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article

Experience of specialist DVA provision under COVID-19: listening to service user voices to shape future practice

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In the context of high rates of domestic violence and abuse (DVA) during the pandemic, specialist DVA services have been required to adapt rapidly to continue to deliver essential support to women and children in both refuges and the community. This study examines service users' experiences and views of DVA service provision under COVID-19 and discusses implications for future practice. Data are drawn from a wider evaluation of DVA services in five sites in England. Fifty-seven semi-structured interviews and five focus groups were conducted with 70 female survivors and seven children accessing DVA services during the pandemic. Analysis identified key themes in respect of the influence of COVID-19 on the experience of service delivery. COVID-19 restrictions had both positive and negative implications for service users. Remote support reduced face-to-face contact with services, but consistent communication counteracted isolation. Digital practices offered effective means of providing individual and group support, but there were concerns that not all children were able to access online support. Digital support offered convenience and control for survivors but could lack privacy and opportunities for relationship-building. The pivot to remote delivery suggests directions where DVA services can expand the range and nature of future service provision.

Key words COVID-19 • domestic violence and abuse services • survivors • interpersonal violence • online support

Key messages

- Adult and child survivors were able to derive benefit from remote service provision during the COVID-19 pandemic in 2020 and the creative and flexible support of specialist DVA practitioners was evident.
- Challenges were identified in relation to remote support for children and providing group-based peer support and recovery work for women.
- Service providers should consider how to incorporate greater choice of support methods including online formats as part of their support for women and children in future and ensure that these are accessible to all users of DVA services.

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Introduction

Domestic violence and abuse (DVA) is recognised as a significant gendered global issue (UN, 2020). Across the world, women are more likely than men to be murdered by their intimate partners and family members (UNODC, 2019). The Crime Survey for England and Wales consistently confirms that women are more likely to suffer DVA (ONS, 2020a). DVA also affects 20 per cent of children and young people (Radford et al, 2011) which can be harmful to their health and development (Holt et al, 2008; Stanley, 2011). Not only are women and children the primary victims of DVA, they have also suffered disproportionately during the COVID-19 pandemic (Davidge, 2020) which the United Nations termed a 'magnifier of inequality' (Thornton, 2020). There have therefore been concerns about the consequences of the COVID-19 pandemic for the prevalence and severity of DVA and its impact, alongside the risk to survivors associated with reduction in support from both specialist organisations and universal services (Graham-Harrison et al, 2020; Sánchez et al, 2020; ONS, 2020b).

In March 2020 measures implemented in the UK to restrict the spread of COVID-19 drastically changed many aspects of daily life. These included social distancing restrictions, self-isolation, quarantine, national and local lockdowns, and closures of places of leisure, education and work. The media and public health messages, including prime ministerial broadcasts drew attention to the issue of DVA (Williamson et al, 2020) and a national campaign #YouAreNotAlone was launched by the Home Secretary in April 2020 (Home Office, 2020). In England, Women's Aid, a national charity working to end DVA against women and children, described the situation as 'a perfect storm' with many features of the pandemic preventing or severely reducing routes to support and places of safety (Davidge, 2020). Restrictions on movement and social contact were described as intensifying abusive behaviours (Bracewell et al, 2020; Kofman and Garfin, 2020), while limiting access to support services whose operation was affected by restrictions (Usher et al, 2020; Peterman et al, 2020). Increases in calls to national DVA helplines were reported (ONS, 2020b; Refuge, 2021) although there is uncertainty as to whether this reflected increased DVA rates or increases in the severity of DVA alongside restricted access to other forms of support (ONS, 2020b; Harvard, 2021).

In addition, victims/survivors experienced additional forms of abuse specific to the pandemic, such as perpetrators using restrictions as an excuse to prevent child access, not return children or threatening to expose women and children to the virus (Davidge, 2020). Research also highlighted the loneliness of survivors (Goodman and Epstein, 2020). Domestic homicide figures were reported to increase between April and June 2020 (Ingala Smith, 2020; ONS, 2020b). At the start of the pandemic there was concern that children living in abusive households would experience increased DVA (Children's Commissioner for England, 2020; Davidge, 2020), although referrals to specialist services for children appeared to reduce in the first lockdown (Donagh, 2020). However, at this short distance from the experience of lockdown, it remains difficult to distinguish whether lower service use reflected low levels of need or restricted access to services.

