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Understanding the Impact of COVID-19 on Victim Service Provision: Challenges, Innovations, and Lessons Learned

Final Report | December 2023

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Section 1: Introduction and Problem Statement

1. Introduction and Problem Statement

Research has associated the impacts of COVID-19 with an increased rate of gender-based violence (GBV), including sexual assault/abuse, intimate partner violence (IPV), and sex trafficking (Nix and Richards, 2021; Piquero et al., 2021; UNODC, 2021; Wood et al., 2022). Research has also indicated that the nature of violence experienced during the pandemic was more severe (Jetelina et al., 2021). Under typical circumstances, survivors of GBV may experience a wide range of impacts as a result of their victimization, including negative physical, psychological, and psychosocial outcomes (Aldrich and Kallivayalil 2013; Black et al. 2011; Farley et al., 2004; Kilpatrick et al., 2007; Yuan, Koss, and Stone 2006). These effects of GBV can be immediate (e.g., lack of physical security, increased stress), long-lasting (e.g., increased risk of depression, anxiety), and cumulative across the lifespan (Yuan et al., 2006). . The COVID-19 pandemic may have amplified these impacts for victims[1]. Many of the factors that place individuals at increased risk for or exacerbate the impacts of GBV have also been documented as impacts of the pandemic, including housing instability, job loss or changes in job security, economic strain, new childcare responsibilities, lack of social support, and increased substance use, among others (Prime, Wade & Browne, 2020). For survivors of GBV navigating these amplified impacts, the presence of and services available through community-based victim service providers (VSPs) were and continue to be essential.

At the same, pandemic altered normal social functioning in ways that significantly disrupted VSPs and the systems with which they interact and on which they rely. VSPs faced the competing needs of higher demand for services and a heightened call to follow public health guidelines to reduce the spread of COVID-19. Physical distancing, limitations on the number of people allowed in an enclosed space, and closures to infrastructure critical to service delivery (e.g., schools, courts, public transportation) in some areas impacted providers' ability to meet victims' needs. Although these efforts are effective in preventing the transmission of COVID-19, they create unique challenges for those supporting individuals experiencing or recovering from victimization. The resulting adaptations that VSPs made were immediate and necessary but also inspired innovation and modernization in service delivery, some of which was long-lasting and even overdue. This unique combination of circumstances presents a critical opportunity to understand the impacts of such service modernization on victims and VSPs, as well as the value of established practice models.

The purpose of this study was to understand the impact of COVID-19 on service provision for victims of GBV in eight U.S. counties that vary in geography, urbanicity, and sociopolitical settings. This study includes a sample of eight county-level sites from four states, with one rural and one urban county from the western (Washington), southern (Texas), midwestern (Illinois), and northeastern (Massachusetts) regions of the United States. This study was guided by three main research questions: (1) How did local legal, policy, and cultural frameworks impact victim

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[1] The terms victim and survivor are used interchangeably throughout this report to reflect that gender-based violence is a form of victimization takes tremendous strength and courage to survive. Individuals with these experiences may also be referred to as clients in this report, as they are using the services of victim service provider agencies.

service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises? (2) How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful or sustained in the long term? And (3) Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

1.1   Impact of COVID-19 on Gender-Based Violence

1.1.1   Increased Rates and Severity of GBV

Advocates and researchers predicted that rates of GBV, such as IPV, sexual assault, and sex trafficking, would increase during the COVID-19 pandemic (UNODC 2020; Wood et al., 2022). Crisis hotlines (Polaris Project, 2020; RAINN, 2020), service providers (National Network to End Domestic Violence, 2022; Reynolds, 2020), and victims (Peitzmeier et al., 2022) confirmed this trend by documenting increases in requests for service and self-reports of violence throughout the pandemic. Research conducted on the phenomenon has found that this trend extends beyond a single city or even country: one study found that domestic violence calls for service increased immediately at the onset of the COVID-19 pandemic in five U.S. jurisdictions (Nix & Richards 2021), and a meta-analysis documented increased rates of domestic violence globally between pre- and post-pandemic periods (Piquero et al., 2021).

In addition to increased rates of violence, GBV may have also increased in severity during the pandemic. A study by Jetelina and colleagues (2021) found that among those who experienced IPV during the early stages of the pandemic, both physical and sexual violence had significantly higher odds of worsening during the pandemic period. Another study, a survey of 1,160 people in Michigan, found that over a quarter of victims reported victimization increasing in severity (Peitzmeier et al., 2022). Notably, service providers also reported witnessing an increase in severity of violence during the pandemic (Schrag et al., 2022).

Initial research posits that this increase in severity may be related to how pandemic-related restrictions and use of technology has change how abuse is perpetrated. Stay-at-home orders, shifts to remote work from home, and other restrictions on public and third spaces access mean victims of domestic violence had more proximity to their abusers. Abusers also targeted victims' increased reliance on technology to connect to social networks and the outside world as another tool over which to exert control (Schrag et al., 2022). Additional research is needed to better understand the impacts of the pandemic on GBV beyond domestic violence.

1.1.2   Increased GBV Risk and Help-Seeking Behaviors

These trends are unsurprising given how the COVID-19 pandemic exacerbates conditions that increase risks of GBV. Conditions such as financial instability, loss of routine activities, lack of social support, and other sources of daily stress already increase risks for GBV perpetration and victimization (Regalado et al., 2022). These conditions characterize the early years of the pandemic, with many jurisdictions around the country issuing stay-at-home orders and social distancing requirements and millions of people experiencing economic stressors. To avoid

COVID-19 infection, people isolated from their family and social networks. These conditions, including situations where an abuser partner maintains control over child custody arrangements (Archer-Kuhn et al., 2023) or uses pandemic-related restrictions as a basis for verbal and emotional abuse (Lyons & Brewer, 2022), allow for coercion, control, and abuse from perpetrators of GBV (Ragavan et al., 2022; Regalado et al., 2022; Williams et al., 2021).

Economic shocks and mass layoffs to certain industries and increased caretaking responsibilities for children and family members also increased financial strain among GBV survivors, exacerbating their risks of victimization (Murugan et al., 2022). These impacts may be harder felt for victims living in communities that were already at risk for violence. Victims in rural areas have less robust access to social services and infrastructure (Lynch & Logan, 2022). Victims living in communities with fewer economic opportunities also experienced an increased risk for COVID-19 and victimization, specifically GBV (Centers for Disease Control and Prevention 2021; Parker et al., 2020; West, 2005).

Not only did these conditions potentially lead to increased GBV victimization, but they simultaneously presented barriers to accessing help and leaving abusive or otherwise dangerous situations (Kaukinen, 2020). Navigating crisis and support services during the early phases of the pandemic may have been particularly challenging for victims who were unclear about ever-changing stay-at-home orders or pandemic guidelines (Williams et al., 2021). For example, victims seeking to leave abusive partners may have felt that they could not because of stay-at-home orders (Bright et al., 2020). Similarly, victims experienced barriers to accessing services due to lack of clarity regarding service provider capacity and disruptions to service (Lyons & Brewer, 2022). Some found virtual services offered by helping systems inaccessible due to of unfamiliarity with technology, lack of access to technology, or difficulty finding needed privacy (Murugan et al., 2022; Schrag et al., 2022; Voth Schrag et al., 2023; Williams et al., 2021; Wood et al., 2022). During the peak of the COVID-19 pandemic, victims also refrained from seeking medical attention in an effort to prevent COVID-19 exposure, such as in the case of sexual assault survivors refraining from receiving medical care in hospital settings. Challenges to employment and financial stability may have also resulted in setbacks to short- and long-term financial independence, often a key factor in victims leaving abusive situations (Hansen & Lory, 2020; Kaukinen, 2020; Williams et al., 2021). Increased childcaring duties caused by schools and childcare shutting down may have prevented victims from successfully seeking help (Williams et al., 2021).

1.2   Impact of COVID-19 on Victim Service Providers

1.2.1   Challenges to Victim Service Provision

The increase in need for services and barriers to help-seeking were compounded by VSP staffs' own experiences of pandemic-related challenges (Williams et al., 2021; Wood et al., 2022). Throughout the pandemic, VSPs were front-line, essential organizations and most sought to remain open. Like other essential organizations, VSP organizations implemented many COVID-19 mitigation practices, such as physical distancing, limiting the number of people in an

enclosed space, and shifting some services to remote and virtual options (Garcia et al., 2022; Houston-Kolnik, Feeney, & Pfeffer, 2020; Murugan et al., 2022; Voth Schrag et al., 2023).

Although these practices reduced risk of contracting COVID-19, they made providing services to victims of GBV challenging. Clients may not have had access to reliable internet at home to receive virtual services and could not access them in public settings that are not private or confidential (Houston-Kolnik et al., 2020; Williams et al., 2021). In addition, organizational capacity declined among many VSPs as a result of decreased staffing for pandemic-related reasons, such as staff needing childcare, fearing getting sick from COVID-19, or actually getting sick themselves (Wood et al., 2022). This also led to less robust referral pathways when VSPs or their peer organizations reached capacity or could not provide needed resources (Schrag et al., 2022; Wood et al., 2022).

Research has suggested that these challenges were even more pronounced for VSPs located in rural communities that already had less capacity and fewer referral networks before the pandemic, when compared to their urban counterparts (Hansen & Lory, 2020). This is also true for culturally specific VSPs that were already tasked with meeting the additional barriers faced by underserved and historically marginalized clients, such as immigrant survivors who did not have legal status or were not able to access services offered exclusively in English (Garcia et al., 2022; Murugan et al., 2022; Wood et al., 2022).

Like many other front-line, essential workers during the early pandemic, research on limited samples has demonstrated that VSPs experienced many pandemic-related workplace stressors. These mirror the stressors faced by medical providers and first responders, whose challenges during the pandemic have been well-documented (Pfefferbaum & North, 2020). New sources of workplace and occupational strain resulting from the COVID-19 pandemic, include concerns about personal and familial risk of exposure to the virus caused by working in person, sudden shifts to day-to-day work (including onset of virtual work practices), lower boundaries between work and home, financial stress from unemployment or unstable employment in the household, decreased mental health, experiencing various and secondhand trauma related to clients' own pandemic-related barriers to safety, lower morale from being unable to serve as many clients as effectively, and general uncertainty about the long-term trajectory of the pandemic (Bradbury-Jones & Isham, 2020; Garcia et al., 2022; Murugan et al., 2022; Voth Schrag et al., 2023; Wood et al., 2022). In one study, VSPs characterized working through the pandemic as "exhausting" and "overwhelming" (Williams et al., 2021).

1.2.2   Innovative Shifts to Victim Service Provision

Despite the difficulties faced by VSPs, many shifted and adapted their practices to continue providing critical care to victims of crime with minimal disruption or notable innovation (Houston-Kolnik et al., 2020; Schrag et al., 2022; Roberto et al., 2021; Williams et al., 2021). A survey of VSPs in one state during the early months of the COVID-19 pandemic found that some services, such as hotlines, were mostly able to continue without interruption, but almost all survey respondents (92%) had adapted at least one service they provided (Houston-Kolnik et al., 2020). These shifts demonstrated the creativity and flexibility of VSPs, which included

practices such as moving service delivery online (Posick et al., 2020; Voth Schrag et al., 2023), changing physical locations for service delivery (Houston-Kolnik et al., 2020), procuring personal protective equipment (PPE), finding new referral sources, identifying new partnerships for needed services such as transportation and housing (Garcia et al., 2022; Murugan et al., 2022; Schrag et al., 2022; Williams et al., 2021), changing the focus of safety planning from long-term distancing from the abuser to immediate safety needs (Schrag et al., 2022), and interpreting information about COVID-19 for their clients (Ragavan et al., 2020). VSPs also found some of these shifts in service delivery to result in more frequent contact from their clients and faster communication practices (Garcia et al., 2022; Schrag et al., 2022; Voth Schrag et al., 2023). Some have speculated that the pandemic may have advanced changes within these organizations that would have taken years to implement previously, such as more support for clients on how to safely use technology, more technological capacity at the organization (Murugan et al., 2022; Schrag et al., 2022; Voth Schrag et al., 2023), and long-term use of hybrid models (Williams et al., 2021).

Necessary shifts in service provision bolstered resilience among VSP professionals. VSPs across studies detailed how their workplaces provided pandemic-related leave, mental health leave, and childcare accommodations, while their colleagues built solidarity in the face of workplace challenges (Garcia et al., 2022; Murugan et al., 2022). The pandemic forced some VSP organizations to reorganize their practices and policies to be more accommodating of their workers and increase transparency around agency decisions and practices.

These shifts may have encouraged VSPs to broaden their clientele and think about underserved, culturally specific client populations they did not previously reach who they now could via technology (Schrag et al., 2022; Voth Schrag et al., 2023). Whether these shifts are successful for underserved victims remains to be seen. Some studies report these adjustments to service delivery practices as less successful for culturally specific victims, including Black, Latina, and Asian American victims; victims with disabilities, LGBTQ+ victims; and immigrant victims (Garcia et al., 2022; Lipp and Johnson 2022; Murugan et al., 2022). For instance, one study found that immigrant survivors may be less amenable to virtual service delivery, leading to less access to services during the pandemic when many VSPs shifted to virtual work (Sabri et al., 2020).

1.3   Victim Services in Times of Crisis

Although COVID-19 did not result in the mass displacement of people across geographic regions the way that natural disasters, manufactured disasters, and militarized social conflict usually do, there are many similarities between the pandemic and these other crises that result in simultaneously more needs and more barriers to help-seeking. Like early evidence regarding COVID-19, there is some evidence that GBV increases during natural disasters. For example, several studies have examined the rates of GBV in the aftermath of Hurricane Katrina, finding that rates of violence increased (Harville et al., 2011; Schumacher et al., 2010). Similar to increasing rates of GBV during COVID-19, these increases may be a result of additional environment stressors as a result of natural disaster.

VSPs' shifts in their work during the COVID-19 pandemic mirror how other social service providers have adapted their day-to-day operations in response to external shocks, such as natural disasters and violent conflict. Like during the pandemic, social service providers during other displacement crisis must adapt quickly to the changing nature of their clients' needs, which includes impacts on income, transportation, child care, and education (Vance et al., 2023). Research on the aftermath of Hurricane Katrina has argued that social service organizations that can adapt to broadened clients' needs were the most effective, such those that expanded their networks and partnerships with non-traditional partners (Campbell, 2020) and successfully reframed their work and missions (Jenkins et al., 2015). For example, organizations that advocated for and helped clients address exploitation in the workplace were most effective in addressing workplace abuses that increased after Hurricane Katrina (McCallum, 2020).

Post-disaster literature has also highlighted the importance of federal agencies and programs that support individual and community recovery, namely the Federal Emergency Management Agency (FEMA) but also programs from the U.S. Department of Housing and Urban Development for people's unmet housing needs and the U.S. Department of Agriculture for low-income families' unmet food needs (Vance et al., 2023). VSPs, unlike many other types of social service agencies, are not traditionally recipients of FEMA funds for post-disaster recovery. During COVID-19, however, local VSPs were the beneficiary of federal pandemic relief funds as subaward grantees in their state, or from existing VSPs that clarified their pandemic-related policies or made their policies more flexible. For instance, the state of Colorado used a portion of their award from federal COVID-19 funds to fund VSPs. How federal grant programs and recovery support funding impacted VSPs' day-to-day work remains to be seen, as the current literature on VSPs during the pandemic does not highlight this aspect.

Section 2: Methodology

2. Methodology

2.1 Goals, Objectives, and Research Questions

Through this research study, we sought to understand the impact of the COVID-19 pandemic on service provision for victims of GBV, including survivors of sexual assault/abuse, IPV, or sex trafficking in eight U.S. counties that vary in geography, urbanicity, and sociopolitical settings. Our specific objectives were to document and understand (1) the challenges posed by the pandemic—including related societal changes, such as social distancing, court closures, and legislative mandates; (2) how agencies pivoted to address these challenges; and (3) which innovations were successful in ways that warranted lasting changes in practice. Equally important, we explored which changes in practice were discontinued as COVID-19 restrictions eased and how it was determined that these changes were not worth sustaining beyond the pandemic.

Exhibit 1 presents key project research questions and the data collection approaches used to address each.

Exhibit 1.   Research Questions Mapped to Data Collection Approach

Research question	Data Collection Approach		
	Site-Specific Policy Analysis	Web-Based Survey	Interviews & In-Depth Case Studies
1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?	●	●	●
2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful or sustained in the long term?		●	●
3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?		●	●

2.2 Study Design and Methods

To answer the study's research questions, we used a parallel mixed-methods design for multilevel data (Tashakkori, Johnson, & Teddlie, 2020), implementing state- and county-level policy assessments (archival data), county-level web-based surveys (quantitative data), and interviews and in-depth case studies on individual VSPs (qualitative data). The research process intentionally narrowed in scope from a broad state and local policy analysis to a focused inquiry of one agency in each participating county.

2.2.1 Site and Partner Agency Selection

We implemented a purposive stratified sampling approach to select eight county-level project sites that varied in geography, urbanicity, and the presence of GBV VSPs. We first stratified our sample by geographic region to better understand whether and how diverse U.S. communities were impacted differentially by the COVID-19 pandemic. Stratifying by geographic region increased diversity and the opportunity to examine whether communities implemented different policies at the state, local, or organizational levels in ways that reflected the presence of COVID-19 in their area. Ultimately, sites were selected from Illinois (IL), Massachusetts (MA), Texas (TX), and Washington (WA).

Next, we stratified by urbanicity such that we selected one primarily urban site and one primarily rural site within each region (see *Exhibit 2*). Counties with a major urban epicenter were chosen as urban sites. Rural counties were chosen based on the presence of GBV VSPs within the region (e.g., at least one centralized community and expansive rural representation). All selected rural counties included at least one centralized community but maintained between 67% and 95% rural area.

Exhibit 2. Participating Study Locations
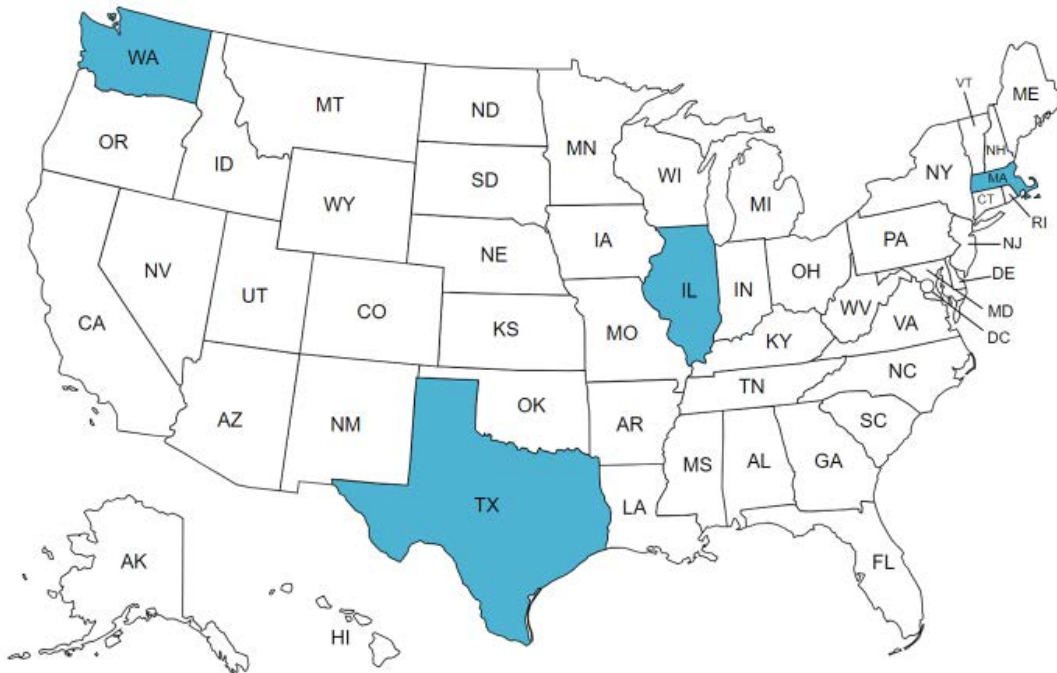
Within each selected county, the research team identified one partner agency with which to complete an in-depth case study (see *Interviews and In-depth Agency Case Studies*). Eight VSP partner agencies were selected by identifying GBV VSPs that were known to be well-connected and engaged in each county of interest, whether through a task force, coalition, multidisciplinary team, or other means. Each partner agency received a $2,000 stipend to cover

the time and cost associated with participating in the project, such as administrative tasks, pulling/redacting records, and scheduling stakeholder interviews.

2.2.2 Site-Specific Policy Assessment

We conducted an assessment of state, county, and local policies implemented in response to COVID-19 for each of the eight selected sites. To do so, the research team reviewed open-source, publicly available information on COVID-19 mandates and responses, focusing specifically on changes implemented March 2020 through October 2022. More specifically, data were collected on business, school, court, or public transportation closures/re-openings; mask mandates; social distancing requirements; crime rate trends; changes in the criminal justice system; and changes to other community-based institutions on which VSPs may rely for referrals and space for services. The most fruitful secondary data sources leveraged for this policy assessment included the following:

- The Center for Disease Control and Prevention's *COVID Data Tracker*
- Boston University's *COVID-19 US State Policies (CUSP)* website
- The Federal Bureau of Investigation's *Crime Data Explorer*

These data were supplemented with additional resources from each state and county's government websites and COVID-19 databases. In some communities, information about public health mandates was most consistently documented by local newspapers; therefore, we leveraged this secondary data source as well.

