ADVANTAGES AND DISADVANTAGES OF REMOTE BATTERER INTERVENTION PROGRAMS DURING THE COVID-19 PANDEMIC

by

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ABSTRACT

ALEXA SOTIROFF. Advantages and Disadvantages of Remote Batterer Intervention Programs During the COVID-19 Pandemic. (Under the direction of DR. JENNIFER LANGHINRICHSEN-ROHLING)

Many psychological services that have been historically conducted in-person have made the switch to remote platforms. Recently, the COVID-19 pandemic accelerated these changes, making virtual settings the norm for many services (Augenstein, 2020). Some services were forced to switch so quickly that there was little time to consider the utility and concerns associated with conducting such a service remotely. One such service is Domestic Violence Intervention Programs (DVIPs), which primarily provide treatment to individuals who have been convicted of a domestic violence related offense but can also serve clients who are lawyer-, partner-, or self-referred. DVIPs are unique in that they are typically court-mandated, group-based, and populated by clients who have an increased risk of violent behavior. Various stakeholders depend on these programs to be effective in reducing rates of domestic violence, including the members of the criminal justice system and DV victims. One of the most notable departures from standard operating procedure was that the COVID-19 pandemic forced DVIP facilitators to negotiate their own comfort level with providing in-person versus remote services. However, very little is known about how DVIP facilitators navigated these decisions and what their impressions were of the consequences of their choices; this qualitative study was designed to fill that gap. Additionally, considering prior mixed results on the effectiveness of DVIPs conducted in-person formats (Dunford, 2000; Eckhardt, 2004; Easton et al., 2007; Graña et al., 2017; Herman et al., 2014; Haggard et al., 2017; Puffett & Gavin, 2004), it was also important to examine facilitators' perceptions of the advantages, disadvantages, and overall implications of using remote service delivery platforms for DVIPs. This study focused on the qualitative

experiences of DVIP facilitators (n = 19). Facilitators were of interest due to their experience with both face-to-face and virtual/remote platforms, which would allow them to compare and contrast service delivery methods. Emerging qualitative themes were sorted into three main categories: (1) the impact of COVID-19 on service delivery, (2) comparing and contrasting remote vs. in-person treatment, (3) and the future of remote service provision. Main findings from the semi-structured interviews indicated that most DVIP facilitators were able to adapt to the changes necessitated by COVID-19, but they reported differing levels of control over treatment-related decision-making. Remote service delivery was generally perceived as more accessible and convenient for both facilitators and group participants while in-person service delivery was generally perceived as more engaging and interpersonally effective. Facilitators wanted access to research on the effectiveness of conducting DVIP groups remotely. They typically lacked guidance from relevant state entities on pandemic or disaster-approved methods of DVIP service delivery; consequently, pandemic service delivery decisions varied substantially among facilitators.

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CHAPTER 1: INTRODUCTION

On March 11, 2020, the World Health Organization (WHO) declared the world as being in a pandemic due to the coronavirus (Cucinotta & Vanelli, 2020). In order to reduce virus transmission, most American (n = 42) states implemented stay at home orders and closed all nonessential business operations (Moreland et al., 2020). The criminal justice system was not immune to such changes. In many areas, courts closed or slowed to a crawl. In response to high rates of transmission in criminal justice facilities, jail times and prison admissions were reduced, allowing individuals convicted of crimes to return to or remain on the streets (Nowotny et al., 2020). Due to the novelty of the coronavirus and the lack of a standardized, disaster related plan related to the U.S. justice system, there was great variation between and within states regarding their pandemic response and virus containment procedures. These changes resulted in disruptions of standard operating procedures for a variety of criminal justice related services, including those offered to perpetrators of domestic violence (DV).

As a primarily court-mandated service, domestic violence intervention programs (DVIPs) were impacted by the COVID-19 pandemic. Treatment facilitators had to quickly adapt to the changing viral landscape. This landscape included state variations in the extent of the COVID outbreak as well as in the degree to which state law dictated changes in treatment provision (Gostin & Wiley, 2020). Because of this, different DV service delivery organizations were likely to have been complying with different state and city-specific lock down orders and safety precautions as the pandemic was unfolding. In some cases, individual facilitators may have been the primary decision makers regarding when and how to deliver services including whether to continue utilizing an in-person classroom or group treatment format and whether and how to implement COVID-19 safety procedures. One of the most notable departures from standard

procedure was that the COVID-19 pandemic forced individual facilitators to negotiate their own comfort level with providing in-person versus remote services. However, little is known about how facilitators navigated these decisions and what their impressions were of the consequences of their choices; this qualitative study was designed to fill that gap.

Prior to the pandemic, providing remote services was an option that many DVIP facilitators likely never considered implementing for a variety of reasons. Intimate partner violence (IPV) offenders are typically a vulnerable population with the potential for on-going and future violent behavior, which may have made individual providers, and state regulatory processes hesitant to allow programs to go online as there would be less ability to directly monitor IPV offenders' reactions and behaviors in real time. Remote settings may also decrease the ability of organizations to practice standard safety measures, such as in-person safety checks with both perpetrators and victims/survivors. There were also financial considerations in some cases, with state laws varying in their support for allowing renumeration for individual, let alone group, teletherapy. Another barrier might have been tradition, with DVIP treatment historically taking place in mandated in person group formats, with both facilitators and offenders having varying amounts of access to and familiarity with use of technology. This tradition comes from the standard practice of DVIPs, which has been criticized as being based on outdated domestic violence theories and in some cases has been shown to lack evidentiary support (Cannon et al., 2020).

However, there are reasons that remote delivery of DVIPs may have benefit. For example, common problems with DVIPs, such as their notoriously high attrition rates (37.8% as reported by Olver et al., 2011), may be reduced if treatment is offered remotely. Moreover, as offenders typically attend DVIPs in an outpatient setting, remote treatment may be more

convenient, as it could reduce the need for travel, childcare, lost time from work, and other associated expenses. In short, virtual or remote services may be a valuable option for DVIP delivery, if they are not unsafe for offenders, survivors, or other stakeholders.

Consequently, this study is designed to consider the perceptions of DVIP facilitators who provided DVIP services during the early stages of the COVID-19 pandemic, specifically with regard to the benefits and drawbacks of remote versus in-person services for treating IPV offenders. In order to consider these perceptions, it is necessary to review the prevalence and characteristics of DV, which is also known as intimate partner violence or IPV, the nature of IPV offenders, and the typical treatment course for IPV offenders. Additionally, the existing literature comparing in-person and virtual therapy for other conditions will be described and a brief overview of the COVID-19 situation in the US will be delineated.

1.1: Intimate Partner Violence Background Information

Intimate Partner Violence (IPV) has been defined as "any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in that relationship" (World Health Organization [WHO], 2020). IPV is a pervasive occurrence in the United States, experienced by over ten million women and men each year (National Coalition Against Domestic Violence, 2020). This means that each minute, approximately twenty Americans are abused by an intimate partner (NCADV, 2020). All forms of IPV, including physical, psychological, and sexual violence, have serious health implications. Direct and indirect physical maladies, such as injury and chronic disease, respectively, have been linked to the experience of IPV (Black, 2011; Coker et al., 2002). Female victims of IPV are at a higher risk for HIV/AIDs (Gielen et al., 2002) and miscarriage (Silverman et al., 2007). IPV has also been implicated as a factor in the development and maintenance of depression and depressive symptoms in survivors

(Coker et al., 2002). In the most extreme cases, those subjected to IPV may pay the ultimate price: death. Those individuals represent the one in five homicide victims who are killed by an intimate partner (Centers for Disease Control and Prevention [CDC], 2020). Thus, experiencing IPV impacts many domains of health, including physical well-being, mental health, and even mortality (Black, 2011; CDC, 2020; Coker et al., 2002; Gielen et al., 2002; Silverman et al., 2007).

The pervasive nature and devastating health impacts of IPV make it an important public health problem. IPV has even been named a public health crisis, due to its status as a "leading cause of both acute injury as well as chronic medical illness" (Sisley et al., 1999, p. 1105). Despite the fact that rates of IPV were already notable prior to the pandemic, researchers, clinicians, and policy makers have theorized that rates may have increased due to the COVID-19 pandemic. In fact, a study by Boserup et al. (2020) found increases of up to 20% when measured by police reports of domestic violence in various cities around the United States. Additionally, a recent qualitative study that examined 48 reddit postings found increases in severity of violence experienced by victims during the pandemic (Lyons & Brewer, 2021). Unfortunately, changes in the amount and severity of IPV during the COVID-19 pandemic are not surprising when one considers the drastic alterations of day-to-day life that many individuals in the United States experienced. Stay at home orders, as well as school and business closures, often forced victims and abusers to spend additional time together at home with little to no contact with the outside world (Evans et al., 2020). Additionally, many risk factors associated with domestic violence have increased due to the pandemic such as substance abuse and unemployment rates (Anurudran et al., 2020). For these reasons, the perpetration of IVP during the COVID-19 pandemic has even been referred to as a "pandemic within a pandemic" (Evans et al., 2020, p. 1)

or a “double pandemic” (Bettinger-Lopez & Bro, 2020, p. 2302). Therefore, what was already an extremely pressing public health concern may have become an increasingly urgent matter to address following the COVID-19 pandemic. Yet, policy decisions related to arresting, trying, and mandating IPV offenders to treatment in the context of the pandemic have not gotten much, if any, national attention.

1.2: Domestic Violence Intervention Programs

The necessity of delineating appropriate treatment methods and service delivery formats for DV is apparent. Perpetrators of IPV are predominantly treated through DVIPs, which traditionally involve weekly, group-based, in-person sessions with one to two facilitators (Diefenbeck, 2003). Qualifications for facilitators vary depending on program state standards. According to Flasch et al. (2021) the most common requirements for facilitators are to have a bachelor’s degree (n = 19 states) and between 36-49 hours of training (n = 11 states). However, a large proportion of states (n = 21) do not have specified educational requirements for facilitators. States also differ in the types of trainings that facilitators must complete before leading programs. Training courses often include information on IPV generally, lethality and impacts on victims and children. In their own lives, facilitators are required to lead violence free (n = 34), substance free (n = 23), and lack a criminal history (n = 19).

Program length varies depending on state law but are often five to seven months in length, with longer programs lasting 12 to 24 months (Maurio & Eberle, 2008). Batterers or DV offenders are referred to these programs through the court system, associated governmental agencies such as Child Protective Services or the Department of Marriage and Family Services, and, more rarely, via self- or lawyer-referrals. Extant research suggests that the overwhelming majority of DVIPs provide services solely to males (Kernsmith & Kernsmith, 2009).

The common goal and general purpose of each DVIP is to reduce or eliminate violent behavior. In order to achieve this goal, programs employ various program models. Program models can be defined as the educational foundation that DVIPs use in treating offenders of IPV and domestic violence. The model that a program utilizes significantly impacts the type of treatment an offender receives, as it dictates program philosophy, structure of program, level of confrontation facilitators will engage in with participants, and the definition and conception of risk factors for domestic violence taught in classes (Rosenbaum & Leisring, 2008).

The most common program model, used in 73% of programs, is the Duluth model (Cannon et al., 2020). This model assumes that domestic violence is a result of patriarchal social structures (Dutton & Corvo, 2007). DVIPs that utilize the Duluth Model typically teach participants (mainly males) that their violent actions are an exertion of power and control over their typically female victims (Dutton & Corvo, 2007). The core teachings of this model cannot be separated from the gender of the perpetrator, as the ability to have power and control over another individual is thought to emerge from a social hierarchy where males are dominant, and females are secondary or subservient (Dutton & Corvo, 2007). According to this model, violence is a way to maintain and reinforce patriarchy. The second most common model relies on a cognitive behavioral therapy (CBT) approach, which is used in 23% of programs (Cannon et al., 2020). According to CBT, individual dysfunction results from an interaction between three key areas: thoughts, behaviors, and emotions/physiological responses (Tolin, 2017). Programs that utilize a CBT approach address four factors: cognitive misattributions and schemas, emotional regulation, interpersonal skills, and goal setting (Wong, 2021). Other less commonly used models are psychodynamic or based on interpersonal interaction deficits or couple dynamics (Keilholtz & Spencer, 2022).

1.2.1: Efficacy of DVIPs

Research on the effectiveness of DVIPs is mixed, regardless of program model or how success is measured (e.g., recidivism rates, violence perpetrated as reported on the Conflict Tactics Scale (Straus, 1979)). The most common definition of treatment success is decreased recidivism rates, or lowered rates of domestic violence re-offense, among participants following treatment (Ferraro, 2017). This is not surprising due to DVIPs' existence within the justice system and the explicit goal of reducing rearrest and reincarceration. Recidivism can be measured by official police reports, perpetrator self-reports, and/or victim reports of experiencing IPV. In addition to measures of recidivism, recent research often examines secondary outcomes of interest, such as treatment completion (Lila et al., 2018) and relationship satisfaction (Taft et al., 2014), in determining the efficacy of DVIPs.

1.2.2: DVIPs vs. Control Groups

There is no clear consensus on whether DVIPs are effective in reducing recidivism when treated participants are compared to participants assigned to the control condition. Many studies have failed to find statistically significant differences in recidivism rates between individuals who participated in DVIPs and those who received no treatment (. A notable example is the large and methodologically strong study by Dunford (2000), which involved random assignment of 861 batterers to one year of treatment or to a no-treatment control group. In the year following treatment, recidivism rates did not differ significantly between those in the treatment or control group when measured by police records, husband (i.e., perpetrator) self-reports, and wife (i.e., victim) reports of IPV (Dunford, 2000). Similar non-findings have been obtained in more recent research. Graña et al. (2017) found DVIPs to be ineffective in reducing recidivism when compared outcomes from those assigned to a wait list control group. In their sample of 347

batterers, recidivism rates did not significantly differ when measured by police record or self-report (Graña et al., 2017). In addition, Haggård et al. (2017) found identical rates of recidivism (19%) between men who completed treatment and those who did not enter treatment. The results of these three studies suggest that regardless of how recidivism is measured, DVIPs are not effective.

In contrast, several other studies on the efficacy of DVIPs have found significant differences in recidivism rates between treatment and control groups (Bennett et al., 2007; Boots et al., 2016; Hasisi et al., 2016; Kelly & Westmarland, 2015; Pamstierna et al., 2012; Snow Jones et al., 2004). Additionally, three recent meta-analysis by have found statistically significant differences between treated and untreated groups that support the effectiveness of DVIPs (Arce et al., 2020; Cheng et al., 2019; Park & Kim, 2022). Importantly, Arce et al. (2020) found support for the effectiveness of both CBT and Duluth programs, but that a stronger effect size was observed for CBT programs. Additionally, a recent study by Hasisi et al. (2016) reported very promising results for participants emerging their program. Specifically, prisoners who participated in a CBT-based DVIP were 47.9% less likely to be rearrested and 61% less likely to be reincarcerated one year after release when compared to a matched control group who did not receive treatment. These differences stood the test of time. After four years, prisoners who took part in the program were 38.7% less likely to be rearrested and 39.7% less likely to be reincarcerated (Hasisi et al., 2016). In addition to significantly reduced rates of future IPV, offenders who participated in treatment had significantly lower likelihood of committing other types of violent offenses following treatment (Hasisi et al., 2016). Findings by both Park and Kim (2022) and Hasisi et al. (2016) provide empirical support for the efficacy of CBT-based DVIPs in reducing recidivism among IPV perpetrators.

In summary, research on the effectiveness of DVIPs is mixed. While some studies report significant, lasting improvements post-treatment, others fail to find significant differences between control and treatment groups. However, certain treatments may be more effective than others, such as CBT when compared to the Duluth-based DVIP. Treatment modality and features of implementation may be essential factors to consider when determining effectiveness. Thus, the move from holding DVIP groups in person to conducting treatment using remote or virtual platforms may be particularly important to consider as this factor may impact the effectiveness of a service that has yet to reach sustainable and demonstrable effectiveness.

1.2.3: DVIPs vs. Other Modalities

DVIPs are typically offered in a group of 8-15 individuals (Diefenbeck, 2003). Some research has focused on whether this standard treatment, consisting of group delivery with 8-15 individuals and one or two facilitators (Diefenbeck, 2003), is as effective as other modalities. Specifically, they have considered the effectiveness of delivering treatment in individual sessions (Murphy et al., 2017) and couple sessions (Dunford, 2000; Taft et al., 2014). Research on individual service delivery for DV perpetrators is limited but suggests that group treatment is slightly more effective than individual treatment in reducing self and partner reports of IPV. Murphy et al. (2017) found that both administration of individual and standard group CBT-DVIPs were associated with statistically comparable improvements in several domains of IPV measured by the Conflict Tactics Scale and its updated revision (CTS; Straus, 1979; CTS2 Straus et al., 1996), which included measures of physical assault, physical aggression and injury, and emotional abuse. However, the group format outperformed individual treatment on several other CTS2 domains, including in reducing rates of psychological aggression and partner reports of physical assault (Murphy et al., 2017). These results suggest that while both modalities led to

significant decreases in self and partner reports of IPV-related behaviors, group treatment formats likely have significant advantages over individual formats. Moreover, despite the hopeful decreases in CTS2 scores for group and individual CBT-DVIPs immediately post-treatment, rates of rearrest in the year following treatment were strikingly high for both modalities at around 50% (Murphy et al., 2017). Therefore, group CBT-DVIPs may be more effective in improving the self-reported experiences of participants and their partners, but equally ineffective in preventing rearrest and reincarceration.

