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Title: "We adapted because we had to." How domestic violence perpetrator programmes adapted to work under COVID-19 in Australia, the UK, and the US.

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Purpose – This study explores responses by domestic violence perpetrator programme providers of three Western countries (UK, US, and AU) to the COVID-19 pandemic and population movement control measures on their practice. The goal of this work was to offer an evidence base for changes to programme and intervention delivery around domestic violence to sustain integrity of safe, effective working practices with perpetrators, survivors, and staff.

Design/methodology/approach – Based on 36 semi-structured qualitative interviews conducted July to September 2020, the authors mapped the experiences of changes in service with frontline staff, managers, and sector-wide representatives.

Findings – The findings focus on how providers of Domestic Violence Perpetrator Programmes (DVPPs) adapted to the increase in referrals and workload that had a positive impact on service delivery innovation but an adverse impact on staff wellbeing. Digital services were reported to be adopted into mainstream approaches but introduced new barriers to service access and group dynamics. Integrated safety support for survivors, if not adequately connected to programmes pre-pandemic, risked being disconnected from DVPP that may undermine positive programme outcomes.

Originality/value – The paper provides a documentation of changes in DVPPs, and a cross-comparison of services across three Western countries during the first wave of COVID-19. The work offers implications of the development of digital modes of service delivery for DVPPs and highlights the need for focus on resource management and integration of safety services for survivors in DVPP services.

Keywords: Domestic violence perpetrator programmes; Intimate partner violence; Digital service delivery; Global pandemic; Practitioner perspectives; Perpetrators of domestic violence

Article Type: Research paper

"We adapted because we had to." Domestic violence perpetrator programmes during the COVID-19 pandemic in the UK, the US, and Australia.

Introduction

Intimate partner violence (IPV) during the COVID-19 pandemic has been described as the "shadow pandemic" (UN Women, 2021; Usher *et al*., 2021) and the 'perfect storm' (Women's Aid, 2020). The isolation of victim-survivors with those who caused them harm, combined with sudden surges in unemployment, income loss, and mental health conditions are all factors that consistently link the pandemic with increasing the risk of harm to victim-survivors (Moreira and Pinto da Costa, 2020). Pandemic-specific forms of abuse used by perpetrators have also been reported, such as using household mixing bans and the threat of infection as a means of 'weaponising the pandemic' and further isolating the survivor from support networks (Women's Aid, 2020; Heward-Belle *et al.*, 2021; Westmarland *et al.*, 2021). However, the perpetrators of abuse, and the role of practitioners providing perpetrator intervention services have been largely absent from research (van Gelder et al., 2021).

Domestic violence perpetrator programmes (DVPPs), known in the US as Batterer Intervention Programmes (BIPs) and in Australia as Men's Behaviour Change Programmes (MBCPs) are used in many countries to reduce the perpetration of IPV and to increase the safety of victim-survivors and their children. Programmes are run over a period of three to twelve months, normally consisting of weekly group sessions that provide the pro-social environment conducive for reinforcing non-violent behaviours. Although controversial, multi-site studies of established, well run programmes, integrated into wider systems do show a number of positive benefits (Westmarland and Kelly, 2015; Gondolf, 2001). Before COVID-19, such programmes were almost exclusively run as in-person interventions. An international scoping of English-speaking countries found only a handful of attempts to operate outside of this model. First, an Australian 'e-learning' type self-paced programme with no 'live' sessions which appears to be no longer running (though we are aware of others in development); second, a pilot in the US which attempted to recreate a 'live' groupwork programme using video conferencing technology (evaluated in Bellini and Westmarland, 2021), and third a small collection of self-paced, remote learning 'lessons' offered in the United States (US) which, as Vlais and Campbell (2020) point out, would not meet state-based mimium standards.

Although there may be benefits to developing 'online', 'digital', or 'remote access' perpetrator programmes, there clearly exist many challenges and risks. These challenges include digital barriers to participation, privacy concerns, and the ability for victim-support services to be properly integrated (Bellini and Westmarland, 2021). Coupled with the context of COVID-19, concerns have been raised that elevated safety concerns for victim-survivors may go overlooked (Ivandic et al., 2020). As Vlais and Cambell (2020) concluded, "the lack of research on the safety, appropriateness and effectiveness of videoconference group-based MBCPs means that a cautious approach is required" (p. 19).

