Examining organization and provider challenges with the adoption of virtual domestic violence and sexual assault interventions in Alberta, Canada, during the COVID-19 pandemic

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Abstract

Objectives: In Canada, calls to domestic violence and sexual assault hotlines increased during the COVID-19 pandemic as stricter public health restrictions took effect in parts of the country. Moreover, the public health measures introduced to limit the transmission of COVID-19 saw many health providers abruptly pivot to providing services virtually, with little to no opportunity to plan for this switch. We carried out a qualitative research study to understand the resulting challenges experienced by providers of domestic violence and sexual assault support services.

Methods: Twenty-four semi-structured interviews were conducted to gather in-depth information from service providers and organizational leaders in the Canadian province of Alberta about the challenges they experienced adopting virtual and remote-based domestic violence and sexual assault interventions during the COVID-19 outbreak. Interview transcripts and field notes were analysed using a thematic analysis approach.

Results: Our findings highlighted multiple challenges organizations, service providers and clients experienced. These included: (1) systemic (macro-level) challenges pertaining to policies, legislation and funding availability, (2) organization and provider (meso-level) challenges related to adapting services and programmes online or for remote delivery and (3) provider perceptions of client (micro-level) challenges related to accessing virtual interventions.

Conclusions: Equity-focused policy and intersectional and systemic action are needed to enhance delivery and access to virtual interventions and services for domestic violence and sexual assault clients.

Keywords

Virtual delivery, domestic violence, sexual violence, service adaptation, organizational change

Introduction

Global statistics reveal a drastic increase in violence against women during the COVID-19 pandemic.[1] Women's shelters and the justice system in Canada have seen increasing reports of domestic violence and sexual assault incidents.[2] The Canadian Femicide Observatory for Justice and Accountability reported 92 women and girls were killed in the first half of 2021, mostly by men.[3] That was 14 more than in the first half of 2020 and 32 more than in the first half of 2019.[4,5] In Alberta, Canada, calls to domestic violence and sexual assault hotlines rose by 57% in the early months of the pandemic.[6]

Public health measures and strict social distancing guidelines in many countries hugely impacted individuals and families, and the service systems that support them.

Health and social sector service providers needed to quickly reconfigure services and supports to clients and communities, as physical distancing rules made service delivery

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adaptations a necessity. Service providers have rapidly pivoted their practices to virtual or remote-based delivery to support individuals throughout the pandemic, with little to no opportunity to plan for this switch.

The circumstances of COVID-19 and associated service disruptions differed across service systems. We define service providers within the anti-violence sector as including a range of community organizations, agencies, networks, advocacy groups, health centres and primary care clinics that provide domestic violence and sexual assault-focused services. These include sexual assault centres, mental health counselling centres, women's shelters, transition houses, settlement services, victim and perpetrator services and primary care clinics. Domestic violence and sexual assault-focused services include specialized counselling, risk assessment, shelter or temporary housing to individuals fleeing violent relationships, safety planning to ensure that those experiencing or at risk of experiencing violence or assault have a clear understanding of where they can go if they need help or support, education and training about violence and healthy relationships and assistance in navigating complex systems, including immigration, criminal justice, housing, social services and health care.

As discussed below, for service organizations in the anti-violence sector in the province of Alberta, the rapid transition to virtual and remote-based service delivery posed difficulties in anticipating barriers or impacts from abrupt service transformations and in determining how to implement virtual interventions successfully. But having said that, experience of remote and virtual care delivery has been growing over the last 20 years and have shown to be acceptable and useful for some patients. For instance, advancements in the delivery of telehealth for mental health and substance abuse treatment within rural areas have the potential to reduce the disparities in the delivery of substance abuse and mental health services between urban and rural communities.[7]

Scholarship on virtual or remote delivery of domestic violence and sexual assault services, and service providers' experiences of it, has been scarce. Prior to the pandemic, communication technologies and helplines provided options for clients, but only a small literature explored the implications of technology-mediated and virtual service delivery for individuals experiencing violence or abuse and for survivors.[8]