Research that compares standard group DVIPs to couple's DVIPs, in which a perpetrator and victim receive conjoint treatment, is mixed. Some research has failed to find a significant difference between standard group provision and couple's treatment. For example, Dunford (2000) found that the recidivism rates one year post treatment did not significantly differ between standard group and couple modalities. However, other studies have shown significant results that support the use of couples' treatment. In a study of 75 couples, O'Leary et al. (1999) found that couple's treatment was associated with significantly lower rates of psychological and physical aggression as compared to gender specific DVIP treatment. As measured by the CTS, "husbands reduced their psychological aggression by 47%, their moderate physical aggression by 55% and their severe physical aggression by 51%" (O'Leary, 1999, p. 475). This study supported the use of couple's treatment and its efficacy in improving outcomes for male batterers and female victims. Additionally, a recent study of veteran male perpetrators and their female victims found that both couple and group modalities were associated with reduced recidivism rates; male perpetrators in both groups had zero incidents in the six months following treatment (Taft et al., 2014). While this study supported the efficacy of both formats, there were benefits of couple's CBT over standard group DVIP. Couple's treatment was more effective than standard DVIP

group formats in reducing veteran perpetrator and female partner use of psychological IPV (Taft et al., 2014). Furthermore, female partners in couple's treatment reported decreased use of physical IPV, while female partners of men in the standard group increased their perpetration of physical IPV following treatment. Overall, findings by Taft et al. (2012) suggest that regardless of modality, CBT is associated with reduced frequency and occurrence of IPV for perpetrators and their partners. However, couple's treatment may be preferable over standard group CBT-DVIPs for married couples who are interested in continuing their relationship. In many states though, couple's treatment for IPV offenders is prohibited by law (Arment & Babcock, 2016). Therefore, it is not a method of treatment that is widely used.

1.2.4: Theories on Inconsistent Effectiveness of DVIPs

There are several theories about why DVIPs do not consistently show effective results. Some researchers have critiqued theoretical models for their "one size fits all" approaches. Perpetrators of IPV are known to differ in important ways, such as in personality traits or physiological functioning (Gottman et al., 1995; Holtzworth-Munroe & Stuart, 1994, Johnson, 1994) that may impact treatment outcomes. The heterogeneity in batterers (e.g., age, personality traits, comorbid conditions, substance use) may account for why some individuals succeed in reducing or stopping their violence while others do not follow participation in DVIPs.

Another critique of DVIPs is that they typically leave out known risk factors that relate to perpetration of IPV, such as curtailing substance use (Klosterman et al., 2006; Sotiroff et al., 2022) and addressing past trauma (Voith et al., 2020). Individuals with substance use disorders have been found to benefit more from programs that also incorporate substance use treatment (Timko et al., 2012). Lastly, another theory is that many individuals who participate in DV programs are not ready to change, as they are not typically attending treatment on a voluntary

basis. Lila et al. (2018) cited this as one of the "main challenges to improving batterer intervention program effectiveness" (p. 309). This is an especially salient concern in DVIPs, due to their often mandated rather than voluntary nature. Theories regarding the effectiveness, or lack thereof, of batterer intervention programs illuminate some of the challenges with treating this population as well as with highlighting the importance of considering how variations program implementation might affect effectiveness, as is the focus of the current study.

1.2.5: The Case for Research on DVIPs

In addition to providing services for victims of domestic violence, a focus on perpetrators and their treatment is a key component in reducing the occurrence of IPV. However, addressing the needs of perpetrators has lacked consistent scholarly and clinical attention. Despite knowledge of significant [1] problems with DVIP structure and implementation (e.g., "one size fits all" approaches, lack of motivation to change in participants), the theory, format, and structure underlying DVIPs across the US have remained largely unchanged for decades (Corvo et al., 2009). Outside of a few university laboratories, relatively little innovation has taken place. Additionally, some of the least effective treatment modalities have been reified (Corvo et al., 2009). The most commonly used approach was developed in 1993 and has remained relatively the same since publication (Pence et al., 1993; Corvo et al., 2009). While the field's conceptualization of the mechanisms behind IPV have changed, treatments have stayed relatively static. For example, the fact that there are known associations between substance abuse or childhood trauma and IPV (Gerlock, 2004; Stuart et al., 2003) are notably absent from primary treatment modalities. Advances in therapeutic techniques and modalities (i.e., ACT, DBT), have also yet to be widely adopted by or integrated into DVIP programs (Cannon et al., 2020). The lack of attention to and advancement of DVIPs highlights a general lack of concern for

perpetrators of IPV and their treatment, despite the devastating nature and impacts of IPV on victims and society. Not only does this the lack of attention prevent perpetrators from getting effective help but does little to prevent current and future victims from further suffering and from experiencing deleterious health effects.

1.3: Perpetrators of IPV

When contemplating how a treatment should be implemented, it is important to consider the population who will be receiving treatment. Perpetrators of intimate partner violence are a population with unique needs and characteristics. One shared characteristic among perpetrators of intimate partner violence is their engagement in violent, controlling, and abusive behavior. Within the justice system, it is common that perpetrators are physically and sexually violent in addition to their psychological violence (Archer, 2000; Johnson, 1995). Treatments must consider that the perpetration of a diverse array of violent or abusive behavior towards victims, other participants, or the group facilitators is a real possibility. Safety considerations that may not be present for other populations are of the utmost importance when evaluating the utility of particular treatment modalities for perpetrators of IPV.

Several mental health characteristics have also been identified as common among batterers. These should also be considered when evaluating different forms of treatment. One of the most prominent findings in research on partner-violent men is the significant association between childhood exposure to violence as a victim or a witness and adult IPV perpetration. A meta-analysis by Kimber et al. (2017) reported that out of 19 relevant studies in the literature, 16 found significant positive associations between childhood exposure to IPV and adult IPV perpetration. However, it is important to note that although exposure has been found to increase risk, most individuals who are exposed to IPV do not go on to perpetrate IPV in their adult life

(Roberts et al., 2011). In addition to early childhood exposure to violence, batterers are also more likely than the general population to have certain mental illnesses, such as substance use disorders, alcohol use disorders, and post-traumatic stress disorder (Caetano et al., 2001; Rosenbaum & Leisring, 2003). Due to the higher prevalence of certain mental health concerns in batterers than in the general population, IPV offenders can be considered a vulnerable population. These vulnerabilities may elicit different responses and reactions to particular treatment modalities and must be considered.

In addition to the commonalities among perpetrators of IPV, there is also considerable variability, including with regard to motivations for violence, developmental history, and psychological influences (Butters et al., 2021; Carabajosa et al., 2017; Gottman et al., 1995; Holtzworth-Munroe & Stuart, 1994; Holtzworth-Munroe et al, 2000; Johnson, 1995; Kelly & Johnson, 2008). Differences in certain personality traits have been found to correlate with different IPV presentations and, importantly, different treatment outcomes. For example, batterers who are high in antisocial traits (e.g., lack of empathy, callousness) have been shown to be more likely to commit severely violent acts and to act violently towards both family and nonfamily members (Gottman et al., 1995; Weber & Bouman, 2020). Meanwhile, batterers who are high in borderline traits (e.g., impulsivity, emotional volatility) have been found to perpetrate the most frequent amounts of violence when compared to all other types of offenders (Weber & Bouman, 2020). Similar to offenders with antisocial traits, these perpetrators were also likely to have committed violence towards nonfamily members (Weber & Bouman, 2020). Batterers who have low levels of psychopathology and fewer personality disorder traits show the lowest levels of violence; typically, their violence is only directed towards family members (Holtzworth-Munroe, 2000; Weber & Bouman, 2020). This diversity must be accounted for when considering

different treatment modalities, such as the switch from in-person to remote services. Individual differences in traits, such as personality characteristics, may lead some individuals to be more appropriate for remote services than others. For example, for individuals who commit violence that is more severe (i.e., life threatening) and/or who perpetrate IPV at a greater frequency, online methods of treatment may be less appropriate. Conversely, remote methods may be suitable for individuals who can be considered lower risk.

1.4: Remote Services

Although remote delivery of services is a new mode of delivering DVIPs, this is not the case for health services broadly. Remote service refers to a variety of virtual services that require no in-person contact between individuals. This includes clinician to clinician contact (e.g., email or video communication), clinician to patient contact (e.g., video communication, remote wireless monitoring), and patient to mobile health technology (e.g., medication adherence, mobile apps) (Tuckson et al., 2017). In 2017, the U.S. Department of Health and Human Services estimated that over 60% of U.S. health care institutions were using some form of remote service delivery (U.S. Department of Health and Human Services, 2016). This means that even before the pandemic, healthcare had slowly been shifting towards the inclusion of virtual services for mental health and health care delivery.

To this author's knowledge, there is no direct literature relating to the effectiveness of delivering DVIPs remotely versus in-person. However, there is a strong evidence base for the effectiveness of telehealth for other types of group therapy (Morland et al., 2011; Pugatch & Kim, 2021; Turk et al., 2010). The literature on the effectiveness of telehealth for group veteran treatment, such as at VA hospitals, indicates that remote treatment is comparable in many ways to in-person treatment. Reduction of primary symptoms of interest, such as symptoms of

depression and PTSD, has been observed among groups who received telehealth treatment. Additionally, other important outcomes such as treatment satisfaction (Turk et al., 2010; Pugatch & Kim, 2021) and safety (Morland et al., 2011; Turk et al., 2010) did not significantly differ between those receiving in-person group versus telehealth treatment groups.

Qualitative research on group treatment in veteran samples has elucidated some of the potential advantages and disadvantages of conducting group treatment with primarily male populations. In a study of 51 veterans by Miller et al. (2021), thematic analysis identified important areas to consider when conducting group telehealth. One important consideration was described as external context. The external context of an individual, such as age, distance from treatment center, and specific diagnoses, led to different experiences with telehealth. For example, those who had extensive commutes often expressed a preference for virtual treatment, due to the ease of accessibility. However, many who lived within minutes of service centers preferred in-person treatment due to short travel times. Miller et al., (2021) stated that one of their most important findings, which was also consistent with existing literature, was the potential of remote treatment to address the "myriad challenges in accessing and coordinating care stemming from rural geography, staff recruitment and retention, and unavailability of services" (Miller et al., 2021, p. 442). In summary, service location and accessibility of resources in participants' area are of interest when conducting group telehealth.

In addition to other forms of group treatment, a strong evidence base already exists for the use of telehealth, or telepsychology, for various other mental health conditions, including the treatment of depression, anxiety, and PTSD (Berryhill et al., 2018; Coughtrey & Pistrang, 2018; Drago et al., 2016; Gentry et al., 2019; Ostenbach et al., 2013; Varker et al., 2018). In general, this literature suggests that remote services are equal in efficacy of symptom reduction when

compared to face-to-face treatments. For example, a recent metanalysis of randomized controlled trials found telehealth to be equivalent to in-person service delivery methods in terms of satisfaction with care, quality of the therapeutic alliance, and attrition rates (Bellanti et al., 2021). While still limited in scope and generalizability, the research on telehealth for psychotherapy treatment shows that it may be a promising alternative to traditional, face-to-face treatment. Importantly, equivalence has been seen for both efficacy of treatments and degree of interpersonal connection.

Several studies have assessed the qualitative experiences of patients receiving virtual services, illuminating perceptions of relevant advantages and disadvantages. One advantage of virtual services is the convenience and flexibility of attending virtual services (Hardy et al., 2021; Wolson, 2016). In some cases, virtual services are the only treatment modality available to a client. For example, clients who live in rural areas may not be able to get to an in-person treatment group (Swinton et al., 2009; Wolson, 2016). The ability to reach clients who lack access to resources is a benefit of virtual services. Another benefit of virtual services that has emerged in qualitative research is that individuals may feel more comfortable discussing personal matters from their own home (Hardy et al., 2021) as opposed to when they are situated in a more formal or impersonal treatment setting. Overall, from a patient perspective, the advantages of virtual services are the accessibility of services, the convenience for therapists and clients, and the increased client comfort level.

Disadvantages of remote services have also been identified through qualitative research. Studies in various contexts (e.g., medical settings with nurses, individual teletherapy sessions) have cited technological issues as a key disadvantage. For example, internet connection and connectivity, ease of using virtual platforms, and diminished ability to read clients' mood,

engagement, and non-verbal communication have all been noted as problematic (Hardy et al., 2021; Radhakrishnan et al., 2016; Wade et al., 2016; Sanders et al., 2012). Another important drawback of telehealth is its potential threat to confidentiality. Facilitators are not able to control, and may be unaware of, other individuals who may be in the room during appointments. Additionally, clients may not have a private room to call from or they may call from a public or unsecured location (Hardy et al., 2021; Sanders et al., 2012; Wolson, 2016). Virtual platforms present confidentiality concerns that are not likely to be present in a controlled, office setting. Group settings may exacerbate virtual confidentiality risks that have been found in studies on individual treatment, as there is an increased number of participants who must follow safety and confidentiality guidelines in each session. Lastly, some researchers have cited interpersonal difficulties that arise in telehealth settings. In contrast to in-person modalities, virtual treatments have reportedly reduced the provider's sense of responsibility for their patents (Radhakrishnan et al., 2016), impacted the ability for patients to practice appropriate self-care and coping techniques (Sanders et al., 2012), and does not sufficiently mimic in-person human interactions (Wolson et al., 2016). In summary, qualitative research has identified technological problems, confidentiality concerns, and interpersonal disconnections as disadvantages of virtual modalities.

1.4.1: Established Best Practices for Remote Telehealth

There are many researcher-generated recommendations regarding best practices for telehealth and teletherapy. Many of the recommendations center on the importance of considering relevant cultural and ethical concerns (Luxton et al., 2014; Goldin et al., 2020). Acknowledging the age, technological literacy, and accessibility of telehealth in a given population is essential to address this concern. Sensitivity and accommodations based on these factors can help ensure treatment satisfaction and utility (Goldin et al., 2020). Another

suggestion in the literature is to examine the location and accessibility of services for a given population (Miller et al., 2021). Population setting (e.g., urban, rural) and commute time (e.g., long, short) may impact preference for one form of treatment over another (Miller et al., 2021). Consideration of safety, privacy, and confidentiality have also been raised (Luxton et al., 2014; Watzlaf et al., 2015). For example, the extent to which an individual is alone, the ability to screen record, and the ability to use a cloud to store documents. The literature on best practices for remote telehealth began prior to the COVID-19 pandemic but has expanded to include COVID-19 related guidelines as well (Goldin et al., 2020; Byrne, 2020).

Past research on telehealth has illuminated themes regarding advantages and disadvantages of remote service provision for other medical and psychiatric conditions. However, DVIPs and their participants vary in significant ways from individuals receiving standard telehealth treatment, due to their heightened risk of violent behavior and their mostly non-voluntary treatment attendance. Additionally, the mandated nature of DVIPs differs from standard, voluntary telehealth treatment. Individuals who attend DVIPs often attend out of necessity rather than desire, which may be associated with differences in observed advantages and disadvantages. This is especially important to consider, as an individual's readiness to seek help and change are known to impact treatment adherence and outcomes (Scott & Wolfe, 2003). Due to these differences in safety concerns and attendance requirements, certain drawbacks or advantages may be of greater importance for this population. Differences in the structure and implementation of DVIPs also differ from standard telehealth procedure in the literature in that sessions are group based. The majority of qualitative research on telehealth focuses on those who are engaged in individual therapy appointments. The qualitative themes that emerge from studies on individual telehealth may differ from how facilitators and attendees experience group

sessions. Thus, research is needed that directly considers the advantages and drawbacks associated with group treatment for DVIP as it was implemented early in the pandemic. That is the focus of this study.

CHAPTER 2: STATEMENT OF THE PROBLEM

The COVID-19 pandemic forced many treatment facilitators to utilize remote service delivery methods for some period of time. In a world that is moving towards virtual workspaces, DVIPs may continue to be administered with these methods even after the pandemic comes to an end. Remote delivery of group services may be a beneficial option for DVIPs. Remote treatments offer the advantages of convenience and cost-effectiveness when compared to in-person treatment methods (Hardy et al., 2021; Wolson, 2016). However, it is important to ensure that remote delivery methods are safe and comparable in effectiveness and engagement to in-person methods. Before remote service delivery becomes the new normal for DVIPs, the advantages and disadvantages of this new form of treatment must be examined. This is important for DVIPs specifically, due to the unique aspects that differentiate them from other forms of psychological treatment and remote service provision.