The UK government acknowledged that the order to stay at home caused anxiety for those who were experiencing or at risk of DVA (Home Office, 2020). Updated guidance addressing the needs of DVA victims was released in April 2020 (no longer available) and further updated throughout 2020 and 2021 (Home Office, 2021). This guidance included exemption from social isolation for DVA victims who needed to leave their homes and provided details of support services. The government announced additional funding for the national DVA helpline and for DVA services to provide online support (Harvard, 2021). While these measures were welcomed, government support arrived in a context where DVA specialist services had been consistently cut and underfunded for many years (Barter et al, 2018; Gregory et al, 2021). Specialist services remain insufficient and unsustainable while statutory provision is also being reduced and demand is increasing (Davidge, 2019). There are also particular concerns for DVA services with respect to supporting Black and minoritised communities (Barter et al, 2018; Thiara and Roy, 2020) which have been particularly affected by austerity measures and the pandemic (Imkaan, 2020).

As access to specialist DVA services, statutory services and healthcare provision has been restricted, professionals responding to DVA have faced new challenges and demands imposed by the pandemic (Moreira and da Costa, 2020). DVA specialist services have reported reductions in delivery or slower responses due to COVID-19 (SafeLives, 2020; Thackray et al, 2021; Cortis et al, 2021). There have been concerns that opportunities to identify and support children experiencing DVA were constrained, particularly during lockdowns when schools were closed (Crawley et al, 2020; Hefferon et al, 2021).

Many services that have typically been delivered face-to-face adapted to online and remote delivery in the pandemic (Martin et al, 2020; Joshi et al, 2021; Stanley et al, 2021a). Prior to this, online interventions for survivors tended to focus on immediate help-seeking rather than recovery (Rempel et al, 2019). Digital delivery can be useful where service providers and service users have access to the necessary technology and the skills to use it (Tarzia, 2018; Joshi, 2021) and remote service delivery can improve flexibility and availability of services (Bracewell et al, 2020). However, there are concerns about replacing face-to-face contact with remote and digital delivery, especially regarding survivor safety and risk assessment (Cortis et al, 2021). Thackray et al's (2021) early findings confirm that, during the pandemic, digital poverty prevented access to services, so exacerbating existing inequalities for marginalised women experiencing DVA. Furthermore, remote working and digital service delivery have an impact on practitioners, with DVA staff working from home

reporting concerns about privacy, working environments and wellbeing (Bracewell et al, 2020; Emezue, 2020; Cortis et al, 2021). While other studies have examined DVA provision under COVID-19 from the perspective of staff (for example, SafeLives, 2020; Thackray et al, 2021; Cortis et al, 2021) or using surveys of survivors (Davidge, 2020), in this article we explore in depth the impact of COVID-19 restrictions by drawing on interviews with survivors and children using DVA services.

Methodology

Data is drawn from a large mixed-methods evaluation of DVA services undertaken with two major third sector DVA organisations in England from 2017 to 2021 (Stanley et al, 2021b). The services were designed in conjunction with survivors as part of a project designed to achieve 'system change' in service provision for women experiencing DVA through innovative service delivery, increased training for agencies and community awareness. The evaluation was funded by the Big Lottery's Women and Girls Initiative and evaluated new services in five sites: services designed by Women's Aid Federation of England were delivered and researched in three areas and SafeLives co-designed pilot services were evaluated in two sites. Services delivered directly to survivors offered primarily community-based support, including individual outreach or independent domestic abuse advisor (IDVA) support and recovery group work and with one service including refuge support. In two areas, the service adopted a model of 'whole family' support which included individual and group support for children aged 4 to 17 and work with perpetrators where couples wished to stay together as well as providing interventions for parents and their children to support parenting and family relationships.

Fieldwork for the wider evaluation was already underway when the COVID-19 pandemic began and methods were modified in response to the lockdown restrictions. Ethical approval was provided by the University of Central Lancashire's ethics committee. This article draws on data provided by adult survivors via interviews and focus groups, and from children's interviews completed as part of a series of family case studies. Individual interviews with adults were conducted by telephone and online focus groups were conducted using Microsoft Teams or Zoom. Children were interviewed either via Microsoft Teams or by telephone and interviews focused on their experience of using the service.