2.2.3 Web-Based Survey

RTI developed a voluntary web-based survey that was distributed to GBV VSPs in each county site. The survey was developed in Voxco, included 10 key questions, and was designed to be completed in approximately 10 minutes. The survey included measures to address (1) agency demographics, (2) challenges experienced as a result of the COVID-19 pandemic, (3) changes and innovations made to service delivery as a result of the COVID-19 pandemic, and (4) state and local policy.

The sampling frame for each county site was co-developed with the local VSP partner agency to ensure that all GBV VSPs in the county were included. We triangulated the sampling frame with task force directories, the Office for Victims of Crime directory, and general web searches.

Surveys were distributed to each county site on a rolling basis between November 2022 and September 2023. Surveys were distributed via email, typically to the agency Executive Director or other leadership. The invitation email included a description of the study, an individualized link to participate, and instructions about who could take the survey (i.e., anyone at the VSP who could speak to how the agency navigated the COVID-19 pandemic). Recipients of the survey invitation were instructed to forward the email to someone else at their agency if they did not have time to complete the survey themselves.

To minimize nonresponse, we conducted multiple follow-up efforts, including follow-up reminders via email and phone calls, using publicly available information (e.g., email addresses and phone numbers) to request the email of a preferred respondent.

2.2.4 In-depth Interviews and Agency Case Studies

RTI completed an in-depth case study with each of the eight VSP partner agencies between September 2022 and July 2023. Site visits were completed in 1 to 2 days, depending on the agency's scheduling preferences. Seven of the eight site visits were completed in-person,[2] with additional interviews being completed virtually as needed.

Case study data collection was conducted in the form of semi-structured interviews and secondary data record reviews. Similar to the web-based survey, interviews explored constructs related to (1) agency demographics, (2) challenges experienced as a result of the COVID-19 pandemic, (3) changes and innovations made to service delivery as a result of the COVID-19 pandemic, and (4) state and local policy. Additional constructs were explored related to funding and impacts on staff and volunteers. Interviews ranged from 20–70 minutes and were completed with leadership, supervisors, program staff, administrative staff, and volunteers.

2.3 Data analysis

Data analysis was guided by Tashakkori et al.'s (2021) instruction for parallel mixed-methods design for multilevel data. This approach relies on appropriate data analytic approaches for parallel mode-specific analyses. Findings from each independent analysis approach are then "linked, combined, or integrated" to identify convergent or divergent results (Tashakkori, Johnson, & Teddlie, 2021, p. 268).

2.3.1 Site-Specific Policy Assessment

Open-source information pertaining to policies, procedures, and mandates specific to each of the eight sites were reviewed and coded for information relevant to victim service provision. Coders searched identified secondary data sources for key constructs, including business, school, court, or public transportation closures/re-openings; mask mandates; social distancing requirements; crime rate trends; and/or changes in criminal justice system.

2.3.2 Web-based Survey

To initiate analysis of web-based survey data, descriptive results were generated for all key measures, including services offered by each VSP, changes made to service provision, and innovations sustained to service delivery. We then used correlational analyses to examine emerging relationships between key variables. Survey constructs were then explored by geographic region, urbanicity, and victimization type. Correlational analyses were conducted within and across sites, whereby findings were compared both within region and across urbanicity.

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[2] One of the eight in-person site visits was canceled due to illness and in-person dates were unable to be rescheduled. All associated interviews were completed virtually.

2.3.3 Interviews and Case Studies

All interviews were audio-recorded and transcribed by an automated transcription service. Research team members conducted quality assurance with each transcription to ensure accuracy. Transcribed interview data were then uploaded into QSR NVivo 12 and analyzed following Miles, Huberman, and Saldana's (2018) three stages of qualitative data analysis. Stage 1, *Data Processing*, is analogous to "open coding" and includes assigning labels and emergent constructs. Coders used NVivo's *attribute codes* to develop and assign codes to all transcribed interviews. Next, pattern coding condensed this information into meaningful units of analysis, whereby coders used NVivo's *index codes* to condense data. Through Stage 2, *Data Display,* all data were organized into accessible displays (e.g., matrices) to facilitate interpretation and to identify themes and connections. In this stage, reports were generated for each index code so coders could review themes more easily. Then, the research team developed detailed coding summaries based on each index code report to further distill down information. The research team leveraged Mural, a visualization tool, to extract prominent themes from each coding summary. Finally, Stage 3, *Drawing and Verifying Conclusions,* included interpreting findings from the data and then either verifying, revising, or removing the findings depending on additional analyses (e.g., negative case analysis and rival explanations reviews).

2.3.4 Integration Analyses.

Upon completing independent analyses, we developed a set of findings that could be "linked, combined, or integrated" to identify convergent or divergent results (Tashakkori, Johnson, & Teddlie, 2021, p. 268). We then synthesized our findings to answer all research questions and develop key themes, recommendations, and best practices regarding victim service provision during events of social disruption.

2.4 Respondent Characteristics

2.4.1 Web-based Survey Respondent Characteristics

Ultimately, N=73[3] agencies completed the survey and were included in the final sample (56.6% response rate; see *Exhibit 3* for individual county information).

Most responding agencies staffed between 11–50 individuals and 11–50 volunteers (see *Exhibit 4*). Domestic violence agencies were most likely to respond to the web-based survey (see *Exhibit 5*). Before February 2020, very few agencies provided services

Exhibit 3. Completed Surveys by County

County	N	Response Rate
Urban IL	16	57.1%
Rural IL	2	66.6%
Urban MA	9	45.0%
Rural MA	3	42.8%
Urban TX	18	45.0%
Rural TX	12	85.7%
Urban WA	11	78.5%
Rural WA	2	66.6%
Total	73	56.6%

[3] n=37 agencies were not included in this final sample because of (1) being outside of the study scope (e.g., an agency from a non-participating county or an agency that does not serve victims of GBV; n=6), (2) duplication (e.g., more than one response from a singular agency; n=12), or (3) incomplete response (e.g., completing no substantial

virtually (13.1%), with most providing in-person services at their agency's office (88.5%).[4] Responding agencies also reported providing services at shelters, medical centers, courts, schools, and out in the community (i.e., community centers, off-site trainings, foster homes) before the COVID-19 pandemic. Responding agencies connected with clients primarily through referrals (83.6%) or by outreach directly from victims (82.0%). County-specific survey demographics can be found in **Appendix A, Site Briefs.**

Exhibit 4. Agency Staff and Volunteer Volume

	Staff		Volunteers	
	n	%		n
1–10	11	15.07%	1–10	11
11–50	43	58.90%	11–50	43
51–100	10	13.70%	51–100	10
100+	8	10.96%	100+	8
N/A	0	0.0%	9	12.33%
Missing	1	1.37%	2	2.74%

Exhibit 5. Type(s) of Victims Served[3]

Type(s) of victim served	n	%
Sexual Assault	19	30.16%
Domestic Violence	37	58.73%
Stalking	12	19.05%
Human Trafficking	20	31.75%
Variety	4	6.35%
Other	4	6.35%
Missing	9	14.29%

Note: Categories are not mutually exclusive.

2.4.2 In-depth Interviews and Agency Case Study Respondent Characteristics

The eight VSP partner agencies that participated in case studies primarily served victims of domestic violence (n=3), sexual assault (n=2), human trafficking (n=1), or multiple victim types (n=2). VSP partner agencies provided a wide variety of services to clients, including shelter, hotline support, counseling (group and individual), financial assistance, legal accompaniment, referrals, and other forms of advocacy.

Across the eight VSPs, N=71 interviews were completed (see **Exhibit 6** for individual county information). Interviews were completed with agency leadership, program staff, and administrative staff. At a subset of VSPs, volunteers participated in interviews. VSP partner agencies were offered the opportunity to invite clients to participate in case study interviews, but they all declined. Additional information about each VSP partner agency can be found in **Appendix A.**

Exhibit 6. Completed Interviews by County

County	n
Urban IL	8
Rural IL	6
Urban MA	7
Rural MA	10
Urban TX	14
Rural TX	8
Urban WA	10
Rural WA	8
Total	71

questions after agency demographics; n=19). For duplicates, we retained the submission with the most questions completed.

[4] Response categories were not mutually exclusive. Responding agencies were able to select multiple service locations, thus percentages do not sum to 100%.

Section 3: Findings

3. Findings

3.1   Research Question 1: How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

This first research question is addressed through three sub-questions, including (1) what was the pattern of the COVID-19 infection rate in the state, and at what point were various mitigation policies adopted; (2) what were the state and local COVID-19 policy responses in the following areas, and did these policies impact victim service provision (business closures, mask mandates, school closures, social distancing requirements, public transportation closures, changes in criminal justice systems); and (3) what was the pattern of crime in the county (i.e., crime rate, reported emergency department admissions), and was this pattern reflected in demand for victim services? Answers to each of these sub-questions are detailed below.

3.1.1   What was the pattern of the COVID-19 infection rate in the state, and at what point were various mitigation policies adopted?

Open-source information pertaining to policies, procedures, and mandates specific to each of the eight sites was reviewed and coded for information relevant to victim service provision. Analyzing the state and local policies implemented in response to COVID-19 provided better understanding into how local context may have informed VSP decision-making. Through a review of publicly available information, including databases, government documents, press releases, and newspaper articles, we collected data on state- and county-level COVID-19 mandates and responses, focusing specifically on changes between March 2020 and December 2021, including business, school, court, or public transportation closures/re-openings; mask mandates; social distancing requirements; crime rate trends; changes in the criminal justice system; and other community-based institutions on which VSPs may rely for referrals and space for services. Site specific policy information can be found in **Appendix A, Site Briefs**, including how COVID-19 infection rates within each community correlate to the timeline for when policies and mandates were implemented. Key findings from this policy analysis are summarized in **Exhibit 7** below.

Exhibit 7.   Key Findings Contained in Site Profiles

State	Highlights of Policy Assessment
Illinois	▪ Stay-at-home advisory began on March 21, 2020, including non-essential business closures. Non-essential businesses were allowed to reopen on May 29, 2020, and the stay-at-home advisory ended on June 11, 2021. ▪ School closure at all levels happened on March 17, 2020, and again on January 11, 2021. Until July 25, 2021, the state routinely closed or opened schools with alterations because of infection rates. ▪ IL did not implement a public transportation closure. ▪ Court process postponements and tele-courts activities were decided at the local level.
Massachusetts	▪ Stay-at-home advisory began on March 10, 2020, including non-essential business closures. Non-essential businesses were allowed to reopen on May 18, 2020, and the stay-at-home advisory ended on January 25, 2021. ▪ School closures for all levels occurred on March 23, 2020. For the 2020–2021 school year and beyond, the state then closed or opened select levels with alterations regularly through March 2022. ▪ MA mandated closures across sectors like state prison visitations, courts, and public transportation through May 2020.
Texas	▪ Stay-at-home advisory began on April 2, 2020, including non-essential business closures. Non-essential businesses were allowed to reopen on May 1, 2020, and the stay-at-home advisory ended on March 10, 2021. ▪ TX issued recommendations over mandates making it the least restrictive on movement of the general public. ▪ Initial school closures occurred on March 20, 2020, but did not include day care closures. From August 2020 through December 2021, the state recommended select level closures or openings with alterations and then did not make school recommendations after December 2021. ▪ The state did not make any recommendations for public transportation, and state prison visitation was stopped for less than a month. ▪ Court proceedings were dictated at the local level.
Washington	▪ Stay-at-home advisory began on March 23, 2020, then non-essential business closures occurred on March 25, 2020. Non-essential businesses were allowed to reopen on June 1, 2020, and the stay-at-home advisory ended on March 10, 2021. ▪ Schools were closed on March 17, 2020, but day cares were never closed. The state reopened select levels to start the 2020–2021 school year, but then closed all levels on April 6, 2021. The state provided recommendations on May 24, 2021, but that was the last state guidance for schools. ▪ Public transportation was limited or closed beginning with the stay-at-home advisory, and restrictions were not lifted until November 2021. ▪ Court process postponements and tele-courts activities were decided at the local level.

See also *Appendix A, Site Briefs*.

Across the four states included in this study, closures and mandates such as masks and social distancing had similar start dates at the beginning of the rise in COVID-19 infections. However, states differed in the stringency of what was included and length of time that they held these types of state-wide responses.

Interviews with VSP staff provided more a nuanced understanding and revealed that organizations followed both Centers for Disease Control and Prevention (CDC) or state guidelines to determine their own policies to maintain the services they were providing as safely as possible. At times, this guidance differed (CDC versus state) and each VSP was left to determine which protocols to implement in their own agencies. Interviewed VSP staff reflected on how making these decisions felt particularly challenging during the peak of the pandemic and how it would have been helpful to have more clear guidance from their funders and government leadership.

3.1.2 What was the state and local COVID-19 policy response in the following areas, and did these policies impact victim service provision (business closures, mask mandates, school closures, social distancing requirements, public transportation closures, changes in criminal justice systems)?

State and local policy responses are documented briefly in the previous section and in more detail in *Appendix A, Site Briefs*. The ways in which VSPs experienced these mandates were addressed both through our county-wide web-based surveys and agency-specific case study interviews.

Our survey gathered perspectives on the types of public health measures instituted at the onset of the COVID-19 pandemic. Interestingly, survey data revealed that certain types of mandates or closures were inconsistently understood by local VSPs. Although some responding agencies believed a mandate or closure was instituted, others did not. This lack of clarity was most acute for vaccine mandates and public transportation closures. Additionally, rural counties felt unclear about social distancing mandates (see *Exhibit 8*).

Exhibit 8. Perceived COVID-19 mandates and required closures by county

County	Mandates				Closures		
	Mask	Social distancing	Vaccines	School	Courts	Businesses	Public Transportation
Urban IL	X	X	\	X	X	\	0
Rural IL	X	X	\	X	X	X	\
Urban MA	X	X	\	X	X	\	\
Rural MA	X	\	\	X	X	X	\
Urban TX	X	X	\	X	X	X	\
Rural TX	X	\	\	X	X	\	\
Urban WA	X	X	\	X	X	X	\

Rural WA	X	\	X	X	X	X	0

X=Majority of responding VSPs reported this mandate or closure in place.
0= Majority of responding VSPs reported no mandate or closure in place.
\=Disagreement among responding VSPs about whether the mandate or closure was in place. Indicated by less than 75% of respondents in agreement.

Survey data also explored to what degree respondents felt like their community complied with those mandates and public health measures. Most responding agencies reported that their community complied with closures, but there was less consistency for mandates (see *Exhibit 9*).

Finally, the survey explored to what degree specific public health measures impacted VSPs' ability to provide their core services (see *Exhibit 10*). Many agencies noted that public health mandates (mask, social distancing, vaccines) never impacted service delivery or presented challenges when they were previously in place. Some agencies noted that these mandates were or continue to be helpful to their service delivery. Conversely, the majority of agencies reported that closures to schools, courts, and public transportation presented challenges when they were in place. Only two agencies stated that such closures were helpful to service delivery.

Exhibit 9. Perceived Compliance with COVID-19 Mandates and Required Closures by State

State	Most individuals complied, n (%)	Some individuals complied, some did not comply, n (%)	Most individuals did not comply, n (%)
Mask Mandates (n=61)			
IL (n=16)	16 (100.0)	0 (0.0)	0 (0.0)
MA (n=10)	9 (90.0)	0 (0.0)	1 (10.0)
TX (n=27)	18 (66.7)	9 (33.3)	0 (0.0)
WA (n=8)	5 (62.5)	3 (37.5)	0 (0.0)
Social Distancing Mandates (n=57)			
IL (n=16)	12 (75.0)	4 (25.0)	0 (0.0)
MA (n=9)	5 (55.6)	3 (33.3)	1 (11.1)
TX (n=24)	10 (41.7)	14 (58.3)	0 (0.0)
WA (n=8)	5 (62.5)	2 (25.0)	1 (12.5)
Vaccine Mandates (n=35)			
IL (n=10)	3 (30.0)	7 (70.0)	0 (0.0)
MA (n=6)	5 (83.3)	1 (16.7)	0 (0.0)
TX (n=12)	4 (33.3)	7 (58.3)	1 (8.3)
WA (n=7)	3 (42.9)	4 (57.1)	0 (0.0)

Exhibit 10. Impact of COVID-19 Mandates and Required Closures by State

State	Did not impact service delivery, n (%)	No longer in place – was helpful, n (%)	No longer in place –was a challenge, n (%)	Still in place- remains helpful, n (%)	Still in place – remains a challenge, n (%)	Still in place – no longer impacts, n (%)
Mask Mandates (n=60)						
IL (n=15)	7 (46.7)	2 (13.3)	2 (13.3)	4 (26.7)	0 (0.0)	0 (0.0)
MA (n=10)	4 (40.0)	3 (30.0)	1 (10.0)	2 (20.0)	0 (0.0)	0 (0.0)
TX (n=27)	7 (25.9)	7 (25.9)	8 (29.6)	4 (14.8)	0 (0.0)	1 (3.7)
WA (n=8)	2 (25.0)	2 (25.0)	4 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)
Social Distancing Mandates (n=56)						
IL (n=15)	6 (40.0)	2 (13.3)	6 (40.0)	0 (0.0)	0 (0.0)	1 (6.7)
MA (n=9)	3 (33.3)	1 (11.1)	4 (44.4)	1 (11.1)	0 (0.0)	0 (0.0)
TX (n=24)	7 (29.2)	3 (12.5)	12 (50.0)	0 (0.0)	0 (0.0)	2 (8.3)
WA (n=8)	4 (50.0)	1 (12.5)	2 (25.0)	0 (0.0)	0 (0.0)	1 (12.5)
Vaccine Mandates (n=34)						
IL (n=9)	4 (44.4)	1 (11.1)	3 (33.3)	1 (11.1)	0 (0.0)	0 (0.0)
MA (n=6)	2 (33.3)	1 (16.7)	2 (33.3)	1 (16.7)	0 (0.0)	0 (0.0)
TX (n=12)	7 (58.3)	1 (8.3)	4 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)
WA (n=7)	2 (28.5)	1 (14.3)	3 (42.9)	0 (0.0)	0 (0.0)	1 (14.3)
School Closures (n=54)						
IL (n=13)	1 (7.7)	0 (0.0)	12 (92.3)	0 (0.0)	0 (0.0)	0 (0.0)
MA (n=8)	2 (25.0)	0 (0.0)	6 (75.0)	0 (0.0)	0 (0.0)	0 (0.0)
TX (n=25)	6 (24.0)	0 (0.0)	19 (76.0)	0 (0.0)	0 (0.0)	0 (0.0)
WA (n=8)	2 (25.0)	1 (12.5)	5 (62.5)	0 (0.0)	0 (0.0)	0 (0.0)
Court Closures (n=53)						
IL (n=12)	0 (0.0)	0 (0.0)	12 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)
MA (n=9)	2 (22.2)	0 (0.0)	7 (77.8)	0 (0.0)	0 (0.0)	0 (0.0)
TX (n=24)	5 (20.8)	0 (0.0)	18 (75.0)	0 (0.0)	1 (4.2)	0 (0.0)
WA (n=8)	1 (12.5)	1 (12.5)	5 (62.5)	0 (0.0)	1 (12.5)	0 (0.0)
Business Closures (n=47)						
IL (n=11)	3 (27.3)	0 (0.0)	7 (63.6)	0 (0.0)	1 (9.1)	0 (0.0)
MA (n=7)	3 (42.9)	0 (0.0)	4 (57.1)	0 (0.0)	0 (0.0)	0 (0.0)
TX (n=22)	5 (22.7)	0 (0.0)	16 (72.7)	0 (0.0)	1 (4.5)	0 (0.0)
WA (n=7)	1 (14.3)	0 (0.0)	6 (85.7)	0 (0.0)	0 (0.0)	0 (0.0)
Public Transportation Closures (n=24)						
IL (n=4)	0 (0.0)	0 (0.0)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)
MA (n=5)	1 (20.0)	0 (0.0)	4 (80.0)	0 (0.0)	0 (0.0)	0 (0.0)
TX (n=13)	1 (7.7)	1 (7.7)	11 (84.6)	0 (0.0)	0 (0.0)	0 (0.0)
WA (n=2)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)

Interview responses offered insight into how these mandates and policy changes impacted VSPs. Mandates and protocols that resulted in closures or a move to fully remote services as

determined by the VSPs and their external partners were hugely impactful on victim service provision. Additionally, closures of systems such as schools, courts, corrections facilities, and faith-based organizations affected VSPs' ability to both reach victims to provide services or case management and to make necessary referrals. Additionally, business closures sometimes meant fewer locations to refer victims, which in turn meant that agencies had to fill gaps in service. VSPs had to work quickly to provide typically out-of-scope services to meet the needs of their clients when suddenly an agency was not available. As described by one service provider,

> *But we did, I think, have to take more of like the burden to give like direct services to our clients where maybe we would refer them out previously because a lot of other organizations that were more, like, national or had like more, you know, maybe they're not local. They were following like nationally, like standard, like restrictions kind of thing. And so we didn't ever stop in-person services, but a lot of the other agencies around us did. (TX, rural, 3)[5]*

During the time of widespread business closures, VSPs reported that there were an influx of requests for support, even from community members who did not fit the agency's typical client profile. For example, one agency that focused specifically on providing services for people who have experienced IPV, reported receiving calls from other communities impacted by the pandemic and in need of specific services like shelter, such as newcomer migrants and unhoused persons. This VSP reflected that many of the typical referrals they would provide in these circumstances were closed due to pandemic-based restrictions, but that they worked to fill the needs amidst increasing financial instability of communities.