There are several reasons why remote service provision should be studied in DVIPs. First, the efficacy of DVIPs has yet to be widely supported in the literature. If remote services were to reduce the efficacy of DVIPs, this would be problematic. Victims of domestic violence may have expectations about these programs, believing that once their offender has completed treatment, the perpetrator's use of violence will be reduced or eliminated. Victims may even make assumptions regarding their own safety with their offender following treatment. In fact, hope for the offender to change or improve their behavior is one of the most compelling reasons that women choose to stay in domestically violent relationships (Donovan & Hester, 2015; Langhinrichsen-Rohling et al., 1998). One thing that is likely to foster hope for victims is that their offender is in treatment. While we cannot make promises with certainty about the outcomes

of treatment, it is our responsibility to assess the implications of varying the mode of treatment to the extent possible.

Second, DVIPs typically utilize a group-based modality; advantages and disadvantages associated with one-on-one telehealth treatment may not generalize. Although some research has focused on qualitative experiences of those receiving remote treatment, very little has focused on those experiencing group telehealth delivery. It is expected that main themes in past research will be replicated (i.e., technological difficulties in remote settings), as well as novel concerns due to differences in group format, legal context, and the COVID-19 context.

Third, population specific considerations may lead to unique qualitative experiences of facilitators. DVIPs are primarily court mandated rather than voluntary, leading to a population that is not attending treatment by choice. Themes that relate to treatment resistance may be more likely to emerge when comparing remote to in-person delivery formats. Furthermore, due to documented heterogeneity in batterer populations, we expect to find that some clients are better suited for remote service delivery than others.

Fourth, DVIPs have only been conducted virtually during the context of the COVID-19 pandemic. This will likely lead to themes that were not present in pre-pandemic research on remote service provision. The COVID-19 context is especially important since DVIPs have limited support for their effectiveness during normal times, let alone during the course of a pandemic which has increased stress in many domains of life. These programs are not proven to be efficacious to start with and may be differentially experienced by facilitators and participants when conducted remotely.

Lastly, the intersection of psychology and law are an important consideration for DVIPs. During the COVID-19 pandemic, there was not an agreed upon federal response related to

criminal justice service delivery. Other disasters, such as Hurricane Katrina, had more guidance by the federal government (Schneider, 2005). This was not the case during COVID, during which facilitators had to make their own decisions about public health. To further complicate matters, facilitators needed to navigate relevant state guidelines, lockdown orders, and mask mandates, which differed greatly from state to state (Goolsbee et al., 2020).

CHAPTER 3: RESEARCH AIMS AND HYPOTHESES

The purpose of this study is to understand the advantages and disadvantages of conducting remote DVIPs in order to recommend best practices and to highlight who may or may not be most appropriate for virtual DV treatment. In order to address this purpose, this study will examine the qualitative experiences of facilitators who conducted remote DVIPs during the COVID-19 pandemic. Most, if not all of these facilitators were previously conducting their DVIP using an in-person group format. Facilitators of DVIPs play a key role in implementing treatments and often have decision making power over the curriculum and content. The inclusion of facilitators in this study also addresses a gap in the literature on DVIPs, as their perspective and role are often overlooked. Research on the therapeutic alliance (Horvath & Luborsky, 1993; Martin et al., 2000) would indicate that facilitators may be a key component in the success of interventions, due to their status as a direct treatment provider. Therefore, their experiences with implementing virtual DVIP services are vital to examine.

Specifically, this study seeks to address three main research questions:

1. How did facilitators experience their work during COVID-19?
2. From the facilitator perspective, how does remote service delivery compare to in-person service delivery for DVIP groups?
3. What does the future of remote service delivery of DVIPs look like?

It is expected that this qualitative analysis will find similar themes on remote group treatment as are noted in the literature (e.g., convenience, accessibility, appropriateness, safety) Specifically, it is hypothesized that remote batterer intervention group delivery will have many of the same advantages and disadvantages as reported in past research on remote service delivery (Radhakrishnan et al., 2016; Sanders et al., 2012; Wade et al., 2016). Expected advantages

include convenience, accessibility, and comfort level; expected disadvantages include reduced interpersonal connection, and greater communication difficulties, confidentiality concerns, and technological difficulties.

Additionally, it is hypothesized that facilitators may recommend similar best practices to those conducting remote DVIPs as others have recommended for different remote telehealth services. When considering whether or not to implement remote DVIPs, it is hypothesized that facilitators will consider location of participants and participants' personal characteristics as important variables, as has been seen in prior research (Hardy et al.; Miller et al., 2021; Swinton et al., 2009; Wolson, 2016;).

Despite the expected similarities, it is also expected that new themes will emerge due to the uniqueness of the population, the mandated nature of participating in DVIPs, and context of the COVID-19 pandemic. It is hypothesized that safety concerns, particularly victim safety, will emerge as a unique theme raised by DVIP facilitators.

CHAPTER 4: METHODOLOGY

4.1: Participants

In order to locate facilitators of DVIPs that would be willing to share their experiences of service provision during the COVID-19 pandemic, an announcement was sent to a national listserv of DVIP providers. The announcement provided general information about the study, what could be expected from participation, and how to get involved. Participants were told that there would be two parts to the study: a brief initial survey and an interview. The announcement contained the link to an initial survey, which participants were prompted to complete if they were interested in participation. The purpose of the initial survey was to receive informed consent for participation, gather relevant background information, determine eligibility for the interview, and obtain needed contact information for scheduling the interview.

4.1.1: Sample

Sixty-four participants completed the initial survey expressing interest in the study. All individuals who completed the initial survey were contacted to set up a subsequent interview with the research team. Of those individuals, 19 individuals participated in the interview phase. Therefore, this study included 19 DVIP facilitators. Sixty-three percent (n = 12) of these facilitators identified as female, while thirty-seven percent (n = 7) identified as male. At the time of the study, all participants were currently leading DVIP groups either within the United States (n = 17) or Europe (n = 2). Among those from the U.S., 30% reported working in a Southeastern state (n = 5), 30% worked in a Western state (n = 5), 18% worked in a Southwestern state (n = 3), 12% reported working in a Northeastern state (n = 2), and 12% worked in a Midwestern state (n = 2). Facilitators had an average of 16.8 years in total clinical experience (SD = 7.8) and an

average of 13.6 years in DVIP-specific service delivery (*SD* = 8.7 years). Participants were almost exclusively white (*n* = 18), with one Mexican American facilitator (*n* = 1).

Facilitators of DVIPs can vary in their background and qualifications, with different state laws specifying what is required in order to lead groups (Maurio & Eberle, 2008). As such, facilitators in this study endorsed a range of educational backgrounds, from a bachelor's degree to a PhD in Clinical Psychology. Some facilitators owned the organization in which they worked, while others were one of many employees at a large, regional or national institution. Facilitators also varied in the extent to which they perceived that they could influence and dictate the content of their curriculum, with some designing their own curriculum components and others following a standardized program. Most facilitators in this study reported working at a small organization, where they were offering less than six groups per week *(n* = 11). All participants (*n* = 19) worked at organizations in urban areas, which was defined by being located in a United States county with over 50,000 residents. Only one participant from a given DVIP site was included to avoid duplicate information. To compensate facilitators for their time, they were offered a $20 Amazon gift card. Several participants chose to decline the compensation.

4.2: Study Instruments

4.2.1: Brief Initial Survey

A Qualtrics survey was used to collect information from participants. This survey contained 11 questions about the facilitator's work (e.g., "how many groups do you conduct on a regular basis?") and about their experiences in providing DVIP services during the COVID-19 pandemic (e.g., "What challenges of the COVID-19 crisis have you observed for individuals' functioning and/or progress in treatment?"). This survey was created collaboratively by the study team prior to interviewing participants.

4.2.2: Semi-Structured Interview Guide

A semi-structured interview guide was used to conduct the interview (See Appendix A). This interview guide included open ended questions about the participant's experiences in providing DVIP services prior to and during the COVID-19 pandemic (e.g., "Will you maintain any of the current service delivery after stay-at-home orders are lifted? Why/why not?"). In total, the guide consisted of 25 questions. Research Aim One, how does remote service delivery compare to in-person service delivery for DVIP groups? was addressed with questions such as: "What were the pros and cons of [remote / in-person] service delivery method?" Research Aim Two, "What are the implications of remote delivery for perpetrators, facilitators, and survivors?" was targeted using questions such as: "What are the pros and cons of this new service delivery? (Prompting for: safety, security, etc.)". Lastly, research Aim Three, "What do facilitators recommend as best practices for conducting remote DVIPs?", was addressed with questions such as: "What suggestions do you have for improving remote delivery of batterer intervention programs?".

After the first draft of the interview guide was created, a pilot test interview was conducted with a local DVIP facilitator to assess the clarity and utility of the interview guide. Alterations were made to the wording and order of the questions to improve interview flow based on the test interview. For example, questions were reordered so that pre-COVID and post-COVID questions were all grouped together. Additionally, areas of clarification, such as inquiring about group characteristics and structure, were added to the interview guide.

4.3: Procedure

After indicating interest on the brief initial survey, individuals/facilitators were directly contacted by the study team to arrange an interview. Interviews were conducted remotely via

zoom and ranged from 60-90 minutes in length. One team member conducted the interview while a second team member took detailed notes. Participants had the option to have their video on or off during the recording based on their level of comfort. All participants consented to audio and video recording. Interviews were saved and stored securely in a shared google drive, which was only accessible by the research team.

After the interviewing process was completed, the interviews were prepared for qualitative data analysis. Fourteen interviews were transcribed word for word by research staff. Due to technological issues related to the videos, five interviews were translated into a word document using the detailed notes obtained during the interview.

CHAPTER 5: ANALYTIC PLAN

For the current study, the interviews were qualitatively coded following the methodological approach of grounded theory. Under grounded theory, analysis involves three phases of coding: initial coding, intermediate coding, and advanced coding (Tie et al., 2019). Initial coding immediately follows data collection, during which interviews are transcribed and main categories are identified (Tie et al., 2019). Intermediate coding involves selecting core categories and reaching data saturation, meaning that "new data analysis does not provide additional material to existing theoretical categories, and the categories are sufficiently explained" (Tie et al., 2019, pp. 6). Lastly, advanced coding produces coherent theory grounded in the data by synthesizing categories and refining data (Tie et al., 2019).

5.1: Initial Coding

This study followed all three phases of coding delineated by grounded theory. In the initial coding phase, a coding scheme was created to identify main areas of interest (e.g., COVID-specific information). In total, three separate drafts of the coding scheme were created collaboratively with the research team before it was finalized. Alterations were made to decrease subjectivity and minimize crossover between codes for optimal reliability, validity, and theoretical value. Prior to the alterations, crossover between codes (i.e., significant overlap) made it difficult to select which code was a better fit and led to low inter-rater reliability. For example, the number of main coding categories was reduced from over fifteen to seven to decrease the difficulty of sorting information for coders. Additionally, subcategories were adjusted to correspond to specific questions asked in the interview (e.g., "how can remote services be improved?"). These changes resulted in higher initial inter-rater reliability estimates (percent agreement > 0.8) among all parts coded by two coders. Ultimately, six codes were

identified as main categories: (1) COVID-Specific Information, (2) In-Person Services, (3) Remote Services, (4) Appropriateness, (5) Future Plans, and (6) Future Improvement of Remote Services. These codes largely followed the question structure of the interview guide, which allowed for coded sections to be broad enough for further inductive analysis and distinct enough where only one to two codes could be applied per section. Interrater reliability among two coders was assessed at 0.83 for the 6 codes listed below.

1. How did Facilitators Experience COVID-19
    a. Covid-Specific Information

    This code was assigned to any information regarding COVID provided by the facilitator, including general impact and rates of illness in the area, contraction of the illness (e.g., by the facilitator themselves, program attendees, or staff at the facility) and/or the impact of the pandemic on the organization (e.g., mandatory lock down and stay at home orders).
2. How does Remote Service Delivery Compare to In-Person Service Delivery?
    a. In-person Services

    This code was applied to any information about in-person services that the facilitator provided. Two separate subcodes were utilized: Pros of In-Person Services and Cons of In-Person Services. Pros of In-Person Services was assigned to any information that referred to the facilitator's stated advantages of face-to-face service delivery, while Cons of In-Person Services was coded whenever the facilitator referred to a perceived disadvantage of face-to-face service delivery.

    b. Remote Services

This code was used to refer to any information about remote services that the facilitator provided. Three subcodes were utilized: Pros of Remote Services, Cons of Remote Services, and Graduation of Attendees. Pros of Remote Services was applied to the facilitator's perceived advantages of online service delivery, while Cons of Remote Services applied to their perceived disadvantages of online service delivery.

c. Appropriateness

This code was assigned to statements regarding "who" is most or least appropriate for remote services. Statements were coded as "Appropriateness" when the facilitator mentioned a certain group that they believed would be more or less successful in their participation in an online or virtual DVIP. These groupings could encompass a broad range of factors, such as level of dangerousness/lethality, age of participant, and socioeconomic status.

3. What does the Future of Remote Service Look Like?

a. Future Improvement of Remote Service

This code was used when facilitators remarked on how remote services could be improved.

themselves, their organization, or other relevant entities.

b. Future Plans

This code was assigned when facilitators discussed their plans and/or hopes for the future of service delivery for their group and/or organization.

5.2: Further Coding

After the initial coding phase was complete, the primary coder began the intermediate process of data coding in which core categories were selected and data saturation was reached.

Using Google sheets, the primary coder summarized every utterance from each participant that related to one of the main six codes. Using inductive reasoning, the primary coder identified themes among the participants for each code using these summaries. While the initial categories were established through deductive reasoning and drawn from the interview guide itself, later coding involved inductive reasoning, allowing information to emerge from the words of participants themselves. This process ensured that the participant's views and perspectives would be represented in the most authentic way possible. A secondary coder was consulted regularly and provided consensus on these codes, supporting their validity. The themes that emerged through this work will be reported in the results.

Finally, the third phase of coding consisted of refining and organizing the coded information into coherent themes. Codes that were still too broad after the second coding phase went through another round of coding to divide themes and subthemes appropriately. Information that was dissected in stage two was grouped with other relevant information (e.g., "Problems with Audio" and "Poor Wi-Fi" were grouped into "Technological Difficulties"). The analysis was complete when data saturation had been reached, meaning further analysis of the data did not yield any additional categories or codes. Coding and analyzing was an iterative process between the data and established themes until a final analysis strategy was created.

CHAPTER 6: RESULTS

First, this chapter will summarize themes related to research Aim One: How did facilitators experience COVID-19? This information provides the context in which facilitators were providing service at the time of their interview. The COVID-19 pandemic undoubtedly impacted how facilitators conducted services, including whether they transitioned to remote modalities or not. Therefore, this is an essential component in understanding their experiences with remote and in-person service modalities. Next, this chapter will summarize information from the interviews that addresses research Aim Two How does remote service delivery compare to in-person service delivery for DVIP groups? The themes in this section will illustrate the major advantages and disadvantages of remote service according to the perspectives and in the words of facilitators. Special considerations, including graduating attendees remotely and differences among perpetrator populations, will be discussed. Finally, this chapter will present the findings related to research Aim Three: What does the future of remote service delivery look like? The information presented in this section highlights the facilitator's future plans for service delivery and what could make them more confident in providing effective remote DVIP services moving forward.

6.1: How Did Facilitators Experience COVID-19?

Table 1.

Themes and Subthemes Related to COVID-19

Themes	Subthemes	Facilitators	
		N	*%*
COVID-Specific Information	Change	19	100
	Control	11	58

6.1.1: COVID-Specific Information

The COVID-specific information obtained by the interview provided considerable context for the facilitator's decisions during the COVID-19 pandemic. Facilitators' experiences were both specific to their program, as well as to their day-to-day life and job duties and the area in which they lived. Two main themes emerged: change and control.

6.1.1.1: Change

The first theme that emerged regarding COVID-19 and its impact on DVIPs was change. Every single facilitator in the study (n = 19) described changes that affected service delivery during the COVID-19 pandemic. Changes were experienced at several different levels, including community changes and program-level changes. Seven facilitators described community level changes that affected the area in which they conduct their programs. Some of the changes related to the COVID-19 virus itself, such as high rates of the virus in the community or within associated jails. Other changes were indirect impacts of the virus, which resulted more from the response to the virus than from the virus itself. For example, programs were impacted in areas where many public places were shut down or courts were closed. When asked about the experience of COVID-19 generally, Facilitator 1 simply stated, "It's been, from our point of view, a nightmare."

In addition to the disruption of daily life, another change that impacted facilitators at the community level was the observation of increased mental health concerns in general, as well as among group attendees. The presence of COVID-19 appeared to impact those who were already vulnerable within the community. Facilitator 6 described how those with existing mental health conditions were impacted:

> I think COVID with regard to mental health, what it showed me is it magnified underlying conditions that were not there as a presenting problem. So, where people had a lot of what I would consider reasonable fear and anxiety driven type of choices, really it became very apparent with the ability to return to in-person sessions- and these people refusing. So, it took treatment in a whole different direction which was very interesting. I'm also a counselor educator, that's my full-time job and that and researching constantly, going to trainings and so on, I'm always thinking that - Anyway patterns and themes. I'm not sure other counselors were really aware of how COVID magnified underlying concerns that really weren't apparent before but that became clearly obvious to me.