The shift to virtual delivery also raised important concerns for service providers in the anti-violence sector regarding the appropriateness and acceptability of delivering trauma-focused counselling, safety planning and other types of services remotely. This is especially true when these services are fundamentally driven by relationships, connection and safety[9] and clients' inability to participate in telephone or virtual supports due to lack of technology or internet access, lack of privacy or space to use the phone or computer and/or discomfort with receiving services normally provided face-to-face over phone or video.[10]

Virtual or remote delivery of domestic violence and sexual assault interventions

During the pandemic, the adoption and implementation of virtual or remote-based domestic violence and sexual assault services and programmes have been implemented at three tiers of intervention (See Figure 1). Primary prevention includes educational tools offered through web-based applications to help women experiencing or at risk of domestic violence. These tools were widely promoted across Canada during the pandemic.[11,12] The apps provide appropriate security measures (e.g. emergency exit buttons) and offer anonymity and a forum where women can seek help without judgement – for example, digital safety decision aids allow both privacy and real-time access to resources and may be appropriate for a hard-to-reach population disclosing information on a sensitive topic.[13] Early (or secondary) intervention focuses on early detection after experiencing violence or abuse and includes crisis and mental health counselling sessions conducted via phone or videoconferencing platforms, digital tools for safety planning and mental health apps used for the diagnosis, monitoring and treatment of psychological trauma or mental distress.[14] Crisis (or tertiary) intervention includes strategies to mitigate the long-term impacts of previous or current experiences of domestic violence and sexual assault, such as virtual trauma-focused counselling for survivors.[11]

Virtual or remote delivery of domestic violence and sexual assault interventions offer the opportunity to continue serving individuals and families who are most vulnerable and at greater risk in the midst of a pandemic. There is an urgency to assess and address the barriers and ethical issues presented by virtual service and digital tools for domestic violence and sexual assault clients, such as privacy and data protection, access to digital technologies and patient safety.[15]

Factors influencing the implementation and uptake of virtual or remote delivery of interventions during the COVID-19 pandemic

Studies aimed at understanding the facilitators and barriers that influence the implementation of innovations or service adaptations have pointed to organizational factors (e.g. capacity to change, readiness for virtual interventions), contextual barriers (e.g. funding availability) and knowledge and beliefs of service providers about the innovation or new service.[16] Rogers[17] identifies three key characteristics that relate to an organization's propensity for innovation: (1) individual (leader) characteristics, (2) internal characteristics of organizational structure (i.e. capacity and provider/
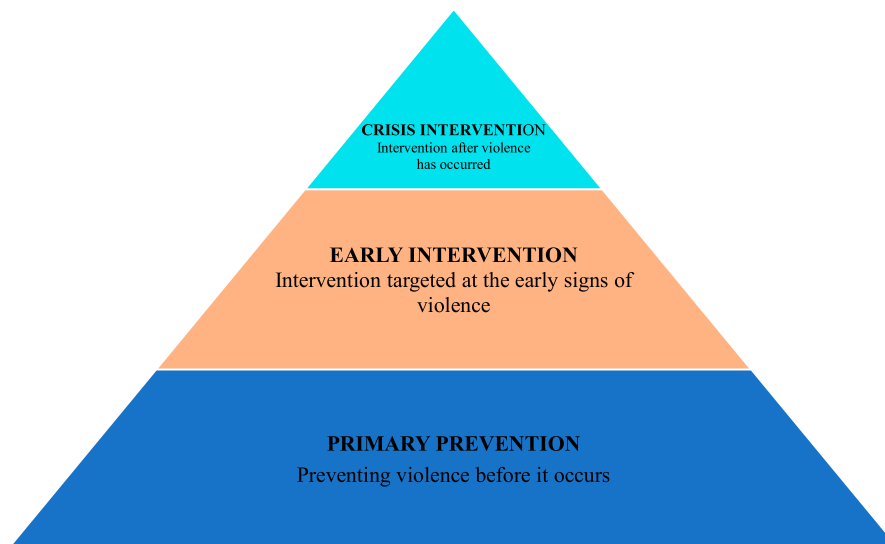
Figure 1. Points of intervention for domestic violence and sexual assault.

staff expertise) and (3) external characteristics of the organization (i.e. access to resources). Organizational readiness for change is considered a critical precursor to the successful implementation of changes in organizational settings.[19] Virtual care readiness is defined as the degree to which an organization is prepared to participate and implement virtual care interventions, including digital tools and online programmes.[16] It considers both the capacity for making changes, as well as the perceived need to change.