Although some agencies were able to provide referrals and resources, others were restricted by their funding provisions. As one respondent described, "We do get calls where it has nothing to do with domestic violence, but we have a book of resources so we cannot help them because if they don't fall under domestic violence and they need to qualify for us, for our services" (WA, rural, 1).

Closures of community systems such as public transportation, schools, and courts also required flexible problem-solving by VSP staff. For example, with public transportation closures, VSPs had the new challenge of figuring out how clients could actually get to shelter or to other services. One respondent described thinking through how to provide transportation for their clients:

> *I mean, I know the transportation was definitely something that we were trying to help people figure out, not because they were coming to us at that time, but how they could safely get to if they did have doctor's appointments or other things that they just had no choice around that they needed to get to. (MA, urban, 3)*

VSP agencies described having to quickly switch from providing transit vouchers to using ride shares (e.g., Uber, Lyft) when those were available and when they had funding to support this

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[5] Quote attributes describe the respondent's state, urbanicity, and respondent ID. Respondent IDs for surveys begin with an S.

approach. Several respondents across different agencies described that they personally drove victims to appointments or shelter as a means of maintaining victim engagement with services. As detailed by a respondent from the rural Texas site, "But, but yeah, I think just like the, the filling in the gaps of like this feels hard for them to do on their own sometimes. But if they know that you can pick them up from the residence and like actually drive them there, they're a lot more like willing to say like, Yes, I will do X, Y and Z" (TX, rural, 3).

School closures impacted children and their families and left VSPs scrambling to provide unexpected support. A top concern among some respondents was for the well-being of the children and youth themselves being without the support system schools provided, which has caused and will continue to cause lasting impacts on the lives of these individuals:

> *Sometimes school is the safest place for these kids. For many of those that I worked with and they were not able to come to school. And so, yes, the vulnerability - I would assume that them being home in some unsafe environments or even the environments that they might live around would be very hard for them and they would be more vulnerable to that for sure.* (TX, rural, 1)

Other agencies that provide shelter to families with children found themselves suddenly in the position of needing to support remote schooling for resident children, which had implications for technology provision and network connectivity capabilities. These were new challenges that needed to be addressed quickly but required materials and resources that were not necessarily readily available. One respondent spoke to this challenge, "In the early pandemic stage, a lot of families that lived in poverty and don't have access to wifi or Internet in the way that is necessary so that a child can access, even if they had the technology," which meant this agency had "to figure out how [they] were going to get kids to school virtually and ended up having to pour, I want to say, a good $100,000 of nonprofit money that we didn't have to be able to update our wifi so that kids could go to school" (MA, rural, 4). One other VSP partner agency took a similar approach, investing in upgraded technology so children residing at the shelter could attend remote school during the pandemic.

School closures also stopped school-based education, outreach, and prevention programs provided by VSPs, and access by other professionals was still restricted even when schools opened back up for students and staff. As one participant said, "So there was still a lot of like closures or only like direct teachers were able to go into the schools or they were still, you know, doing Zoom. And so, there was a lot less in-person prevention that I was doing as well" (WA, urban, 7). Once schools began to resume in person, VSPs still had immense challenges finding time, access, and capacity within school systems to provide outreach, training, and prevention because schools were playing catch up or had to prioritize other programming. This impacted long-term relationships with schools and did not align with the increasing risk of online safety concerns, particularly youth trafficking. As one provider explained, access to schools was inconsistent, and there was concern that access was still limited among schools with the greatest need for education and outreach: "Some school systems were much easier to get into than others. And unfortunately, that did not align with highest risk communities" (TX, rural, 8).

Victims and families faced stress with court closures or limited operations in the court system. Interviewees frequently described the challenges of accessing restraining and protective orders, especially when clients did not have access due to inadequate court processing or because their cases were stalled. If courts were operating in person, mandates determining who could enter the courthouse had further impact on support for victims, as advocates or friends and family offering support were frequently not permitted to accompany victims.

> *Well, you know, some of them were upset because they would even, you know, having us there is a good thing. But, you know, some people wanted their mom to go in or, you know, I, I need so-and-so to go with me. But they were not allowed to go in, even into the courthouse. They would have to wait outside.* (IL, rural, 1)

These closures have had a lasting impact on these communities; backlogs of cases had formed and that had not been fully cleared at the time of each site visits.

Hospitals similarly did not allow advocates, family, or friends to provide in-person support during the peak of the COVID-19 pandemic. Although hospital systems did not close, their policies had huge impact on hospital-based advocacy services, and communication was difficult as they navigated a challenging pandemic landscape. VSPs described how hospitals overburdened with COVID-19 response, ceased collaboration with advocate programming, impacting their ability to provide services or identify further victimization such as trafficking. Additionally, because of safety procedures, hospitals could no longer follow established protocols for responding to GBV, such as providing forensic examinations in predetermined locations.

> *And previously, if somebody was, say, inpatient at the hospital and disclosed sexual assault, they would bring them to the ICU because it's calmer there. And so having somebody go to the ED but that no longer happens because the ICU is just completely full with COVID patients.* (MA, urban, 2)

Within the VSPs, policies were created and amended throughout the beginning and enduring stages of the COVID-19 pandemic, both to ensure the safety of clients and VSP personnel during interactions and to minimize impacts of exposure if someone contracted COVID-19. Examples of these types of mandates and policies included guidance around mask wearing and social distancing, but it also included moving to off-site service delivery to accommodate mandated closures and client safety (i.e., hotels, parks, satellite offices). Overall, staff felt the VSPs were working to ensure minimal impacts on service delivery; however, many reported feeling uncertainty about what the mandates would mean for service provision in the long term. Some interview respondents described that there was disagreement among some staff over the duration of keeping mandates in place as it began to feel like these policies were preventing optimal service delivery. Some respondents also described pushback from clients about adherence to mitigation policies, particularly mask wearing in shelter settings:

> *But that was probably my biggest fight with everybody who was in shelter about them keeping the masks on. That was like the biggest thing. And then it was hard. Like if you're in your own space in your house and you want to cook dinner, you don't want to cook dinner with the mask on. But if you're in a common area*

*with other people, you have to wear the mask. And that went on for several,
several months. And so that was probably one of the hardest things.* (WA, urban,
4)

Another respondent from a different site described the same issue but also described the
necessity to be flexible and forgiving with clients who could not abide by these mandates, given
their unique circumstances as a shelter for people who had experienced IPV:

> *Because if the client is, as you just stated, sometimes that's not a priority. The
> client needs to process what's going on from a trauma perspective. And so
> sometimes COVID took a backseat because you want to make sure that you get
> that client in a place where they can start to rebuild themselves. And you didn't
> always, you wouldn't always, Well, get your mask on! You know, it was, you
> know, Let's talk about what's going on with you and how do we help and support
> you.* (TX, urban, 10)

Ultimately, VSP staff felt that the mandates were impacting trauma-informed administration of
service provision. Having to focus on the greater good over the individual's experience was a
difficult decision for VSPs and their leadership, and respondents overwhelmingly indicated that
there was a point for each agency where weighing the impacts of the virus over the needs of the
victims was necessary:

> *And I think that was a significant challenge for us, right, is that this push of, like,
> We have to be really trauma informed and, and be very survivor focused and
> survivor led while being in the middle of a pandemic where people were getting
> really sick - and so you have this pull of like, what, really to keep everyone safe,
> like, I have to tell you to wear a mask. I have to tell you to stay in your room if
> you're sick. I have to move you to a different place, right. Because you're trying
> to, you have 58 people you're trying to protect as opposed to one.* (MA, rural, 4)

3.1.3   What was the patterns of crime in the county (i.e. crime rate, reported emergency department admissions), and was this pattern reflected in demand for victim services?

Although crime statistics illustrate rates of reported crime, it is well-understood that GBV is often
underreported in official crime statistics. Moreover, while helpful for understanding patterns in
crime, statistics do not provide an understanding of the nature of those experiences with
victimization. Interviews with VSP staff provided insight into the nature and reality of GBV
victimization during the pandemic and how this victimization seemed related to the conditions
related to the pandemic.

Although some participating agencies reported very short-lived drops in demand for services
during the very beginning of the pandemic, agencies overwhelmingly reported an increase in
demand for services—an increase that persisted for years after the onset of the pandemic.
VSPs reported seeing drastic increases in needs of victims of IPV due to isolation from both
stay-at-home policies but also loss of work—for both victims and perpetrators. Additionally,
VSPs saw an increase in the level of violence in the home making it completely unsafe for the
person to stay and attempt to safety plan for remaining in the home. One respondent described

the challenge of trying to provide remote services for victims facing unthinkable conditions while isolated at home with their abuser:

> *But I will say that there was definitely an uptick of abuse. We had a lot more, we call them kidnaping cases, even if they're living with a person of like I mean, I'm not divulging names, but we had a lot of people getting locked in like a cellar or a closet for like hours at a time. You know, where are they going to go? Because they're trapped in there with them. We had a lot more strangulation cases. That is still happening.* (MA, rural, 2)

Another respondent from the same agency, corroborated this by saying, "we are seeing across programs - it doesn't matter which program - a significant uptick in mental health, a significant uptick in substance misuse, a significant uptick in self-harm behaviors in the programs in the clients that we're servicing. And I will also say a significant uptick in how violent the abuse is" (MA, rural, 4). This respondent went on to describe how this pattern was observed not only in IPV but among clients seeking services for other forms of GBV as well:

> *The physical violence aspect, what we're seeing women come in with, is so brutal that there are clients that are coming in that have to have hospital stays before they're even able to be discharged to come to us. So we're seeing a different level of brutality. The same thing around sexual assault. It's just the brutality that, that people are enacting on each other is different than what we were seeing pre-COVID.* (MA, rural, 4)

A service provider from a different state described similar observations but also talked about how this increased severity of violence also impacted VSP staff:

> *The severity of abuse was higher. So more people with broken limbs or, you know, they were coming from hospitals, just some of it was just things that we had never seen. Like somebody was stabbed with a crowbar. I mean, it was just it was just so severe that we began to see so that is taking not only a toll, and that's why it was taking a toll on us.* (TX, urban, 7)

Additionally, respondents noted that they were seeing a shift in the demographics of people seeking services, which may relate to how VSP experiences during the pandemic are not necessarily reflected in official crime statistics. Respondents described increasing need and VSP engagement among elder victims of crime, children and youth, refugees, and migrant community members. One respondent said, "[Demand for services] keeps going up, because there's always something new happening. So the pandemic, then we have refugees coming in that we're a safe haven for them. So it's just like the call volume keeps going up because people keep asking, you know, how can we help them?" (IL, urban, 5). Importantly, because these populations may be less likely to engage with the criminal legal system, their victimization experiences may also be underrepresented in official crime statistics.

Lastly, changes in types of services requested and the length of time that services were needed were reported across all sites, and many respondents connected these changes to impacts of the COVID-19 pandemic. The combination of decreased job opportunities, increased isolation

among community members and in households, and increased severity of violence resulted more resources needed by clients and for longer.

3.2 Research Question 2: How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful *or* sustained in the long term?

This question is addressed through the exploration of three sub-questions, including (1) of the adapted practices adopted during the pandemic, what will be sustained, and how is this determined; (2) what approaches will not be continued and why; (3) what was the role of technology in changes to service provision, and what, if any, were the limitations of that use; (4) did changes to service provision allow agencies to serve different clientele or to serve the same clientele in different ways; (5) what types of services were best and worst suited for different modalities of service provision (in person, remote, or hybrid) as well as how was this determined and will agencies continue experimenting with differential service provision in the future; (6) have there been any sustained changes to staffing, staff expectations, or staff satisfaction since the onset of the pandemic; and (7) how have shifts in service delivery changed victim engagement with services? Answers to each of these sub-questions are detailed below.

3.2.1 Of the adapted practices adopted during the pandemic, what will be sustained, and how is this determined?

Our understanding of how VSP practices changed during the pandemic and whether those changes will be sustained is informed by both survey responses as well as by case study interview responses. Our survey of VSPs collected information about the types of services that needed to be permanently suspended or adapted as a result of the pandemic and why those changes were perceived to be necessary. Results are presented in *Exhibit 11.*

Exhibit 11. Services Suspended, Adapted, or Continued as Usual

Impact	Services[6]
Service suspended permanently	Only three services were reported as being suspended permanently as a result of the COVID-19 pandemic: ▪ Mental health services (4.3%) ▪ Legal assistance (4.3%) ▪ Legal advocacy/accompaniment (2.4%)
Service suspended temporarily	Other services were suspended temporarily. These were typically services that relied on access to outside organizations (e.g., visitation centers, business, hospitals). The services most commonly reported as being suspended temporarily were as follows: ▪ Supervised child visitation (33.3%) ▪ Community member training (25.0%)

[6] Percentages are based on those who reported providing this service, not the entire sample of agencies. For example, of the 23 agencies that reported providing mental health services only one reported that this service was suspended permanently (4.3%).

Impact	Services[6]
	▪ Medical advocacy (17.4%)
Service adapted permanently	Some agencies chose to sustain their service adaptations in perpetuity. The services most commonly reported as being adapted permanently were as follows:
	▪ Mental health services (26.1%)
	▪ Interpretation and sign language services (21.4%)
	▪ Community member training (20.0%)
Service adapted temporarily	Each service type was reported as being adapted temporarily by at least one agency. The services most commonly reported as temporarily adapted were as follows:
	▪ Emergency medical care (66.7%)
	▪ Legal assistance (65.2%)
	▪ Legal advocacy/accompaniment (63.4%)
	Notably, legal assistance and legal advocacy/accompaniment were also reported as one of the few types of services that were suspended permanently. This highlights how some agencies were able to adapt services for a distinct period of time, but others did not have this capacity.
Service continued as usual throughout the COVID-19 pandemic	Each service type was reported as continuing as usual by at least one agency. The services most commonly reported as being able to continue as usual were as follows:
	▪ Hotlines (72.4%)
	▪ Transitional housing (71.4%)
	▪ Information and referrals (55.8%)

Agencies reported needing to permanently suspend services because COVID-19 prevention measures made the delivery of that specific service unfeasible long-term. For services that were permanently adapted, the most commonly reported adaptation was shifting to virtual service models (i.e., completely virtual or hybrid).

Additionally, this study's web-based survey collected information as to whether VSPs needed to add services as a result of the pandemic. Nearly one-third (31.5%) of the sample reported adding services since the onset of COVID-19. Responding agencies described a wide variety of added services, including (1) more intensive case management services, (2) housing support services (e.g., eviction defense, resources for housing for victims of domestic violence, temporary hotel housing), (3) cash assistance, and (4) food distribution. These service additions may reflect the changing needs of victims in responding agencies' communities; although agencies typically provided support for specific forms of victimization, during the pandemic they expanded their service delivery to provide for victims' other, more pressing needs (e.g., housing, food). In addition, one agency reported inheriting services from another organization that no longer had capacity to provide such services. One survey respondent shared, "We also saw a decrease in other agencies providing care, which meant our crisis line was busier with both survivors and folks outside our scope of services calling" (WA, urban, S61). Reported sources of funding for adaptations and additions to agencies services are presented in *Exhibit 12.*

Exhibit 12. Funding Sources for Service Adaptations and Additions

Funding source	n	%
Grants	45	76.3
Reallocation of available funds	30	41.4
Material donations (e.g., personal protective equipment)	27	37.0
Fiscal donations incurred through increased fundraising efforts	26	35.6
Fiscal donations incurred spontaneously	22	30.1
Other	5	6.8

Note: Response categories are not mutually exclusive. Responding agencies were able to select multiple funding sources, thus percentages do not sum to 100%.

Although our survey results inform our understanding of how specific programmatic access was impacted by the pandemic, the survey did not address changes to agency protocols, practices, or service modalities. Case study interviews provide important insights into the ways that the COVID-19 pandemic resulted in sustained changes how VSPs operate and the rationale behind the more permanent adoption of these strategies.

Many of the sustained changes to participating VSPs in this study have to do with how they operate and the modalities in which they offer services. Most VSPs participating in this project did not have an option for virtual client engagement prior to the pandemic. However, as is discussed in more detail in *Section 3.2.3* below, almost all of the participating agencies in this project were forced to modernize their technology, adopting virtual client engagement platforms and processes. Even when stay-at-home orders and social distancing restrictions were lifted, many agencies reported that they would keep virtual service delivery available to clients. Interview respondents frequently described specific client populations that benefited from virtual service delivery. Chief among them were victims of IPV or human trafficking who were often still living with their abusers. These clients may not have had access to transportation to come in for face-to-face counseling or safety planning or may face additional danger if they leave home to seek services:

> *So I've noticed that implementing virtual therapeutic sessions for families have worked, very much so. Um, we found out that sometimes a survivor that is still living with their perpetrator, that's the best way for them to be able to actually do a virtual therapeutic session, because they're still at home. And if the person is not there, they're able to do it and feel somewhat safe at that moment. So we are able to fulfill more needs when it comes to emotional support virtually, because we know that sometimes a lot of survivors, if they're still living in that home with the perpetrator, they're not able to leave. So, and the access to transportation is very limited. So we definitely still to this day incorporate a hybrid model because we still want survivors to feel that we're providing an option.* (MA, rural, 5)

Virtual service delivery was also noted as helpful for people with disabilities or mobility issues or who are immunocompromised:

> *Yeah, I mean, it forced us to get online to be able to deliver services and virtually. That's been impactful, especially if you think about individuals with disabilities who may not be able to come in person or who may have compromised immune systems. It's created more accessible meetings and training events and client services for sure.* (MA, urban, 6)

Respondents also mentioned clients with children and those who do not have reliable access to childcare as benefitting from virtual service options. This also applied to clients with inadequate or unreliable access to transportation (see *Section 3.2.4* for more information on how changes to service provision allowed agencies to serve different clientele). Some respondents also described continuing to offer hybrid service delivery as an opportunity to give clients choice and agency about how they would like to engage with VSPs:

> *Yeah, I think we'll always have hybrid now. It just seems to make sense. And we really decided that in some ways when, you know, it was clear that the world was opening up again. But also our funders like [Funder] was saying, you know, we expect you to have office hours again and all of that, that many clients, when given the option, still wanted to do their work with us remotely. And now we know how to do it. We have the right technology set up. We can do it in a secure, confidential way. And so that's just something that in some ways we've given much more flexibility to the client to decide like, does this work for you or not?* (MA, urban, 3)

However, across agencies, respondents noted that there are limits of virtual client engagement. Almost universally, respondents agreed that virtual services for young children were harder and lower-quality than face-to-face interaction. Additionally, though okay in a pinch, some types of services like school-, jail-, and community-based education and outreach are better suited for in-person engagement, as reported by some study respondents.

In addition to providing remote services for clients, many agencies have embraced either hybrid or remote work environments for their own staff:

> *In terms of innovation, and some of the things that we're going to keep, is what we learned about people working remotely. They can be productive. We didn't know that before COVID because we'd never done it. But what we learned is people can be very productive. So if you set them up with the right tools, the right materials, and give them the right access to what they need, they can be successful in a, in a work model that might be 100% remote, hybrid or, or some combination of that. And so we're going to maintain this approach of allowing employees to be hybrid.* (TX, urban, 10)

Agencies that have adopted hybrid or remote work environments described several benefits, including that advertising a hybrid or remote work environment seems to be attractive to potential job candidates, many of whom have become accustomed to hybrid work. Additionally, existing staff, particularly in large urban settings, appreciate having a break from longer commutes. Lastly, by embracing a hybrid workforce, some agencies are able to offer services for additional hours of the day:

Now we're saying, you know, what kind of work arrangement would be best suitable for you? And let's look at the work times, because we want to be able to service clients all the way to 9:00. Before, we were only doing three, three evening sessions on a Saturday for the clients to come in. Now we can be, we can do that every night of the week if we've got enough staff. (TX, urban, 10)

Another sustained change to operations and agency culture that many interview respondents noted was an increased adherence to suggested public health practices. Many of the participating agencies have normalized staff working from home if they are sick or have a child home sick but are still able to complete their work. Additionally, many agencies, particularly those that operate communal shelter services, are maintaining some public health practices from COVID-19 to prevent the transmission of other viruses:

But I think it annoys the clients that we're still to this day so, like, we have to follow these guidelines, you have to - you know, because I feel like people think COVID's not a thing anymore. But we're not just doing it for COVID. You know, there's the, it's flu season. And then there was all those upper respiratory things going around for children. I don't know what it's called, but you know what I'm talking about. And there's so many other things out there that it's like, we're going to do it anyway, you know what I mean? Like the disinfecting and keeping everything - now we don't go around with the big fogger machine like we did at the peak of COVID. But we still are very mindful. (IL, rural, 5)

When describing sustained changes to services and service delivery, most respondents also discussed upgraded technology, service delivery platforms, and networks. Most agencies experienced an accelerated upgrade of technology, including hardware for staff (laptops, hot spots, cell phones) and software meeting certain security requirements. At the time the pandemic began, many of the agencies participating in this study were still using paper record systems, and almost all have since converted to electronic case management systems. One participant described their slow realization that it would be necessary to modernize their technology systems:

Prior to COVID, I was anti-teletherapy. Like, we never offered teletherapy. We would never offer teletherapy. I had very strong negative beliefs about the effectiveness of therapy via video. And so - I had no experience with that. I, we were still operating with paper records, which I loved because I've been here 30 years. So, you know, there's nothing to worry about a computer messing up paper charts, paper records in the filing cabinet. I think the waiting list had recently just moved into whatever century and was, was computerized, which was good. But I just remember, I think it was a couple, 1 to 2 weeks in, when it was like, This, this is going to be much longer. We have to be able to provide services. What does that even look like? And so I just went online and started like - not like long term, but a little bit long term. I mean, I wasn't thinking I was building something that would last forever. (WA, urban, 8)

3.2.2   What approaches will not be continued and why?

Interview respondents offered some perspective on innovations that occurred toward the beginning of the pandemic that were determined to be helpful short-term solutions but ultimately were not sustained. One of the ways that several agencies participating in our case studies described changes to service delivery during the onset of COVID-19 involved reallocating staff from services that could not be offered (e.g., hospital advocacy) to critically needed services (e.g., hotline response). This was described as a strategy to both respond to changing demand for certain services and to retain staff who were unable to do their typical jobs because of pandemic-related restrictions:

> *We didn't want to lay people off. And so what we did was we transferred everyone onto the crisis team to take phone calls. That way, my staff wasn't constantly getting burned out. And because there wasn't…you know, all of the housing stuff was shut down, all the legal stuff was shut down. At first all of it was shut and everything was shut down. And so we transferred everyone onto the crisis line.* (WA, rural, 6)

Although described as a helpful short-term strategy, these staff rotation decisions were ultimately described as temporary. Most staff were able to shift back to their original roles because there are challenges inherent in rapid staffing pivots, especially around training and preparedness.