In addition to those with existing mental health conditions, facilitators also described the impact of the pandemic on non-majority or BIPOC community members. Three facilitators expressed that individuals with BIPOC identities were hit harder by the direct and indirect impacts of COVID-19. When asked about their experience of COVID-19 within their own community, Facilitator 1 stated:

> I don't know about specifically where I live but [in a nearby zip code], which is very heavily populated with Hispanic, Asian, and Vietnamese communities and I know that they've been hit hard, at least the Hispanic community.

DVIP group-level changes were also endorsed by all 19 facilitators. Regardless of whether groups went remote or remained in-person, groups were impacted. Eleven facilitators shut down services due to the COVID-19 pandemic for some period of time. Nine facilitators shut down their services for a brief period of less than four weeks, while two shut down services for an extended period. In one case, DVIP services were shut down for a period of up to six months.

Facilitator 15 expressed their concerns about such a long shut down, describing a past incident where delayed contact led to devastating consequences:

> Many years ago, I was really quite disturbed by a guy that ...contacted us about this kind of time of the year. And we weren't due to work until January. When I got back in touch with him, at the beginning of January, so I went through the application form with him in in December, and then got back in touch to say, we're ready to work now on January the sixth, or the 10th, or whatever it was. And his wife said he committed suicide. And it just reminds me that the service is so important for people that you can't really afford to have the gift with the gap between it. So, you know, we need to make contact with them as quickly as possible. And to get on with it. And of course, COVID has just really meant that things beyond, are things beyond our control mean that we just can't do that.

Four facilitators did not have any delay in their transition to remote services and experienced no shut down period. There was no recognizable commonality among facilitators or their organizations to determine who was able to transition and keep services going without delay. Some worked at larger organizations that already had some technological infrastructure in place prior to the COVID-19 pandemic, while others had little technology experience and worked in a small or single-group business. Facilitator 12 described their immediate transition by stating:

> We never shut down. We always provided services. The county, I mean, for domestic violence in general. We never, we never closed down. Neither for others. I mean, we tried it. We were working from home, working through our, you know, at our office without bringing anybody else in. We stayed at the capacity that we were told, and but yeah, we never shut down.

Fifteen facilitators reported that their services went remote for a period of time during the COVID-19 pandemic. A couple of facilitators (n = 2) only went remote for one or two groups, before deciding that they would like to return to face to face services. However, most facilitators who went remote (n = 13) did so for the duration of the pandemic.

In addition to changes in service delivery, facilitators also reported changes to group logistics such as group structure, group attendance, and payment. Several facilitators (n = 5) reported conducting smaller groups during the pandemic. In some cases, the rationale for conducting smaller groups than usual was to adhere to state restrictions on social distancing. In other cases, smaller groups were used due the ease of facilitating online treatment with smaller rather than larger group numbers. Five facilitators also mentioned there were changes to their attendance policy during the COVID-19 pandemic. Due to the potential of sickness due to COVID-19, potential exposure to COVID-19, and difficulty using new online platforms, many decided to relax their attendance policies. Facilitator 4 described their policy as much more lenient:

> The other change is that we've become very lax with our attendance policy. I mean, we've always had kind of a flexible attendance policy anyways, but now it's like, "okay you sneezed? Don't come to class". Usually if somebody's been sick, I would usually probably count that absence anyway and now I'm like "nope, if you're sick I'm not going to count that absence towards your total because I don't want you here, I want you to go home.

Four facilitators also mentioned changes to their payment method or system, which occurred due to the COVID-19 pandemic. Some changed their payment schedule to be more lenient, as many attendees had lost their job and could no longer afford the previous rates. Other facilitators took a

different approach and chose to increase fees or implement a stricter payment schedule during the pandemic. This may have been due to the fact that the transition to online platforms was expensive for some organizations, particularly those who conducted a small number of groups, had fewer participants in each group, and/or did not have an existing infrastructure for remote services.

6.1.1.2: Control

Another theme that emerged in relation to the COVID-19 pandemic was control. This theme was present in eleven out of nineteen facilitator interviews and transcripts (58%). DVIPs are nested within a greater criminal justice system, which varies greatly by state and by country. Additionally, within a state, different organizations may have different policies and procedures that facilitators are required to follow. For example, rules varied with regard to in-person service provision (e.g., mask wearing, increased sanitization, temperature-taking, social distancing) and whether or not remote service delivery was acceptable. When facilitators described their decision-making process, it became apparent that facilitators had different levels of control when it came to making decisions about their groups. Some facilitators described a great deal of control and autonomy over their program. For example, Facilitator 6 described autonomy in making decisions regarding in-person COVID-19 safety procedures:

> I always offered people to - if they wanna wear a mask they can, if they don't wanna wear a mask they don't have to. Do they want me to wear a mask? I will. If they don't care, then I won't. With the group, we do a vote every week for people's comfortability. I let the group decide. And then, each individual if they're not comfortable can choose to wear a mask or ask me as the facilitator to wear a mask. The group is pretty comfortable.

> I try to advocate for people to be empowered and to be assertive. That's another one of the tools I teach them in group, which is assertion not aggression.

However, eight out of the eleven facilitators who referenced control described a lack of control and autonomy over their program. For these facilitators, decisions about their program were largely made by state government or a DV coalition. Facilitator 18 shared how their program was largely impacted by the state's decisions during the COVID-19 pandemic:

> So, I want to say, March 15 was the last day that we were live. That was our last day. And then after that on the 17th, they shut us down. And we were not in the 21st century. Okay, our company. So, I mean, we had never done anything virtual. So that was very new to us. So, I would say probably it took us about three weeks and then we started up again.

Some facilitators openly discussed their negative emotions surrounding their lack of control. In other words, they were unhappy with the way that the state was interfering with their program, or they didn't find their state guidance valuable. For example, when asked about their state's procedure to switch to remote groups, Facilitator 13 stated:

> They had us apply which was really stupid it was so bureaucratic. So, it was a request for expedited standard variance for use of teletherapy or e-therapy and so it was this 30-day thing and the questions that they asked us are "describe how the proposed variance addresses victim safety", it doesn't! And then the next one says, "describe how the proposed variance addresses community safety", it doesn't!"

6.2: How Does Remote Service Delivery Compare to In-Person Delivery for DVIP groups?

6.2.1: Pros of In-Person

All nineteen facilitators (100%) were able to identify aspects of in-person service delivery that they perceived to be strengths or benefits. Five main themes emerged under this category: Interpersonal Advantages, Observation and Assessment Advantages, Logistical Advantages, Safety, and Preference.

Table 2.

Pros and Cons of In-person and Remote Services

Themes	Subthemes	Facilitators	
		N	*%*
Pros of In-Person	Interpersonal Advantages	15	79
	Observation and Assessment	9	15
	Logistic Advantages	6	32
	Preference	9	47
Cons of In-Person	Inaccessibility	16	84
	Safety Concerns	4	21
Pros of Remote	Decreased Barriers	11	58
	Accessibility	8	42
	Client Comfort	9	47
	Safety	4	21
	Facilitator-Specific	5	26
	Preference	5	26
Cons of Remote	Effectiveness Concerns	15	79
	Technology-Specific	11	58
	Increased Demand	9	47
	Interpersonal Impairment	8	42
	Privacy/Confidentiality	7	37
	Safety	7	37

6.2.1.1: Interpersonal Advantages

Interpersonal Advantages was the most prevalent advantage of in-person service delivery, mentioned by fifteen facilitators. Facilitators who mentioned this theme found value in the types of relationships that one is able to cultivate in an in-person environment. In order to capture the variety and depth of this particular theme, it was broken down into three subthemes: Connection, Mentorship, and Community.

The subtheme connection referred to the ability to relate to individuals on a deep, meaningful level. Fourteen facilitators mentioned connection in their interviews. Often, connection referred to the relationship between facilitator and group participant. Facilitators found that they had better interpersonal interactions, got to know their group members better, and were able to cultivate a stronger therapeutic relationship when sharing the same physical space. When asked about the advantages of providing services in-person, Facilitator 4 shared:

> My favorite part, the thing that worked about it was just being able to be present and build these relationships with these people because I feel like again just thinking about our therapeutic relationship, our therapeutic alliance like we've gotta have that if we're gonna create change, right? So, getting to be able to be present, being able to ask questions, to really follow up with people well.

Many facilitators (n = 9) also observed a stronger connection among and between group attendees during face-to-face interactions. During their interviews, these facilitators shared that men were able to build a support system amongst one another, communicate more effectively with others in the group, and even experience the power of standing before their peers to share their story. Facilitator 4 described these connections by stating:

> The pros was the relationships between the clients and they could see each other, they could run out to the car and get something for one of the other guys, and so I think the closeness, the physical interactions and we also have a part of our curriculum requires that they hold hands at the end and recite a pledge of non-violence.

In addition to connection between the men, seven facilitators reported that in-person services created the opportunity for mentorship between men. Mentorship was described by facilitators as the ability for men who were further along, or even previous graduates of the DVIP, to take new attendees under their wing. These more advanced men in the program would model how to succeed in the DVIP, help to ensure that new members had appropriate transportation and resources, and hold them accountable for their behavior and participation throughout the group. When asked about the advantages of in-person services, Facilitator 6 shared:

> I like that mix when I can have guys with more group experience or more trust in the facilitator because they're almost mentoring to these new guys or showing without saying how to participate in the group fully, how to get the maximum out of it.

The final interpersonal advantage that emerged through interview transcripts was community, which was coded as occurring in six interviews. Community referred to the benefit associated with the type of environment that facilitators felt they were able to create in-person. Facilitators who described community as a strength of in-person treatment found that they were able to easily create a warm atmosphere, which set the stage for a positive treatment experience. This was most often described as the community between men in the group but could also refer to non-male populations and the relationship between facilitator and group members. Facilitator 4 described the community of their environment when they shared:

> One of the strengths of our program is the creation of this kind of collaborative environment that's very welcoming. We just create a very welcoming environment. A lot of times people will come in and they will say "I really didn't want to take these classes, I wasn't looking forward to them, I expected ya'll to be just shaming and blaming and blah blah blah, but I actually look forward to it.

6.2.1.2: Observation and Assessment

The second broad theme that emerged for the advantages of in-person services was the enhanced ability for observation and assessment, or the ability for facilitators to gather information on their attendees by evaluating their physical presence and behavior when they were in-person. This theme was present in nine of the nineteen interview transcripts. Some facilitators described observation and assessment in a general manner, such as being able to be in the participant's space with them, see their body language, and even assess sobriety. For example, Facilitator 18 shared that:

> Well, the pros is that you can actually see your client and you can actually see where they're at. I mean, you can tell by body language, you know, we're trained in substance abuse, so we can tell if they're under the influence. Being on a computer screen they can be drinking the beer on the side during group and we really don't know.

Six facilitators also mentioned the importance of in-person observation and assessment when determining participant's level of engagement. These facilitators felt that it was much easier to discern whether attendees were engaged with the course content when they were physically present in-person. Furthermore, when facilitators noticed that someone was disengaged, it was easier to re-engage these individuals in an in-person, rather than remote setting. Facilitator 4 described this process by stating:

> Another thing that I liked about [in-person service delivery] was that it was really easy to kind of gauge people's connection, their engagement in the lesson. And to call them out on it or to engage people who were unengaged. That was another thing, a thing that I liked about that delivery method.

6.2.1.3: Logistic Advantages

Logistical advantages were another positive aspect of in-person treatment, which was reported by six facilitators. Three facilitators found that it was easier to share materials amongst program attendees face to face. They also shared that certain classroom activities, such as writing on the whiteboard or having a guest speaker attend, were simple and straightforward for in-person groups. For example, Facilitator 10 shared how online groups compared to in-person groups for sharing materials by stating:

> [In online groups], you see a lot of problems sometimes with the connection and audio and being able to view the data that's being placed up on the screen, where in the classroom setting, you've got a big whiteboard and everyone's within a distance of being able to see clearly and videos.

6.2.1.5: Preference

Several facilitators (n = 9) expressed a preference for in-person services over remote services. These facilitators extolled the benefits of in-person services, and many even struggled when asked to describe or consider drawbacks related to this modality. Some facilitators explicitly stated that they believe in-person to be more effective than remote services for treating their clients. For example, Facilitator 10 stated that:

> Personally, I think the teaching in-person is much more effective. You build that one-on-one relationship in the group. I think you get to know your group members better. You obviously can see body language a lot clearer and attitudes and all that good stuff.

Others spoke about their expertise when explaining why they preferred in-person treatments. These facilitators reported that they have been conducting in-person services for many years and, for this reason, they experience few difficulties when using this method.

6.2.2: Cons of In-Person

Sixteen out of nineteen facilitators described the disadvantages of in-person treatment in their experience. Even when prompted, three facilitators were unable to offer any perceived disadvantages of in-person treatment. Among those who did speak about the disadvantages, two main themes emerged: Inaccessibility and Safety Concerns.

6.2.2.1: Inaccessibility

Inaccessibility was a prominent theme for the disadvantages of in-person treatment. Every facilitator who spoke about the cons of in-person (n = 16) spoke about inaccessibility. Facilitators described many barriers that they believe negatively impacted their group members' ability to attend groups in-person. The main difficulty that facilitators described were transportation difficulties for their group members, which was mentioned in ten interviews. Facilitators reported that their group attendees were often unable to obtain transportation, pay for transportation, or have the time to transport themselves to and from groups. In some groups, facilitators have group attendees that make commutes of two hours or more to the DVIP, making transportation an important barrier to receiving services. Facilitator 1 explained the issues associated with transportation, by stating that:

> Now, the disadvantages of face-to-face was location and transportation. Like if they're coming from [a neighboring county], right, it may take them an hour and a half in traffic to get to our office and then some clients, especially in the outlying areas, there's no public transportation and if they didn't have transportation today, they would have to get rides or pay for rides, Uber you know and that can be expensive and it's not reliable.

Work conflicts were mentioned by eight out of nineteen facilitators, which contributed to the inaccessibility of in-person services. Several types of conflicts with work were discussed, such as work and groups taking place at the same time, inability to make it to group on time due to tight scheduling, inability to take time off work, or inability to afford to take time off of work. Facilitator 14 stated that out of all barriers to attending group, "work schedules [and] transportation are the biggest. I don't know if there are any others other than snow here."

Four facilitators mentioned family and childcare obligations as a reason for in-person group inaccessibility. These facilitators reported that group attendees had a hard time getting to group due to the additional barrier of having to set up childcare arrangements. For some group members, a barrier was the cost of childcare, while for others, the barrier was having childcare plans fall through or be inconsistent. When asked about common barriers to service, Facilitator 6 shared that for her group attendees, it is:

> Their lack of childcare because a lot of people in this area are not from here. They've migrated from [further counties] and so their family are elsewhere, so they're relying on their partner and themselves. If their partner has to work, who is gonna take care of the kids? That's what happened this past Monday, one of my guys said I have to watch my girls. And that means his wife was probably working.

Another reason that facilitators described in-person services as inaccessible was due to financial difficulties. The concept of financial difficulties as a barrier to in-person service delivery was present in eight out of nineteen interviews. Finances appeared to limit participating in group in several ways. Facilitators reported that group attendees could not afford to pay for transportation, to take time off work, or to pay for childcare services. Finances were described as tied to accessibility independently, as well as in combination with other barriers. Interestingly, finances appeared to underlie other barriers as well (e.g., transportation, childcare). Several facilitators even described finances as being the largest barrier for their clients. When asked about barriers to in-person service, Facilitator 4 responded:

> For some of them, finances, I think finances is probably a big reason. There's some of them who don't want to do it and it costs money and so they're just not willing to because they don't have the money to do it. So, I think probably finances is a big reason. And then other people, it's probably work or transportation might be other reasons why they might not get in. If I had to pick one, I would probably say finances would be the biggest reason people wouldn't come.

6.2.2.2: Safety Concerns

Four facilitators expressed concerns about safety during their in-person groups or while providing in-person services. One of the main situations in which facilitators seemed more likely to feel unsafe was while conducting intake assessments for the program. Some facilitators believed that the intake process poses a higher risk to safety due to the fact that they have not yet established a relationship with the new group participant, and they may have to be a bearer of bad news (e.g., informing the patient about a failed drug screening, explaining the cost and

extent of treatment needed). When asked about if they ever had safety concerns, Facilitator 13 shared:

> Well, there was probably more than once where I felt like I was gonna get my ass kicked… We've had quite a bit of police contact. Well not quite a bit, that sounds terrible. I would say in my career, probably eight times where we were hitting the panic button because typically intakes, people are coming in, they don't think it's their fault, they don't want treatment, then you gotta tell them they have to come twice a week and it's going to cost this much money… We've had quite a few people fight in the parking lot because somebody looked at somebody the wrong way, gang members or opposite gang members being in the same facility.