When COVID-19 was declared a global pandemic in March 2020, there were many clients already engaged in perpetrator programmes across the world. While much of the attention

was on victim services (Pfitzner et al., 2022; van Gelder et al., 2021), perpetrator programmes also had to adapt to the new way of working. This was the primary aim of the research - to understand how perpetrator programmes in Australia, the UK and the US adapted their work during the first six months (March to August 2020) of the COVID-19 pandemic.

Methods

The United Kingdom (UK), United States of America (US) and Australia (AU) were selected as countries for comparison. Each country has established IPV sectors, legislation that criminalises IPV and contain federal/national coordination organisations. As national approaches to containing, mitigating, and eradicating the impact of COVID-19 were also economically and politically driven, all three countries also maintain liberal market economics, and leverage two-party political systems to enact policy change. However, there were also key differences, such as how DVPPs are funded and regulated. Another key difference was how the countries responded to COVID-19 and therefore how much the 'first wave' impacted on the work of perpetrator programmes. The UK had a legally enforced 'lockdown' from 23rd March 2020, one of the highest numbers of deaths in Europe, and only started opening social spaces and very restrictive household mixing from June 2020. The US declared a state of national emergency on 13th March, was state dependent in its measures, and suffered a very high death toll. Australia also declared emergency measures in March 2020 – naming it a human biosecurity emergency. Stringent measures for returning residents in lockdown hotels resulted in a far lower-case rate and death rate in Australia during this six-month period than in the UK and USA.

The authors sought respondents with experience of working as practitioners or managers of frontline services in their work with perpetrators. Representative, non-government organisations (UK, US) or 'peak bodies' (AUS) were also approached for further recommendations of participants to add to the sample. Semi-structured interviews were conducted between July and September 2020 with a purposive sample of 36 practitioners from specialist IPV services across the United Kingdom (England and Wales, Scotland, and Northern Ireland), the United States and Australia (Western Australia, Northern Territory, South Australia, Queensland, New South Wales, and Victoria). 14 (4 male, 10 female) participants were from the United Kingdom with 12 (4 male, 8 female) participants from the United States and 10 (4 male, 6 female) participants from Australia.

[Table 1: Participant Demographics]

Participants were asked to define the challenges experienced by their organisation pre-COVID-19 (pre-March 2020); describe how these changed during COVID-19 and how their services had adapted with specific reference to referral rate, staff capacity and use of digital technology; and identify any future challenges. Interviews lasted between 55 and 110 minutes, with a median of 68 minutes. Interviews were conducted on video-conferencing platform Zoom, with a small number of interviews (4) conducted via Go-To Meeting and Teams in accordance with the privacy policy of the organisation. All audio recordings and transcripts were stored on an

encrypted, password-protected cloud server. Ethical approval was attained from the [anonymised for peer review] Ethics Committee.

All interviews were transcribed and analysed using Braun and Clarke's (2019) Reflexive Thematic Analysis (RTA). The transcripts and interview notes were re-read and then an initial round of coding was conducted (e.g., *rising demand*, *thinking creatively, accessing adequate technologies)* by going through each transcript line-by-line. This stage was then followed by a focused round of coding to merge and hone the codes of each transcript. As RTA positions subjectivity as a strength rather than a risk, inter-rater reliability was not calculated.

Results

We report our findings in line with the five themes we identified in our analysis: Staying with the stress; From the fringes to the mainstream; Shifting the group dynamic; Thinking (way) outside the box; and Forcing the cracks, bridging the gaps.

Staying with the stress

All participants reported a substantial increase in pressure to deliver essential services to existing perpetrators in their service and to be able to take on new referrals from other services. A noticeable geographical difference across our participants was the level of dependency on referrals to DVPPs through law enforcement such as criminal courts and policing – which was far higher in our US sample. All participants reported an initial slowing or even cessation of court-mandated referrals to DVPP due to criminal court closures, followed by a rapid increase in number of referrals in the following months:

> "The court stopped so referrals went down or stopped entirely but now we're paying for it as they've all come in again … there's been a renewed drive for police call out to people's homes … we've had more referrals last month than we did last year!" (P26, Frontline Practitioner, AU)

Three participants from the UK felt that the cases being referred to them were higher risk cases as compared to previous months:

> "We have noticed a lot more high-risk cases … there was also a significant increase of perpetrators seeking support for their relationship during lockdown. It was intensive, some people were known to us already and some new; maybe about a 60/40 split?" (P10, Manager, UK)

The shift in referral patterns away from statutory organisations was paired with increased levels of self-referrals made by perpetrators rather than third-party intervention - particularly in AU and UK. A peak body in AU, speaking on behalf of their members, reported that both existing and new perpetrators to their services were more engaged. This was at all levels -

attendance on DVPPs and evaluations, phone contact with support workers and self-referral to other community services (e.g., mental health services):