Other short-term changes to service delivery that were discontinued centered around technology and were ultimately replaced by different, more sustainable and secure solutions. For example, some respondents described using personal cell phones (with or without Google Voice phone numbers) to provide advocacy services by phone. One respondent described how, at their agency, they were taking videos of themselves using their digital systems to show each other data management systems because they did not have any virtual trainings available for staff who were not prepared or trained to use their systems as it was not typically part of their job duties. As described in more detail in ***Section 3.2.3***, most participating agencies quickly upgraded their technology and adopted enhanced communication systems, both for communicating internally and with clients. The makeshift strategies described in this section mostly served as imperfect ways to continue service provision until more sustainable, trusted solutions were adopted. This generally happened quickly—within weeks—as agency leadership recognized that pandemic-related disruptions would be significant and l last longer than initially anticipated.

Other short-term strategies involved shifting from in-person education and outreach activities to conducting webinars and posting educational materials on the agencies website. Although this worked and the staff gained important skills, this agency shifted back to face-to-face trainings when it was deemed safe to resume social interactions. This was particularly true for agencies that provided school-based prevention education and training. The shift to virtual service delivery did not work well and was not a priority for educators or school administrators who were already trying to deliver mandated core curricula to students:

And unfortunately, what we found to be true is that schools were so overwhelmed with just trying to figure out how to teach their own content at short notice in the virtual space that the ability to carve out space for our content in the midst of that was not, you know, there just wasn't capacity at their level to do….they were, you know, literally figuring out how to get kids to finish learning to read. (TX, rural, 4)

One agency that typically provided in-person school-based prevention trainings to youth pivoted their approach during the pandemic once they lost access to students due to school closures. Instead, they sought out individuals who were interacting with youth in-person or online (e.g., medical providers, teachers, coaches, faith leaders) and provided trainings to these groups. While this strategy worked in the short-term, the agency intended to continue providing in-person services to youth once social distancing restrictions lifted.

Another change that occurred but was largely not sustained was that many agencies relied much more heavily on hotels to provide shelter to clients throughout the pandemic because of social distancing protocols. At the beginning of the pandemic, this worked well for both service providers and the hotels, as the typical demand for hotel rooms was drastically decreased and rooms were abundantly available at reduced rates. However, that changed over time. There were also challenges with using hotel rooms for shelter related to security and the lack of communal spaces for important functions such as cooking for shelter residents. Many programs reduced or stopped their hotel sheltering programs, even if social distancing strategies were still being implemented in the shelter space, resulting in less availability within shelters. In some instances, the use of hotels for shelter space was deemed a success but could not be sustained without continued funding. As one respondent said, "with respect to housing and shelter and hotline, we were making those sort of real time decisions about what to prioritize and how to do it based on funding that was coming" (TX, urban, 13).

Finally, some service providers described implementing virtual fundraising strategies during the pandemic. One respondent described pivoting an annual 5k run fundraiser to a virtual 5k run. Another described transitioning their gold tournament fundraiser to an asynchronous, virtual event. And at another agency, an interviewee described the challenges of launching a planned capital campaign and the difficulties of soliciting private donations during the pandemic:

So we did not or I did not tour anyone at the shelter or at our administration in counseling building until probably mid to late 2021. So it was a long time. So we shared a lot of data. And I mentioned this is just a moment ago. It was not just the donors, but we launched a capital campaign. And I think you've talked to enough people on these calls to know where we are with that particular piece. So coupled with our need to raise annual operating dollars and raise capital, campaign dollars was tough. So, you know, we use a lot of visuals. We use we would send videos, we try to send testimonials to people. It would be it was difficult. I mean, I'll admit it, it was very difficult to make that connection, that human connection without that human connection. And even when you have the human connection, you know, you weren't shaking hands. You had a mask on. It was just totally different than what any development professional is used to doing. (TX, urban, 15)

Ultimately, staff described that they gained some new skills and learned a great deal from these adapted practices, but these were not incorporated into sustained practice.

3.2.3 What was the role of technology in changes to service provision, and what, if any, were the limitations of that use?

County-level surveys explored how agencies changed or upgraded technology to adapt to the changing environment of the COVID-19 pandemic and whether they found the approach successful (see *Exhibit 13*).

Exhibit 13. Agency Changes to Technology

Type of technology changed or updated	Number of agencies that:		
	Made this change, n (%)	Perceive the change or updated to be better than their previous approach, n (%)	Perceive the change to be permanent, n (%)
Staff hardware (e.g., computers, phones, tablets)	51 (69.9)	48 (65.8)	50 (68.5)
Staff software (e.g., case management systems, operating systems)	46 (63.0)	42 (57.5)	42 (57.5)
Office hardware (e.g., network security, internet capabilities)	45 (61.6)	42 (57.5)	44 (60.3)

Nearly all VSP partner agencies described relying on technology in new ways during the pandemic, particularly as they navigated remote service provision. One of the most consistent ways VSPs engaged with technology was switching service delivery from in-person to virtual platforms (e.g., Zoom). This transition was made for multiple other service delivery types, including individual counseling, group counseling and support groups, case management, provision of information and referrals, trainings (e.g., trainings with victims, perpetrators, youth in schools, youth in juvenile detention facilities, professionals, and other community members), and general community engagement.

At many agencies, these transitions were swift and required patience on behalf of service providers, their funders, and their clients. VSPs with flexible staff and funders appeared to be the most successful through these challenging transitions. For example, at the beginning of the pandemic, most VSPs did not have laptops or work phones for their staff to use during the stay-at-home orders. However, VSPs went above and beyond, pivoting to using their personal devices to provide services. As one advocate described, "…we were [using Google phone on our personal devices] until we were given work computers, which probably took … like two or three months" (MA, rural, 3).

Leadership at VSPs reflected on how it took them time to invest in the required technology, because the long-term nature of COVID-19 impacts was so unknown. This caused major lags in agency staff acquiring new technology, furthering their reliance on personal devices:

> *If you recall, everyone was scrambling at that time. Oh, my God. We got to buy, we got to buy - Well, we didn't, we were thinking, oh, we'll be back. You know, we'll just let people, you know, work, try to work remotely as best they can... And the second hurdle was, [when we eventually decided to purchase resources] we could not get any product because everyone else had already ordered it. So we were like two, three weeks behind.* (TX, urban, 10)

Most partner agencies were able to acquire devices (e.g., laptops, cell phones, wifi hot spots) for staff or provide technology stipends so staff could upgrade their at-home set-ups in ways that allowed them to continue to provide services to clients. Interviewed staff were generally satisfied with the resources they were provided as part of this transition to remote work:

> *In terms of resources, they really set us up well. They gave us a laptop, a cell phone, a little hotspot to connect our stuff to, an additional monitor, like to connect to your laptop in case you need to. Because at the office we have two monitors… They gave us even a laptop bag. Like everything you would need, really.* (IL, urban, 2)

In addition to virtual service delivery, VSPs identified other unique ways to engage technology to continue agency operations. As previously described, some agencies described how they pivoted to fundraising via online mediums that were new to them (e.g., Facebook). One respondent described a new donor management system. Many agencies also swiftly shifted their case management records from paper and pencil to digital. Multiple partner agencies shared that this was a transition they had intended to make for years, but COVID-19 expedited the process:

> *As soon as this happened, whenever we went in and we scan as much as we could and then started the digital process. So, I think that is very freeing because you don't know what happens, right? The building can go on fire. You lost everything and I can't believe that we're functioning like that for years.* (IL, urban, 10)

The shift from paper to digital case management proved to be an arduous process, particularly when completed under the conditions brought on by the COVID-19 pandemic. Agency staff described trying to quickly stand-up brand-new systems, train staff on them, and upload client records, all while trying to manage their typical work responsibilities and the added stress of stay-at-home orders. For some, this process took much trial and error.

Partner agencies leveraged in-kind and fiscal donations, small grants, and discretionary funds to purchase new technology (e.g., devices, programs, infrastructure support). Whether and how quickly funding for technology was available determined many VSPs' experience during the COVID-19 pandemic. While some struggled for months to pull together the resources they needed to serve clients, others were able to jump right back into service provision because of their grant funding. One agency was able to maintain consistent connection with clients throughout COVID-19, in part because of their grant funding: "this was like an incredible grant. They paid for computers for staff. It paid for cell phones. Like advocacy staff, we get a work cell

phone for client communication… basically anything that we needed to stay in contact with clients" (TX, rural, 3).

Funder flexibility also played a key role in agencies' ability to be responsive to their ever-changing environments. As one respondent stated, *"…funders were, in my opinion, they were extremely flexible with us and using [Zoom]… most funders were really supportive of allowing us to move right over on to a virtual platform. And we had some funding from various funders at different points to provide technology"* (MA, rural, 10).

3.2.4 Did changes to service provision allow agencies to serve different clientele or to serve the same clientele in different ways?

Nearly half (43.8%) of county-level survey respondents reported that changes to technology impacted their clients. Many perceived these changes to be for the better, as they believed services became more accessible to clients. One survey respondent noted, "Many clients liked virtual visits because it is less taxing on their limited resources and it is easier to fit into their complex lifestyles" (IL, urban, S7). Other respondents reported inverse impacts, noting that some clients were unable to access technology, creating a barrier to services.

These findings were also reflected in case study interviews. First, some clients lacked access to the technology that was necessary to receive virtual services. VSPs often serve vulnerable individuals who may not have consistent access to personal phones, computers, or wifi. This was true in both urban and rural communities, with some parts of rural communities experiencing even less access to wifi:

> *I think it has created a barrier for clients who have less access to technology. So if you're a client that one day you have one phone, next week you've got another phone or you've got a phone but it's been a flip phone for the last 10, 20 years... That's a problem.* (MA, rural, 4)

> *They didn't have Internet. A lot of the kids that we were working with were very low poverty and Internet was not an expense the families could afford.* (WA, rural, 4)

Others did not have access to a private or safe space to receive services. This was true for survivors who had unstable housing or who could only access wifi in public spaces (e.g., the library), those with multiple family members in their home, and those who lived with their abusers. As one respondent stated, "If they're living with an abuser, they have very limited resources for themselves, and it's all controlled" (MA, rural, 2). Although some agencies found that virtual service delivery *increased* accessibility for individuals in acute crisis, others found this approach *limited* accessibility. This finding highlights how survivors experience victimization in diverse ways, and it is unlikely one model will work for all individuals. Some victims may be

more safe accessing services outside of their home, while others may not have the option to leave.

This presented unique challenges to ensuring client safety during sessions. Many agencies shared stories of fearing for clients' well-being during remote sessions, with one individual stating the following:

> *I called a client to talk to her about the criminal court process. And I'm uncomfortable with what I'm hearing in the background. So I'm like, why don't we schedule a time for you to come in and meet me and talk? So see when you're trying to do stuff over the phone. You don't safely know who's on the other side or who you're talking to or who's telling you or what their wishes are with regards to the criminal case.* (IL, rural, 2)

In fact, one agency chose to never adapt to virtual sessions because of concerns around client safety and confidentiality. Others reverted to in-person service delivery as soon as social distancing mandates were lifted. This challenge became even more complex when providing group support or counseling sessions:

> *We asked them, Are you in a safe place? It had to rely on them sometimes, right? If anybody's hiding. Then they signed a contract explaining about confidentiality … and every Zoom class we went through it step by step, how you needed to keep it confidential, how … nobody else could be in the room, etc.* (MA, rural, 3)

For clients who did have access to technology and private space to use it, VSPs had the additional burden of educating victims on how to use the new platforms. As a result, service providers became responsible for helping victims set up Zoom accounts or navigate audio issues:

> *As we rolled out zoom, like we had a couple of weeks where it's just like group practice, like let's just log in, let's kind of get our feet wet. This is where like some time was spent, like 'this is where you turn off the camera.' Some like, like literal tutorials in group about like this is where you do this. This is how you click off this. If you're on your phone, you're going to do this like you can swipe here just to provide some education around it.* (TX, urban, 1)

For this reason, remote service provision was noted to be particularly challenging with children or older individuals who were less familiar with technology. Children were unable to focus or participate in the modalities that are found to be most successful for this audience. For some elderly clients, the technology felt like too much of a barrier to overcome, and they withdrew from services or used critical time in their sessions to wrestle with the technology. Staff

described instances of tech set-up taking so long, that children and older patients missed their entire sessions, "the kid ended up doing the connection and we ended up starting the session really late or missing it. Because if it takes a long time and I really have another session, I cannot continue" (MA, rural, 6). To counteract some of these impacts, one partner agency created a new internal position to support clients through technical challenges:

> *We created kind of a client access specialist position… just because it was a lot of work for the therapist to get a client set up to come in for the appointment. Do you have a computer? How does your computer work? Here, let me get the forms to you. Did you get the link to the forms? Did you fill the forms out? Do you know how to sign - like, all that. So that was a position just to help people almost navigate as opposed to, just come in Tuesday at ten and meet with me.* (WA, urban, 8)

However, for many, virtual services worked incredibly well and even expanded service availability to particularly vulnerable groups. One respondent described how remote service provision increased access for individuals with disabilities:

> *Yeah, I mean, it forced us to get online to be able to deliver services and virtually. That's been impactful, especially if you think about individuals with disabilities who may not be able to come in person or who may have compromised immune systems. It's created more accessible meetings and training events and client services for sure.* (MA, urban, 6)

Transportation barriers to services were also removed through a virtual service delivery model. Victims no longer needed access to cars, public transportation, or discretionary funds (e.g., gas money, bus tickets) to receive services. Domestic violence advocates noted that this was particularly critical for individuals' whose abusers may have monitored their movement or spending. One staff member stated, "we found out that sometimes a survivor that is still living with their perpetrator, that's the best way for them to be able to actually do a virtual therapeutic session" (MA, rural, 5). Advocates also reflected how remote options made services more available to individuals who required childcare, had inflexible work schedules, or other similar constraints. Put succinctly, "I mean, the convenience of Zoom, I think is huge for survivors," (MA, rural, 10).

3.2.5 What types of services were best and worst suited for different modalities of service provision (in person, remote, or hybrid) as well as how was this determined and will agencies continue experimenting with differential service provision in the future?

Although advancements to technology played a critical role in agencies' ability to provide service to clients throughout the pandemic, interviewed individuals also identified limits to its application. VSP staff quickly learned that remote service provision was often not as easy as opening up Zoom and replicating an in-person experience:

> *…a lot of it was very much like, okay, how do we replicate what we used to do? Because that was where our mind was. This is a short-term thing. While this gap*

exists, how do we replicate what we used to do so that sort of we're checking all the boxes we need to check. (MA, urban, 7)

As such, throughout the COVID-19 pandemic, many agencies experimented with different approaches to service delivery, including remote, in-person, and hybrid models (e.g., services provided both in-person and remotely). Although some services were just not able to be offered remotely (e.g., shelter, medical accompaniment, food provision), it took trial and error for staff to determine that others were not the right fit for this modality. For example, support groups and group counseling sessions were noted as being particularly difficult to offer virtually:

> *You don't know what they're all doing. They turn off the cameras, they're not paying attention. One of them can make a comment and agitate the others, somebody didn't mute themselves and then is disrupting the class. So I think that's all the things that it's just not working out.* (MA, rural, 3)

Other times, VSPs were limited in their ability to provide remote or hybrid services, because their partnering agencies did not offer these options. This was particularly true for state or government-run partners, such as juvenile detention centers and courts. Organizations reported that they had to wait for these services to reopen to reinitiate their services, reducing their interactions with clients:

> *The juvenile detention center, even though we had the Zoom remote infrastructure, I think it took us probably at least a year, if not longer, before they started to accept us virtually back into that space to do advocacy, outreach and prevention education.* (WA, urban, 2)

In acknowledgement of the key differences between virtual and in-person service delivery, some interviewed agencies opted to develop formal written protocols and

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Optimal service modality for each service type

Services best suited for **in-person models:**

- shelter
- accompaniment (legal, medical)
- resource provision (food, gift cards, hygiene)
- trainings with youth (in schools or detention settings)
- support groups or group counseling

Services best suited for **remote models:**

- hotlines
- information and referrals in crisis scenarios

Services best suited for **hybrid models** where clients can choose the approach that works best for them:

- intake
- counseling
- case management
- trainings with adults
- community engagement

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procedures for these new modes. Protocols generally described how staff should set up their office space, how to engage with clients, and how to handle common challenges:

> *Like it happens more often when we're working from home than in the office that someone's wifi will cut out for a second we'll have to refresh or like, guys, I'm going to log out and log back in… Just tech stuff like that.. we do have a protocol in place when that happens. But yeah, that didn't happen as much in the office.* (IL, urban, 2)

> *During this time I was also looking at like how are we going to do groups? So pulling a lot of like policies, procedures from other organizations. I did like hours*

and hours and hours of webinars and trainings because I developed then the policies and procedures around virtual groups. (TX, urban,1)

Staff expressed personal preferences for various service modalities. Many preferred remote or hybrid options because these modalities increased flexibility for themselves and their clients. Interviewed staff shared how working from home gave them time back in their day, which in turn allowed for self-care activities.

However, other service providers struggled with remote or hybrid options. Multiple interviewees shared that they worried that remote sessions impacted victim engagement or their ability to provide an intangible human connection to their clients. One respondent stated, "What gets lost in using the technology is the human touch, the human kindness. Being able to read people. Um, I think all of that is lost. So I think that there are limits" (MA, rural, 3). Respondents also described challenges adapting to the new technology, particularly for staff who had been in their roles for 10 or more years. As one respondent said, "A lot of them [staff] have been here for ten, 20 years, they have gotten used to just, okay, this is you know, these are the programs that we need to use… it was like a little bit of a learning curve" (IL, urban, 4). Other respondents just generally preferred working in-person and looked forward to being back in the office full time.

Ultimately, the large majority of individuals perceived shifts to new technology as a net positive. Even when restrictions on in-person engagement were lifted, many agencies opted to continuing offering hybrid models as these approaches were deemed to work better for clients *and* staff (see *Section 3.2.7* for more information about sustained changes):

> *I think we've walked away from the pandemic being able to recognize that there was an additional way to provide service virtually that we probably would have never explored had it not been for this situation. And still, to this day, we probably have 35% of our clientele that choose to engage virtually. And that has promoted an opportunity for survivors who don't have transportation, who are currently homeless, who live with their abusers still, to access, access us in a way that made them more safe on the back end. So I will say that. And I didn't expect that, but that's organically what has happened, and we've continued to provide service as such for those clients.* (MA, rural, 4)

3.2.6 How have shifts in service delivery changed victim engagement with services?

As noted previously, there are differences in how well various services translate from in-person to remote or hybrid modalities that obviously impact victim engagement with services. Study respondents provided ample anecdotal evidence that shifts in service delivery did impact victim engagement. Some respondents described situations in which the pivot to remote or hybrid service offerings resulted in decreased or lost engagement with clients, or even groups of clients. One service provider described how their agency seemed to lose touch with the undocumented immigrant population that they served because they did not want to engage in virtual services and how they unable to reach out via email to clients who, either by choice or because they did not understand technology, did not have email addresses. They essentially

could not serve these clients during the pandemic when remote service provision was the only option:

> *I think the spaces that we have experienced a lot of challenges like specific populations, is we have a lot of our undocumented residents who have lived here [in the city] for years, but there's still a great deal of fear around being found, or so we also have in that, like populations that are unfamiliar with like technology and don't have emails, and in previous times when you're like sitting in a room, it's like, create, let's create an email together. You're going to go like this, You're going to be able to check it here. But because we're over the phone, we weren't able to like walk them through that process. So we send our Zoom links through an email. So if you don't have an email address, you can't join in to group essentially.* (TX, urban, 1)

On the other hand, when public health restrictions loosened and agencies were able to offer hybrid service delivery, some respondents described that clients' ability to choose how they wanted to receive services was important. Some clients continued to opt for virtual services, as that worked better for them because of time constraints, difficulty with transportation or the distance of the physical office space, or other personal reasons:

> *I had a client yesterday who was like, "yeah I got to go for a run," and then she just popped right on to our zoom. But we had mixed up the time. And so if she had had to come in in person, she probably would have just missed the session versus being able to like meet this me right after her run. Or people being able to then get off and go cook themselves a nice meal or, you know, do something to take care of themselves that's in their created space, I would say. For some people, I think it has given them, as I mentioned before, like increased comfort or like ability to, like, take that step to reach out. I've had clients where we started on the phone earlier in the pandemic and once we built enough rapport, kind of asked if they would take be willing to try Zoom, and then we met over Zoom for the rest of it. And I think there could be a similar thing of trying Zoom and then trying to come in in person and seeing what that's like. Yeah, and I think for some who are within our service area but don't have access to ... the public transportation's very challenging or their child care or things like that, that might give them a little bit more wiggle room to have services.* (MA, urban, 1)

Because the circumstances of the pandemic brought not only an increase in demand for victim services but also a change in the types of services needed (e.g., an increase in the need for shelter, basic need provision), this study could not ascertain whether victim engagement services shifted as a result of changing modality availability or just out of necessity. Future research is necessary to examine patterns in client retention in victim services and whether there are any patterns based on client demographics or types of services.