However, contrary to expectation, nine of nineteen facilitators reported a history of few to no instances of safety concerns in their career as a DVIP facilitator. When asked about whether they ever had any safety concerns in their group, Facilitator 17 shared:

> Not really. I did never see a safety issue, whether it be with the men or the women and, quite honestly, I was really not worried with the men because if ever there was a client in the men's group that started acting as if they were becoming hostile, the rest of the group really jumped in and kind of took care of it.

6.2.3: Pros of Remote Service

The perceived advantages of remote service were mentioned in sixteen out of nineteen interview transcripts. Six themes emerged among these advantages: Decreased Barriers, Increased Accessibility, Client Comfort, Safety, Facilitator-Specific, and Client Preference.

6.2.3.1: Decreased Barriers Associated with In-Person Treatment

The most prevalent advantage to providing remote DVIP treatment reported by these facilitators was the ability to decrease the main barriers associated with in-person treatment. Specifically, remote treatment was able to tackle four common barriers to in-person service delivery: (1) low access to transportation, (2) finances, (3) childcare needs, and (4) work barriers. Eleven of nineteen facilitators mentioned this theme in their interviews. The barrier addressed by remote delivery that was brought up most often was transportation, which was mentioned by ten facilitators. The elimination of time traveling to treatment removed a substantial barrier for many group attendees. Transportation could be a barrier due to the time in transit, cost of transit, cost of childcare, or conflict of transit with other obligations (e.g., work schedule, childcare). Therefore, facilitators expressed that this was a vital benefit associated with providing remote groups. When asked about the ability for remote services to decrease in-person barriers, Facilitator 11 emphatically shared:

> Time, the time that it took to get to the program. Especially if, like, I just got a referral or I got just got a call from the police officer from one of my other counties who lives in yet another one of my counties and he wants to come to group at 6 p.m. Well, virtually he'll be able to do that. He can take off five minutes early and go out in his car or wherever and join group. But if he were working to 6 p.m. and having to drive to a group, then he would have to adjust his whole work schedule or change the group that he's going to.

Other important barriers that were decreased include cost of services, decreased need for childcare, and decreased work barriers. Facilitators shared that these common barriers to accessing in-person DVIPs were greatly diminished, and in some cases even eliminated, through remote service delivery.

6.2.3.2: Accessibility

The theme of greater accessibility was present in eight out of nineteen interview transcripts. Facilitators described several ways in which groups were more accessible for attendees, including shorter waiting times to enter group, attendees could enter group at any time from any location, and more attendees could be enrolled in groups at a given time. In the past when clients have not been able to attend their DVIP group due to life events such as illness or vacation, they would have been forced to miss group. Remote service options were now able to provide an alternative to missed groups in such situations. When asked about the advantages of remote service, Facilitator 14 stated:

> The pros are accessibility and the cons are accessibility. The better word would probably be immediacy because you don't have to travel, you can pick up the phone and you're on immediately. … Overall, I think the greatest pro is just being able to get online whenever and wherever I am.

6.2.3.3: Client Comfort

Nine facilitators mentioned client comfort in their interviews as a perceived advantage of remote services. When compared to in-person settings, facilitators found online platforms were generally experienced as an emotionally safe and low-stress environment. Because of the less intimate setting, facilitators observed that clients appeared to be more at ease when calling in from the comfort of their own home. For example, Facilitator 16 experienced that, in their groups:

> Some people feel more comfortable. They're kind of not 'out there' in front of everybody. And, they may be in the comfort of their own room. So, I think some feel more comfortable.

6.2.3.4: Safety

Four facilitators referenced the theme of safety in their interviews. These facilitators perceived that providing services in a remote setting eliminated their concerns about physical violence directed towards themselves or between group members. Even facilitators who felt safe in their face-to-face meetings were comforted by the fact that they faced no threat of physical violence during remote groups. This was particularly important for intake interviews, during which the facilitator is unfamiliar with the client and there may be issues of substance use present. For example, Facilitator 13 stated:

> I started doing intakes from home and I was like "wow, I can breathe doing this" and if somebody gets out of control I can hang up. So, I feel safer. I think that our clients are safer… In fact, I'm nervous to go back to in-person intakes and I had a meeting with the [state DVIP governing committee] and they had this big lunch-in about online services and I said, "I think all intakes should be done online". I think it's safer for us, it lets us assess their dangerousness level without having that, "I don't know this person, and I have to tell them that they have to sign a release so we can talk to the victim."

In addition to increased safety for the facilitator, facilitators also mentioned increased safety for group attendees and victims. Similar to heightened safety for facilitators, group members themselves also do not face any risk of physical violence between one another when groups are held remotely, as they are not in the same room together. It also decreases the chance for inappropriate relationships between clients, such as if male and female offenders attend back-to-back classes at the same facility. In other words, "safer from clients hooking up with each other in the parking lot" (Participant 13).

6.2.3.5: Facilitator-Specific

When speaking about the advantages and disadvantages of both methods of service delivery, facilitators often discussed their perceptions of what was beneficial or detrimental to their group attendees. However, some facilitator-specific advantages to remote services did emerge, including Ease of Delivery, Flexibility, and Preference.

Five facilitators perceived remote services as easier to deliver than in-person services. These facilitators perceived that several aspects of remote delivery run more smoothly, including contacting clients, maintaining regular communication with clients, and using internet-based platforms. Facilitator 1 described his/her experience by stating:

> It's certainly easier for me once you get past all the glitches in the delivery, logging people in and getting people to understand that it's the same freaking login every week that I don't need to send them a new invitation, that kind of thing. So, it's just different, you know, with face-to-face I've got to make sure I get to the office in time.

In addition to relative ease of delivery, five facilitators described flexibility as a benefit of remote service. These facilitators found value in the convenience of remote groups. By providing groups remotely, facilitators were able to have a better work life balance, take advantage of the downtime between groups or sessions, and have extra time to devote to their job. When asked about the advantages of remote DVIPs, Facilitator 14 described the flexibility and convenience of attending from home by stating:

> I can brush my teeth, put on shorts and a shirt, and sit down here and I'm here. And I'm in my house and my dog may walk up behind me, you know and it's like this is great in some ways. In other ways, it's more stressful, but I think it's seeing myself doing what I do, and I think that's one reason why it's getting less stressful for me because I'm getting used to it. And I love being at home, I kind of don't wanna go to the office anymore.

Lastly, preference emerged as an advantage of remote service delivery in five interviews. Facilitators who expressed a preference for remote service stated that the pros outweigh the cons. Some described the experience of a learning curve, where they have become so accustomed to using remote services that it would be an adjustment to transition back to in-person. Facilitator 16 even described that remote services are similar to their experiences in-person, by stating:

> There have been a lot more pros than I thought would be because I was not a proponent of Telehealth. No, it can't be the same. It definitely can't be the same and - but I was forced into this. And you know, I'm a licensed professional counselor, so I see a lot of my own clients now Tele Health, and I've been pleasantly surprised at Yes, you can do deep counseling through TeleHealth, and I was so sure that you couldn't so… I was happy to be proven wrong on that and to be forced to learn it 'cause I think it is going to be a way of the future.

6.2.4: Cons of Remote

Sixteen out of nineteen facilitators indicated that they experienced some disadvantages with remote treatment. Even when prompted, three facilitators were unable to offer any perceived disadvantages of remote treatment. Among those who did provide disadvantages, six main themes emerged: Effectiveness Concerns, Technology-Specific Difficulties, Increased Demand for Facilitator, Interpersonal Impairment, Privacy/Confidentiality Concerns, and Safety Concerns.

6.2.4.1: Effectiveness Concerns

Effectiveness concerns emerged as a theme in fifteen out of nineteen interviews. In some cases, these concerns were explicit. Four facilitators stated that remote services were not as effective nor productive as in-person treatment. For example, Facilitator 13 stated that:

> There are the challenges. Another challenge would be content. Number one would be like in the room, we can do activities, we could do breakout groups. We can have them come up with the types of abuse that they have potentially used in the past. Challenges in relationships, red flags in relationships, communication skills. We can't do that over Zoom. I mean we can **but it's not nearly as effective,** people seem distracted.

In other interviews, facilitator's concerns about effectiveness were less explicit, but were also related to program effectiveness. The first subtheme was no-show increases, which was mentioned by four facilitators. These facilitators stated that a higher number of individuals were absent from their remote groups as compared to their in-person group sessions prior to COVID-19. When asked about the reason behind heightened no show rates, one Facilitator 11 reported that:

> I think the forgetting is more common, I think the forgetting is more common now, you know people are asleep and they just, their alarm doesn't go off or they forgot to set it.

The second subtheme that emerged under effectiveness concerns was reduced engagement, which was mentioned in ten interviews. Facilitators described a variety of ways in which individuals were disengaged from their group sessions. In some cases, they observed that men were simply disconnected or not paying attention to the group content. Facilitator 11 stated that:

> I mean the main con doing it this way is that not everybody is, I mean not everybody is engaged when they are sitting in the group either, I mean they can certainly check out, but they are not watching television and they are not playing video games.

In other cases, group attendees were disengaged because they were doing other activities during the group time. Remote settings allowed group attendees to disengage in ways that would have never been possible in an in-person setting. Clients were observed doing activities such as

watching TV, making dinner, and driving. Facilitator 16 described two different incidents where the DVIP group was disrupted through inappropriate activities:

> I've had somebody on a fishing boat fishing. I'm like no, no, no, no. Somebody who I'm like, "I hear water running in your background. Can you turn that off?" "Oh, I'm about to get in the tub". I'm like, "no you are not about to get in the tub in this group."

6.2.4.2 Technology-Specific Concerns

Technology-specific disadvantages were one of the most prominent themes that emerged when speaking about the disadvantages of remote treatment. Eleven facilitators described difficulties that they faced when conducting groups remotely. To capture the breadth and depth of potential technical difficulties, this theme contains three subthemes: Glitches, Poor Internet and Wi-Fi Oh My!; Accessibility to Technology; and Lost in Translation.

The Glitches, Poor internet, and Wi-Fi-oh my! theme refers to the wide array of problems that facilitators indicated were related to their use of technology or platforms. One of the most frequently mentioned difficulties was lack of Wi-Fi connection, which was specifically mentioned by six facilitators. Both difficulties with the facilitator's connection to Wi-Fi as well as difficulties with their group member's connections to Wi-Fi resulted in problems. And, as Facilitator 16 described, it only takes one poor connection to disrupt the entire group:

> Your group is as good as your weakest link. You have somebody that you know keeps getting booted. You can't hear me. I can't hear you. Or they're breaking up and glitching. So, technology, the smoothness of technology is the hardest. That's the big con… It's definitely a different energy as opposed to when you're all in the room together. If a couple try to talk at one time, they're blocking each other out. Mostly, it's technology is the cons.

In addition to poor Wi-Fi, other features of remote platforms were difficult to navigate. Facilitators described experiences of frequent glitches, poor audio quality, and poor webcam quality. Facilitator 4 described how these factors could negatively impact group:

> The problem with that is that my webcam and audio were terrible so I could only see maybe six guys at the most and everybody else was off camera. And then the other problem was just with the audio. I couldn't hear what everybody was saying and so that got in the way of everything. I couldn't listen well, I couldn't respond with empathy, it was mostly me going "I'm sorry, what'd you say", "I'm sorry, can you repeat that?" It was kind of in the way of anything productive happening.

Accessibility to technology was another subtheme nested under technology-specific disadvantages, which was mentioned by eight facilitators. These facilitators observed that, for several reasons, their group attendees had difficulty obtaining the appropriate technology to attend group in a meaningful way. In some instances, group members did not possess their own computer or didn't have reliable access to another person's computer, making it difficult to attend group or complete online assignments. The most vulnerable were perhaps the most impacted by these challenges. Facilitator 18 described how a lack of accessibility to certain technology impacted their DVIP group negatively:

> A lot of clients may not have access to computers. They may not, they may be a sex offender, so they can't be on the computer. So, we took precautions for them. There's some, in fact, I want to say we have two or three that do not have access to a computer and their phone is you know, old school, they don't have the camera accessibility.

Other facilitators found that their attendees did not have access to a safe space for remote calls. This was a disadvantage, as these individuals were forced to call from inappropriate or non-

private locations. A couple of facilitators reported that hearing children in the background of calls was a frequent occurrence during remote groups. Facilitator 12 described the difficulties that arose for their group when group attendees did not have access to a private space to attend group:

> We usually, you know, tell him go to someplace where you can be isolated where you can, you know, your confidentiality is not, you know, not hurt or anything. So, they, they do try, but there's always some distraction going on outside or knocking on the door and stuff like that. So, and these gentlemen, some live in sober living homes. There's maybe one or two that live alone. But the rest are, are all in other homes. So, it's kind of hard.

Regardless of the reason, lack of access to technology was a significant problem because such access was necessary to attend the DVIP group remotely. Additionally, facilitators reported that lack of access to a private space was distracting to everyone in the group, not only the individual.

The third and final subtheme of technology-related disadvantages was named Lost in Translation, this subtheme was coded in seven of nineteen facilitator interviews. This subtheme referred to instances where facilitators described in-person activities that were not able to be replicated in an online space. Several facilitators described this phenomenon in reference to using the whiteboard. In a classroom setting, a whiteboard is extremely easy to use and easy for group attendees to observe. Despite the existence of online whiteboards (i.e., through Zoom), facilitators found them to be insufficient replacements for in-person whiteboards. Facilitator 17 expressed their opinion on remote whiteboards, by stating:

> But the other challenge with the technology was, I use a lot of, I use the whiteboard a lot. I'm a very visual learner and I find that they are too and so I use the whiteboard a lot. Thank goodness Zoom has a whiteboard, but it's not as easy to use as a real whiteboard.

6.2.4.3: Increased Demand for Facilitator

Another prominent disadvantage of remote service delivery that was described by facilitators in this study was an increased demand for the facilitator, which was mentioned by nine facilitators. Demand could refer to emotional demand or it could describe a more demanding workload. Facilitator 4 described the emotional toll that remote service provision can take on the group facilitator, by sharing:

> I like being with people and I like connecting with people. This was a complete energy suck. It took all this energy to be on and talk. It's all on me and there's no getting energy back from my audience. I found that even though it was convenient in some ways, it was just a complete energy suck. To me, it was exhausting. Afterwards I would just be like, "I know that I'm just exhausted".

Four facilitators reported that it was more difficult to assess and observe individuals in their group when compared to in-person service provision, which increased the demand or complexity of their workload. They were not able to observe body language, behavior, and demeanor in the same way that they would be able to in-person. Facilitator 17 described the difficulty of remote assessment, by stating:

> The other thing is that a lot of them I tell them that they must be on camera at all times, and sometimes they're not. They go in and out and they say, well, I got kicked out because somebody called me or I'm trying to do a screenshot, or I don't know. My tech isn't working and it's just a lot harder to assess. For me, it's a lot harder to assess their

> level of engagement when it's just you know of this, I call it Hollywood Squares. Just little boxes on my screen and so it's harder to get them for me to assess how engaged they are. It's harder for them to interact with each other, and **it's also harder for me.**

Three facilitators spoke about experiencing a difficult learning curve for remote treatment, which also played a role in increasing the demand on facilitators. These facilitators stated that both group attendees and the facilitator themselves had a steep initial learning curve when it came to the provision and participation in remote services.

6.2.4.4: Interpersonal Impairment

When asked about the disadvantages of remote treatment, eight facilitators spoke about interpersonal interactions. These facilitators felt that they personally lacked a connection with their attendees when DVIP groups were conducted remotely. Additionally, they observed a lack of connection between attendees. They perceived that this lack of interpersonal connection impacted the DVIP group negatively. Communication difficulties were common, such as attendees talking over each other or interrupting one another. Group attendees also were able to easily avoid vulnerability in remote settings, which detracted from certain group activities and the bonding among the group. When asked about the drawbacks to remote service delivery, Facilitator 10 shared, “personally, it’s just the interpersonal relationships between the facilitator, the group members themselves as well as the individuals being able to engage.”

Five facilitators also mentioned difficulties in the assessment and observation of members in their group when DVIP sessions were conducted via remote platforms. This was problematic in general assessment, such as viewing an individual’s body language, gauging their current mental health status, or even listening in on casual conversations that previously occurred before and after class. In addition to general assessment difficulties, facilitators also mentioned

difficulty in assessing engagement specifically. When compared to in-person treatment, facilitators found that it was much more difficult to discern whether individuals were engaged in online settings. Finally, some facilitators also mentioned the lack of ability to assess for sobriety via remote platforms. Not only were facilitators unable to administer urine drug tests or breathalyzers but they also had a diminished ability to assess signs of sobriety visually over remote platforms. Facilitator 18 detailed their difficulties in determining sobriety in remote groups:

> We're trained in substance abuse, so we can tell if they're under the influence. Being on a computer screen, no. They can be you know, drinking the beer on the side during group and we really don't know.