Additionally, attitudes and beliefs of service providers are also shown to act as both facilitators and barriers to the acceptance of virtual care interventions.[20] Positive provider attitudes can include beliefs that new service adaptations would benefit clients,[21] and interest in virtual or digital health solutions.[20] Negative perceptions can include beliefs that virtual or remote-based interventions would disrupt the delivery of care, and doubts that virtual delivery can improve client care.[21]

We carried out a qualitative research study to understand the challenges in the implementation of virtual and remote-based services and interventions from the perspective of organizational leaders and service providers from the anti-violence sector in Alberta during the COVID-19 pandemic. We also identify policy-level actions to address the challenges and promote uptake of virtual and remote-based services and interventions during the pandemic.

Methods

This study adopted a qualitative descriptive approach.[22] We gathered in-depth information about the challenges service providers and organizational leaders in Alberta experienced with the adoption, uptake and implementation of virtual and remote-based services and interventions for reaching individuals and families experiencing, or at risk of, and survivors of domestic violence and/or sexual assault during the COVID-19 pandemic. A qualitative descriptive study design is based on the general principles of naturalistic inquiry, which allows for flexibility in sampling techniques, data collection strategy and reporting styles.[22] With this qualitative approach, the researcher works hard to stay close to the surface of the data and events where the experience is described from the viewpoint of the participants.[22] This study was reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta (REB #Pro00101547).

Participants

Semi-structured interviews were conducted with 24 participants working with and serving individuals experiencing, or at risk of, and survivors of, domestic violence and sexual assault in Alberta. Interview participants were identified from existing relationships among the research team and community partners, as well as a participant recruitment poster distributed through a provincial collective impact network of service providers to eradicate family, domestic and sexual violence in Alberta. Interview participants were also selected based on the diversity of client populations served. For instance, we interviewed an Indigenous domestic violence outreach worker, who serves rural and remote Indigenous communities, and a clinical psychologist, who provides counselling for newcomers and an ethnic and culturally diverse population in an urban area. All interview participants, except two who are family physicians, provide specialized domestic violence and/or

sexual assault services. Table 1 presents the characteristics of the 24 interview participants.

Data collection

The data collection took place in June to August 2020. The participants were given detailed information, both verbally and written, about the aims of the study and the voluntary nature of their participation. All interviews were completed via telephone or videoconference and lasted approximately 1 hour. Interview questions covered topics relevant to the factors that shaped the adoption, uptake and implementation of domestic violence and sexual assault-focused virtual interventions or digital services during the pandemic, as well as perceived challenges or barriers that organizations and service providers encountered with virtual or remote-based service delivery. We carried out participant interviews until data saturation was reached.

Data analysis

Qualitative data analysis was undertaken by the first and second lead authors. Interview transcripts and field notes were analysed in NVivo v.12 using a thematic analysis approach. Codes were consolidated into emergent representative themes in an iterative process throughout coding. Once all qualitative content was coded, we reviewed the emergent codes and identified key themes.

Researcher reflexivity

Part of ensuring the quality and transparency of qualitative research is for investigators to recognize their subjectivity – the values, beliefs, personal qualities and knowledge they bring to their research. The lead author of this paper is a white settler woman and academic researcher. The second lead author is a Black female scholar and doctoral student and immigrant to Canada. Both authors study gender-based violence and employ feminist ideals and equity principles to underpin their research.

Results

Multiple challenges with the adoption and delivery of virtual interventions during COVID-19

A predominant theme that emerged from the interviews was the multiple challenges participants experienced with the rapid shift to virtual or remote-based delivery of domestic or sexual violence services and interventions during COVID-19. The providers and organizational leaders across the anti-violence sector described three main types of challenges: (1) systemic (macro-level) challenges pertaining to policies, legislation and funding availability, (2) organization and

Table 1. Profile of participants.