Individual interviews were arranged via the DVA service and practitioners contacted the survivor in the first instance to seek their permission to share their contact details. Steps were taken to ensure the safety of participants, including consultation with practitioners about preferred modes of contact and ensuring the survivor was safe and able to speak at the time of interview. Children were recruited via their mothers who also participated in the family case studies. Consent forms were delivered to participants by the service by email or in person for refuge service users, and verbal consent was obtained at the start of interviews. Both children and their mothers provided consent in the case of children's interviews. Group participants received at least one week's notice of the intended focus group. In all cases, it was made explicit that participation was voluntary. Groups were facilitated by two researchers and the team included a trained survivor researcher. All participants received a voucher to thank them for their time.

Interviews were conducted with survivors who had been using the service for at least six weeks with some having used the service for up to 18 months. Interviews explored

their experience of service provision, its impact on them and their family life and included questions about whether and how these had been affected by the lockdown and restrictions. The interviews were conducted from May to December 2020, a timespan which included two national lockdowns and regional restrictions. All interviews were transcribed and a thematic approach to analysis (Braun and Clarke, 2006; Saldana, 2013) was utilised to draw out key themes relating to the influence of COVID-19 on the experience of service delivery. Care has been taken to anonymise all participants.

Participant characteristics

Adult survivors were all female in line with the women and girls remit of the Big Lottery's funding programme. Fifty-seven individual interviews were conducted with adult survivors and five focus groups were conducted with 21 women. In total, data was gathered from 70 individual adult survivors since some women participated in both interviews and focus groups. The majority of survivors interviewed were white British (74%, 40/54 where this data was recorded) which was broadly reflective of the wider population in the five sites. Most were aged between 40–49 (45%) or 30–39 (36%). Only a small number (n=2) were still living with the perpetrator, fewer than in the service user group overall which is likely to reflect the availability of survivors to participate in the research. In the two sites that operated a whole family service, 84% had a child under the age of 18. Family case studies were conducted in these two sites: seven children participated: six children were interviewed and one submitted written information. The children were aged between 7 and 11 years old; four were female and three were male.

Results

Restrictions under COVID-19 resulted in the DVA services having to respond swiftly to the pandemic and develop innovative ways of delivering services to survivors and their children when face to face contact was not permitted. Findings are reported below using three main themes identified from thematic analysis: service users' responses to their experience of remote support; children's experience of remote service delivery; and finally the implication of the pandemic restrictions on survivors' opportunities for recovery.

Service users' responses to remote support

Service responses included providing one-to-one support by phone or video call to adults, and to a lesser extent, to their children; delivering adult recovery groups online; and sending out written information and materials to service users by post. While telephone support was already a feature of these services, online services were a new form of delivery which required the distribution of equipment to enable staff to work from home and new safety protocols to be established by the organisations. Most participants (76%) were already using the DVA service prior to the pandemic, but for a quarter of service users, their service use began during the pandemic. Participants were interviewed across the five sites: 53 participants were from the two sites delivering 'whole family' interventions. In these two sites participants received a mixture of interventions including group support (25/53, 47%), IDVA support

(18/53, 34%), and 14 received parenting interventions. In the three remaining sites, participants were using refuge (n=6) and outreach services (n=11).

Individual support

Most survivors who commented on remote service support under COVID-19 spoke positively of their experiences and trust in individual practitioners during this period was high. For example, survivors who had been using the service prior to the pandemic frequently reported that staff continued to support them during lockdown through regular telephone or online calls. Feeling connected to services through regular contact was important to survivors and helped to generate a sense that they weren't 'forgotten'. Understanding that staff were 'accessible' to women by telephone when they were needed was valued highly:

> It was about six months but [workers] did call me every couple of weeks, just for a check and see how things were, and whether I needed anything whilst waiting. So, I wasn't forgotten. (Survivor 11, Area 2)

> …during the Covid time and everything was on lockdown. They were accessible on telephone, on the phone. So, it was, I would say, a hundred per cent good accessibility, i.e. to pick up the phone. (Survivor 9, Area 3)