3.2.7 Have there been any sustained changes to staffing, staff expectations, or staff satisfaction since the onset of the pandemic?

Our county-level surveys provide limited insight into how staff and volunteer levels changed during the pandemic. Many agencies increased in staff but decreased in volunteers (see *Exhibit 14*). When asked how their current staffing needs compare with the beginning of the COVID-19 pandemic, most agencies responded that they require *more* total staff (n=39, 65.0%), though rural agencies were more likely than urban agencies to report that their staffing needs remained unchanged. No agencies responded that they require fewer total staff (35.0% reported that their staff needs remain unchanged).

Exhibit 14.   Impacts on Staff and Volunteer Volume by County

County	Number of staff increased, n (%)	Number of staff decreased, n (%)	Number of staff fluctuated, n (%)	No change to number of staff, n (%)
Urban IL	10 (62.5)	5 (31.3)	1 (6.3)	0 (0.0)
Rural IL	0 (0.0)	0 (0.0)	1 (50.0)	1 (50.0)
Urban MA	3 (33.3)	2 (22.2)	2 (22.2)	2 (22.2)
Rural MA	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)
Urban TX	8 (44.4)	1 (5.6)	7 (38.9)	2 (11.1)
Rural TX	4 (33.3)	2 (16.7)	2 (16.7)	4 (33.3)
Urban WA	7 (63.6)	2 (18.2)	1 (9.1)	1 (9.1)
Rural WA	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)

County	Number of volunteers increased , n (%)	Number of volunteers decreased, n (%)	Number of volunteers fluctuated, n (%)	No change to number of volunteers, n (%)
Urban IL	7 (50.0)	3 (21.4)	1 (7.1)	3 (21.4)
Rural IL	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)
Urban MA	1 (12.5)	4 (50.0)	1 (12.5)	2 (25.0)
Rural MA	1 (50.0)	1 (50.0)	0 (0.0)	0 (0.0)
Urban TX	4 (22.2)	10 (55.6)	2 (11.1)	2 (11.1)
Rural TX	0 (0.0)	5 (63.5)	3 (37.5)	0 (0.0)
Urban WA	1 (16.7)	3 (50.0)	1 (16.7)	1 (16.7)
Rural WA	0 (0.0)	2 (100.0)	0 (0.0)	0 (0.0)

When asked how, if at all, changes to service provision impacted the organization's staff and volunteers, some survey respondents shared how staff had unexpected changes to their roles, responsibilities, and work hours. Many survey respondents reported increased mental health challenges and burnout. This in turn has resulted in challenges with staff retention. One survey respondent stated, "We continue to have high levels of turnover, burnout, and transition during

and since the pandemic. Even with increased pay and benefits, it is overwhelming" (WA, urban, S71).

Case study interview responses provide greater insight into the experiences of staff and staffing challenges that presented during COVID-19. Some impacts on VSP staffing were limited to the early weeks of the pandemic. VSPs that participated in this study faced unique challenges throughout the pandemic. As front-line responders to survivors of GBV, the demand for their work and services did not slow down or stop. Generally, VSPs were not recognized as essential personnel during the onset of the pandemic, yet their work remained essential. Several respondents, particularly those who worked in shelters, described the tension of being required or feeling compelled to continue reporting to work during mandatory stay-at-home orders.

One of the most commonly reported challenges experienced by study participants during the early pandemic was the stress of trying to stay safe and protect your family from contracting COVID-19 while still providing services to clients. As one respondent described, "I know they [the staff] were freaking out. Yeah. Really scared to get sick. Just because of so many people dying, you know? I know that was a big fear for them" (WA, rural, 3). Another study respondent described how she could no see her family members because of the risks she faced continuing to report to work: "My staff was scared. You know? You could tell staff was scared...I had a mom that was really sick at the time, and I didn't get to see her because of my job, you know? And so it made it really difficult" (IL, urban, 10). Although these challenges were certainly not unique to VSPs as they were faced by many types of essential workers during the early pandemic, VSPs were not often recognized or considered essential workers during that time. This also meant that whatever protective measures may have been offered to other essential workers, such as personal protective equipment or free COVID-19 testing, were not routinely offered to staff in these agencies.

Several respondents described the challenge of responding to victims of GBV in light of social distancing requirements and recommendations:

> *In the early pandemic, before we know anything about what was happening with COVID, we didn't know what to do. We didn't know how we should dress. We didn't know how close we could get to somebody…The normal, you know, you have a person that's coming in and they've been severely beaten. And so you'd normally help them, you know, you'd give them a hug. Everything is going to be okay. All of those things were gone. And so it became a very sterile environment. And I think that was hard for staff.* (MA, rural, 4)

Another staffing change that was commonly described, especially during the early phases of the pandemic, was asking or mandating staff to take on different and sometimes unfamiliar roles within the agency. Sometimes this was done as a way to respond to increased demand for some agency services (e.g., hotlines), but sometimes agency leaders described shifting staff roles and responsibilities as a way to prevent having to lay off staff whose normal duties were halted because of the pandemic. Staff commonly described having to pivot from their pre-pandemic duties to take on different work during the beginning of the pandemic. For some staff, particularly those who were suddenly spending more time responding to active crisis among

clients, this shift was difficult, particularly against the backdrop of the personal challenges of navigating the beginning of the pandemic. One respondent described the impact that switching from school-based prevention work to crisis management work had on staff at their agency:

> *But I feel like you kind of mentally get burnt out and COVID was such a big thing that like mentally it took a change on you. So I'm going to say, because of domestic violence, like, it's not an easy thing to work here. And it takes a lot out of you. So I'm sure, like at least with prevention, like we have our prevention work, but at the end of the day, like we're not frontline with crisis. So I'm sure among those who were here during that time, that also took a big toll on them because now they really did have to deal with a crisis part of it versus just doing what we usually do in the schools.* (WA, rural, 1)

Although some challenges related to staffing, staff morale, and staff expectations were finite and ebbed as the pandemic continued, there were a number of changes to staffing that were long-lasting or built into sustained and lasting plans for the agency.

Respondents commonly described the challenge of staff burnout, which presents a difficulty in victim service work, even without a pandemic:

> *…A focus on victim services and the burnout that can come. I think with advocates, I think even in my previous agency and here….And I always kind of felt that there was some training offered, but there wasn't anything I think that there was a long term....help that was provided for the people that are providing the services and to the victims that kind of focuses around their [provider's] self care, mental health, and just their capacity to work under stressful occupations for long periods of time, whether it be months, to years, and is checking in with those people that are providing those services and doing those hard jobs. I don't feel like any agency in particular really makes sure that they really focus on …. taking care of the staff that are in the trenches and doing the hard work versus the admins who sit in the offices and make the bigger, higher up decisions. I would love to see that. More of a focus.* (WA, urban, 4)

Respondents ascribed the heightened sense of burnout with multiple factors related to the pandemic, including the competing demands of taking care of children and loved ones at home, the mental toll of keeping family members safe while still working, sometimes being asked or mandated to work in an unfamiliar or undesirable modality (whether that be in person or remote), or being asked to take on unfamiliar or different work within the agency. Some respondents described a heightened sense of personal burnout while others discussed burnout they observed among their colleagues. Interestingly, some respondents described that staff morale was also interwoven with social justice issues simultaneously arising throughout the United States. One respondent stated, "we saw more of a like a mosaic of crisis kind of hit" (WA, urban, 6).

Somewhat related to staff burnout, one of the enduring changes to staffing that was described by staff from almost every participating organization in this study was the challenge of recruiting new staff to fill vacant roles at the organization. Several agency leaders described inefficiencies

in service provision because of the inability to fill vacant positions within the agency. As one respondent said, "You will get a million applications and people will no-call, no-show consistently. And it's so hard" (IL, rural, 5).

Agency representatives also described the challenge of a loss or large reduction in number of volunteers. Several respondents discussed that when certain institutions either shut down or restricted public access, such as hospitals or courts, the agency eventually lost touch with advocates who had received specialized training for advocacy in these settings. Many volunteers were not adequately trained, nor equipped with the technology, to transition to other work such as answering hotline calls. Respondents described the challenge of maintaining the interest of volunteers when they could not actually engage in any volunteer work. Although agencies described varying levels of reliance on volunteers, it will take time to replenish the volunteer base of these agencies, whether large or small.

Across participating agencies in this study, respondents described an increase in the attention paid to staff morale and well-being by agency leadership in response to the challenges of the pandemic. This was demonstrated in very different ways by different agencies and at different points throughout the pandemic. Respondents described, toward the beginning of the pandemic, strategies such as virtual check-ins and increased flexibility with paid time off. As the pandemic continued, some agencies began offering new wellness benefits to staff, including free access to meditation and other wellness applications. Other agencies recognized the stress of responding to GBV during the pandemic and began offering hazard pay and other financial incentives to staff. One agency implemented a standard 32-hour work week as a means to counterbalance workplace stress and encourage staff retention and long-term well-being. Lastly, some agencies have adopted a hybrid workplace model, allowing staff to determine their own preference for their work modality, as appropriate for their individual position.

3.3 Research Question 3: Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, or region, number of staff?

As described in prior sections, study findings revealed patterns in the ways VSPs were impacted by COVID-19. Chi-square tests of independence were performed to examine relationships between key agency characteristics (i.e., region, urbanicity, type of agency, type of services) and select survey measures. Statistically significant results are presented below.

3.3.1 Relationships by region

An *increase* in service utilization for *case management services* was found to have a significant relationship with region (X^2 [3, N = 42] = 8.6, p = .035), such that VSPs in MA were more likely than other regions to report an *increase* for this service.

Additionally, a *decrease* in service utilization for *case management services* was found to have a significant relationship with region (X^2 [3, N = 23] = 10.6, p = .014), such that VSPs in TX were more likely than other regions to report a *decrease* for this service.

Survey respondents were asked whether they were able to fill all available positions with qualified staff. This variable was had a significant relationship with region (X^2 [3, N = 60] = 8.3, p = .039), revealing that respondents in some regions were more able to fill positions than others. Respondents in MA were least likely to be able to fill available positions with qualified staff.

3.3.2 Relationships by urbanicity

We also explored relationships for VSPs supporting clients in urban vs. rural communities. Urbanicity was found to have a significant relationship with *decreases* in service utilization, specifically for shelter services and information and referral services. Although shelter service providers experienced no decreases in service utilization, shelter services in rural areas did (X^2 [1, N = 23] = 14.6, p = .000). Similarly, information and referral services were more likely to experience a decrease in utilization in rural communities than in urban communities (X^2 [1, N = 23] = 5.8, p = .016).

Survey respondents reported on how changes or additions to services were funded (see **Exhibit 12**). Urban VSPs were more likely to report leveraging material donations (e.g., personal protective equipment; X^2 [1, N = 59] = 5.3, p = .020) and fiscal donations incurred through increased fundraising efforts (X^2 [1, N = 59] = 7.7, p = .005) than rural agencies. Instead, rural agencies were more likely to report not requiring additional funding for any of changes or additions to their services (X^2 [1, N = 59] = 8.5, p = .003).

3.3.3 Relationships by type of agency

Domestic violence agencies were more likely than other types of VSPs to report increases in utilization of crisis counseling services. Although this finding was not statistically significant, it trended toward significance (p = .072) and was supported by findings from case study interviews. Anecdotally, case study interviews also revealed increased experience of domestic violence in ways that were not reported for sexual assault, human trafficking, or stalking. Interview participants detailed seeing more extreme forms of violence, particularly physical violence, than years past (see **Section 3.1.3**). Combined, these findings may indicate an increase in domestic violence crisis scenarios.

Despite an increase in need, domestic violence agencies were also more likely to report *not* being able to fill available positions with qualified staff compared with other agency types (X^2 [1, N = 60] = 7.8, p = .005).

3.3.4 Relationships by type of service

Changes in the number of staff and volunteers were found to have significant relationships with multiple service types. Agencies that had hotlines were more likely than others to report that their number of staff increased since February 2020 (X^2 [3, N = 62] = 10.2, p = .017). Agencies that provided medical advocacy and accompaniment were more likely to report a decrease or fluctuation in number of staff (X^2 [3, N = 61] = 12.7, p = .005). Similarly, agencies that provided legal advocacy and accompaniment were more likely than others to report a decrease or fluctuation in number of staff (X^2 [3, N = 61] = 8.3, p = .039).

Agencies that had crisis counseling were more likely than others to report that their number of volunteers decreased or had no change since February 2020 (X^2 [3, N = 52] = 9.1, p = .028).

Agencies with shelter services were also more likely to report a decrease in volunteers (X^2 [3, N = 52] = 8.2, p = .041).

Section 4: Conclusions and Recommendations

4. Conclusions and Recommendations

4.1 Main Conclusions

VSPs, such as domestic violence shelters, rape crisis centers, and anti-trafficking organizations, play a critical role in supporting survivors of GBV. Yet as victims' vulnerabilities were exacerbated throughout the COVID-19 pandemic, VSPs were also presented with unique challenges when attempting to support their clients. The purpose of this study was to understand the impact of COVID-19 on service provision within this context. Through data collection within a sample of eight U.S. counties that vary in geography, urbanicity, and sociopolitical settings, we explored three main research questions: (1) How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises? (2) How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful or sustained in the long term? (3) Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Nationally, GBV organizations adapted their services to comply with federal, state, and local mandates for mask wearing, social distancing, and (at times) vaccines. They also continued to provide services in the wake of closures to business, courts, schools, public transportation, and other critical infrastructure. GBV VSPs adjusted their service delivery models, sometimes in significant ways. For example, most agencies shifted at least some of their services to virtual formats so they could continue to connect with victims while social distancing. This approach had unintended benefits, with VSPs increasing flexibility for their staff and accessibility for some clients. VSPs were aided by flexibility from their funders, donations, and increased funding opportunities through COVID-19–specific grant funding. However, GBV VSPs also faced myriad challenges and identified what did *not* work for circumstances of social disruption. For example, service providers noted that working with children in virtual formats was not successful. They also shared that leveraging hotels as interim shelters should only be used in crisis scenarios. In general, GBV VSP capacity was stretched to its limit, with organizations being asked to serve more clients, in greater distress, and with limited additional support. Yet through absolute adversity, GBV VSPs found ways to continue to provide services to their clients. As one surveyed individual stated, "I am most proud of the resiliency of our advocates and clients during a difficult season. We had a mutual understanding for one another that we were trying to make things work and had to think outside of the box to make things happen… I am proud of the innovative ways we tried to meet our clients' needs" (TX, urban, S47).

4.2 Recommendations

Drawing on the study findings summarized previously, we developed a set of recommendations to better support VSP agencies in times of future crises so they are prepared and able to maintain service delivery through times of disruption. We include recommendations for

consideration by victim service agency leadership, policymakers, and funders. We also offer considerations for future research.

4.2.1   Agency leadership

- **Make changes to agency processes and services that are flexible and can be maintained in the long term.** The findings in this report are relevant for various forms of service disruption (e.g., natural disasters, future public health emergencies, or other crises). Additionally, the findings in this report may also be applicable to secondary and longer-lasting challenges that occur as a result of these primary crises, like the need for stable housing. The effects of crises are lingering, and VSPs play an important role in responding to long-term care needs. Consider ways to increase the sustainability of processes through these kinds of challenges, like training all staff on critical agency activities (e.g., responding to crisis calls), even if the activity is not a part of their typical work duties.

- **Integrate an expert on relevant technologies into agency staff or advisory boards.** Many agencies reported having insufficient technology to handle remote service delivery during the pandemic. Moreover, many VSPs did not have staff who specialized in technology. Technology will continue to advance, and while cutting-edge technology may not be paramount for the everyday functioning of VSPs, ensuring that systems are secure and appropriately up to date is important. Consider prioritizing an expert on the technology needs of your agency for a role on your agency's advisory board. These individuals could help keep technology and related contingency plans updated regularly. Agency leaders should be aware of these plans and the resources required to implement them.

- **Consider client autonomy as you think about the permanent adoption or suspension of hybrid or remote service provision modalities.** This study finds that there are many client populations that benefit from the availability of remote services, including historically marginalized communities, such as individuals with disabilities. Additionally, some study respondents believe that offering clients choice in how they receive services is important. For people who have experienced GBV, having the opportunity to decide how they will engage with VSPs can be empowering.

- **Consider the benefits of hybrid service delivery to agency staff as well.** Many VSP staff interviewed for this project spoke to some benefits of being able to work from home at least some of the time, including increased time for self-care, decreased time commuting to the office, and less burnout. Having the option to decide for themselves how they wanted to work was also empowering for staff members. As other industries embrace hybrid and remote work, VSPs may need to consider maintaining this option as a way to attract and maintain a competitive workforce.

- **Embrace data metrics that capture client experiences with services (e.g., track client satisfaction, maintained services/engagement, qualitative feedback), especially for efforts that are different from typical service provision**. This study found that in shifting victim services, some agencies began providing services that were

more victim-centered, such as using ride share services to transport clients to shelter or appointments instead of providing bus passes or housing a single family in a shelter room instead of multiple families. Although these changes were instituted out of necessity, it is worth considering whether new practices should be maintained instead of automatically reverting to typical practices. To support generating the funding for these approaches, collect data on client experiences with these alternative approaches.

▪ **Leverage existing network and systems.** Communication and information networks were established during the COVID-19 pandemic (e.g., collaborative meetings, resource fairs). Consider how these efforts can be maintained in a low-burden way so that when future service disruptions occur or there is another critical need, these systems can be leveraged again.

4.2.2   Policymakers

▪ **Establish VSP staff who respond to GBV as essential workers and provide them with the same protections and benefits as other essential workers.** This study identified that despite the imperative to continue reporting to work, especially for agencies providing shelter and other emergency services, VSP staff were not recognized as essential workers during the onset of the pandemic. Like other essential workers, VSP staff should receive hazard pay and receive prioritized access to the provisions necessary to continue working safely (e.g., for COVID-19, personal protective equipment, COVID-19 testing and vaccines). VSP staff reported that although they continued to work, sometimes facing stressful and uncertain risk, they did not receive any of the emotional and social support that other types of essential workers in the community did.

▪ **Agencies that provide services to survivors of GBV should be considered and included in municipal crisis planning**. They *are* essential workers who provide safety and resources to the community's most vulnerable citizens, much like medical providers, law enforcement, and other essential staff. The stressors that may increase clients' risk of victimization are likely to rise during other forms of widespread or community-level crises.

▪ **Anticipate that reported crime rates during crisis will not reflect the actual experiences of GBV agencies.** This study found that the official crime statistics during the COVID-19 pandemic did not fully capture what VSP staff were observing within their agencies. Establish plans to solicit information about on-the-ground experiences of GBV agencies during crises and be prepared to support observed changes in service needs. This includes establishing a way for agencies to share observed changes in service delivery patterns with law enforcement, if relevant, and finding ways to provide flexible funding to address these changes.

4.2.3   Funders

▪ **Offer opportunities for flexible funding during times of crisis.** Agencies described how the burden on administrative staff increased significantly during the COVID-19

pandemic, but the percent of their grants allocated to administrative work did not. Obligating a small portion of funding that *can* be used for a variety of circumstances, including administrative activities, during periods of service disruption would benefit agencies and their clients.

- **Consider providing some flexibility in the defining service eligibility for clients and provide flexibility in funding restrictions**. This study finds that many VSPs were forced to modernize their service provision, enabling them to offer high-quality, remote services. It is worth considering the implications for the community that they can serve. Traditionally, many VSPs have been restricted to service provision in specific geographic areas, but it may be worth considering whether service providers that have established high-quality remote services and offer specialized services (e.g., anti-trafficking case management) or specialize in specific populations (e.g., LBGTA2+ youth) may be more effective if they are able to serve clients from a broader area.

