and telepsychiatry, have been popular responses across the globe (Emezue, 2020). For example, in Spain, the Canary Islands Institute for Equality partnered with pharmacies on a help-seeking campaign in which women could approach pharmaceutical staff and request a ‘Mask-19’ to signal that they were experiencing gendered violence (Higgins, 2020).
While the lockdown triggered service innovation and the widespread adoption of digital technologies across the state, practitioners reported that this transition was not without its difficulties. Many practitioners highlighted the challenge of effectively maintaining contact with clients and ensuring continuity of support during lockdown:

Clients’ inability to communicate safely/communicating with the client and potentially placing their safety at risk. Clients’ unable to answer phone at scheduled contact time due to perpetrator presence… balancing provision of service with keeping clients safe within their environment.

Perpetrator in the home, unable to leave home due to COVID-19 restrictions, children in the home. The list goes on.

Practitioners explained this manifested in several ways, including decreased calls for help from women and a lack of call-backs to services. Several practitioners expressed particular concern for the women who were isolated at home and unable to make contact with a support service:

I am concerned that given the current social-distancing laws women are unable to leave the house [and] cannot communicate safely with services.

I think women are staying home and not help-seeking.

We are deeply concerned for the women who are unable to contact us at the moment… women have been struggling without face-to-face support at police stations and courts.

For those practitioners who could contact clients, several identified lack of privacy in homes during the lockdown as a key obstacle to providing effective IPV support, explaining that many clients were isolating with their abusers. Numerous practitioners discussed the difficulties of assessing risk and determining protective factors remotely. As two practitioners explained:

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

Less opportunities to engage safely due to perpetrators being out of work [and] at home more often.

Additionally, some practitioners reported that the presence of perpetrators (and other family members) in homes inhibited open and frank communication by clients, often negatively affecting safety planning. As one practitioner commented ‘it is hard to know whether the perpetrator is in the room as you can’t see much on Zoom’.

Many practitioners remarked on the challenges posed by their inability to offer in-person support to women experiencing violence during the restrictions:
Being able to have a conversation – it’s difficult to really understand the patterns and dynamics of the violence when there is less time to speak and barriers to engagement.

The lack of face-to-face feels as though it is impacting on rapport building and trust.

Not being able to do face-to-face work, clients are often very isolated in our service and it has become much worse.

Practitioners noted that the focus of work changed during lockdown to become largely reactive and crisis-driven as distinct from pro-active and early-intervention focused. Practitioners also reported that frequency of contact decreased in some cases and there was increased lag time between making a referral remotely and the client taking that referral up. One practitioner explained that this had had an impact on the ability to coordinate care for a woman, child and/or family with multiple agencies as they were dealing with ‘different platforms, IT/connectivity and internet speed issues’, all compounded further by a ‘lack of access to technology, devices, data, adequate internet speed’. Other practitioners noted that some referral options they often used had either closed or had limited capacity to support women during this period.

A smaller number of practitioners noted that the increased presence of children at home presented barriers to service provision. One practitioner described a situation of ‘women feeling unsafe to talk to service[s] because children are present’, while another practitioner stated that ‘mothers [are] unable to get private time from children to have sessions’. This was further compounded by an acknowledgement that women requiring support may also be juggling the demands of children learning from home. In recognition of this, some practitioners noted that they tried to contact clients when they would not be supervising remote learning.

Numerous practitioners noted that securing safe housing options during the COVID-19 restriction period posed a significant challenge. As described by three practitioners:

All of our transitional housing is full, and we are now placing families in caravan parks (which means sharing bathrooms) and it is not ideal. Women are returning to perpetrators because we cannot provide emergency housing.

Providing longer term accommodation is always challenging but the COVID-19 situation has impacted on demand on services which is making it very difficult to find options.

[There is] limited resources in community services sector i.e. refuge, long-, medium- and short-term housing, providing women emergency aid – when they don’t have access to online vouchers, transport options, refuge housing, limited referrals [and so on].