Consistent and regular contact from DVA services helped counteract feelings of isolation and helplessness for some women and was important for maintaining contact with services until face-to-face contact could be resumed. Telephone and online support were considered suitable temporary substitutes by most survivors who commented on this shift, although the survivor quoted below also looked forward to resuming face-to-face contact:

> It will take a lot of time to kind of get it to work but talking to someone online is, obviously, better than doing absolutely nothing. […] when things start to lighten up, they'll be doing more like actual interactive things… actually have someone in front of me, might be something that will help a lot more, rather than just online. (Survivor 12, Area 3)

This survivor described how telephone contact with staff had increased during lockdown, even though under normal circumstances contact would have been less frequent due to her group support sessions coming to an end:

> I was getting the odd phone call, but they've been more frequent in lockdown, understandably, you know, with domestic abuse going through the roof. Yes, and it has been really, really nice to have that contact, particularly during lockdown. (Survivor 15, Area 1)

Regular contact was important for promoting stability and maintaining relationships with staff and this required a flexible approach to ensure the needs of individual women were prioritised. This included an adaptable approach to the provision of practical support for families, for example help with accessing food and financial support:

> I wasn't working, and she actually helped me with the benefits, helped me with the support. She actually organised the parcel, we got food. So, she done a really good job, she was getting the information from talking to everybody. (Survivor 22, Area 1)

Most survivors in our sample were no longer living with their abusive partners and, for this reason, safety concerns in respect of remote delivery of services were not evident in the data. However, a few negative experiences were reported where survivors felt there had been insufficient contact with their allocated worker, attributable to COVID-19 restrictions:

> I just haven't had contact. But, obviously, I haven't initiated but there's been a Covid situation… I haven't chased it either. (Survivor 13, Area 3)

For this survivor, face-to face contact would have been preferable:

> I'm happy with the phone call but, obviously, I would like face-to-face (Survivor 15, Area 4)

Online group support

Prior to the pandemic, face-to-face groups were valued by survivors who spoke of the opportunities they provided for support and discussion. Group based programmes allowed women, particularly those who experienced social isolation, to reconnect with others and to form friendships and attachments with other survivors with whom they could share and reflect upon their experiences. Some survivors who had used the service prior to the pandemic were disappointed that face-to-face group sessions were postponed because of COVID-19 restrictions, particularly when, as this survivor notes, group activities enabled them to meet with others in the refuge setting and for children to participate in groups with their mothers:

> Well they… did like groups and like activities and that, where the whole house got together. I would love to be still involved in that side of it… obviously, because of Covid, everything stopped. (Survivor 15, Area 4)

However, where services were able to adapt quickly, group sessions switched from face-to-face to online delivery via Zoom. Women were invited to participate in online groups where they and their practitioners judged that it was safe and appropriate for them to do so and, where this was not the case, one-to-one sessions, via telephone or email, were offered as an alternative. Online group sessions were welcomed by several survivors who had already attended face-to-face sessions. Some described feeling relieved to be able to continue their group work online where relationships with other group members were already established:

> because the course, all the group mates knew each other, one another and we were happy to see other after a couple of months of being not in contact. And it was easier for [practitioner] to have groups because, you know, we knew all the participants. (Survivor 18, Area 1)

Others described online groups as more compatible with busy lives where work and childcare commitments meant that face-to-face sessions were not always practical:

> I haven't had to spend time, half an hour travelling somewhere and half an hour travelling back, so it's, it's slotted in quite nicely for me, so that's been a positive. (Participant, Focus Group 4, Area 2)

Online group sessions allowed for flexibility of access. One participant whose partner was also receiving support from the service participated in sessions using her mobile phone in her car. Group dynamics shifted in the online space. Some women attending remote group sessions had 'spoken more openly and honestly' than they would have done in more intimate settings while others described experiencing online groups as less emotionally exposing than face-to-face sessions:

> I was in my comfort zone in my room, so I felt safe there. Secondly, I can kind of just close the camera and, like if I cry or something, so I feel, again, safe, you know… the thing with people, like their smells trigger me, movements trigger me… It's just hard for me, until I'm used to them. (Survivor 28, Area 2)

Although online groups were welcomed by some women, others missed the opportunities that face-to-face groups provided to talk informally and build relationships or to offer physical comfort.