Characteristics of participants	Number of participants (N = 24)
Organization type	
Domestic violence shelters/transition houses	4
Sexual assault centres	2
Mental health and crisis support	2
Primary care	3
Advocacy	4
Outreach and peer-support	2
Multi-service organizations	3
Immigrant and settlement services	2
School divisions	2
Participant roles	
• Directors, supervisors or managers	14
• Consultants (programme or research)	3
• Coordinators	1
• Direct service roles	
- Primary care physicians	2
- Registered provisional psychologists	2
- Crisis counsellors and outreach and crisis support	2
City/town in Alberta	
Edmonton	9
Calgary	6
Spruce Grove, Stony Plain and Parkland County	4
Fort McMurray	1
High River	1
Lethbridge	1
Medicine Hat	1
Red Deer	1

service provider (meso-level) challenges related to adapting services and programmes online or for remote delivery and (3) service provider perceptions of client (micro-level) barriers to accessing virtual interventions.

Please note that while this article considers the challenges experienced with virtual delivery of services and interventions, we have also researched the ways organizations optimized virtual delivery for their clients. Those results are published elsewhere.[9]

Systemic (macro-level) barriers

Participants highlighted system-wide gaps that posed barriers on the anti-violence sector to successfully deliver virtual or remote-based services and interventions during the pandemic for survivors, individuals experiencing, or at risk of domestic violence and sexual assault.

The availability of emergency COVID-19 funding from the federal government was described by some participants as necessary to support the rapid adoption and implementation of virtual services and interventions. However, this climate of 'constant adjustments during the pandemic' (P#10) as one participant described it, placed added burden on an already overburdened sector that is responding to domestic violence and sexual assault. A director of a multi-service organization stated: 'Emergency COVID funding is short term, [and] we need long-term and sustainable solutions' (P#20). Some participants expressed concerns that the fast-paced adoption of virtual service delivery may have repercussions for some long-standing programmes that are not easily adaptable online or through remote delivery. Moreover, participants were concerned about future funding cuts and the capacity of organizations to meet demand, especially with pandemic protocols in place. A director at a sexual assault centre described the strain placed on her organization's staff and the impacts on their mental health in the early months of the pandemic as they transitioned to virtual delivery:

> We had to find funding and resources to support our staff's mental health around this new way of working. I think people automatically think that working from home is like a glam job, and many of us after now trying it saw how it can be isolating. Because we work quite closely together here just in terms of being in physical contact. And so they found it very isolating, but we had to develop a lot of policies and procedures around supporting our staff. (P#18)

While the availability of COVID-19 emergency funding allowed organizations to adapt, innovate and explore alternative service delivery approaches during the pandemic, participants highlighted a lack of stable core operational funding. At the onset of COVID-19 in Alberta, organizations had to urgently pivot to respond to growing concerns of domestic violence and sexual assault during the pandemic, which meant that usual funding-generating activities, such as fundraising, were put on hold. For many non-profit organizations, fundraising activities are critical for the sustainability of the organization. Thus, disruption to normal modes of business have adversely affected revenue and fundraising projections, all at a time when demand for domestic violence and sexual assault services has risen in the province. An outreach manager for a multi-service organization described the impacts that this has had on her organization:

> The biggest cost that we're actually incurring is the loss of fundraising dollars, which is huge, especially this month. We're normally running a seven-day, 15-event food festival which is one of our largest fundraising opportunities of the entire year and we can't have it in the same context so it's going to a modified, mostly online. Although we have a sponsor, we're

going to make maybe a third of the funds, so a huge cost that we have incurred is the loss of fundraising. (P#10)

Many participants explained how interpretations of policy and legislations within the health care act related to data security and privacy can impede implementation of virtual care within organizations. One participant stated that a limitation with current privacy legislation is that it does not account for what 'privacy' or 'safety' within the virtual environment means to the client (P#20). For instance, safety in a virtual environment might mean having a close friend or relative that the client trusts in the room.