6.2.4.5: Privacy / Confidentiality

Another category of disadvantages that emerged was concerns over privacy and confidentiality when conducting the group remotely. These concerns mainly stemmed from the fact that it was impossible to discern whether a room is truly private when an individual attends group remotely, which limits the ability of facilitators to protect the identities of the individuals in their group. In some instances, facilitators were aware that certain group members did not have access to a private room but allowed them to attend because this was the only option for such individuals. Four facilitators reported that individuals in their group called from inappropriate locations, such as the car or the grocery store. Therefore, knowingly, or unknowingly, there was a potential for non-group members to be exposed to the people or information provided during the group. Facilitator 1 described their concerns over confidentiality, by stating:

> We've been using Google meet… I would use something else if I had the money like probably get Zoom or something like that because I can't record in Google Meet and I also can't privately chat with any of the group members or other co-facilitators or interns and so that's a disadvantage to using Google meet, so I would like to be able to record some of these groups. By the way, that's also a disadvantage overall with virtual groups is the clients can screenshot and record on their phones what's going on and violate all kinds of privacy concerns and confidentiality.

6.2.4.6: Safety

When asked about the disadvantages of remote treatment, facilitators also described concerns over victim safety and child safety. Six facilitators mentioned concerns about victim safety as a disadvantage of remote treatment. They expressed that remote groups do not provide an opportunity to debrief and/or de-escalate a member in the same way that an in-person group allows. For this reason, individuals who become dysregulated during group may already be home and then engage in a violent act if they are living with a partner. Holding in-person DVIP groups allows a de-escalation opportunity. Additionally, the physical signs of IPV are not as easily viewed remotely. One facilitator mentioned that current trainings on assessing signs of IPV assumes an in-person interaction between the assessor and the person being assessed. Therefore, there is a lack of adequate training to assess dangerousness and signs of IPV online. Safety concerns were not only hypothetical in this study, Facilitator 13 described an experience in which she observed a victim falling out of a closet in the middle of group:

> The bigge[st] concern is that while [offenders] were in group, that was when our victim advocate would reach out to the victim. So many of our more high risk offenders, they share a phone with the victim. So when they were in group, that was when the advocate

> could stop by their house or contact the victim and know that the offender was not going to be controlling that conversation. So that's been a real challenge. I had a victim fall out of a closet during a zoom group, so he had her listening to the zoom group. That, or he said she wanted to listen in so here's another challenge. So, she fell out of a closet behind him trying to listen in and he was discharged so I don't know what the realm of that really was… We are concerned that they're forcing victims to listen to treatment because they're the problem. These are things that we can't control on a zoom platform.

Concerns about the safety of children during remote groups was also mentioned in three interviews. These facilitators reported that they were often able to hear children in the background of calls. Some of the same fears surrounding victim safety were present for the safety of children, such as the inability to intervene and calm group members down when necessary. Facilitator 19 described their concerns over child safety by stating:

> Occasionally we've had people who have had the kids jumping on. We're like you can't do that. This isn't child protected, you don't know who you know on this call. Let's see if you live in the same area. What if there is a predatory sex offender and you know they got used to seeing this child here, its name, learning a bit about the family. They could easily say, "oh, I know your dad, so and so". So, we have that concern. We wouldn't have that in an in-person group.

6.2.5: Graduating Remote Clients

When asked whether they felt comfortable graduating clients remotely, most facilitators expressed their confidence in both graduating both in-person and remote program completers. Nine of the fourteen facilitators who used remote treatment for an extended period during the COVID-19 pandemic expressed this belief. The reasons for their confidence varied, but common

sentiments were that (1) the program contains the same curriculum and elements and (2) that progress was observed among group attendees. Facilitator 11 shared their perspective on graduating remote clients:

> If you want to learn the information and become engaged and make a change in your life, you still have the opportunity to do it online. There are going to be some people that are just you know marking their time and doing the exact minimum to be able to get through it and it doesn't matter whether it's in-person or online. So, I think the challenge is to get them engaged whether it's online or in-person.

In contrast, seven facilitators expressed concerns about graduating perpetrators who have attended their DVIP remotely. Four facilitators explicitly stated that they are less confident in the changes of their online graduates compared to their in-person graduates. Some facilitators felt slightly less confident in graduating online attendees, such as Facilitator 13:

> I don't know if I would say equal. I would say 10% less, if I were to add a number to it only because we don't have all of the assurances that we had in-person; Are they sober? Has the victim had the opportunity? because we're not always privy to the victim's advocate. Like if the victim doesn't sign a release that she can talk to us, they could be receiving services and I as the client's therapist may not know about it. So, I would say I'm a little bit more hesitant.

Others felt significantly less confident and felt that they could not use Zoom with confidence to conduct their meetings. For example, Facilitator 15 stated, "It's not about semantics, it's about a whole package of changing behaviors, which you can't do via zoom.".

One of the main reasons facilitators stated they lacked confidence in their online graduates was their inability to assess progress in the ways they typically would in-person. For

some, this was through regular worksheets that they administered in-person but were not able to administer and collect in an online environment. Facilitator 14 shared their qualms with graduating clients remotely with no in-person contact:

> It's just that they're not getting what they would've got in-person, but it's better than nothing. It's harder for me to gauge their level of involvement because I don't get their worksheets back or anything like that… Requiring them to come in once a month and turn in their worksheets [may increase confidence], but I've done that and only had two people comply. Even that is a potential way to get sued by them too. So, I'm not in for that.

6.2.6: Appropriateness for Remote Services

When asked about who would be most or least appropriate for remote services, seventeen out of nineteen facilitators shared their opinions. Two facilitators who did not provide remote services chose not to offer recommendations in response to this question. Answers were coded into three categories: individuals who may face challenges in remote environments; individuals who would likely be a good fit for remote environments; and individual differences that do not impact appropriateness for remote treatment. Most conversation surrounding appropriateness was related to potentially challenging individuals or populations. Twelve facilitators shared characteristics of group attendees they believed would make them not the best fit for remote treatment. In contrast, five facilitators spoke on who they believed were most appropriate for remote services. Four facilitators shared the belief that individual differences among group attendees would not impact appropriateness.

6.2.6.1: May Face Challenges

One of the most prominent concerns regarding appropriateness for remote services was clients with comorbid conditions. This was mentioned by nine facilitators. The types of comorbid conditions mentioned as potentially challenging to handle in a remote environment varied. Some facilitators stated that offenders with co-occurring intellectual disabilities or attention difficulties may be less suited for remote group work. Facilitators mentioned that these comorbidities could be exacerbated in online formats, making it difficult for groups to function smoothly. Additionally, it can be hard to give individuals with these disabilities the one-on-one attention that would typically be offered in in-person environments. Facilitator 4 shared their experience with an individual who she suspected to have an intellectual disability:

> There was one guy who I was hesitant to invite him, even though he really wanted to, and I was hesitant to invite him to the online because I suspect he has some sort of intellectual or developmental disability and, in class, he has a tendency to disengage and then when he does engage, engages in ways that are almost meant to be silly or shocking. He just says things that are pretty inappropriate and so my hesitancy about involving him in the online is that I feel like he needs a little bit more. When I'm with him in-person, it's a little bit easier for me to keep an eye on what he's doing or engage him. If he does say something that's inappropriate, address it and handle it better. So, I was kind of hesitant in having him online because I felt like he'd be more difficult to manage online than when I have him face to face.

Clients with comorbid serious mental health diagnoses were also mentioned as potentially challenging to work with in remote environments (n = 3 interviews). The specific mental health concerns varied and included clients with anxiety, clients experiencing a psychotic episode, or clients with current suicidal ideation or intent. In some cases, such as clients with a current

presentation of psychosis, there are needs that must be met before they can participate in DVIPs in a meaningful way; these needs were perceived as more difficult to identify and address in remote settings. Another need that was viewed as difficult to address remotely was to identify and assess risk for suicide. It was also noted that the presence of a serious mental illness may prevent individuals from participating in a remote DVIP group in the same way that they would in-person. Facilitator 14 also expressed concerns about clients with anxiety, which may lead them to participate less in a remote group and instead remain in their comfort zone. In their opinion, in-person environments allow individuals to work through their anxieties and face their fears:

> I'm now finding there are probably some clients who do better, but I still think that even in-person, I can work with a person who does better on Zoom and help them out a lot more in-person because I think Zoom allows introverts and anxious people to remain introverts and anxious people and never work through that at all. We break up a lot into small dyads and triads, we do that both on Zoom and in-person, and I think that many of those people grow tremendously in group. And they would probably report "Oh, Zoom is way better for me," but it's just because it allows them to stay stuck in whatever they believe they are.

Comorbid substance use disorders and alcohol use disorders arose as a potential barrier for participating in remote service delivery in three interviews. Facilitators believed they were less able to properly assess for sobriety through visual observation or other means (e.g., breathalyzer). One facilitator mentioned that they believe it is required by law that they must verify sobriety or individuals could be terminated from DVIP treatment. This posed a unique challenge as their program had more attendees than usual and the facilitator attributed this

change to their lack of ability to screen for drug or alcohol use. Facilitator 13 described their concerns about enrolling individuals with dual diagnoses in remote groups, stating that she would be concerned about individuals with a "history of alcoholism, we want to be able to verify that the person is sober which we can do through UA's and BA's like they're doing naturally as part of probation."

Another population that was thought to pose a challenge in online environments consisted of clients who were judged to be at high risk of future violence. Facilitators reported that clients who are considered "highly lethal" or "dangerous" may have a greater potential to become upset by topics presented or discussions held during group. In remote settings, these clients have the option to log off at any time and facilitators are powerless to de-escalate them. This is particularly concerning for DVIP group attendees who live with their victims. When asked about who may be less appropriate for remote services, Facilitator 1 stated:

> The ones who are with their victims, I would have thought that that was a much higher risk to them controlling the victims and I have seen some of that…I do have one that we refused to see virtually because he's so dangerous… He tried to kill his wife in [their home]. He was trying to cut her throat but instead he cut her face up really badly and so all he got was time served for that attempted murder… the lethality for him is so high, he's already shown what he can do.

Five facilitators mentioned that individuals with low technology literacy are also not the best fit for remote groups. In some cases, facilitators have found that clients who are in the "pre-technology generation" lack understanding of the equipment in a way that interferes with their participation in a remote DVIP group. Facilitator 17 shared their difficulties with individuals who lacked technology proficiency and how this caused challenges within group:

> I have a couple of people who are totally tech illiterate and so even though they were court ordered, I have two people right now who are waiting. I mean, it's not a problem because we're on probation for five years and they're just waiting until we go back to in-person because they just can't figure out the Internet and don't have Wi-Fi and can't afford it.

Four facilitators mentioned that those without appropriate resources to attend a remote group are also not likely to be the best fit. For some individuals, this could be the lack of a computer or smartphone to attend weekly sessions. For others, this could be a lack of finances to pay for data or internet to attend group. Facilitator 6 described how clients with few resources or low educational attainment may face difficulties:

> Some of the younger guys who would've been right for that platform for telehealth or virtual health don't have the financial means. So maybe their data wouldn't have been enough so they would've - what? - attended two groups a month and wouldn't have phone service?

6.2.6.2: Good Fit

Some of the factors that facilitators believed would make a client better suited for remote treatment were the inverse of what they believed would pose a challenge. While clients who lacked resources were mentioned as a potential poor fit, clients with the appropriate resources were described by one facilitator as a potential good fit. Additionally, clients with high technology comfort and literacy were mentioned as a potential good fit for remote services by two facilitators due to their knowledge of the platform and their ability to use it to its fullest potential.

Clients with special considerations also emerged as a potential good fit for remote services. Special characteristics could include individual factors such as occupation, gender, and geographic location. For example, Facilitator 1 described that business travelers or those who live far away would be well-suited for remote groups, by stating:

> Even when we start meeting face-to-face again, I fully intend to keep one virtual group. That is to catch those people who have transportation issues or who are business travelers and who would not be able to come to a group otherwise. Also, to catch people in counties that may not have enough people for a group yet.

Two facilitators stated that individuals with a trauma history or anxiety may be better suited to a remote environment. While some facilitators stated that comorbid mental health conditions may make individuals a challenging fit for remote services, others believed that remote settings were the best fit to provide a safe and comfortable environment for these individuals. Facilitator 14 shared her perspective on how certain trauma survivors may benefit from remote meetings:

> For trauma survivors, I think the experience of closeness is hard for them. So, when you're in a space where you're talking about you, or even expressing any emotion particularly from men, it's scary for them, it doesn't feel safe. And on the other hand, the disconnect from people who feel safe enough to connect is scary for some people. So, it really is person dependent. I don't think it's the same for anybody at all.

6.2.6.3: Individual Differences Don't Impact Appropriateness

When asked who the most appropriate fit for remote services was, some facilitators expressed that individual characteristics of perpetrators do not impact their judgment of appropriateness. In their opinion, the manner of service delivery itself is not significantly different between individuals due to the characteristics of the delivery method. Two facilitators

believed that remote treatment is appropriate for all and were unable to offer any particularly ideal or non-ideal clients. However, two facilitators stated that remote treatment is inappropriate for all. These facilitators believe that the in-person experience is essential for their DVIP groups to function as intended.

6.3: What Does the Future of Remote Services Look Like?

Table 3.

Future of Remote Service Themes and Subthemes

Themes	Subthemes	Facilitators	
		N	*%*
Improving Remote	Optional Best Practice Facilitators	12	63
	Organizational Best Practices	10	53
	Further External Assistance	9	47
Future Plans	Hybrid	11	58
	In-Person Only	6	32
	Remote Only	2	11

6.3.1: Future Improvement of Remote Services

When asked how remote services could be improved, facilitator's responses fell into three categories: Optional Best Practices for Facilitators; Internal Rules, Requirements, and Best Practices; and Further External Assistance is Necessary. The first category, Optional Best Practices for Facilitators, refers to the individual level of the system: the facilitators themselves. These include suggestions that are within a facilitator's power to include in their own program. The second category, Internal Rules, Requirements, and Best Practices refers to changes that could be implemented at the organizational level. For small organizations, facilitators may be able to make these decisions themselves. At larger organizations, these would likely be changes

that are decided in a standardized manner. The third and final category, Further External Assistance is Necessary, refers to suggestions that require broader systems level changes. These are changes that would be decided by local or state governments that dictate how DVIPs are conducted and funded.

6.3.1.1: Optional Best Practices for Facilitators

Thoughtfully establishing remote group rules was the most common best practice that was described by facilitators in this study (n = 10). These rules would differ from standard in-person group rules, as they refer directly to what is and is not acceptable in an online session. All ten facilitators who mentioned rules supported the inclusion of a specific rule that required clients to call in from a safe and private location. Some facilitators were even more specific, including group participation stipulations such as no driving, having to pan the room when logging on, and not allowing individuals to attend when their children or partner were present. Specifically, when asked about the rules to implement to facilitate a remote DVIP group, Facilitator 14 shared:

> No driving, no being in a room with anyone else and if you can't avoid that then you must have headphones on and protect the screen from other people being able to see it and we may not allow that. Or if there's any noise or anything like that, or if we perceive that someone could actually see your screen, we'll stop you or kick you out of the room.
>
> No walking around, no smoking pot, no drinking. We've had all of those things happen.

Six facilitators mentioned that they would require attendees to have their camera on and show their face. Facilitators believed that this requirement would help the group have more engagement and participation. However, despite the potential for increased engagement, some

facilitators expressed hesitancy implementing a group-wide requirement for having their video on during group. Here, Facilitator 11 described their experience:

> Well, I mean this is a more personal thing for the individual client than anything, but I mean, I think the more people whose faces you can see, I think it- just people are likely more engaged. If you can see each other. But that's you know. Sure, we could mandate that. I can't see your face, you can't be in my group. But, that's not something I would be comfortable doing… Just as an extreme example, [there are] people that are in the system, but on very limited income, sometimes the state will provide them with the phone, but it's usually a flip phone and it doesn't have a camera, so. I'm not going to deny them services, just 'cause they can't afford a phone with a camera.

Five facilitators mentioned behavioral rules that they would include in their remote group rules. These rules related to inappropriate activities that would be prohibited during group, such as no smoking pot, no making dinner, no pacing, and no late attendance. These would be intended to reduce distractions during group and ensure higher engagement. Additionally, one facilitator mentioned that they would include appropriate dress as a group rule due to experiences in her group where men were not dressed appropriately. Lastly, one facilitator also mentioned the importance of establishing a similar respect level in communication as if the group were conducted in-person.