While a shortage of safe housing options for women experiencing IPV is not a new problem in Victoria, and Australia generally (Special Taskforce, 2015; RCFV, 2016; Flanagan et al, 2019), these views indicate that the pandemic has exacerbated this
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national safe housing crisis. Given growing recognition of the gendered impacts of COVID-19 related economic recession (Ribeiro, 2020), practitioners’ concerns about the lack of affordable, accessible and permanent housing options for women experiencing violence are concerning. Prior to the pandemic, intimate partner violence was already recognised as a key contributor to women’s homelessness in Australia (Special Taskforce, 2015; Tually et al., 2008; Mason et al., 2020: 35–36). If significant resources are not dedicated to ensuring the availability of emergency and long-term safe housing options in Australia’s recovery from COVID-19, then this historically high risk of homelessness will be further heightened.

Remote work and practitioner wellbeing in the era of COVID-19

Our survey findings underscore the significant toll that responding to IPV while working remotely from home during the lockdown has on practitioner wellbeing. As one practitioner aptly commented:

We are all working from home which has been emotionally, extremely difficult. Having this work in my bedroom, my safe space, has been frankly awful and has wreaked havoc on my work/life balance and self-care routines. Most significantly of all, not being around my colleagues for support, guidance and debriefing has really been the worst.

Practitioners reported that the pivot to remote work and service delivery during lockdown had increased worker stress and raised new challenges associated with practitioners setting up home workspaces. While we did not include a specific question on practitioner wellbeing in the survey, open text responses to our question relating to the challenges arising from the restrictions pointed to significant implications for the workforce. The adverse impacts on practitioner wellbeing of the transition to remote service delivery models and working from home during the restrictions was highlighted by several practitioners:

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

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

Difficulties supporting staff and assisting with vicarious trauma and holding risk in relation to women and children. Staff are using a range of devices and network access to deliver services remotely (personal and work computers, work and personal mobile phones and home data plans). Some staff and women have great difficulties accessing phone and internet due to their rural location.

Previously few Victorian IPV services were delivered remotely, nor were workers based (completely or partially) at home. The pivot to remote service represented a significant
adjustment and cost for many organisations and for individual practitioners. In addition to the breakdown of barriers between work and home, practitioners identified the additional toll on their time. While there has been sustained media coverage in Australia throughout the pandemic on the wellbeing of workers in identified essential care services, particularly healthcare professionals, prior to this study there was no focus on the impacts on the mental health and wellbeing of practitioners responding to women and children experiencing violence. These findings highlight the need to develop new support models for IPV practitioners to avoid burn out and withdrawal from the sector in the years to come.

**Concluding reflections: learning from responses to women experiencing violence during COVID-19**

Pandemic control measures in Australia, while necessary for the community, heightened the risk of violence against women and compounded barriers to help-seeking. While not a demographic population study, this research provides insights into the impact of COVID-19 restrictions on the prevalence and nature of IPV as well as women’s help-seeking behaviours. Drawing from the professional experiences of 166 Victorian practitioners, our study reveals the ways in which the first Victorian lockdown impeded help-seeking for women experiencing IPV and increased the frequency and severity of IPV and the complexity of women’s needs.

The lockdowns triggered a widespread pivot to remote service delivery models for IPV services, often for the first time, while simultaneously challenging services to support worker mental health and wellbeing in remote settings. The predominantly female workforces supporting clients experiencing trauma and abuse were required to manage complex and challenging situations from their homes often while performing increased care work and without the in-person peer support and debriefing typically provided at work. Working with individuals and families experiencing IPV can affect professional and personal functioning with burnout, secondary traumatic stress and vicarious trauma normal responses to the challenging nature of this work (The Lookout, 2019). A 2017 Victorian intimate partner violence workforce census found that almost one third of specialist practitioners were considering leaving their job due to burn out (Family Safety Victoria, 2017). Our study draws attention to the wellbeing considerations for practitioners working remotely to support people experiencing violence during the pandemic. Other studies have reported similar concerns for the violence against women workforce (Carrington, 2021). Governments and service providers in all countries must ensure that practitioner health and wellbeing is prioritised during times of crisis whether that be due to a pandemic, natural disaster or climate change-induced event.