Organization and service provider-level (meso-level) barriers to adopting virtual interventions

At the onset of the pandemic, several organizations incurred additional costs to purchase online platforms and equipment required to support their employees to work from home, where other organizations lost funding due to the pandemic, and lost employees to voluntary layoffs. For example, a programme director of a multi-service organization had incurred C$25,000 to support the adoption of virtual delivery of interventions for a team of 23 individuals. Before organizations could apply for emergency COVID-19 funding from the federal government, many organizations had already incurred costs due to the rapid and urgent need to adapt services and programmes to virtual or remote-based delivery from the onset of the pandemic, which left organizations with little time to prepare. A director of a mental health and crisis support centre described the experience:

> We had no funding at our organization to support the transition to virtual delivery…It was the cost of ensuring secure servers, ensuring the partnership with other organizations who had the specialization training for our staff to be able to deliver services online. (P#10)

For providers, difficulties integrating and adjusting to new procedures and practices into the day-to-day workflow was a perceived barrier to the adoption of virtual services and interventions. Crisis counsellors and clinicians, in particular, described the added time required to reach clients by phone and to schedule appointments:

> In some cases, because people forget appointments, you know, I'm calling several times over the course of a day to try and catch them, leaving messages and whatnot. (P#4)

Providers spoke about their own personal challenges with the shift to virtual delivery of counselling and online treatment. They explained that virtual delivery required more time and effort, and many experienced a type of

mental exertion that they referred to as 'Zoom fatigue' – named after the proprietary videoconferencing software, Zoom. Mental health providers elaborated on their experience with mental exhaustion and burn-out from virtual counselling sessions with clients:

> Staff are reporting feeling more drained after the session [with clients]…When you have them in person, you have them in your four walls and a closed door. You know exactly what's happening in the room. But when you're working with a client remotely, you're attuned to the environment around them on the screen or over the phone, you're listening for sounds in their background. You're looking for unusual body movements, above and beyond the screen. (P#7)

One participant described why virtual service delivery was more demanding and strenuous on the provider in comparison to in-person care:

> We have to think about the online in terms of caring for the staff, because we all know about Zoom fatigue, right? And there's something about online counselling that's very demanding. Spending any amount of time looking at a screen is very draining. When you're in the room with someone there's energy that comes from personal interactions. (P#18)

For some providers, it took time to adjust to using virtual platforms such as videoconferencing. They described how shifting to virtual delivery considerably altered the way they provide counselling or treatment to clients. An executive director of a mental health and crisis support centre explained:

> I struggle with technology because it's not natural to me. If, all of a sudden, my screen froze…I have no idea how to troubleshoot or fix this problem. And because it feels like I'm a stranger in a strange land, I would rather not do it in the first place. So, I think that for me, it wasn't even so much the interaction online. It was this technology feels way too scary and big and overwhelming. I like to be an expert in my own world and I'm definitely not an expert at this. (P#3)

Additionally, participants highlighted what is missed or lost when transitioning in-person services, such as mental health or crisis counselling, to virtual delivery. They spoke about the missed opportunities to build relationships and trust with their clients, which is central to healing trauma and recovery. The following quotes demonstrate the importance of human connection and relational care when treating or providing support to survivors of a violent or abusive relationship:

> I think in a client counselling relationship it's that human connection. And electronically you just don't get that same

human connection. And when you're talking about trauma, you know, and doing trauma counselling, you're looking for physiological reactions, you're looking for facial reactions. (P#11)

> You have to wonder, although we're trying to do the best we can, is providing virtual care really providing that care? Because we're wired for connection, we're wired for…when you're sitting across the table from somebody, I think you can be more empathetic because that person is sitting right in front of you than on computer, you are quite removed. (P#14)

Likewise, a crisis counsellor said:

> It is much harder to build trust over Zoom or over the phone than it is in person…For you to really help someone, they have to trust you and you have to build a relationship, and it's harder to do virtually than it is to do in person. (P#13)

Attending to client safety in the virtual environment was also challenging. As one participant said:

> You can't be certain that people are speaking freely. There's a big difference between having your assaulter within six feet away and being able to talk about how you're doing or how things are. (P#6)

Some participants questioned whether virtual delivery of services and care was the most effective way to reach clients and provide support. As one crisis counsellor asked:

> How do you ensure that they are able to contact you without alerting the offender or the perpetrator? How do you provide space for, say, the victim to talk about what's going on without impacting children who might be listening nearby?' (P#7)