> I know because of Covid it makes it a bit different but when you see them upset it's really sad that you can't sort of offer them a bit, a hug or something, yeah, because it's really hard when you see them on the screen upset. (Participant, Focus Group 4, Area 2)

Some women accessing groups in the family home felt that online groups did not offer the space or the privacy of face-to-face groups outside the home and were concerned about their children or current partner overhearing discussions:

> So I know that I've not said things I might have said if I was in a room just with these guys. So yes, I definitely know I've held back, if you know what I mean, because, just in case, you know, or because people are like popping in and needing something or whatever […] and you know what kids are like, they listen. (Participant, Focus group 2, Area 2)

While there were multiple issues with remote service delivery for adult survivors, practitioners were able to continue to deliver a modified service to the majority of service users. There were greater difficulties in providing services to children during lockdowns as the next section will explore.

Children's experiences of remote service delivery

The second key theme identified in the analysis concerned children's experience of remote service delivery. There were challenges in delivering remote services to

children during the pandemic. Lockdown had interrupted several family-focused interventions which were delivered in two of the evaluation sites, due to restrictions on group gatherings and temporary closure of venues. Although efforts were made to connect with children individually, restrictions on visits which usually took place in school or home meant that support for children was often suspended. Where staff were able to continue contact with children, mothers reported that practitioners tried a range of methods to speak to them, such as meeting outdoors (when restrictions allowed) or by video or telephone. In most cases, children had already met with the practitioner in person before switching to remote support, which was felt to facilitate the move to a different format of support.

Some children were supported with general anxiety and worries, as this mother described for her seven-year-old daughter:

> she was like saying she's obviously quite worried about a lot of things but I think that was more to do with coronavirus and everybody dying and she'll be on her own. More [than] to do, with domestic abuse, but [worker] has been lovely and was able to talk to her about things and then also talk to me about how we can talk about things and draw things down or talk to the teddies and things. (Survivor 16, Area 1)

This also illustrates how practitioners strengthened mothers' support for children. Children and young people's workers adapted their existing approaches and toolkits for working with children remotely where possible, for example, posting children activity packs to be completed during their next video call. The survivor quoted below describes the worker undertaking 'Helping Hands' safety planning work (identifying safe adults in a child's network) and a 'dream catcher' activity used to prompt discussion of children's concerns such as sleep difficulties:

> how [worker] did helping hands and dream catchers over Facetime, I've got no idea. […] So my hat goes off to that lady. How she managed to do that, I guess my son can follow some instructions! (Survivor 30, Area 2)

This parent went on to describe how online delivery was also helpful for engaging her other, older child noting that online communication afforded her daughter increased freedom and control within the counselling session:

> She could walk around her room, she could look out of the window. She had the ability to move around and, yes, I think not having someone sat right opposite you, took the pressure off for her and gave her the ability to open up. (Survivor 30, Area 2)

Being responsive to children's needs and ensuring children felt safe and relaxed in their preferred environment meant that children were more likely to engage and benefit from support sessions. However, there were challenges in delivering support remotely to children. Younger children in particular described missing face-to-face contact with their worker due to COVID-19 restrictions. This child who had received sessions via video calls would have preferred in person visits:

> the only thing was I would like to have seen her [the worker] here. But Corona meant she couldn't come to see us anymore. (Child, Case Study 5)

For some children, continued lockdowns later in the year had interrupted planned work and impacted on their relationship with their worker. For example, one mother explained how cancellations to appointments, as well as missed appointments, had been 'disruptive' for her daughter:

> it has been very on and off and it has been quite, I would say, it's been actually quite disruptive to [my daughter]. I don't think it's been a particularly positive experience in some respects because she's been let down a few times. (Survivor 29, Area 2)

While individual work was possible in some cases, for some it was not considered suitable due to the age of the child:

> they're trying to do some stuff with the boys but obviously they're saying that [five year old son] is too young to do a Zoom call and they're going to look at doing some work with me and [older child] together. (Survivor 24, Area 2)

Furthermore, group work with children was not possible, due to lockdown restrictions and concerns from service providers about the safe operation of online groups for children. This was disappointing for many families and contributed to a long waiting list for children in need of support:

> we wanted to do the one [groupwork programme] where we do it together. But then, I think, obviously, lockdown's just completely stopped every course. (Survivor 5, Area 1)

Opportunities for recovery

The final emergent theme concerned the impact of the pandemic on survivors' opportunities for recovery. Lockdown restrictions impacted on opportunities for recovery in different ways: for some, this time had been positive, but for others, service restrictions had a negative effect.