> "There is a higher uptake in level of engagement, and far more active engagement of new and existing clients making contact with the services themselves … that's been a significant difference for us in that they [perpetrators] are identifying an escalation of risk to others" (P31, Manager, AU)

While we did not identify any US participants reporting a rise in self-referrals, most likely due to their greater dependency on court-mandated referrals, many organisations highlighted positive changes in perpetrator patterns of communication when moving to remote or virtual methods of service delivery:

> "Our clients suddenly became a lot more curious and engaged, and they are a lot more talkative than maybe they would be normally. I'd like to compare the guys we might get now to the guys we work with over this time … only time will tell if this openness continues" (P18, Frontline Practitioner, US)

Nevertheless, this rise in referrals and engagement appeared to be highly time-sensitive to the length of time in-between initial referral and enrolling on a DVPP. As many groups reduced their size in an attempt to improve the conversational quality of remote access DVPPs, this had the compounding effect of increasing the waiting list of perpetrators to be assessed for suitability and risk, and then enrolled on a programme:

> "They [perpetrators] saw it as an opportunity to not do what they had to, so people just dropped off the face of the earth" (P1, Manager, UK)

A rise in referrals to perpetrator programmes could be viewed positively – as indicative of increased awareness by perpetrators of the need for support to reduce their abusive behaviours and in increased recognition in identifying IPV from professionals. However, from our participant accounts this appeared to be a 'double-edged sword' where demand struggled to be met to address this increase.

From the fringes to the mainstream

With the introduction of nationally enforced lockdowns and a closure of non-essential services in the first wave of the pandemic for the UK and the US, and later in AU, all services reported uptake in a variety of digital services to replace in-person work. This is in stark contrast to how work was conducted previously. Participants reported that their services were mainly able to adapt quickly. Video-conferencing software such as Zoom (21 organisations), Teams (10 organisations) and GoToMeeting (3 organisations) proved to the most frequently cited method of communication to facilitate these interventions. In cases where it was not deemed safe or suitable, phone calls (21 organisations) and email/live webchat (3 organisations) and/or texting-support (1 organisation) were used as an alternative to

groupwork interventions. Sometimes these were also utilised as an additional, complementary approach to the remote access DVPPs. Previously, organisations had not tended to take this approach. Digital service delivery was frequently described as experimental and considered on the 'edges' of work with perpetrators and to be used with caution:

> "It was at the fringes of work with men [perpetrators], we did some phone work with our survivors when there was a need for it, but I can't think of anyone who did the same with the men … when you're not co-located with them, heated debate could be left at a high point and you can't bring them down again" (P19, Frontline Practitioner, UK)

Participants in the US explained that they considered digital approaches prior to the pandemic to be 'off the table' due to the heightened levels of risk for victim-survivors. Alternatively, some positioned digital services being seen as additional work to existing service delivery that would take up capacity:

> "Digital wasn't even on our radar, we were so stretched with our frontline services … we didn't even think it was an option for us and we're surprised that it exists" (P18, Manager, US)

However, there was a significant difference between the practitioners in the UK, US, and AU in terms of practitioners' comfort/confidence levels with using digital technologies as a method of service delivery. Interestingly, all the AU DVPP involved in this study reported using digital technologies as a means of direct service delivery citing significant travel distances involved and employment statuses for perpetrators - such as 'fly in, fly out' workers – to attend in-group sessions. This appeared despite direct opposition from the sector:

> "Showing digital alternatives to in-person groups has always been met by apathy from the sector, excuses from participants and a lack of buy in from the system … there's a misperception that either it's an in-person group or nothing. They're not the same, but these men need something!" (P7, Frontline Practitioner, AU)

Such online spaces permitted flexibility of access and all countries noticed the shift in the group dynamics with the translation to online work between staff members:

> "Nobody that I've talked to likes doing zoom groups … they say that they are not as effective, there's too much downtime and they can't wait to get back into in-person groups … it's not what people are trained for and there's a real divide between how tech savvy our workers are." (P24, Manager, US)

Shifting the group dynamic

Most practitioners spoke positively of the ability to communicate and deliver essential services using digital methods under challenging COVID-19 restrictions. However, as identified across our UK and US participants, frontline practitioners reported a notable shift

in group dynamics when translating in-person group work to online contexts; citing being unable to guarantee stable environments for perpetrators enrolled on the programme. For instance, participants highlighted the increase of interruptions, such as loss of signal, loud street noise, and a rise in what some described as 'casual engagement' by the men, resulting in a change to rules of engagement in DVPP sessions:

> "We had to make new rules, some men were lying in their bed and some facilitators didn't mind but we really did … we don't mind some eating or drinking, but no alcohol, all things that wouldn't come up in [in-person] group that we had to watch out for" (P15, Frontline Practitioner, US)

On occasion, these dynamics proved so difficult to work with that some providers, most notably in the UK more than their US and AU counterparts, defaulted to more individualised, one-to-one work:

> "It's been challenging getting people engaged at the right time … we did try online groups but as soon as a minority fall out, we can't run them and then suddenly we don't have a programme. We are sticking for one on ones for now" (P30, UK, Manager)

In this way, there was a shift in the power dynamic away from intensive group DVPP sessions with two facilitators of one to two hours with six to twelve men, to intensive, one-hour sessions that reportedly 'doubled the work'. While we did not notice this shift in AU participants, the impact of reducing group size still had a notable impact on staff scheduling and work patterns:

> "The challenge now is having enough staff to do all the calls, the numbers are always blowing up, but we can't work with everyone at once … half the size is double the work for the facilitators … it's just about manageable but for how long?" (P21, Frontline Practitioner, AU)

As facilitators that were already reporting stretching capacity, this shift from group work to individual work is significant for DVPP due to the loss of positive reinforcement of social norms from other men on the group, and for facilitators to have 'back-up' from a second facilitator:

> "The one-on-one stuff, it's hard … in a group if someone says something unacceptable or inappropriate, the facilitators and the others might challenge it … on a phone call it's just you and them … there are days where I say the same things over and over to different men …" (P4, Frontline Practitioner, UK)

Present in these accounts was a prominent sense of exhaustion of performing similar behaviours in isolation and the extended working hours required for working with perpetrators individually:

> "The intensity of working online cannot be understated, the fact there's engagements back-to-back, there's no time in between because you have to process everyone … we'll experience a second-wave of exhaustion before long" (P16, AU, Manager)

Thinking (way) outside the box

Evidence-based approaches of safely working with perpetrators face-to-face were unfeasible, inaccessible, or illegal across several time periods of the first (UK, US) and second wave (AU) of COVID-19. In navigating these barriers to service delivery, participants leveraged creative approaches to reaching perpetrators for a virtual DVPP when perpetrators lacked the required technologies (e.g. smartphone, laptop, tablet), services (e.g. internet, mobile data) or private environment to engage from (e.g. semi-/permanent abode, quiet room). For UK and AU participants, this required careful coordination with other community services:

> " … we had to ensure the victim wasn't nearby so we got creative and we would ask the perpetrator to take their daily walk and talk with us to ensure that they were out of the house so that the [integrated safety support service] could do a session with them … it was great, but it was really time-consuming and tiring as well." (P5, Frontline Practitioner, UK)

Creativity around engagement for US participants, potentially due to the larger quantity of fee-paying programmes, meant many 'outside of the box' methods were leveraged around the use of cars, vehicles, and public spaces. This included using the car as a direct means of bridging the gap between access to technology and the need for privacy:

> "In some cases, the people we worked with had the tech … but they didn't know how to use it, they might have an iPhone but couldn't install software on their laptop. We worked with an IT company to transform our car park into an external wireless access point – we now have a drive-in hotspot!" (P27, Manager, US)

Even without the use of digital technologies, we saw evidence of our US participants describing perpetrators' use of the car and the parking lot to 'meet' safely, at a distance and exchange money, emergency packages (e.g., such as food, toiletries) when gatherings were discouraged or disallowed dependent on the state:

> "As an organisation, we do a safe exchange every 10-14 days for guys who are new, and my spouse will go out to them with a mask on. They will have to roll down the window, put the money on the passenger seat, he will count it in front of them, then he will put our workbook in the passenger seat." (P13, Frontline Practitioner, US)

These changes in service due to the impact of COVID-19 had a constructive impact on the psyche of many managers and frontline practitioner in our sample, reporting the 'shock to the established system' nature of a rare and impactful societal event:

> "We can still pull something positive from this. Covid has given us an opportunity to change the way we work. You can't keep doing the same shit and expecting the same outcome." (P29, Manager, AU)

Peak body organisations across all countries in our sample were cautious about promoting these changes to services due to a lack of documentation, monitoring, and ability to identify best practice from a non-existent evidence base. Nevertheless, some peak bodies tentatively highlighted that these changes could bring benefits to monitoring and evaluation:

> "… we want to get to a place where accredited programmes can be monitored a bit more, technology opens new avenues for that. At a programme level, programmes hold their participants accountable, but we hold programmes accountable; we need to be as forward thinking as we can" (P22, Manager, US)

Forcing the cracks, bridging the gaps

The pandemic proved to have a consistently negative impact on the ability to coordinate between DVPP providers and other essential services, as integrated safety services (ISS) and other community organisations (e.g., healthcare, policing). Services for victim-survivors of IPV that worked in tandem alongside the DVPP were identified as an essential insight into a perpetrator's behaviour outside of the context of the programme:

> "Some survivors took us up the offer [of ISS], some didn't, it's not compulsory … we have our integrated safety support and the men's behaviour change worker got together and compared accounts so it gives us better insight … that way we could see what was actually going on" (P10, Frontline Practitioner, UK)

Changes to service provision during the pandemic were reported to negatively impact the ISS pathways to victim contact for most services in our study. One experienced manager of a DVPP identified the closure of schools and in-person victim-survivor services due to lockdown measures to be compounding factors to reaching partners, particularly when perpetrators were attending a DVPP remotely:

> "It's been a challenge for many of our partners for survivor support, particularly with men living with their partners and children … you can never be sure there isn't eavesdropping happening and there is no privacy so you can't get an easy honest answer." (P28, Manager, AU)

We found this concern around eavesdropping and overhearing of DVPP work in domestic environments to be validated by accounts from other countries, specifically US participants. Concern was expressed around a victim-survivor challenging what a perpetrator participating in DVPP may share in the programme but be unwilling to discuss with them:

> "We did a phone around of partners of the men on the programme. We asked, 'would you bring things up that you heard your partner say?' 'Would you do it if what they said untrue?' All of them said yes." (P11, Frontline Practitioner, US)

With the challenge to establish strong lines of communication between survivor services and DVPP, or for programmes without pre-existing established links, some practitioners took it upon themselves to reach out to survivors to perform safety assessments. We however noticed that this predominantly included questions around the DVPP, rather than providing a broader space for enabling space and time to reflect on their experiences of abuse as this practitioner demonstrates:

> "We want the household members to know that the men need a two-hour session by themselves, and we didn't want the partner to be concerned at who they were talking to … the victim has never said "this video-conferencing service is causing havoc for me", to be honest it seems like the least of their concerns" (P14, Frontline Practitioner, AU)

For some DVPP coordinators, communicating effectively with other services also proved challenging without clear guidance and communication from agencies on how to proceed without valuable data to establish risk:

> "If you have a gap in your coordinated community response, this pandemic is going to really highlight that gap and you can't fix it … our greatest barrier is being unable to perform risk assessments for perpetrators as we can't just go to the police department to get the data, that's closed … it's not just one agency either" (P12, Manager, US)

Discussion

Our study extends the knowledge base in this area by documenting the changing trends in DVPPs for perpetrators of IPV during the initial period of the COVID-19 pandemic. Due to a dearth of perpetrator-focused studies, as highlighted by other scholars (Ivandic, Kirchmaier and Linton, 2020; WWP European Network, 2020; Bellini and Westmarland, 2021), we draw on wider practitioner studies in the IPV field across the UK, US, and AU contexts to draw actionable implications for practice and research. Previous reviews of IPV interventions for victim-survivors have validated the fragmentation to group delivery witnessed in this work, also reporting significant changes to participant dynamics (Usher et al., 2021). However, such practice with victim-survivors did not result in a change to rules of engagement nor a rise in unprofessional behaviour from attendees – marking this as a unique aspect of the change to perpetrator work. Future work is needed to understand perpetrators' perspectives when joining DVPPs from domestic environments, guided by the knowledge of the online disinhibition effect to mitigate disruptive behaviour.

In the UK, a sector shift in focus from group-based to individual-based work may be cause for concern, even in the short term. This is due to the raised risk of collusion between

perpetrator and facilitator, and the increased workload in performing similar work with less individuals that exacerbate technostress and burnout (Pfitzner et al., 2022; WWP European Network, 2020). In line with Bellini and Westmarland (2021), the gap between linking DVPP interventions and ISS still remains prominent, potentially undermining positive outcomes reported by the use of programming. We suggest investigating what qualities of DVPP are supportive of ISS, particularly when these services may not be physically co-located. We see a great potential in jointly addressing the concerns of ISS integration and vicarious trauma by designing complementary ISS/DVPP processes to reduce the replication of work.