The limitations in providing counselling services by phone were described to be potentially harmful when treating clients dealing with trauma because the counsellor is unable to pick up on visual clues or the client's body language. One participant used the analogy of 'driving blind', pointing out, 'If somebody was sobbing quietly, or just listening quietly, you would not be able to tell'. (P#18)

Participants also cautioned that virtual care platforms can potentially disrupt and impact provider-patient relationships and quality of care. While the pandemic stimulated innovation across the sector in order to continue to provide access to needed mental health and crisis support services, the urgency to adapt services online or remotely also meant that clients' needs and preferences are not factored into how they would use virtually delivered services. One participant explained that: 'There is a fine line between innovation and doing what's best for our clients, and trying to push forward new options and new initiatives and really listening to what our clients need'. (P#20)

Another factor affecting quality of care was highlighted by a primary care physician who spoke about modifications to physician fee schedules to meet the emerging need for virtual care services during the pandemic. Changes to the fee schedules and new virtual care billing codes were introduced by the Alberta Medical Association in 2020 to facilitate the adoption of virtual care. Patient assessments, consultations and tele-psychiatry provided through phone or secure videoconference are not subject to the daily patient visit cap and modified fee codes are available for certain diagnostic conditions such as mental health. This primary care physician explained a limitation with the new virtual codes on quality of care and time spent with patients:

> There are time limits on a patient visit with the new virtual codes, and what this means is if it is not a mental health or palliative care issue [referring to complex care issues], I cannot bill extra time spent with the patient. So there are many complex issues and trauma experienced by these patients [who experience domestic violence] who are absolutely going to take more than 10 minutes, and that I would be unable to claim any compensation for that extra time spent with the patient…So, frankly, the main barrier I think is more the business model as opposed to having reliable technology or acceptance [of virtual care] by patients. (P#4)

Provider perceptions of client (micro-level) barriers with accessing virtual interventions

Most participants stated that COVID-19 had underscored inequities in clients' ability to access digital technologies. What they described as the 'digital divide' is shaped by access (does the virtual service reach clients?) and uptake (are clients using the virtual service?). Service providers in particular raised concerns about the accessibility of such virtual services for clients who may face barriers such as a lack of access to technology (computers or smart phones), and data plans or sufficient bandwidth – in rural and remote communities in particular – to participate in virtual care interventions or services. A manager of a multi-service organization in northern Alberta described the barriers that clients in rural and remote Indigenous communities face in accessing virtual services:

> For some of our remote and rural communities, even if we could send a client a tablet to be able to connect with us online, they need effective data or Wi-Fi. And some rural and remote places in Alberta definitely don't have that. (P#3)

Participants said issues of digital equity were deeply connected to pre-existing social and economic inequities and disparities in access to services experienced by underserved and vulnerable populations. For instance, participants spoke about financial strain as a major barrier for accessing virtual services during the pandemic. They described people living in rural and remote communities, those who are low-income, Indigenous and people of colour, recent newcomers, and those living with disability as being at a higher risk of digital exclusion.

Addressing access to virtual services alone is not enough to overcome the digital divide, participants said. For some clients, the quality and safety of services that are delivered virtually are a greater concern than affordability of devices and connectivity. Participants stressed that patient safety needs to be a priority when delivering virtual services. For clients living with domestic violence and sexual assault, limited privacy and being in close proximity to their abuser can make it unsafe for them to seek help from a provider while they are in their home. This was expressed by several participants who have been grappling with this issue throughout the pandemic:

> Even if you can have technology access, but you're living with somebody who is using violence or could be using violence, then accessing online programming or counselling is unrealistic. (P#20)

> When we think of client safety, it just might not be safe in the home for women to virtually connect to their counsellors or support, because it could easily be discovered or overheard. (P#11)

Several participants said clients who were receiving remote counselling and other services while at home could be re-traumatized, as home is often the place where violence or abuse occurs. As one provider pointed out:

> I think some people in their places, their living spaces, it's going to be quite triggering and re-traumatizing. Everything around them could be a trigger. (P#17)