For those survivors not living with their abuser, restrictions on movement during lockdowns could increase feelings of safety and security. Women who had felt unsafe leaving their homes and worried about being followed by abusers who were familiar with their usual routines reported some respite from this during lockdown:

> I wasn't going to work, I wasn't going to my usual places to shop. So, I think, in some ways, we felt… much safer. (Survivor 23, Area 1)

Social distancing also provided a unique opportunity for survivors to sever unwanted social ties, which might have been difficult to achieve under normal circumstances:

> I mean I'm still trying to sort of get myself out of bad habits of, sort of getting used by people. What I'm tending to do now is distance myself a lot from people and lockdown has been great with that too. (Survivor 16, Area 1)

Several women reflected on the opportunities that COVID-19 restrictions offered in relation to space and time for families to 'stop and just be together' and to enable them to process and reflect on their abusive experiences. Having the chance to spend time with their children in safety was a significant part of the recovery process:

> I quite like Covid because of it, because it has meant that everyone has to have a simple life… you know, for me, actually, I needed this year to just be with my kids at home and get better. (Survivor 10, Area 2)

However, changes to service provision during the pandemic were reported to affect recovery for some survivors. Survivors noted that some additional services they had anticipated accessing, such as specialist counselling, were no longer available.

For some in refuge accommodation, the pandemic had resulted in a delay in the next stage of recovery since they were unable to move on to new accommodation:

> before all of this I was feeling like ready to get my own flat and I was confident going to work, I was confident thinking I can take [ex-partner] back to court. (Survivor 6, Area 4)

Post-separation abuse and contact with ex-partners under COVID-19 presented a significant barrier to recovery for survivors with some reporting delays and inadequate responses from the courts during lockdown. Progressing child contact arrangements with abusive ex-partners was particularly difficult without clear guidance and communication from courts about how to proceed:

> lockdown, that didn't really affect me so much but what it did affect was like the child arrangements that I have with my ex-partner, which became very difficult and I tried to go through the courts… it was so difficult because courts weren't open, not responding, so that was really, really challenging. (Survivor 26, Area 2)

This survivor had received telephone and email support from an IDVA, which included emotional support, and support with making safe contact arrangements with her ex-partner.

Discussion

Survivors valued the flexible support from DVA services at a very challenging time. For some, lockdown was an intense, anxious, and difficult period and the support of community based DVA services was a 'lifeline'. While flexible and individually tailored support has always been a cornerstone of DVA support (Howarth and Robinson, 2016), the pandemic prompted a major shift to online service delivery, which had not previously been a routine part of service delivery. Online sessions were convenient

for some survivors as they offered flexibility around other commitments such as work and childcare. Women's Aid (Davidge, 2020) have reported that working women and students found it easier to access online support during the pandemic.

The expansion of remote service delivery, however, has implications for reaching survivors who may struggle to access services such as those living in geographically dispersed areas, physically disabled women, and those with caring responsibilities. The survivors participating in this study were able to access remote service provision, which included telephone support. However while remote delivery offers considerable opportunity to increase access to support services, not all groups may be able to benefit equally from this; for example, older women and those lacking resources or living in 'digital poverty' without capacity to access technology such as laptops, smart phones or wifi (Emezue, 2020; El Morr and Layal, 2020; Thackray et al, 2021). This has also been highlighted as a factor by specialist DVA organisations, such as Imkaan (2020) who note that Black and minoritised women may experience multiple barriers to accessing services, including a lack of access to technology and limited availability of information about services in languages other than English. With this in mind, Thackray et al (2021) emphasise the need to carefully consider which elements of service might continue to operate remotely and which should resume face-to-face support post-pandemic.