- **When providing funding for crises, be prepared to scale down post-crisis.** Many GBV agencies included in this study received specialized COVID-19 funding and faced challenges when that additional funding ended. Organizations who receive emergency funds may use the monies to increase staff capacity, resources, or adjust programming for evolving client needs. Provide support to agencies whose monies and responsibilities have ballooned during service interruption to comfortably reduce those services when the situation calms. Consider options like step-down funding to help agencies transition to more sustainable approaches.

4.2.4 Researchers (Future Research)

- **Conduct retrospective, systematic inquiry into whether specific clients remained engaged with services.** Explore engagement based on various client demographics (e.g., age, gender, employment status) and service type (e.g., case management, shelter, counseling) during shifts in service delivery modalities.

- **Investigate and document best practices for service delivery modalities, specifically for hybrid vs. remote service provision.** Explore modality by various client demographics (e.g., age, gender, employment status) and service type (e.g., case management, shelter, counseling). Currently, VSPs make decisions about service delivery modality anecdotally. Although this approach is productive and allows them to identify what works best for their specific client population, systematic investigation may allow for less trial and error at the expense of active clients.

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Appendix A:

The Impact of Covid-19 on Victim Service Provision:
County-Level Key Takeaways and Findings

Case Study Site Briefs | December 2023

Understanding the Impact of COVID-19 on Victim Service Provision:
Challenges, Innovations, and Lessons Learned

Key Findings and Takeaways
Urban County in Illinois

RTI International Team:

Hannah Feeney, PhD
Rebecca Pfeffer, PhD
Lauren Vollinger, PhD
Ruthie Grossman
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Madalyn Diaz

STUDY OVERVIEW

The COVID-19 pandemic disproportionately impacted victims of crime and community-based victim service provider (VSP) agencies were tasked with maintaining accessibility to their critical services. This research study explored (1) the challenges posed by the pandemic—including related societal changes; (2) how agencies pivoted to address these challenges; and (3) which innovations were successful in ways that warranted lasting changes in practice.

This study's sample included eight county-level project sites that vary in geography, urbanicity, and the presence of VSPs serving victims of gender-based violence (i.e., sexual assault, intimate partner violence, human trafficking, and/or stalking). To answer the study's research questions, we conducted (1) state and local policy assessments, (2) a web-based survey of all VSPs in each project county, and (3) eight in-depth agency case studies to explore more deeply the impacts of COVID-19 on individual agencies.

This document highlights key takeaways from an individual county in our study. You can access the full report here to learn more about this and other counties.

RESEARCH OBJECTIVES

1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful and/or sustained in the long term?

3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Click here to read the full report.

To be responsive to the COVID-19 pandemic, this agency shifted the ways they provided referrals and staffed their hotline. The agency was the only interviewed site to continue staffing hotline advocates in-person during the beginning of the pandemic.

Interviewed

8

staff members
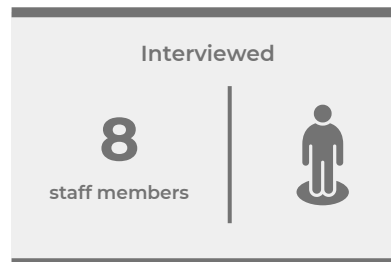
FACILITATORS

- The agency's Board was particularly helpful in providing guidance throughout the pandemic and supported them in creating protocols for future instances of service disruption.

- Hotline staff were satisfied with how the agency provided the necessary technology to work from home and serve clients.

- Hotline staff appreciated how the agency created a support group to give them the space to discuss their burnout and work-related stress resulting from the pandemic.

BARRIERS

- The city recognized the agency's hotline advocates as essential workers and thus required these staff to continue to work in-person throughout the COVID-19 pandemic. Other agency staff (e.g., administrative staff), however, were approved to work remotely or via a hybrid model. Staff reported feeling conflicted about this arrangement, as many were concerned about their personal health and safety. Supervisors worked to allow certain individuals to work remotely as needed, alleviating some stress over potential COVID-19 exposure.

- Hotline staff experienced an increase in calls and an increase in the length of calls. While the hotline was able to be responsive to this influx, this increased the strain on those responding to hotline calls.

- While leadership was able to increase the salaries of all staff across the organization, some staff perceived inequities experienced between agency and hotline staff (the agency staff received a larger increase in pay despite not having to work in-person).

INNOVATIONS

- This agency developed a relationship with Uber Health during the pandemic to provide hotline clients with transportation to shelter services. This partnership is still in place today.

- Hotline staff quickly developed protocols for how to handle such instances.

- This agency recognized that training youth via virtual mediums was not particularly effective and shifted to conducting trainings with adults who interact with youth.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

16
agencies

❯ The majority of responding agencies had 11-50 staff members and 11-50 volunteers.

❯ Agencies that responded to the survey reported that they support victims of sexual assault, domestic violence, stalking, and human trafficking.

Nearly all agencies reported experiencing challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses. Agencies also reported mask mandates and social distancing requirements. Some (37.5%) reported that mask mandates were helpful to service delivery.

IMPACTS TO STAFFING

50.0%

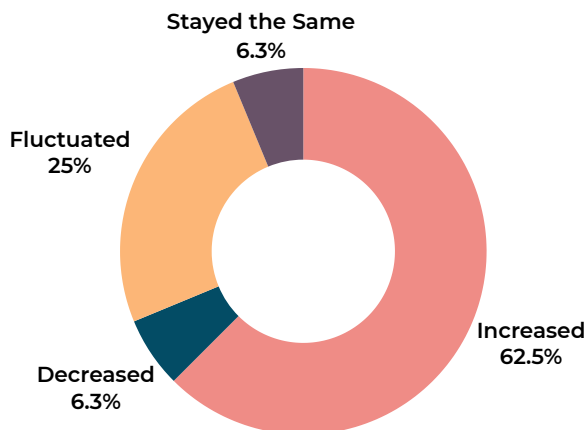Agencies reported that their **current staffing needs are <u>not</u> met**

Agencies reported **needing more staff** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

Fluctuated
6.3%

Decreased
31.3%

Increased
62.5%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

Stayed the Same
6.3%

Fluctuated
25%
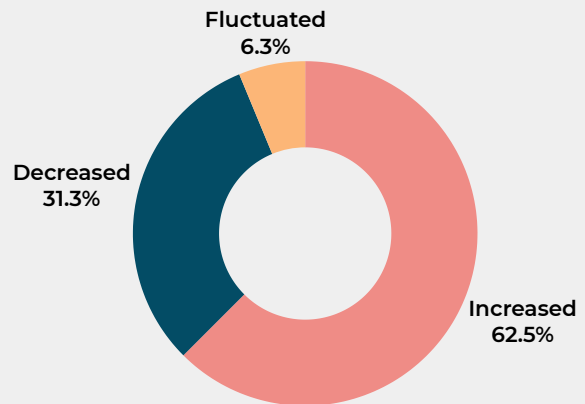
Decreased
6.3%

Increased
62.5%

81.3%

Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:
- Information and referrals
- Financial and material assistance
- Hotline services
- Crisis counseling

43.8 %

Agencies reported at least one service that experienced *decreased* utilization

Services most likely to have experienced a reported decrease in utilization:
- Legal advocacy/accompaniment
- Community member training and education
- Victim/survivor training and education

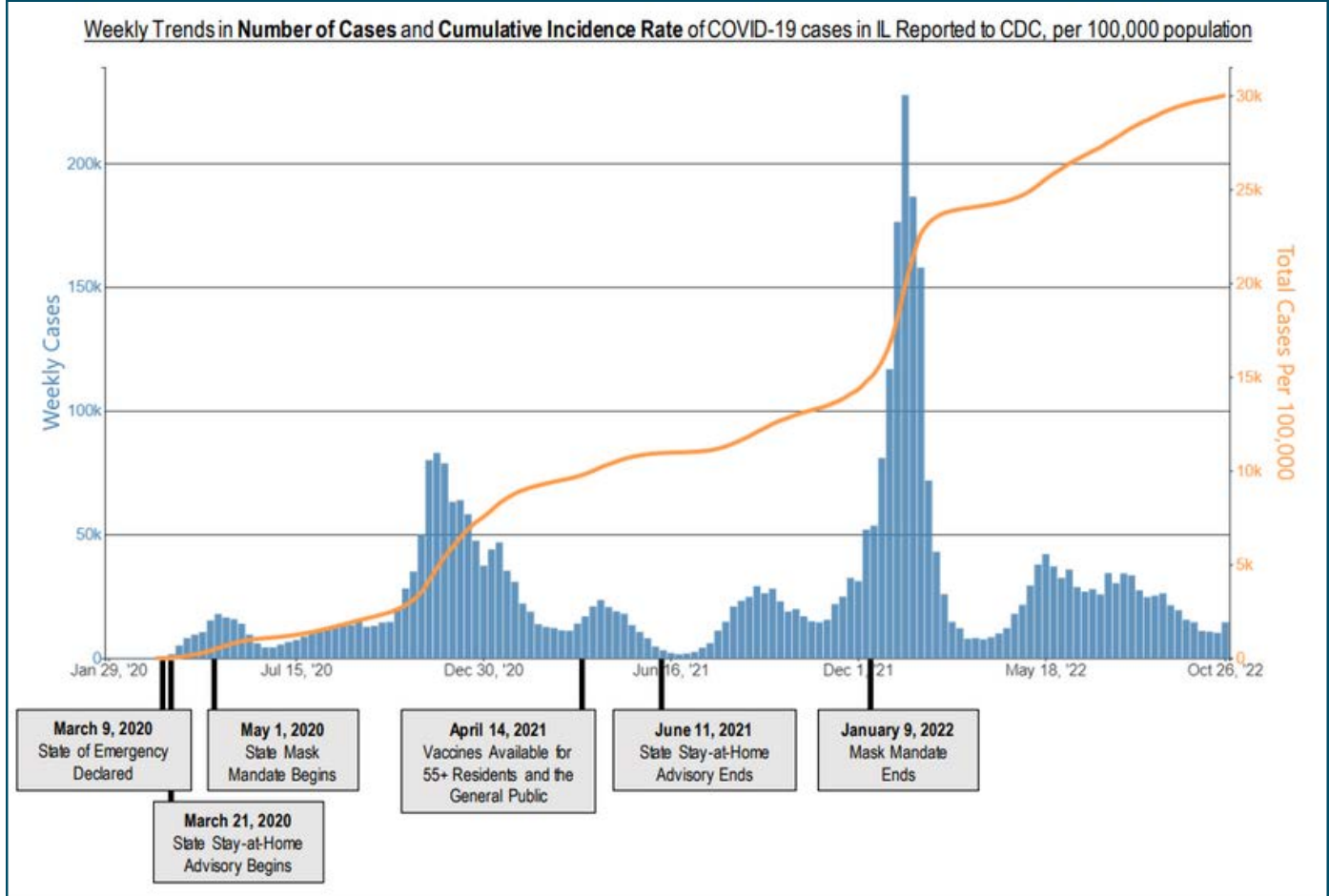# WHAT WAS THE POLICY LANDSCAPE OF ILLINOIS DURING COVID-19?

Illinois implemented a variety of mitigation measures since March 2020. Illinois declared a state of emergency around the same time as the other states in this study. Of the four states included in this study, Illinois was the first to implement a mask mandate and and was the state with the longest mask mandate period.

System Closures During COVID-19

Schools	State Prison Visitation
March 17, 2020 – July 25, 2021	March 14, 2020 – April 12, 2021
Courts*	**Non-essential Businesses**
March 17, 2020 – July 6, 2021	March 21, 2020 – May 29, 2020

* indicates Urban County-level mandate

Below is a timeline of Illinois COVID-19 mitigation policies from March 2020 to September 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in IL Reported to CDC, per 100,000 population

- March 9, 2020 State of Emergency Declared
- March 21, 2020 State Stay-at-Home Advisory Begins
- May 1, 2020 State Mask Mandate Begins
- April 14, 2021 Vaccines Available for 55+ Residents and the General Public
- June 11, 2021 State Stay-at-Home Advisory Ends
- January 9, 2022 Mask Mandate Ends

Understanding the Impact of COVID-19 on Victim Service Provision:
Challenges, Innovations, and Lessons Learned

Key Findings and Takeaways
Rural County in Illinois

RTI
INTERNATIONAL

RTI International Team:

Hannah Feeney, PhD
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STUDY OVERVIEW

The COVID-19 pandemic disproportionately impacted victims of crime and community-based victim service provider (VSP) agencies were tasked with maintaining accessibility to their critical services. This research study explored (1) the challenges posed by the pandemic—including related societal changes; (2) how agencies pivoted to address these challenges; and (3) which innovations were successful in ways that warranted lasting changes in practice.

This study's sample included eight county-level project sites that vary in geography, urbanicity, and the presence of VSPs serving victims of gender-based violence (i.e., sexual assault, intimate partner violence, human trafficking, and/or stalking). To answer the study's research questions, we conducted (1) state and local policy assessments, (2) a web-based survey of all VSPs in each project county, and (3) eight in-depth agency case studies to explore more deeply the impacts of COVID-19 on individual agencies.

This document highlights key takeaways from an individual county in our study. You can access the full report here to learn more about this and other counties.

RESEARCH OBJECTIVES

1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful and/or sustained in the long term?

3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

WHAT DID WE LEARN FROM THIS AGENCY?

Despite challenges with funding, technology, and general morale during the COVID-19 pandemic, this agency maintained services consistently and was generally able to serve their client population as needed.

Interviewed

6

staff members
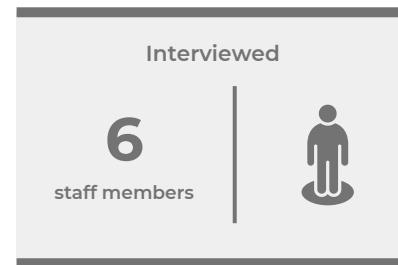
FACILITATORS

- This agency received increased funding during COVID-19. Much of this funding was allocated to supporting client directly, such as through moving clients into housing. They also budgeted and planned well for the eventuality of that funding decreasing after the pandemic.

- Most staff expressed that leadership made sure they knew they're valued through material and immaterial means. Undesignated grant funding was used to provide small tokens of appreciation to staff throughout the pandemic.

- Telehealth was very popular among certain populations, especially those who were remote, immunosuppressed, or who required childcare.

BARRIERS

- Many of the organizations in this agency's community shut down during COVID-19 (both permanently and temporarily). As a result, they received many requests for service that ordinarily would have gone to other organizations. This increased burden on staff.

- Agency staff were initially required to use their own cell phones. Ultimately, work telephones and computers were purchased for staff.

- This agency's staff expressed how they observed more mental health challenges clients during the pandemic (both victims and their abusers), increasing the complexity of cases to which the agency was responding.

INNOVATIONS

- Public health measures during the COVID-19 pandemic limited this agency's ability to provide survivors with advocacy via in-person court accompaniment. Agency staff advocated to return to this space, and were among the first to be allowed to re-enter the courts with clients.

- Increased COVID-19 funding was used to great effect, including for housing and wi-fi.

- Laptops and work cell phones were provided to staff, such that telehealth can now continue if desired.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

2
agencies

> The majority of responding agencies had 11-50 staff members and 201-500 volunteers.

> Agencies that responded to the survey reported that they support victims of domestic violence and stalking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements.

IMPACTS TO STAFFING

50.0%

Agencies reported that their **current staffing needs are <u>not</u> met**

Agencies reported **needing more or the same amount of staff** compared with their staffing needs at the beginning of COVID-19.

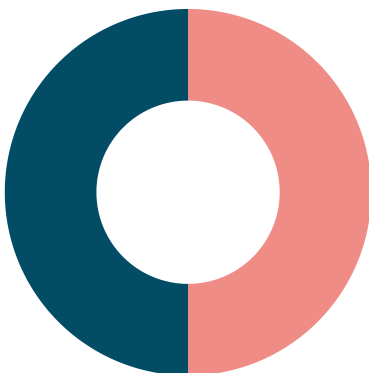### Changes in Staff Volume Since February 2020

Stayed the same
50%
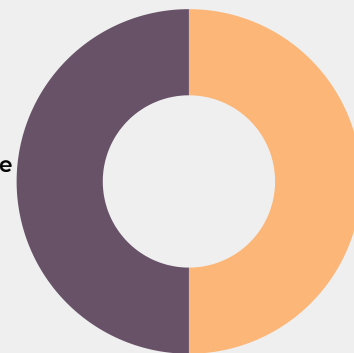
Fluctuated
50%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

Decreased
50%

Increased
50%

0.0%
Agencies reported at least one service that experienced *increased* utilization

50.0%
Agencies reported at least one service that experienced *decreased* utilization

Services most likely to have experienced a reported decrease in utilization:

- Information and referrals
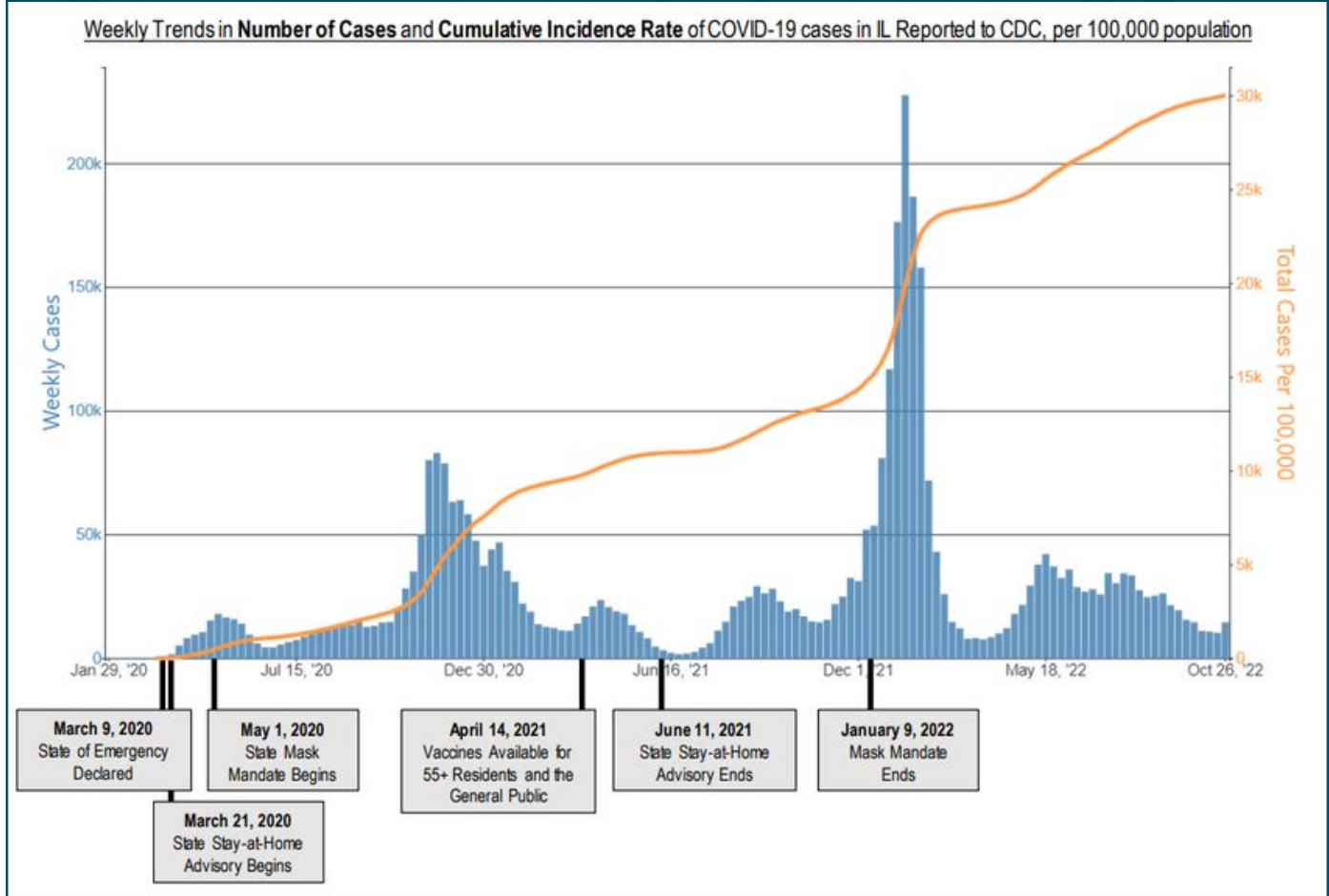- Community member training and education

Illinois implemented a variety of mitigation measures since March 2020. Illinois declared a state of emergency around the same time as the other states in this study. Of the four states included in this study, Illinois was the first to implement a mask mandate and and was the state with the longest mask mandate period.

System Closures During COVID-19

Schools	State Prison Visitation
March 17, 2020 – July 25, 2021	March 14, 2020 – April 12, 2021
Courts*	Non-essential Businesses
March 16, 2020 – July 26, 2021	March 21, 2020 – May 29, 2020

* indicates Rural County-level mandate

Below is a timeline of Illinois COVID-19 mitigation policies from March 2020 to September 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in IL Reported to CDC, per 100,000 population

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May 1, 2020 State Mask Mandate Begins

April 14, 2021 Vaccines Available for 55+ Residents and the General Public

June 11, 2021 State Stay-at-Home Advisory Ends

January 9, 2022 Mask Mandate Ends

March 21, 2020 State Stay-at-Home Advisory Begins

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Challenges, Innovations, and Lessons Learned

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Urban County in Massachusetts

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3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Click here to read the full report.