Discussion

In the province of Alberta, the quick shift to virtual or remote-based delivery of services and interventions during the pandemic was challenging for many organizations providing direct care, treatment or support to individuals experiencing, or at risk of, and survivors of, domestic violence and sexual assault. Nonetheless, through necessity, organizations across the sector quickly adapted their organizational practices, procedures and practices to accommodate virtual delivery and transitioned their interventions and programmes online. In doing so, several organizations incurred additional costs for online platforms and equipment required to facilitate virtual delivery. Recent studies from the US and Canada also report changes to workflow and additional costs associated with the rapid

adoption of virtual care.[23,24] These include purchasing new virtual care platforms or updating existing platforms to serve clients at a larger volume, training service providers and clients on how to use these platforms, expanding the technology infrastructure and accommodating service providers and clients who had difficulty accessing technology.[23,24] The pandemic also heightened pre-existing funding inequities in the anti-violence sector, and providers had to stretch already limited resources to implement virtual interventions.

Our findings resonate with Rogers' description of characteristics within internal organizational structures that shape the adoption of innovations.[17] Participants spoke about the complexity of delivering services and interventions virtually, organizational capacity to support virtual delivery, the knowledge and expertise of providers and staff with virtual platforms and the availability of resources to support the cost of virtual delivery and/or transitioning programmes online. All these factors posed challenges with the adoption and implementation of virtual or remote-based interventions for the anti-violence sector.

Participants in our study described macro-, meso- and micro-level challenges that placed constraints on delivering virtual services and interventions. The rapid and urgent attention that was focused on adapting interventions and programmes during the pandemic meant that many organizations had to put other commitments and programme activities on hold, thus disrupting their normal mode of business. The speed at which virtual services and interventions were adopted also raised concerns for service providers as to whether the quality and safety of care were being compromised. Participants emphasized that trauma-focused domestic violence and sexual assault services are driven by relationship, trust and safety.

Other studies have noted that the provision of virtual services and interventions is demanding and time consuming for providers.[24] The need to navigate virtual care platforms, having to maintain constant attention to non-verbal cues and experiences with 'Zoom fatigue' resulting from prolonged online counselling sessions are common challenges encountered by service providers with virtual service delivery in other settings.[24,25] These barriers combined with individual provider's personal COVID-19-related challenges (i.e. navigating childcare and working from home) can have negative long-term impacts on the mental health of service providers.[24]

The loss of the human connection when adopting care and treatment virtually was a primary concern of service providers in our study. Similar studies have highlighted the loss of human connection and difficulties in re-building trust among patients and clients in the virtual environment.[24,26] Some scholars have recommended reframing the existing client-provider dynamic and therapeutic approaches into virtual settings instead of trying to replicate the same approach used for in-person care.[27] Further research is needed to better understand the optimal ways to enhance client-provider relationships and experiences in a virtual setting. Our findings demonstrate the need to examine the right combination of in-person and virtual delivery of services based on the needs and realities of individuals who experience domestic violence and sexual assault.[23,27]

Recent research highlights the consequences of inequitable access to virtual care, characterized as the 'digital divide'.[23,27] Participants in our study described multiple barriers to accessing digital technologies experienced by underserved and vulnerable populations, who are at a greater risk of domestic violence and sexual assault during the pandemic. There is ample evidence demonstrating digital exclusion among rural communities where broadband access is limited.[23,24,27] Further research is needed to examine how digital exclusion is experienced by diverse population groups, and across intersecting factors of gender, sex, age, geography, disability, race, ethnicity and culture.

One step towards closing the digital divide was taken recently in Canada with the introduction of the Universal Broadband Fund, introduced by the Canadian Federal government in 2020. This was a C$1.75 billion investment to bring high-speed internet to rural and remote communities.[28] As part of this initiative, up to C$50 million has been made available to support mobile internet projects that benefit Indigenous peoples in Canada. According to the latest CRTC Communications Monitoring Report,[29] only 41% of rural households and 31% of First Nations households on reserves have access to 50/10 Mbps service, compared to 98% access in urban households. Outside Canada, some countries have already implemented policies and plans for national-scale digital triage, catalysed by COVID-19. This includes NHS England's 'digital first' strategy, which aims to ensure all primary care is routed through an online triaging system, which directs patients to either online, telephone or video consulting before a face-to-face consultation.[30]