The use of video call-based technologies allowed some survivors and children to feel more in control and some reported that it was easier to express their feelings online and manage difficult conversations. This reflects Pink et al's (2021) finding that such renegotiation of power dynamics can generate trust between individuals and their workers. This finding also has implications for future service delivery, particularly for survivors suffering with anxiety and other mental health difficulties which may create barriers to accessing traditional face-to-face settings (Davidge, 2020); digital services can offer survivors more control and choice (Tarzia et al, 2018). However, some elements of group work such as immediate and ongoing peer support and friendships were limited by online delivery, and services may wish to consider how to promote this through online or social media platforms, or by blending online and face-to-face meetings where possible.

Services were able to provide remote support to some children at home and this was facilitated by creative and flexible approaches from DVA service staff; these approaches seemed to be more effective where there was an established positive relationship between the child and practitioner, a finding consistent with other research undertaken during the pandemic (Racher and Brodie, 2020; Pink et al, 2021). Furthermore, as Martin et al (2020: 36) note, the relationship is a 'crucial component' of effective online interventions for children. This study has shown DVA practitioners to be innovative and resourceful in utilising a range of methods to maintain children's engagement and deliver support. In future, children may prefer to choose from a 'menu' or mixture of service delivery methods, as others have suggested (for example, Pink et al, 2021). However, not all children were able to access support due to service providers' concerns about the age of the child or about how to safely deliver interventions exploring children's experiences of DVA online, or due to reluctance from children themselves, and these barriers have been identified by other international studies of DVA service delivery under COVID-19 (Stanley et al, 2021a). This indicates a need for careful piloting of online services for children.

Survivors reported delays in court processes and contact arrangements which prolonged difficulties which they were experiencing, as seen in other studies and

reports (Bracewell et al, 2020; Davidge, 2020; SafeLives, 2020; Stanley et al, 2021a). Such factors, combined with the reduction in support for children during the pandemic, will extend the recovery period for some survivors and their children. This suggests that a greater demand for services for survivors and families will be experienced in future, with implications for already over-stretched services. Moreover, there is concern that survivors may require support for more complex and entrenched trauma associated with the experience of DVA under lockdown (Davidge, 2020). However, the pivot to remote delivery may offer DVA and other organisations the opportunity to deliver services in a wider range of formats acceptable to survivors and children.

Limitations

This article has presented findings from research interviews conducted during the pandemic. The research team adapted existing evaluation methods to ensure research processes and interviews were conducted safely. DVA practitioners worked closely with researchers to identify potential participants and assist with recruitment to the study. However, due to ethical and lockdown restrictions we were only able to speak with those survivors who felt safe to speak on the telephone. Those survivors who chose not to participate in interviews may have included women experiencing difficulties accessing DVA services during the pandemic, those with negative experiences of services, those who were experiencing digital poverty and had struggled to access online support or those for whom face-to-face interviews, outside of the home environment, would have been preferable or safer. For example, two services included in the study worked with service users with complex needs and survivors still living with the perpetrator but there were few women with these needs represented in our sample. The adaptations to the evaluation during COVID-19 restricted the ability to interview children face-to-face and thus only a small number of case study interviews were conducted. Finally, while the sample of service users was drawn from those accessing DVA services in five sites across England, the participants were predominantly from a white British background (reflecting the ethnic make-up of the sites included in the study) with most aged 30–49, reflecting wider service user characteristics.

Conclusion

Survivors and their children were able to derive benefit from remote service provision during the COVID-19 pandemic in 2020 and the creative and flexible response of specialist DVA practitioners was evident. DVA services rapidly adapted to the COVID-19 pandemic, despite the lack of a blueprint for doing so. However, while this was often a positive experience for those interviewed, this may not be the case for all users of DVA services, including those still living with abusive partners who were under-represented in this sample. Challenges were identified in relation to remote support for children and providing group-based peer support and recovery work for women. In the longer term, the experience of sustaining DVA services during the pandemic has demonstrated the potential for remote service delivery to become an integrated part of DVA provision, however consideration is required to ensure that remote options are acceptable and feasible especially in respect of children. This will need careful work to adapt, create and systematically pilot online support options before these can be confidently offered and taken up as part of routine service delivery.

Further research is needed to address these issues in relation to support for children. In the longer term, service providers should consider how best to incorporate a wider choice of support methods, including online methods, in delivering services for women and children.

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Conflicts of interest
The authors declare that there is no conflict of interest.

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