Despite uncertainties surrounding the pandemic's impact on the world around them, this agency was able to not only sustain their services for clients but expand those services to address evolving needs throughout the pandemic.

Interviewed

7

staff members
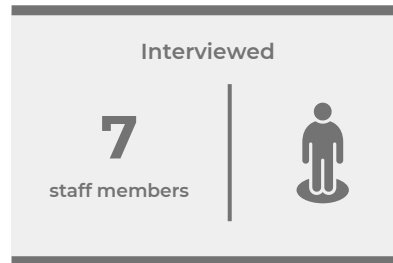
FACILITATORS

- Staff felt the autonomy to make their own decisions about how to engage with clients (e.g., in person, virtually) based on their own levels of comfort even when mandates were loosened or lifted.

- This agency was able to use funds that became available during the pandemic to address victim needs that extended beyond their typical scope of service delivery, including housing and medical needs. This approach expanded their impact on client's lives and wellbeing.

- While some staff experienced a learning curve with the transition to virtual service provision, other more technologically seasoned staff were able to step in and provide support. They developed trainings and protocols, which ultimately allowed all staff to engage in virtual service provision.

BARRIERS

- COVID-19 policies instituted by external partners, including local hospitals and jails, limited this agency's ability to provide some direct services and education.

- Some staff connecting with clients virtually expressed concern about their ability to engage in meaning relationship building via online platforms, particularly when that client contact was facilitated by a third party, such as hospital staff who could connect survivors with medical advocates.

INNOVATIONS

- This agency found creative ways to leverage various COVID-19 funds that were made available through both government and private entities. These funds were used to address client's needs, including housing, utilities, and medical expenses resulting from their victimization.

- Agency leadership were thoughtful about implementing strategies to facilitate staff well-being through the pandemic. Among staff turnover, this agency leveraged changes and technical advances associated with the pandemic (e.g. the availability of hybrid positions) to recruit new staff.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

9
agencies

➤ The majority of responding agencies had 11-50 staff members and 1-10 volunteers.

➤ Agencies that responded to the survey reported that they support victims of sexual assault, domestic violence, stalking, and human trafficking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements. Some reported that mask mandates (55.6%) and social distancing (22.2%) were helpful to service delivery.
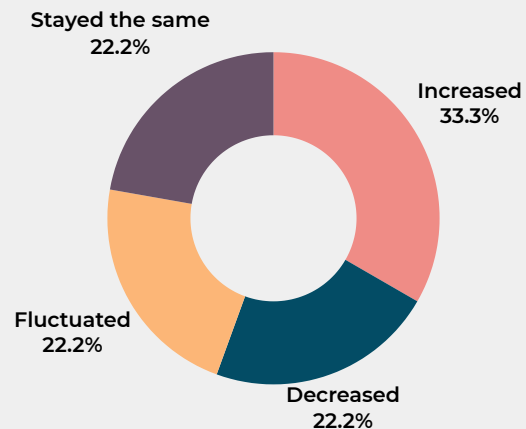
IMPACTS TO STAFFING

77.7%

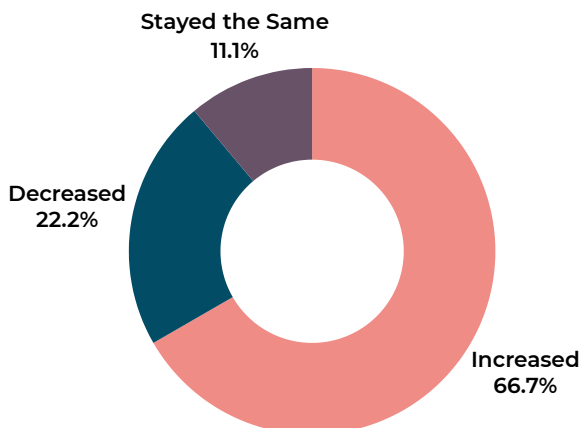Agencies reported that their **current staffing needs are not met**

Agencies reported **mixed feedback about whether they need more or fewer staff** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

- Stayed the same 22.2%
- Increased 33.3%
- Decreased 22.2%
- Fluctuated 22.2%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

- Stayed the Same 11.1%
- Decreased 22.2%
- Increased 66.7%

55.6%

Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:
- Mental health services
- Case management
- Information and referrals
- Finances and material assistance

33.3%

Agencies reported at least one service that experienced *decreased* utilization

Services most likely to have experienced a reported decrease in utilization:
- Medical advocacy/accompaniment
- Supervised child visitation
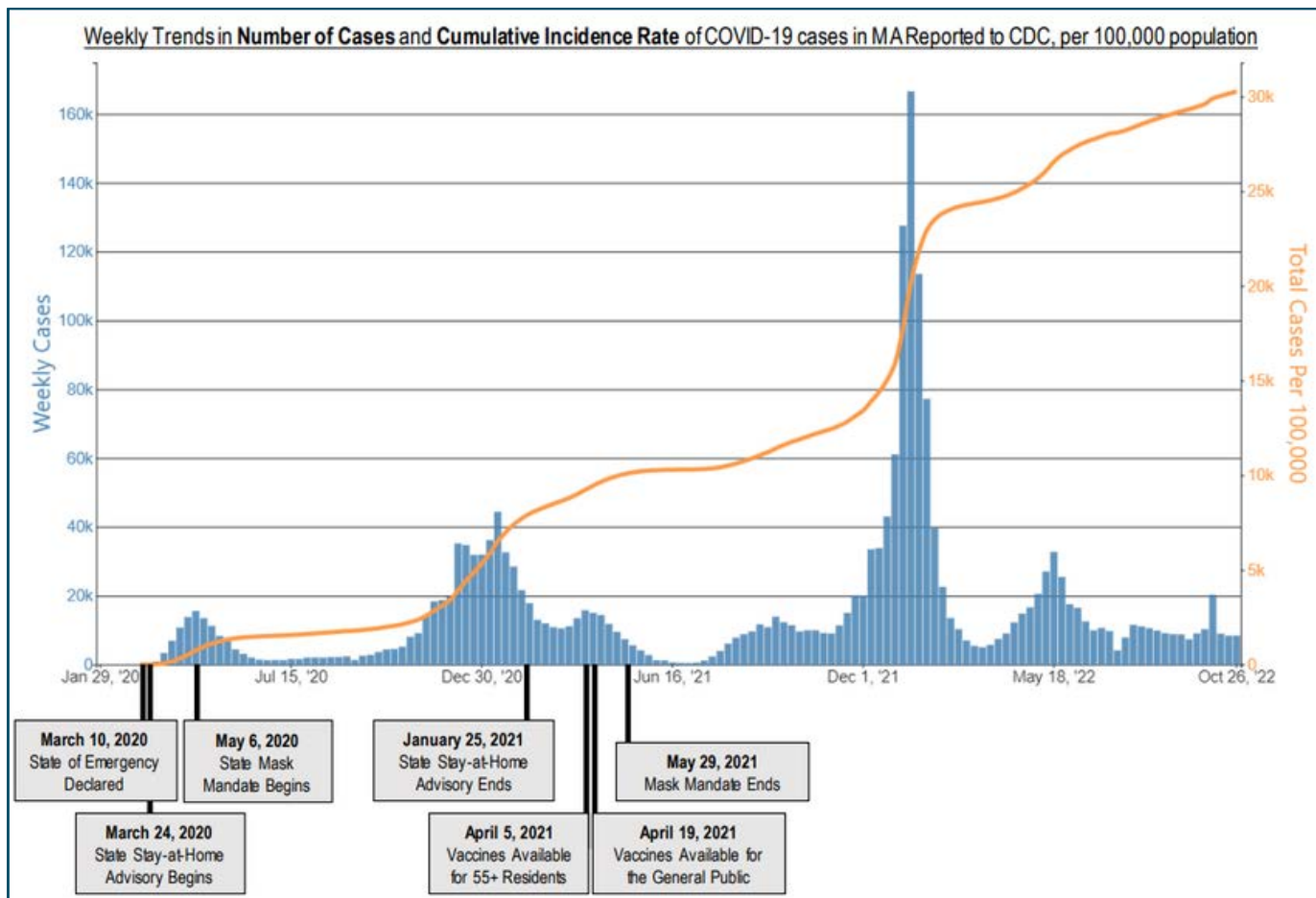- Victim/survivor training and education

* All findings on this page reflect the percentage of agencies that responded to the corresponding survey response.

Massachusetts implemented a variety of mitigation measures since March 2020. Massachusetts declared a state of emergency around the same time as the other states in this study. Of the four states included in this study, Massachusetts was one of the first to implement a mask mandate and was the state with the second-longest mask mandate period.

System Closures During COVID-19

Schools	State Prison Visitation
March 12, 2020 – March 8, 2022	March 12, 2020 – July 8, 2020
Courts	**Non-essential Businesses**
March 17, 2020 – May 4, 2020	March 24, 2020 – May 18, 2020

Below is a timeline of Massachusetts COVID–19 mitigation policies from March 2020 to October 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in MA Reported to CDC, per 100,000 population

March 10, 2020 State of Emergency Declared

May 6, 2020 State Mask Mandate Begins

March 24, 2020 State Stay-at-Home Advisory Begins

January 25, 2021 State Stay-at-Home Advisory Ends

May 29, 2021 Mask Mandate Ends

April 5, 2021 Vaccines Available for 55+ Residents

April 19, 2021 Vaccines Available for the General Public

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Madalyn Diaz

STUDY OVERVIEW

The COVID-19 pandemic disproportionately impacted victims of crime and community-based victim service provider (VSP) agencies were tasked with maintaining accessibility to their critical services. This research study explored (1) the challenges posed by the pandemic—including related societal changes; (2) how agencies pivoted to address these challenges; and (3) which innovations were successful in ways that warranted lasting changes in practice.

This study's sample included eight county-level project sites that vary in geography, urbanicity, and the presence of VSPs serving victims of gender-based violence (i.e., sexual assault, intimate partner violence, human trafficking, and/or stalking). To answer the study's research questions, we conducted (1) state and local policy assessments, (2) a web-based survey of all VSPs in each project county, and (3) eight in-depth agency case studies to explore more deeply the impacts of COVID-19 on individual agencies.

This document highlights key takeaways from an individual county in our study. You can access the full report here to learn more about this and other counties.

RESEARCH OBJECTIVES

1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful and/or sustained in the long term?

3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Click here to read the full report.

This agency was quick to adapt service delivery provision to phone or virtual modalities while maintaining a trauma-informed and survivor-centered approach during the pandemic.

Interviewed

10

staff members
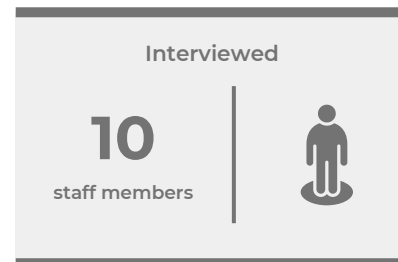
FACILITATORS

- This agency communicated with funders around how to continue to provide high-quality services that adhered to ever-changing public health mandates, while still being in compliance with funding requirements. The agency cited its funders' flexibility and ability to provide direction as one of the biggest facilitators to agency operations.

- Staff transitions to a remote working environment were expedited by the fact that the majority of staff already had the technology they needed to continue service delivery. Those who did not have it at the beginning of the pandemic, received necessary technology within 6 months.

BARRIERS

- Implementing COVID-19 mandates like masking and testing while being trauma-informed and survivor-centric was a challenge. The uncertainty and lack of guidance on how long mandates would be in place further complicated this.

- Not all clients had access to the technology necessary to receive remote services. Not all clients who could access technology preferred this mode of service delivery, with some staff believing they lost engagement amongst some clients because of the lack of "the human touch."

INNOVATIONS

- This agency determined a hybrid service delivery model better served their clients, and they continue to use the service delivery modality to this day. Agency staff noted that this has allowed them to reach or stay engaged with clients they would not have otherwise connected with, like those with transportation issues.

- This agency invested significant funding to update wifi and other technology, so children and youth without access could attend school virtually.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

3
agencies

> The majority of responding agencies had 100+ staff members and 11-50 volunteers.

> Agencies that responded to the survey reported that they support victims of sexual assault, domestic violence, stalking, and human trafficking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements.
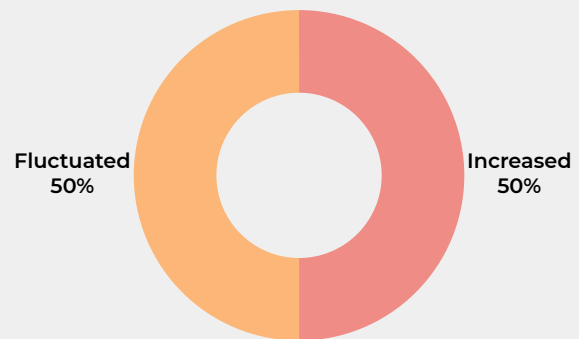
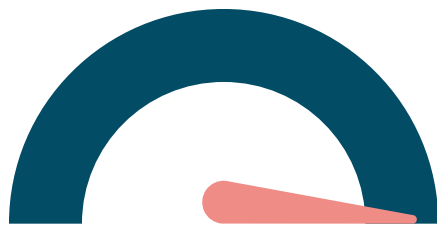## IMPACTS TO STAFFING

100.0%

Agencies reported that their **current staffing needs are <u>not</u> met**

Agencies reported **staffing needs remained unchanged** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

Fluctuated
50%

Increased
50%

IMPACTS TO SERVICE DELIVERY

100.0%
Agencies saw an *increase* in the number of victims served since February 2020.

66.7%
Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:

- Crisis counseling
- Information and referrals
- Mental health services
- Case management
- Finances and material assistance
- Relocation and other services

0.0%
Agencies reported at least one service that experienced *decreased* utilization
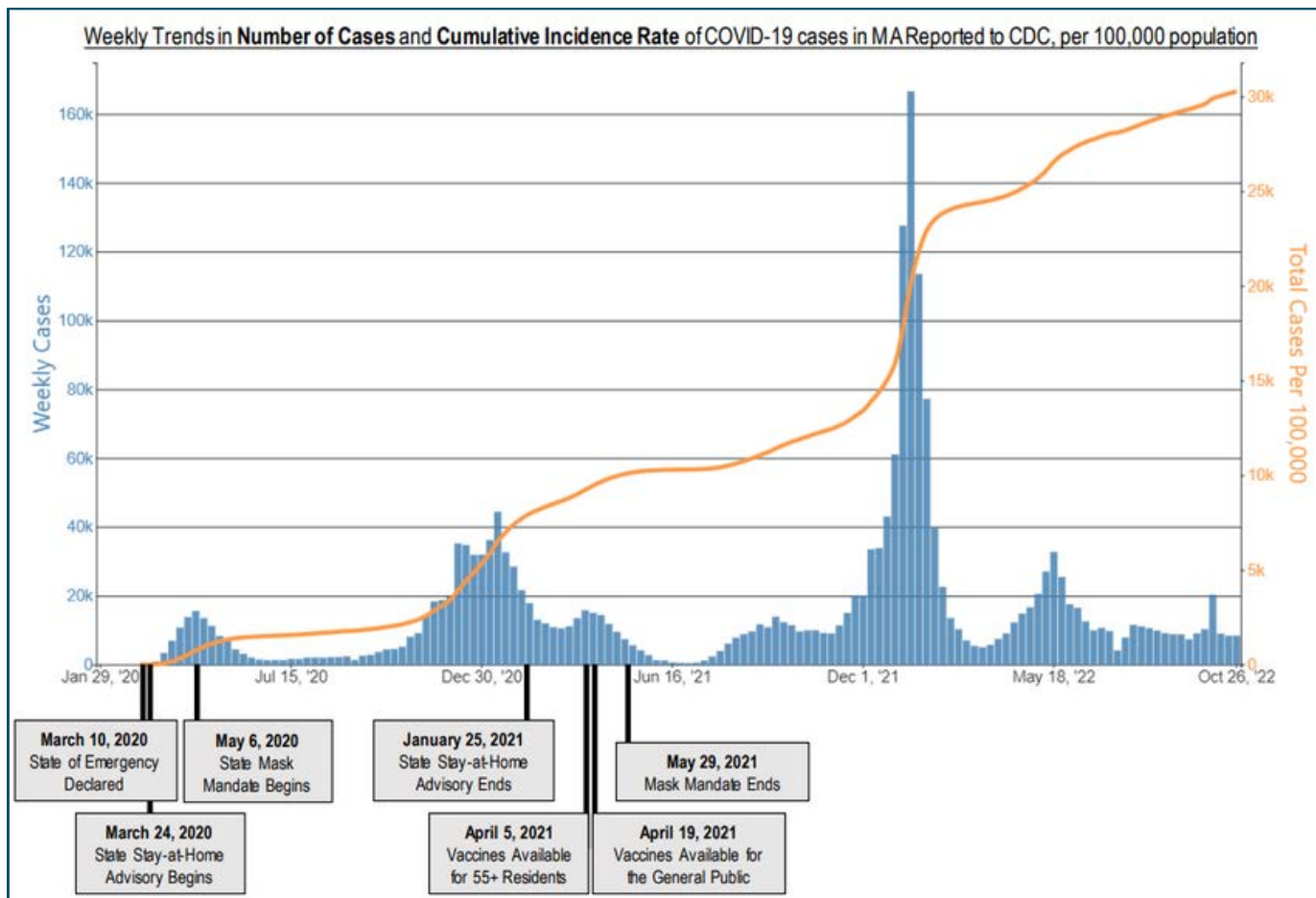
WHAT WAS THE POLICY LANDSCAPE OF MASSACHUSETTS DURING COVID-19?

Massachusetts implemented a variety of mitigation measures since March 2020. Massachusetts declared a state of emergency around the same time as the other states in this study. Of the four states included in this study, Massachusetts was one of the first to implement a mask mandate and was the state with the second-longest mask mandate period.

System Closures During COVID-19

Schools	**State Prison Visitation**
March 12, 2020 – March 8, 2022	March 12, 2020 – July 8, 2020
Courts	**Non-essential Businesses**
March 17, 2020 – May 4, 2020	March 24, 2020 – May 18, 2020

Below is a timeline of Massachusetts COVID-19 mitigation policies from March 2020 to October 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in MA Reported to CDC, per 100,000 population

March 10, 2020 State of Emergency Declared

May 6, 2020 State Mask Mandate Begins

January 25, 2021 State Stay-at-Home Advisory Ends

May 29, 2021 Mask Mandate Ends

March 24, 2020 State Stay-at-Home Advisory Begins

April 5, 2021 Vaccines Available for 55+ Residents

April 19, 2021 Vaccines Available for the General Public

Understanding the Impact of COVID-19 on Victim Service Provision: Challenges, Innovations, and Lessons Learned

Key Findings and Takeaways
Urban County in Texas

RTI International Team:

Hannah Feeney, PhD
Rebecca Pfeffer, PhD
Lauren Vollinger, PhD
Ruthie Grossman
Peyton Scalise
Madalyn Diaz

STUDY OVERVIEW

The COVID-19 pandemic disproportionately impacted victims of crime and community-based victim service provider (VSP) agencies were tasked with maintaining accessibility to their critical services. This research study explored (1) the challenges posed by the pandemic—including related societal changes; (2) how agencies pivoted to address these challenges; and (3) which innovations were successful in ways that warranted lasting changes in practice.

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3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Click here to read the full report.

WHAT DID WE LEARN FROM THIS AGENCY?

The COVID-19 pandemic accelerated technology system transitions and modernized many aspects of service provision for this agency. With dedicated staff and broad support from funders and local government, the agency was able to consistently serve clients throughout the pandemic. Eventual technological updates, hybrid service provision modalities, and expansion of their hotline program broadened their scope of service.

Interviewed

14
staff members
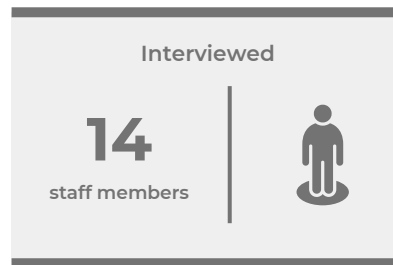
FACILITATORS

- Staff expressed that leadership and supervisors were patient and accommodating to staff needs and concerns.

- Leadership developed a pandemic response team that met regularly and allowed them to make quick decisions and better serve victims and staff.

- This agency leveraged local partnerships in ways that allowed them to re-evaluate the need for planned new construction. This approach allowed for continued collaboration and further embedded the agency in the community.

BARRIERS

- This agency, a larger non-profit agency, experienced challenges while navigating updates to technology amidst a public health crisis. Prior to the pandemic, the agency was preparing for shifts to their documentation system but needed to expedite this process once remote work initiated. Some staff reported how minor errors, complications, or inefficient systems were established because these transitions were necessarily rushed and implemented while staff were working remotely.

- Staff providing in-person services (e.g., shelter staff) did not initially receive formal "essential worker" status by local government. As a result, these staff were concerned about unintentionally violating COVID-19 mandates (e.g., curfews) while completing their essential job duties.

- Staff experienced varied burden — while some staff needed to provide in-person services, others were able to work from home. While some staff took on additional responsibilities, others, whose normal duties had been curtailed by the circumstances of the early pandemic, had more unstructured work time to fill. Staff noticed these differences and, at times, expressed frustration. Agency leadership recognized these inequities and instated hazard pay to a subset of staff who were navigating pandemic-related risks because of their job functions.