But the issue of uptake of digital technologies cannot be fully addressed by enhanced internet infrastructure alone. To do so, risks amplifying digital inequity and widening divides. Instead, we must also examine what hinders people from using the services they do have access to. Our findings demonstrate that the COVID-19 pandemic compounded existing barriers to accessing services and spurred new challenges for clients accessing care and treatment in the virtual environment. For instance, increased surveillance by perpetrators of abuse and limited privacy pose barriers and safety concerns for individuals to connect with a service provider virtually from the home. Indeed, research on barriers that exist for those seeking help for domestic or sexual violence has found that such barriers include a lack of familiarity with services, lack of culturally and linguistically appropriate services, confidentiality concerns and

discriminatory and racist practices embedded in services and service delivery.[31] For individuals who live at the intersections of multiple marginalized identities – such as Indigenous women, people living with disabilities or trans people of colour – disclosing experiences of violence and abuse are shaped by systemic and individual racism, stigma and historical violence. Furthermore, the challenges for women who experience other forms of vulnerabilities alongside domestic or intimate partner violence, such as mental health and/or substance use problems, present unique difficulties in accessing appropriate care.[32]

Our findings provide key directions for future policy and practice on virtual or remote-based service delivery for organizations directly providing domestic violence and sexual assault-focused services. First, provincial and federal resources should be harnessed to support organizations to adjust their service delivery approaches and respond to patient and client needs. This includes equitable federal and provincial funding to support virtual or remote-based service delivery, as well as support for service providers who are grappling with their own mental health challenges during the pandemic. Stable core funding is also required to support organizations' capacity to respond to increases in domestic violence and sexual abuse throughout the pandemic.

Second, evidence-based virtual care resources and guidance can support organizations as they adopt virtual care practices. For instance, the NHS in England implemented guidance for remote consultations to enable practitioners to assess whether virtual consultations were appropriate in the context of safeguarding children and adults at risk of harm or abuse.[30] These resources should take into account ethical concerns in delivering virtual services to domestic violence and sexual assault clients, particularly around patient and client safety, relational care and equity.

Third, as all sectors in Alberta had to quickly adopt virtual care in response to the limiting of social contact during the pandemic, policy and decision-makers must recognize the barriers and challenges faced by sectors with limited or no experience in delivering virtual care. Equity considerations in decisions regarding virtual care were overlooked, as some individuals and families are at a greater risk of digital exclusion.

Limitations

We acknowledge three main limitations in our study. First, our study was confined to 24 participants in Alberta. The experiences and insights of these service providers may not be representative of all domestic violence and sexual assault providers in the province, or indeed those elsewhere in the country or further afield.

Second, we did not capture the perspectives of individuals experiencing domestic violence and/or sexual assault themselves or survivors of such abuse. Those people's experiences and insights are essential to the evolution and development of trauma-focused and equitable virtual care. However, there are potential risks of conducting direct research with individuals who experience violence and survivors during the pandemic, including re-traumatization and the ability to safely connect with at-risk individuals virtually. By collecting data from those connected with the situation but not in immediate danger, we gained insights into situations of accessing domestic violence and sexual assault services and interventions during the pandemic without placing anyone at risk.

Third, there is the issue of timing. The predominant theme that emerged in our qualitative data was that the adoption and implementation of virtual services and interventions was challenging. This may reflect the fact our interviews were conducted just 4 months after the start of the pandemic, a period when providers were still adjusting to virtual service delivery.

Conclusion

In the current COVID-19 climate, organizations directly providing domestic violence and sexual assault-focused services in Alberta had to rapidly pivot to virtual delivery of their services. This placed an added burden on an already overburdened sector. Our research revealed the complex and multiple barriers faced by organizations and service providers in this sector in adapting and delivering virtual services and interventions, as well as the multifaceted barriers that clients encounter in accessing virtual services and online programmes.

Equity-focused policy and intersectional and systemic action are needed to inform delivery and access to virtual services and interventions for domestic violence and sexual assault clients. Moreover, the pandemic presents opportunities for the anti-violence sector to learn about the adoption of virtual care practices, while responding to an increasing demand for domestic violence and sexual assault services and continuing to deliver client-centred care and treatment.

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