It is highly concerning that disruptions to service delivery occurred during a time of heightened risk of gender-based violence. One of the biggest challenges for responding to women’s risk of violence during restrictions is developing alternatives to direct face-to-face service provision. While the specific risks of violence and rates of COVID-19 infection vary between jurisdictions internationally in the context of a global pattern of increased violence, the requirement for service innovation during the pandemic was universal. Innovations included the use of new remote technologies and involvement of new agencies to access victim-survivors.

This experience presents an opportunity and an urgency to capture and share learnings globally to promote effective and innovative best practice strategies for
keeping women safe from violence not only in post-COVID-19 recovery but in preparation for future crises as well. While there is not a blueprint for how governments should respond to keeping women safe from violence during a global health crisis, our findings support calls for the inclusion of violence against women in emergency planning and disaster preparedness and response policies (House of Representatives Standing Committee on Social Policy and Legal Affairs, 2021). Gender-based violence services could be integrated into future pandemic and disaster planning processes as key frontline agencies based on the evidence assembled and impacts of COVID-19 documented by gender-based violence researchers and advocates. Health emergency and disaster preparedness in governments in relatively stable countries could consider ‘protection cluster models’ used in humanitarian situations where agencies responding to the range of human impacts of crisis routinely share information and responsibilities.

This study also underscores the need to prioritise the mental health and wellbeing of intimate partner violence workers in emergency preparedness, response and recovery policies. As the sector moves through this global health crisis and into the recovery phase the next workforce challenge is resilience. Recovery strategies need to actively build the resilience and agility of the violence against women workforce to respond to future crises (Monash Gender and Family Violence Prevention Centre et al, 2021).

In particular, this study highlights the importance of listening to the experiences and needs of practitioners as key to understanding changing patterns of violence and assessing what is needed during crises. Understandings of the different abusive behaviours experienced by victim-survivors throughout the pandemic should be utilised to ensure future prevention campaigns are evidence-based and rooted in an understanding of women’s experiences. Practitioner perspectives, as detailed in this study, provide key insights into experiences of coercion and violence in intimate partner relationships which could be used to inform future help-seeking strategies.

This study also provides emerging evidence about effective and innovative practices for keeping women and children safe from violence during times of emergency. It highlights the need to ensure that the violence against women workforce have the infrastructure and resources to be able to nimbly transition to hybrid service delivery models in future crises. To provide continuity of care for women experiencing violence, during emergencies staff must have the tools and equipment they need to effectively do their job remotely. Resources also need to extend well beyond top-up funding for readily implementable short-term crisis measures responding to increased violence.

Practitioners expressed concern that the needs of the IPV sector will drop off the political agendas as governments in Australia, and elsewhere, move through further periods of restrictions and into recovery. Given the impact of COVID-19 in heightening gender inequalities as a result of the disproportionate loss of female jobs and income (McKinsey Global Institute, 2020), fiscal policies should be re-designed to prevent as well as respond to gender-based violence. Gender-responsive budgeting with a gender-based violence lens, for example, could enable fiscal policy to redress women’s economic vulnerability with regard to employment, income and housing over the medium and longer-term post-COVID recovery. Greater economic security would help women victim-survivors to leave violent relationships and negotiate safe futures even in the face of further crises. Thus far, however, there have been few such feminist policy responses around the world (Turquet et al, 2021), although the
Victorian government recently announced the establishment of a gender budgeting unit in the state Treasury (Hislop, 2021). Our findings highlight the importance of learning from the ‘shadow pandemic’ during the COVID-19 pandemic, and that the prevention of gender-based violence must be a central goal to all local, national and global responses to COVID-19 and future crises.

**Note**

1 At the time of data collection Victoria was under Stage 3 restrictions. People could only go outside their home for four permitted reasons: shopping for food and necessary goods, providing care, exercising and work or education if individuals are unable to do either from home.

**Conflict of interest**

The authors declare that there is no conflict of interest.

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