Our participant accounts offered interesting insights into an overlooked variation of the digital divide in IPV service provision; the emergent divide between practitioners with technical competency and those without. This was notable at the country-level, where AU interviewees reported greater confidence in technical methods due to earlier adoption than the US and the UK, and at the service-level where members of staff expressed dissatisfaction at the requirement to be 'tech-savvy'. As underlined by Cortis et al. (2021), it is important to restate that services innovated out of necessity rather than choice meaning new and untested practices may jeopardise prior evidence-based decisions regarding training and mentorship in IPV services. Greater support should be placed into ensuring that non-digital methods and expertise do not get side-lined with the professionalisation and digitalisation of support work with grassroot origins (Vera-Gray, 2020). Further research could investigate the temporal effects of the performance of digital and in-person activities or hybrid models, scrutinising the retainment rates, level of engagement and positive outcomes for survivors.

Documentation of any changes to approved DVPP programming is vital for maintaining programme integrity and safety planning (Vlais and Campbell, 2020; WWP European Network, 2020), so as with the move to digital mechanisms of delivery it is understandable how peak bodies across each country saw potential avenues for improved surveillance. Nevertheless, digital systems, particularly primarily corporate-based video-conferencing software services, may promote assessments that prioritise quantifiable and outcome measurements (e.g., meeting time, time spent on activity) in the name of efficiency; metrics that can run counter to victim-survivor(s) safety and wellbeing (Westmarland and Kelly, 2013). Such measurements should be handled with care, but may provide a secondary, complimentary source of information to existing workflows that can add to a risk profile of a perpetrator. Technology-mediated service delivery rarely remains completely stable, with updates to software and hardware imposing novel challenges to DVPP who may wish to use them, oft requiring a dedicated support or maintenance professional to attend to its upkeep that can prove costly.

Due to a focus on qualitative practitioner perspectives, our study did not accommodate the cross-comparison of referral rate or engagement figures. We surmised that requesting this information could overburden an already over-extended workforce, as other research has indicated (Bagwell-Gray and Bartholmey, 2020). Nevertheless, IPV practitioners are extremely adept in identifying subtle changes in behaviour, interaction style and engagement, meaning that the consistent reporting of increased referrals and engagement by our

participants across all countries should be validated. However, the extent to which we can claim self-referral rates increased relative to other referrals is questionable given the reduction from third-party referrals (i.e., from professionals and strangers) reportedly decreased during this time (Ivandic et al., 2020). It is still, however, encouraging to see a perceived increase in more perpetrators make a self-referral to professional services, indicating resources may be worth investing further research efforts into signposting and help-seeking behaviours pathways outside of professional contexts. For instance, research into how perpetrators may seek informal support, such as by friends and family (Gregory and Williamson, 2021), or online resources (Spencer et al., 2021), may be the bridge between initial disclosure and steps to referral may produce valuable insights. Such efforts may be especially useful in US contexts whereby an over-reliance on criminal justice referrals proved to generate the most disruption due a lack of diversification of referral pathways.

The COVID-19 pandemic and accompanying nationwide-restrictions may have irrevocably changed how services are delivered in IPV ecosystems, providing perpetrators the perfect scenario for weaponizing movement control measures and threat of infection. Amid this risk comes the opportunity for structured re-evaluation of the relatively fixed delivery designs for DVPP, an ask that practitioners in some of the countries in this review have been calling for. As different stages of a disaster can manifest different types of violence against victim-survivors (WHO, 2020), such as instability of social structures, it is essential that we continue to combat the relative invisibility that perpetrators have been afforded in the hypervisibility of IPV during the COVID-19 pandemic (Quinlan and Singh, 2020).

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Characteristics	Country of Origin		
	United Kingdom *(K1 – K14)*	***United States*** *(S1 – S12)*	***Australia*** *(A1 – A10)*
Gender			
Female	10	8	6
Male	4	4	4
Age Group			
25 and below	0	0	0
26 – 35	2	2	1
36 – 45	8	2	2
46 – 55	3	4	5
55 – 65	1	0	2
65 and above	1	2	0
Ethnicity			
White (European)	7	6	2
White (American)	0	2	0
White (Australian)	0	0	5
Indigenous	0	0	2
Asian	3	0	1
Other	4	2	0
Time in Field			
Under 5 years	1	0	1
5 – 10 years	6	2	3
10 – 20 years	4	4	3
20 + years	3	4	3