Another best practice that facilitators identified was to adjust activities to best suit a remote environment. Four facilitators mentioned that in-person activities would benefit from adjustment to be best suited for remote settings. In some cases, the suggestions were as simple as wearing earphones and setting more boundaries with clients. In other cases, suggestions were more specific, such as to incorporate mindfulness activities into the curriculum, use different

applications to supplement Zoom, or shifting the program curriculum to a discussion-based format rather than an activity-based format. When asked about how they adjusted their program to an online setting, Facilitator 16 shared:

> Well, again it's, you know, having to tweak things in the curriculum for sure. Most of it we've been able to do, I think being able to do follow-ups after because, you know, everything's a lot of communication through email now. Being able to do a follow-up. I think being able to find powerful short videos that you can share your screen to, you know finding ways to make it interesting. I definitely do in every group, they're getting hands on, we're either doing a meditation time, a grounding time, a mindfulness time. You know, but we did that in-person too.

The last facilitator-specific recommended best practice for remote DVIP groups would be to contact clients outside of group for follow-up and appointment reminders. This was mentioned in five interviews. These facilitators found several different types of communication to be helpful for clients and their groups. Some facilitators found it helpful to send appointment reminders prior to group to ensure that attendees did not forget about the remote session. Others used electronic communication outside of the group to send follow-ups with resources or homework assignments. Still others would call clients for check-ins to see how they were doing, which was particularly useful when DVIP organizations were shut down during COVID.

6.3.1.2: Internal Rules, Requirements, and Best Practices

When asked how remote services could be improved, five facilitators gave suggestions at the organizational level. Two facilitators mentioned that their organization could offer, provide, or even require technological support for individuals who did not have the appropriate technological resources to attend and participate in remote DVIP groups. Two facilitators

believed that smaller group sizes would function better online versus larger groups. Facilitators reported that their typical group size was about 12-16 attendees when conducted in in-person settings. However, this same number was more difficult to manage remotely. Facilitator 10 stated that 6 to 8 attendees would be an ideal size for remote environments, and further stated:

> I brought this to the attention of my lead facilitator, smaller groups. I personally like a six person group. I think it's much more effective, you've got a better chance of engaging, getting the others to engage with each other. When it gets too large, it definitely does not work. I won't teach with large groups. I'd rather add another group to my list before I teach a large group.

Another organization-level change that facilitators mentioned was to develop a procedure for ethical considerations that were specific to remote environments. Similar to an informed consent for in-person settings, two facilitators recommended the use of a consultant for telehealth services. One facilitator also mentioned the importance of HIPAA in remote environments. In other words, this person felt it was important to ensure that staff are using the appropriate software to protect client data to the fullest extent possible.

6.3.1.3: Further External Assistance is Necessary

The first type of further external assistance that facilitators requested was to improve the available remote technology, which was mentioned by six facilitators. This included improvement to the actual internet service itself, as well as to the platforms on which the DVIP groups were conducted. Group facilitators felt that many aspects of remote calls could be improved to better mimic the in-person experience. Some of the requested improvements included better breakout rooms where the facilitator could monitor all attendees at once, better ways for small and large group work to occur during calls, and improved ability to do role plays

or collect homework. Facilitator 12 shared their desires regarding future technological developments:

> We would have to develop something to keep them engaged and motivated. Technology nowadays can put them in group, put up a white board, but they can't participate in writing their own answers where all the groups can see, that would be great. I know the white board, only the host can do that. But if there are ways, I know you can type on the chat but it's easier for clients if they can just get the little mouse or whatever and go over the white board and write whatever they need to write and that would show them doing it. It's like just in school, in the classroom. Something that they can do hands on through the computer. I think video games do that; I don't know.

The second type of external assistance that facilitators desired was further research and guidance on how to promote the effectiveness of remote DVIP groups, which was mentioned by six facilitators. These facilitators reported that they are interested in research on remote versus in-person services in terms of their effectiveness and will take the literature into account when making decisions about their future modality of group service delivery. Facilitators were also interested in knowing who is most appropriate for remote services, the results of clinical trials on what method is most effective, and even an actuarial measure to examine risk versus benefit versus need for being online. Facilitator 13 shared what type of tool they would find helpful:

> Some of the criteria that I would like to use that I don't know if [my state government] would approve, is for low-level offenders, maybe people that are no longer with the victim, people that can prove an extraordinary need, so they would lose resources like employment. Of course, we wouldn't be like "hey if you're going to lose your job, you could do online." It would be more of a covert calculation of risk vs benefit of being

> online or in-person… I would say addiction history, level of violence, still being with the victim, have we been able to reach the victim, I think that those are really the criteria and I would say for some people like some of our older clients, how comfortable is somebody online? If somebody does have extreme anxiety where they have trouble leaving their home, if somebody has severe PTSD and sitting in a room full of people who have been convicted of violence may be a blockage to their ability to internalize information. I think that all of those factors would play into it but ultimately what I'd like is for it to be at the clinician's discretion because the second people start saying "A, B, C, D" somebody is going to be outside of that box and I don't want our hand forced. If we've got somebody that we're like this person's going to benefit best in-person or online, that we still have the ability to make that call. (Facilitator 13)

In addition to further research, facilitators also would like to see guidance from appropriate governing bodies surrounding the implementation of remote DVIP groups. Some facilitators mentioned that they would like state-level decisions made about how they would implement programs and what platforms they should use. DVIPs are nested within the criminal justice system, so facilitators depend on state standards, laws, and guidelines to make decisions about their programs. One participant explained how their group is under the guidance of the state, by saying

> The regulatory board here is gonna be one issue, but everybody's opinions are softening. So here, the [regulatory board] is giving us permission to do it for now, and there's no indication of when that's gonna end. (Facilitator 14)

Throughout the interviews, facilitators questioned whose responsibility it is to ensure program attendees have access to appropriate platforms and technology. Facilitator 6 described this experience:

> My only concern is the people with the lack of resources. And I brought this up to our state [administrator]. She oversees the BIP programs here in [my state]. I brought that up and actually we have like a listserv for our batterer intervention providers and nobody replied. I get no response at all about if the state is gonna force us, where are the resources from the state to provide a platform where we can offer this to these people that we know are low income, low education, don't have a lot of resources? Where's our help? What are the suggestions? How can we do this so that other people aren't penalized? And nobody replied so I don't even know what to say. I just feel like I don't get a lot of response when I pose challenging questions here. I didn't expect to get a response, but I was still disappointed when I didn't have that support or any kind of reply. So, I don't know because I don't want to penalize people who can't. And if I don't see them in-person, say they shut everything down and they don't give us notice, it's not like I can sit next to a person and help them with their phone or download an app and explain it to them.

6.3.1.4: Future Plans

When asked about their future plans for providing DVIP services, facilitators had different conceptions of what the service modality they would be using moving forward. The most common plan of action moving forward was to provide hybrid services, where organizations would utilize both in-person and remote components. However, there was great variation in the expected ratio of in-person to remote, as well as the anticipated frequency of

using remote delivery among facilitators. Some facilitators stated that they would like to use hybrid services regularly. In some cases, this could mean that a single organization provides one remote group based on need while all other groups would be provided solely in-person. In other cases, each group could have some scheduled weeks that are remote and other weeks that are in-person, so that individuals within the same group would experience a hybrid curriculum. When asked if their organization will maintain the current level of remote service delivery, Facilitator 16 responded:

> I don't know about the level, but I think we will always have [the option for remote service]. Uh, there are a lot of people that can access treatment easier because of it. I think we would definitely open up more in-person groups. I believe we will always have that option [for remote groups].

Specific plans for hybrid services mentioned included hybrid orientations/assessments and hybrid staff events. Two facilitators expressed that they would like to have all groups in-person but transition all intakes to remote platforms. For these facilitators, the decreased no show rates and the potential safety advantages that remote platforms offered during the intake procedure were extremely valuable. One facilitator stated that they planned on, “doing all intake online because it's safer for the clinicians and then determine whether or not a person is a good fit for in-person or online” (Facilitator 13). Two other facilitators stated that although they would like to keep groups in-person, they would like to maintain remote staff meetings and trainings for convenience.

In contrast to regular use of hybrid services, three facilitators stated that they would like to use hybrid services for emergency purposes only. These facilitators plan on conducting in-person groups but would use remote platforms in the event of sickness, extreme weather,

transportation difficulties, or any other difficulty that prevents an individual from attending in-person or would necessitate cancelling the group. When asked about their future plans, Facilitator 14 shared:

> If we could do what we wanted to do, we would probably provide at least one Zoom group and utilize Zoom whenever there's snowstorms because that's a big deal. It's not really a big deal here, but our clients will use it as an excuse to miss group so this is gonna be a really interesting winter because all of the, "Oh my God, it's snowing. So do we cancel group or not cancel group?" And we watch the snow go up, and the calls come in, and then we either have to make a decision or not make a decision and this will be like "we don't care if it's snowing so come on." So, if it's allowed, we will use it.

Six facilitators stated that following the COVID-19 pandemic, they would like to return to in-person services entirely, with no use of remote delivery in their work. Facilitators cited different reasons for why they would like to return completely to in-person service delivery. Most of these aligned with the advantages of in-person treatment. Facilitator 10 stated, "one of the things that I feel, in my personal opinion, [in-person delivery] is more effective. Clients have requested, they're anxious to get back into the classroom."

Only two facilitators stated that they would prefer to continue to conduct their DVIP groups remotely. Both of these facilitators were open to keeping an in-person component, particularly if their group attendees expressed an interest in in-person groups. However, their first choice would be to have a structure that is entirely or almost entirely remote. Facilitator 19 shared their plans for the future, by stating:

> I think we'll keep predominantly remote, but we will probably try some in-person sessions and see because you can just imagine everyone saying, "Oh yeah, we really like

that" and then no one turns up. So yeah, it's tricky. I mean just from a, from a business point of view. [Remote service] works well, it seems to work better than in-person… I think, I think the benefits outweighing the you know the deficit. So, if it's possible if the group are all from one area, then you know we could ask the group, "Do you wanna have some in-person meetups?" You know, I think we would ask them whether they will value that, and if they did, we'd do it, and if they're, if they're not too bothered, then we won't.

CHAPTER 7: DISCUSSION

The purpose of the current study was to examine the transition from in-person to remote group therapy during COVID, understand the advantages and disadvantages of remote service provision vs. in-person service provision, and to get a sense of what the future of remote treatment could look like, as described through the eyes of DVIP facilitators. Using a national recruitment strategy, 64 facilitators filled out a brief online survey. Follow up contact was made with 19 facilitators, who participated in a semi-structured interview between September 2020 and March 2021. These facilitators were from a variety of locations and types of organizations. DVIP facilitators (n = 19) interviews were then analyzed for emerging themes related to the three main research aims.

7.1: Summary of Main Findings and Insights

Understanding the impact of COVID-19 and remote service provision on the delivery of DVIPs is essential to be prepared for future disasters and to provide the most effective services possible to a clinical population that is at high risk for recidivism and continued violence (Jewell & Wormith, 2010; Murphy et al., 2017). DVIPs are important to study specifically, as they are a unique service. Treatment is typically conducted in a group format rather than individually. The group format is important to the philosophy of DVIPs, as groups themselves are intended to be a mechanism of change (Velonis et al., 2016). Additionally, DVIPs are unique compared to other forms of therapeutic intervention because they are about violence and interpersonal relationship conflicts. In traditional in-person groups, participation would require individuals to remain in-person and work through conflicts that emerge within the group. Online, this may pose challenges due to potential changes in group dynamics or ability to easily remove oneself from the group. Lastly, during emergency situations, there are unique considerations for DV group

attendees. National guidance prioritized virus concerns and neglected DV services (Bright et al., 2020), despite the potentially increased necessity of addressing domestic violence at a time when individuals in violent relationships were potentially quarantined together (Piquero et al., 2021). It is important to consider how to react in future national or international pandemics or emergencies to ensure that the needs of perpetrators, survivors, and facilitators are met.

COVID-19 impacted service provision for facilitators of DVIP services in two main ways: having to cope with change and facing various levels of lack of control. Facilitators experienced many changes to the way they provided services as a consequence of the pandemic, whether they were providing services in-person or remotely. In-person services required social distancing, mask wearing, temperature taking, and increased sanitization. Remote services required an adjustment to new technology for group attendees and facilitators alike. For many facilitators, there was a period where no services were offered during the switch from in-person to remote services. In many situations, it was unclear whose views should be prioritized (e.g., CDC, local governance, the group leader, group attendees) in regard to emerging virus risk and emergency protocols. Therefore, much variation was observed in the decisions that were made and with regard to whose needs were prioritized. Outside of the DVIP programs themselves, facilitators experienced changes in their community. Daily life was disrupted, and risk of illness was prevalent, particularly for already disadvantaged populations. These changes impacted some facilitators more than others. COVID-19 also played out differently across the country, within states, and among facilitators.

Control was a prevalent theme related to the impact of COVID-19 on DVIPs. Facilitators in this study reported varying levels of control over their program due to differences in state laws and variation in their roles within their organization. Some facilitators reported that their state

advised them as to whether remote services were acceptable, while other states were silent on this topic prior to data collection for this study. Additionally, some facilitators reported that their state of residence had strict stay at home orders while others reported that their state allowed for in-person meetings and service delivery to continue. Facilitators varied in how they chose to adapt to the pandemic and institute rules in their group. These decisions were impacted by their level of control over their group. Some facilitators perceived that they had full autonomy to make decisions about service modality and how to address COVID-19 risk (e.g., whether to wear masks or to require that of participants). Others were guided by relevant state laws (e.g., stay at home orders, addendums to allow for remote services) or the organization in which they worked (e.g., organization-level policies on sanitization) when providing services. Some even viewed COVID-19 adaptations as an ongoing and evolving decision for members of the group, encouraging group members to practice autonomy by asserting their own desires on a session-by-session basis. Recent evidence suggests that many DVIP facilitators practice eclectically (Cannon et al., 2020), supporting the idea that facilitators have control over the content and structure of their programs. While the eclectic and variable nature of DVIP practice has not been tested, particularly during the pandemic, a metanalysis that analyzed the efficacy of variable vs. standardized treatments have found both to be efficacious (Truijens et al., 2018). Therefore, variation between providers is not inherently negative. However, it may be helpful to provide facilitators with best practices or recommendations as a disaster unfolds in order to provide the best service possible during unprecedented events.

Themes of convenience and accessibility aligned with past research that has considered the advantages and disadvantages of remote service delivery. Specifically, facilitator concerns related to reduced confidentiality, such as the lack of control over confidential information in

virtual environments, have been raised in research on the qualitative experiences of remote service providers and participants in individual and couples work (Hardy et al., 2021; Sanders et al., 2021; Wolson, 2016). Greater accessibility has been noted as an advantage of offering remote service in previous research, as virtual attendees decrease time associated with transportation and they enjoy the option of participating in the group from the comfort of their own home (Butzner & Cuffee, 2021; Polinski et al., 2016; Powell et al., 2017). However, these themes manifested in the current study with some additional caveats. Facilitators did report similar fears surrounding confidentiality, but the theme of control in this study referred to the amount of control facilitators had over their program during the COVID-19 pandemic. Therefore, control related more to external group factors than control over members or information shared within the group. Accessibility was similar to experiences reported in other qualitative research, but with unique considerations due to the population of interest. Facilitators stated that their clients typically report low SES, indicating that greater convenience and accessibility may be particularly important for group participation and attendance in this population.

Remote services were perceived as having advantages and disadvantages when compared to in-person services. The most prominent advantages of remote treatment identified in this study were greater convenience and increased accessibility. These advantages were particularly salient for certain group members, such as those who have to travel great distances to attend or who do not have the financial resources to travel or take time off from work. Facilitators also reported numerous perceived benefits of providing remote, rather than in person groups, for themselves, as well as for participants. For example, this modality allowed facilitators to conveniently call in from home and spend more time with their own family. This aligns with the benefits observed in other research on remote treatment, where convenience been an advantage for both participants

and treatment providers (Butzner & Cuffee, 2021; Polinski et al., 2016; Powell et al., 2017). The advantages of remote services were perceived as addressing some of the most prominent disadvantages of in-person services, which centered around difficulty getting to group.

Despite facilitators generating several notable advantages of remote services, a higher number of subthemes emerged related to the perceived disadvantages of remote services than for any other area coded for this study (e.g., Pros of In-Person, Cons of In-Person, Advantages of Remote). The most prominent concerns raised when considering the move to deliver services remotely rather than in person, was centered around the reduced quality of interpersonal interactions and the increase of technology-related difficulties. Facilitators spoke frequently about the lack of connection and participant engagement that they experienced while conducting their remote DVIP groups. They felt this modality reduced group cohesion, diminished the strength of relationship between group attendees and the facilitator, and potentially resulted in less uptake of course content. Additionally, technological concerns were an issue for both group members and facilitators. Some facilitators found that group attendees lacked the proper technologies (e.g., some did not have a smartphone or laptop), while others described difficulties with technology literacy for themselves as well as for attendees.

Facilitator's perceptions of impaired group cohesion contrasted with previous findings about remote service, which have suggested that both remote and in-person treatments are able to foster equivalent alliances (Berryhill et al., 2018; Coughtrey & Pistrang, 2018; Drago et al., 2016; Gentry et al., 2019; Morland et al., 2011; Ostenbach et al., 2013; Pugatch & Kim, 2021; Turk et al., 2010; Varker et al., 2018). Results presented in this study suggested the opposite; the relationships between facilitators and group members, as well as between group members themselves, were negatively impacted by the online format. Our findings may have differed from

other studies that compare remote to in-person treatments for a couple of reasons. One, our study focused on group treatments while most research on the therapeutic alliance in online formats appears to focus on individual treatment. Group treatment may function differently in an online environment than individual treatment, leading to differences in findings. Second, the population of interest in this study was court-mandated to treatment, while typical populations are voluntarily attending treatment. Court-mandated patients may differ from voluntary attendees in ways that detract from the group's ability to connect virtually. Future research should examine the extent to which an individual's motivation for treatment, or status as court mandated or self-referred, impact their experience and effectiveness of remote treatments. Such research may illuminate the critical mechanisms of action in DVIPs.

While different facilitators voiced advantages related to both forms of service delivery, facilitators voiced a slight overall preference for providing in-person DVIP treatment. Not only did remote services have a disproportionate number of disadvantages, but very few facilitators in the study planned on continuing only remote service delivery in their future practice ($n = 2$). Furthermore, several facilitators who planned to use hybrid services wanted the majority of their services to be in-person with supplemental remote meetings only as needed. Importantly, several facilitators stated that they prefer in-person service due to its perceived greater effectiveness in addressing the DV of their group members. This was not the case for those who preferred to deliver remote treatment. Those who preferred to provide remote treatment often stressed the convenience and reduced barriers for group attendance. This aligns with other qualitative research on the advantages associated with offering remote treatment such that convenience and accessibility have consistently been highlighted (Butzner & Cuffee, 2021; Polinski et al., 2016; Powell et al., 2017). Further research could consider expanding upon the initial findings reported

here regarding preference and effectiveness. For example, further research is needed to determine whether perceived effectiveness is associated with actual effectiveness (i.e., is there differentially decreased recidivism following group treatment when comparing remote vs. in-person delivered DVIPs?) Additionally, we will need to determine whether facilitator preference for a given format is related to program effectiveness (i.e., do facilitators get better outcomes when they are delivering the treatment modality they prefer?).

Facilitators in this study indicated that remote service delivery may extend beyond the COVID-19 pandemic, as thirteen out of nineteen facilitators stated that they would like to include remote services in their future work in some capacity. A majority of facilitators in this study reported that they plan to use hybrid services. or a combination of in-person and remote formats. A variety of hybrid methods were being considered; no two facilitators described the exact same plan for what their ideal hybrid services would look like. Some of these plans specified using remote platforms only for emergencies (e.g., snowstorms), using remote for certain groups but not others, having a combination of remote and in-person sessions interspersed within the same group, or primarily using remote meetings for facilitator trainings. Future research should focus on the extent to which remote service has remained prevalent in DVIPs following the COVID19 pandemic. These findings could show how accurate facilitators predictions were, as well as understand the current state of DVIP service provision.

These findings are important for future policy and research concerning remote services, as the current literature on remote service delivery (e.g., Butzner & Cuffee, 2021; Polinski et al., 2016; Powell et al., 2017) has predominantly contrasted two options: solely remote versus solely in-person delivery, thus, neglecting consideration of hybrid services that utilize a combination of delivery formats. Future research should aim to examine (1) the extent to which hybrid service

delivery is present in current DVIP service provision and (2) whether the delivery of hybrid services is perceived differently or has different outcomes when compared to solely in-person and solely remote treatment delivery. The examination of hybrid services is important for DVIP service provision, but likely would be important to consider in other types of therapeutic intervention as well (i.e., different types of group therapy, individual therapy; supervision provision).

Facilitators also considered how remote services could be improved moving forward. Facilitators described their ideas about what might constitute best practices on the individual (facilitator) level, the organizational level, and even on a broader, policy level. Many facilitators implemented group rules that were specific for the remote format; some also pushed for smaller group sizes for the virtual environment, which they believed was beneficial to the provision of their remote services. Additionally, facilitators also described a need for organization-level guidance, policy guidance, and research guidance to inform their practice.

7.2: Implications for Policy, Research, and Practice

This study illuminated several important factors to consider when developing policy for disaster-related services, as well as for the delivery of remote psychological services. First, it is important to have a disaster plan on how to handle DV services during events that are likely to interfere with DVIP service provision (e.g., natural disasters, pandemics) while potentially simultaneously increasing the prevalence of DV (Velonis et al., 2016). The plan should be carefully considered to ensure that it works for everyone, including the most vulnerable stakeholders (e.g., victims who reside with their perpetrator). No facilitators in this study mentioned any kind of disaster plan that they were operating from: none that were in place prior to the pandemic and none that were developed during the pandemic. For this reason, facilitators

were often left to make case-by-case, situation-by-situation decisions, often with limited time and resources and variable levels of perceived control. In their interviews, facilitators described their experiences similarly, but the decisions they made were very different. An absence of guidance led to variety in how DVIPs functioned during the COVID-19 pandemic. Minimum standards of practice or guidelines should be available for facilitators to consult or follow during times of disaster, such as the COVID-19 pandemic. DVIPs should be included in state disaster plans so that perpetrators and survivors of IPV who are likely to already be part of the criminal justice system, do not fall through the cracks.

In addition to disaster-related policies, states and relevant psychological bodies should develop guidelines and best practice standards for remote practice. The facilitators in this study have historically relied on state policy, guidance from sources like the American Psychological Association, and findings from the literature when determining how to conduct their DVIP services. However, they did not feel that current guidelines and research were sufficient to provide quality evidence based DVIP group practice using virtual modalities. Facilitators expressed concern regarding the lack of state-specific guidance or assistance on how to best provide remote services. Although stay-at-home orders forced some facilitators to move their groups online, there were no laws or policies that dictated whether remote service is an acceptable platform for DVIP groups. Additionally, there was a lack of guidance from psychological governing bodies and literature. The most recent guidelines for telepsychology were published by the American Psychological Association in 2013 (APA, 2013), prior to numerous technological developments and in advance of telehealth implementation in a broader range of settings. Updated guidelines may be necessary to reflect specific environments and populations, such as among DVIPs nationwide. Importantly, researchers need to examine the

effectiveness of DVIPs conducted with remote vs. in-person modalities and under various conditions. In order to create the best possible laws and policies, more information is needed.

This study also identified implications for practice by identifying three suggestions for improving remote service in the future: best-practice group rules, limitations on group sizes, and effective guidance from appropriate scientific and legal entities. A number of group rules were mentioned, including requiring that participants call from a safe and private location, turning their camera on, and refraining from engaging in other activities during group (e.g., watching TV, driving). Different groups may have to implement different rules that are adapted to the context and culture, but all should aim to adhere to the principles in the ethics code of psychology (APA, 2017) and what is known about evidence-based practice. Confidentiality and safety of perpetrators and survivors is an essential consideration with this population and facilitators should do their best to ensure that all parties are protected to the extent possible. Remote treatment presents threats to safety and confidentiality that don't exist in in-person settings, including greater potential exposure of perpetrators to other children and DV survivors, which should be considered.

Not only did facilitators in this study identify potential best practices for remote treatment (e.g., providing access to, instruction in, and utilization of appropriate technology, delineating remote-specific group rules, addressing threats to safety and confidentiality), but also requested guidance from scientific and legal entities about how to provide the most effective service possible in times of societal stress (i.e., a pandemic or other disaster). To facilitators in this study, scientific guidance of interest would include examination of the effectiveness of remote vs. in-person DVIPs, while legal guidance would include the production of state laws, standards, and/or guidelines that align with and are based on evidence. These guidelines would advise

facilitators on whether or not remote DVIP group treatment is permissible in that particular state, supports that can be accessed to provide this service, and the components of remote treatment that should and should not be included. Facilitators suggestions and requests align with the recommendations of Sheparis and Smith (2021), who also identified a need for telehealth standards of care. These authors proposed twelve domains to be covered, including appropriate platform selection, legal concerns, accessibility, creating an office for virtual work, and working with multiple clients. The longer there is an absence of guidance and standards, the longer facilitators, and the organizations in which they work, are left to make critical decisions regarding their program based on their own personal beliefs and opinions surrounding remote service. In summary, there is a need for (1) further scientific research on remote group DVIPs, (2) evidence-based guidance from states surrounding remote DVIP practices and (3) dissemination strategies to help facilitators stay abreast of timely research and guidance as it emerges.

7.3: Limitations

One of the main limitations of this study is the difficulty in separating the broad advantages and disadvantages associated with conducting treatment remotely from the context of the COVID-19 pandemic and the specifics of working with DVIP perpetrators. While the key findings of this study do align with information found in other studies on the benefits of remote services (e.g., convenience as an advantage of remote delivery, Hardy et al.; Wolson, 2016; Swinton et al., 2009), some of the themes that emerged may be related to the COVID-19 pandemic rather than the mode of service delivery itself. This may be particularly true of factors likely to have been impacted by stay-at-home orders or COVID-related stress, such as perceived improvements in program attendance in remote settings. Stay at home orders may have

eliminated competing engagements, leading to increased attendance rather than the convenience of the platform alone. Further research on the delivery of DVIPs should examine the advantages and disadvantages of remote, hybrid, and in-person service in the absence of stay-at-home orders to confirm that these findings can be replicated in a "post-pandemic" setting. Additionally, further research could illuminate factors of facilitators and participants that make remote, hybrid, or in person settings more effective.

Another limitation of this study is that the sample of facilitators interviewed was small and not likely to be representative. All of the facilitators in this study were from counties that would be defined as "urban" and therefore, this study lacks representation of facilitators from rural areas. However, this may also reflect the general lack of DVIP services and facilitators in rural areas (Kernsmith & Kernsmith, 2009). This lack would be supported by utterances of facilitators in this study, who indicated that some people travel up to two hours to attend their group. Some geographic areas (e.g., Southeastern, Western) were represented more than others (e.g., Midwestern, Northeastern). Additionally, the facilitators included in this study appeared to be particularly passionate about their work, with many even turning down or donating the monetary compensation offered in the study. Therefore, although there was observed variation in the decisions made by facilitators during the COVID-19 pandemic in this sample, the variance outside of this group is likely even greater among the total population of U.S. DVIP facilitators due to differences in geography, population density, and personal factors.

Nonetheless, this study provided information about how facilitators navigated the transition to remote services, as well as highlighted their perceptions of the benefits and drawbacks to remote service for perpetrators of IPV. Three important conclusions can be drawn from these data. First, despite the lack of state-specific or general COVID-related guidance to

draw from, group facilitators were able to quickly adjust to new methods of service delivery that were necessary to decrease rates of COVID-19 transmission or to comply with health-related best practices Second, facilitators who supported the use of online service delivery highlighted barriers to traditional treatment that could be reduced by including this modality including time, travel, and expenses while those who favored the use of in-person treatment emphasized the value of in-person connection and engagement. Third, DVIP facilitators would benefit from further research and guidance from relevant scientific and legal entities about how to provide effective and safe services when doing so remotely or when responding quickly to pandemic or disaster-related changes.

The COVID-19 pandemic presented two public health crises: COVID itself and an increase in DV related to COVID (Velonis et al., 2016). Facilitators were faced with a dilemma of which crisis to prioritize. When the COVID-19 illness was prioritized (e.g., through a more lenient attendance policy), it detracted from the attention placed upon treating and preventing DV (e.g., potential to be absent from a greater number of sessions, missing treatment content). When treating DV perpetrators was prioritized (e.g., allowing participants to collaboratively advocate for their choice on whether or not to practice COVID-19 safety precautions so that everyone would attend), it may have led to increased risk for virus exposure among participants. These decisions could be made by the facilitator, as well as by the agency in which they worked, or they could have been made at the state coalition level or even nationally. In these decisions, it was difficult to support important values that appeared to conflict with one another. To prioritize equity and access, one must give up interactivity and potentially reduce the quantity and quality of exposure to the treatment.

COVID-19 also presented a unique opportunity to conduct DVIP services online for the first time on a large scale. This study utilized this opportunity to have facilitators reflect upon their perceptions of the pros and cons of both delivery methods. One main takeaway is that pros and cons of both methods emerged, leading many facilitators to consider the idea of integrating both methods into their future service delivery. There were lots of ideas about how remote services could support in-person services (e.g., intake, staff meetings), as well as important considerations that could play out over the course of treatment (e.g., treatment monitoring, victim safety, graduations). There was also a significant subgroup of facilitators who thought the benefits of in-person service are such that any hybrid of remote service delivery should be prohibited. It is possible that group dynamics and cohesion are the main ingredients for effective change and that going online is detrimental to the effectiveness of the DVIP treatment.

Unfortunately, we have little to no data to inform us on what the consequences are of using remote methods to provide DVIP services for batterers. Understanding the implications of remote service is of the upmost importance, as DVIPs already have mixed findings in their original, face-to-face format (Dunford, 2000; Eckhardt, 2004; Easton et al., 2007; Graña et al., 2017; Herman et al., 2014; Haggard et al., 2017; Puffett & Gavin, 2004). Additionally, many depend on these programs to reduce offender recidivism and prevent violence, including survivors and community stakeholders. Therefore, it is critical to address whether remote or hybrid hinder or improve existing DVIPs. Facilitators in this study did propose some concrete suggestions for how to conduct quality remote service that were based on their experiences during the pandemic. Some of the most notable suggestions made included: facilitators and participants should call from a safe and private location, all participants should have to turn their camera on, and there should be specific rules guiding the implementation of remote groups. The

main ingredients of what makes an effective DVIP group, and whether or not these ingredients can translate to online environments, need to be tested. However, given the universal agreement by facilitators that incorporating this modality might be helpful, the suggestions provided by facilitators in this study may be a good place to start when developing best practices and universal disaster plans.

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APPENDIX A: Interview Guide

Participant #__:

Interviewer:

Date of Interview:

Length of Interview:___

Introduce yourself...

1. After reading over the informed consent form, do you have any questions? Do you consent to the interview?

2. Do I have your permission to audio record this interview so that I can be as accurate as possible with your responses?

3. Also, I want to remind you that you can choose to use your camera or not, as you are comfortable.

4. In the survey you completed online, you entered a four-digit code. It was made up of the first letter of last name, two-digit number for month of birth, and the first letter of the city in which they were born. What is your code?_____

First, I have a few questions about COVID-19 to get us started.

- Tell me a little about the services you provide.
- What STATE and county/counties do you provide services in?
- What counties do you serve?
- Do you live in the same county you work in? (If not, what county do you live in)?
- What has been your experience with COVID in the area in which you live?
- What work policies have been enacted?

Now I want to take a few minutes to discuss your services prior to COVID….

1. Can you tell me a bit about the organization you work for, the work you do, your role/position, and the model you use to provide services….

2. How did your DVIP provide services prior to the COVID 19 outbreak and subsequent stay-at-home orders?

3. What were the pros and cons of this type of service delivery method?

4. What was your typical no-show rate pre-COVID 19?

5. What were typical barriers to service delivery/access experienced by your clients pre-COVID 19?

6. Did you have safety concerns related to your pre-COVID 19 service delivery method?

7. Did you notice any differences related to men who were court referred versus self-referred?

8. Pre COVID, were there different types of clients you believe would not be appropriate for remote delivery services? Why/why not? Which types of clients would be most ideal?

Now I'm going to ask some questions about your current situation:

9. Are you providing services currently? If no, why not? If so, what is the current delivery method? Was there any time at which you had to suspend/stop services? If so, why? What method of delivery did you use (if any) at this time?

10. What are the pros and cons of this new service delivery? (Ask about safety, security, ability to access and use the necessary technology, is this work harder/more demanding than the prior method of delivery? etc.)

11. Have you had to implement any new work policies to accommodate the current service delivery?

12. Do you think this has differentially affected clients who are court-referred versus self-referred?

13. What is your typical no-show rate with this new service delivery method?

14. What are your plans for service delivery once the stay-at-home orders are lifted? Will you maintain any of the current (remote) service delivery? Why/why not?

15. Do you think there has been an increase in the rate of domestic violence since the pandemic began?

16. If yes, to what do you attribute the increased rate?

17. If the pandemic is going to continue for some time, what recommendations do you have in order to decrease the rate of DV or prevent its occurrence?

18. If the pandemic continues, will you feel comfortable issuing certificates of completion for clients who have engaged in remote service only?

What would increase/decrease confidence in the ability to do this?

19. What suggestions do you have for improving remote delivery of BIP?

20. Are there any disaster-related policies or procedures that you would advocate for related to DV services?

21. Is there anything we haven't covered that you would like to add?

22. Do you have any questions for us? If something else occurs to you or an additional question comes to mind, please do not hesitate to reach out to us via our contact information.

23. We are planning to recruit DVIP clients in the future to learn about their experiences with virtual programs. Would you be willing to share our survey with your clients? If so, can we contact you to coordinate that in the future? What is the best way to reach you?

24. TURN OFF RECORDING NOW!!!!!!!!

25. We would like to send you a gift card as a small thank you for your participation today. What is the best address to send that to? _____