INNOVATIONS

- Staff created videos to help colleagues set up and use their new data management system.

- This agency created a separate hotline that allowed forensic nurses to reach advocates quickly.

- This agency launched a chat feature on their website that allowed them to connect with more clients virtually.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

18
agencies

→ The majority of responding agencies had 11-50 staff members and 11-50 volunteers.

→ Agencies that responded to the survey reported that they provide support to victims of sexual assault, domestic violence, stalking, and human trafficking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements.
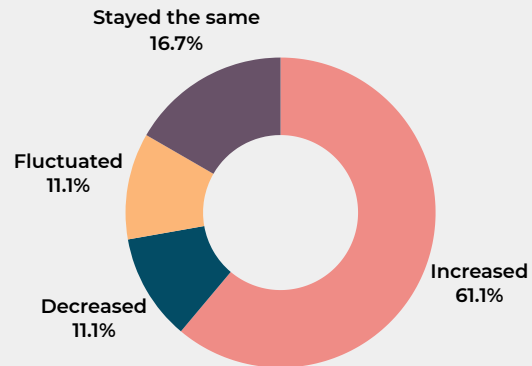
IMPACTS TO STAFFING

61.1%

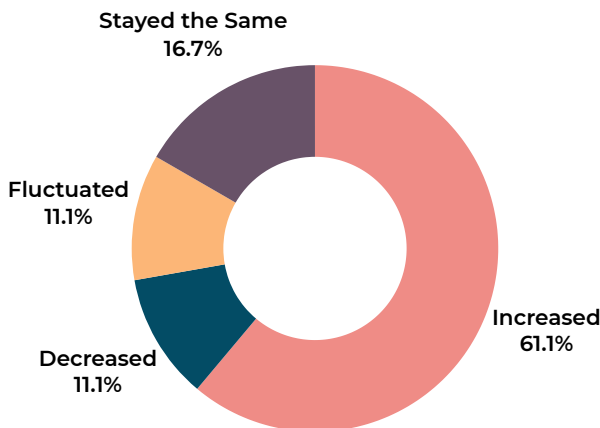Agencies reported that their **current staffing needs are <u>not</u> met**

Agencies reported **needing more staff** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

Stayed the same
16.7%

Fluctuated
11.1%

Decreased
11.1%

Increased
61.1%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

Stayed the Same
16.7%

Fluctuated
11.1%

Decreased
11.1%

Increased
61.1%

16.7%

Agencies reported at least one service that experienced *increased* utilization

↑ **Services most likely to have experienced a reported increase in utilization:**
- Information and referrals
- Finances and material assistance
- Hotline
- Crisis counseling

33.3%

Agencies reported at least one service that experienced *decreased* utilization

↓ **Services most likely to have experienced a reported decrease in utilization:**
- Case management
- Interpretation and sign language services
- Community member training and education

* All findings on this page reflect the percentage of agencies that responded to the corresponding survey question.

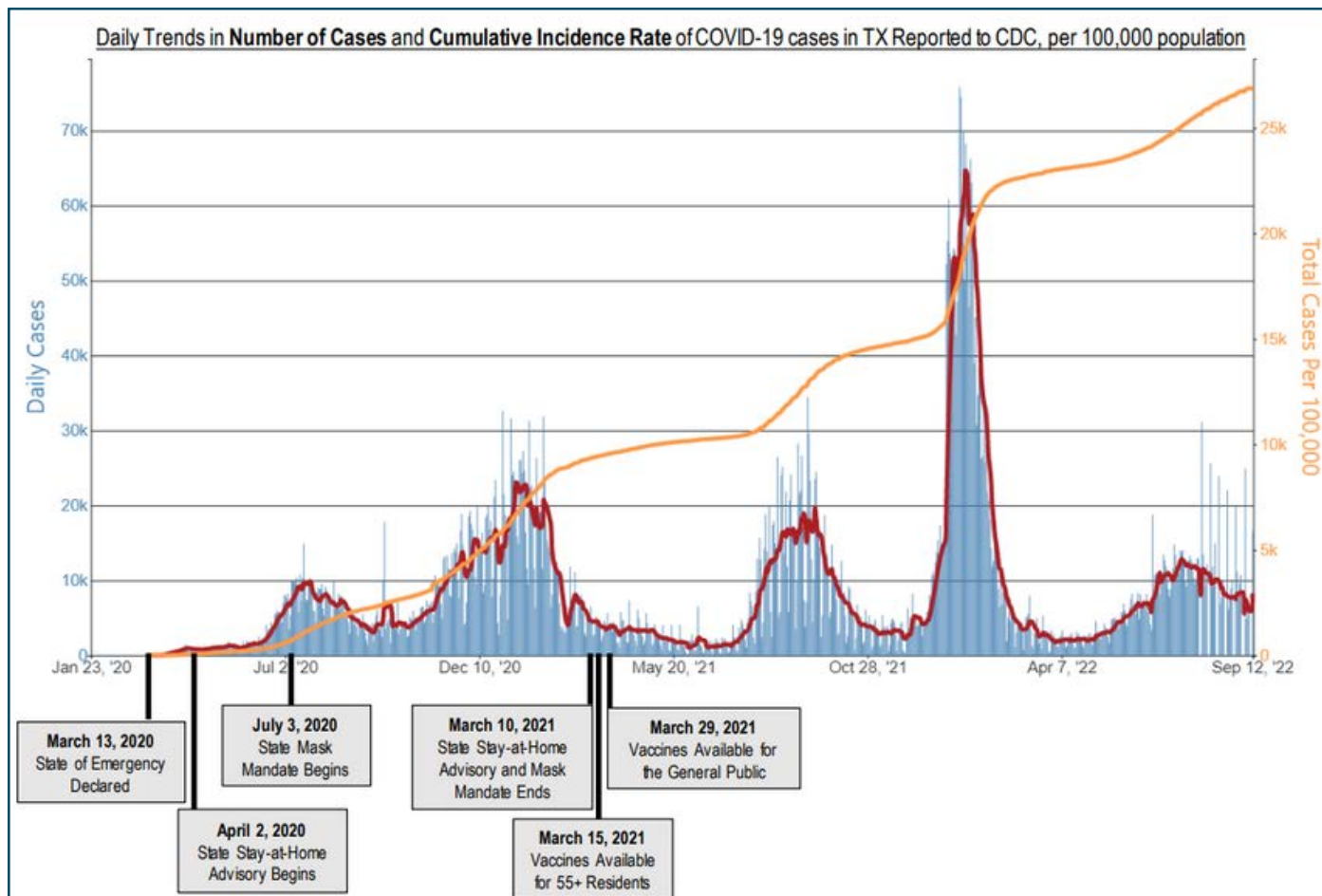# WHAT WAS THE POLICY LANDSCAPE OF TEXAS DURING COVID-19?

Texas implemented a variety of mitigation measures since March 2020. Texas declared a state of emergency around the same time as the other states in this study. Of the four states included in this study, Texas was the last to implement a mask mandate and the first to end their mask mandate.

System Closures During COVID-19

Schools	State Prison Visitation
March 20, 2020 – December 7, 2021	March 13, 2020 – April 23, 2021
Courts*	**Non-essential Businesses**
April 21, 2020 – March 15, 2021	April 2, 2020 – May 1, 2020

* indicates Urban County–level mandate

Below is a timeline of Texas COVID–19 mitigation policies from March 2020 to September 2022.

Daily Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in TX Reported to CDC, per 100,000 population

March 13, 2020
State of Emergency Declared

April 2, 2020
State Stay-at-Home Advisory Begins

July 3, 2020
State Mask Mandate Begins

March 10, 2021
State Stay-at-Home Advisory and Mask Mandate Ends

March 15, 2021
Vaccines Available for 55+ Residents

March 29, 2021
Vaccines Available for the General Public

Understanding the Impact of COVID-19 on Victim Service Provision: Challenges, Innovations, and Lessons Learned

Key Findings and Takeaways
Rural County in Texas

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1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful and/or sustained in the long term?

3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

<u>Click here to read the full report.</u>

Despite difficulties with sustained financial assistance, youth engagement, and general lack of guidance during the pandemic, staff at this agency were consistently able to provide new and continuing clients with most of the same services as before 2020, including shelter, food provision, and teletherapy.

Interviewed

8

staff members
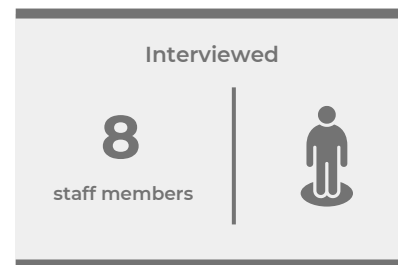
FACILITATORS

- Because the agency's office is situated on the campus of a religious institution and could therefore follow the broader institutional guidance related to public health measures, with precautions in place, agency staff were able to resume in-person service delivery more quickly than other community-based service providers.

- The agency experienced little staff turnover and high morale. Staff attributed this to empathetic and communicative leadership.

- Advances in technology and an unwavering commitment to serving survivors allowed the agency to continue providing services with little to no interruption.

BARRIERS

- The agency's school-based prevention programming experienced significant and lengthy disruption, as most non-essential instruction was deprioritized by schools and districts while students were exclusively learning remotely. Even when schools reopened, visitors were restricted. Similarly, this agency's programming in juvenile detention centers was suspended for a long period of time.

- Lack of public health guidance on federal, state, and local levels was a significant challenge, especially compared with other states; Texas provided relatively little cohesive guidance.

- The project team was one of few local agencies providing in-person services and was therefore overburdened by responsibilities.

INNOVATIONS

- Planned presentations to student groups were pivoted toward educational professionals instead and on short notice; though youth engagement declined, adult engagement skyrocketed.

- Interviewees figured out non-physical ways to provide many of the same services as before the pandemic, such as meeting in an outdoor space to hand a client gift cards, rather than inviting them to "shop" for donated food at the agency office.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

12

agencies

❯ The majority of responding agencies had 11-50 staff members and 1-50 volunteers.

❯ Agencies that responded to the survey reported that they support victims of sexual assault, domestic violence, stalking, and human trafficking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements. Some (41.7%) reported that mask mandates were helpful to service delivery.
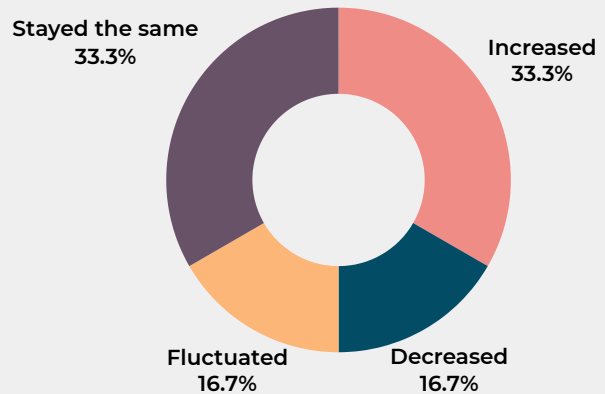
IMPACTS TO STAFFING

41.7%

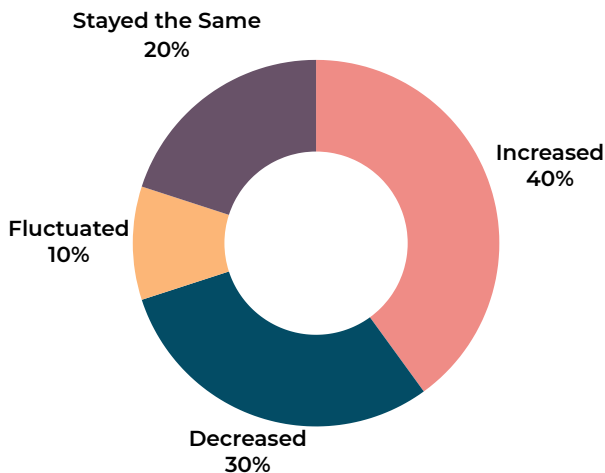Agencies reported that their **current staffing needs are not met**

Agencies reported **needing more or the same amount of staff** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

Stayed the same
33.3%

Increased
33.3%

Fluctuated
16.7%

Decreased
16.7%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

Stayed the Same
20%

Increased
40%

Fluctuated
10%

Decreased
30%

25.0%

Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:

- Information and referrals
- Finances and material assistance
- Legal assistance

16.7 %

Agencies reported at least one service that experienced *decreased* utilization

Services most likely to have experienced a reported decrease in utilization:

- Shelter
- Victim/survivor training and education
- Legal advocacy/accompaniment

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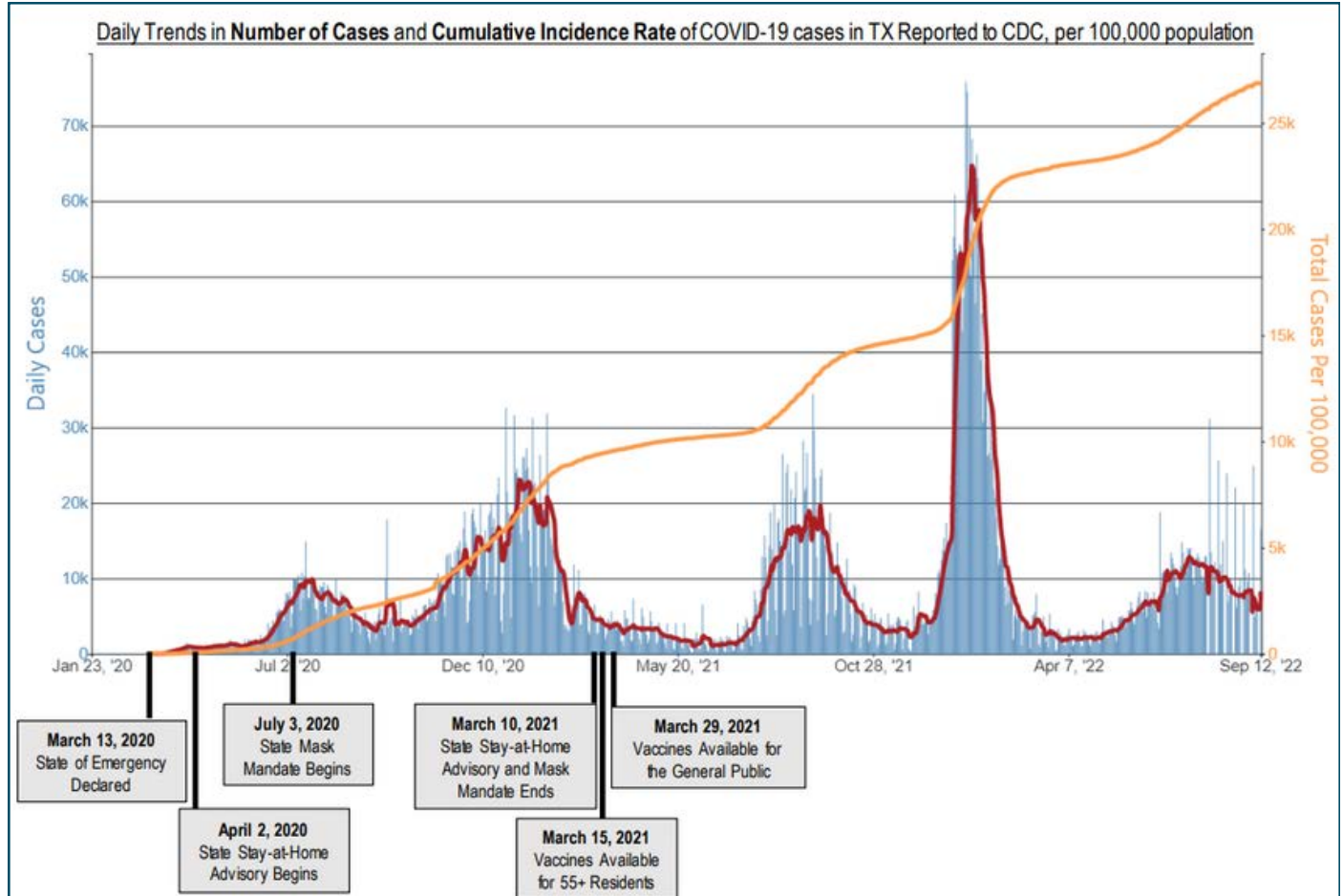
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March 20, 2020 – December 7, 2021	March 13, 2020 – April 23, 2021
Courts*	**Non-essential Businesses**
April 6, 2020 – June 16, 2020	April 2, 2020 – May 1, 2020

* indicates Rural County-level mandate

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July 3, 2020 State Mask Mandate Begins

March 15, 2021 Vaccines Available for 55+ Residents

March 10, 2021 State Stay-at-Home Advisory and Mask Mandate Ends

March 29, 2021 Vaccines Available for the General Public

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Challenges, Innovations, and Lessons Learned

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Urban County in Washington

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WHAT DID WE LEARN FROM THIS AGENCY?

This agency continued to provide services to clients throughout the pandemic through the use of telehealth technology. Staff navigated around not being able to provide in-person trainings in schools and other venues. Ultimately, agency staff underscored how the unwavering support of their leadership ushered them through the pandemic.

Interviewed

10

staff members
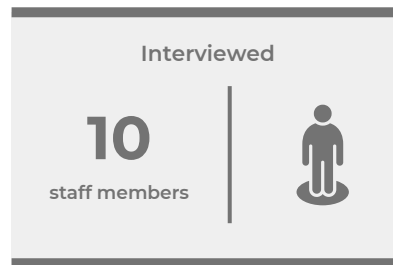
FACILITATORS

- Agency staff were flexible to their everchanging environments, with some sharing how they served in multiple or varying roles during this time period. Staff were also open to trying new things they had previously been uninterested in incorporating into their practice (e.g., teletherapy, digital case notes).

- This agency received a large pool of undesignated funds, which allowed them to procure necessary technology relatively quickly (when compared to other agencies). This shift allowed them to consistently serve clients throughout the pandemic.

- The shift to teletherapy removed barriers for clients living remotely and/or without consistent transportation. Teen clients adapted particularly well to teletherapy options.

BARRIERS

- Due to funding constraints, this agency's drop-in center for trafficking victims was forced to close. At the time of interviews, they had not identified means to reopen the center.

- This agency struggled to find meaningful ways to maintain volunteer engagement. Although pandemic restrictions have loosened, the previously healthy volunteer base has not recovered.

- Some agency staff reported experiencing symptoms of burnout. This agency experienced some staff turnover, though interviewees noted that this was not necessarily due to the pandemic. Staff reported that concurrent social justice events impacted morale, which may have played a role in burnout.

INNOVATIONS

- Technological investments, including transitions to telehealth, an online web chat, and the ability to file court papers online, was a huge and valued change for clients.

- This agency retained hybrid service delivery, which allowed clients to choose an option that works best for them.

- This agency switched from a paper filing system to a digital system. This has proven particularly effective for documenting hotline calls, and allows the agency to better recognize repeat contactors.

WHAT DID WE LEARN FROM OTHER AGENCIES IN THIS COUNTY?

Surveyed

11
agencies

> The majority of responding agencies had 11-50 staff members and 1-50 volunteers.

> Agencies that responded to the survey reported that they support victims of sexual assault, domestic violence, and human trafficking.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, public transportation, and businesses**. Agencies also reported mask mandates and social distancing requirements.
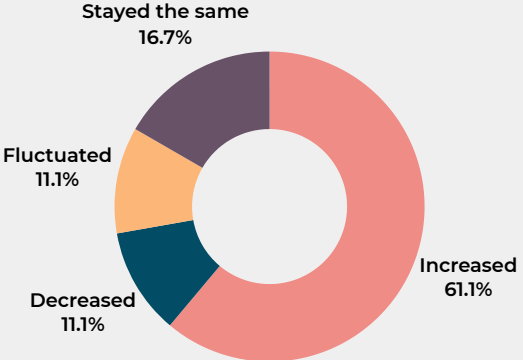
IMPACTS TO STAFFING

36.4%

Agencies reported that their **current staffing needs are met**

Agencies reported **needing more staff** compared with their staffing needs at the beginning of COVID-19.
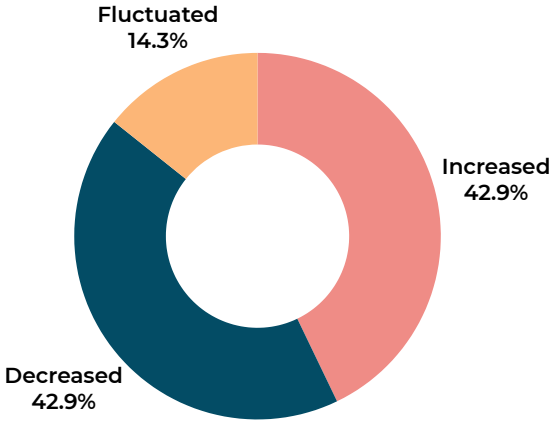
Changes in Staff Volume Since February 2020

- Stayed the same 16.7%
- Fluctuated 11.1%
- Decreased 11.1%
- Increased 61.1%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

- Fluctuated 14.3%
- Increased 42.9%
- Decreased 42.9%

54.6%
Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:
- Information and referrals
- Hotline
- Legal advocacy/ accompaniment

45.5 %
Agencies reported at least one service that experienced *decreased* utilization

Services most likely to have experienced a reported decrease in utilization:
- Community member training and education
- Victim/survivor training and education
- Legal advocacy/accompaniment
- Case management

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Key Findings and Takeaways - Urban County, WA   **3**

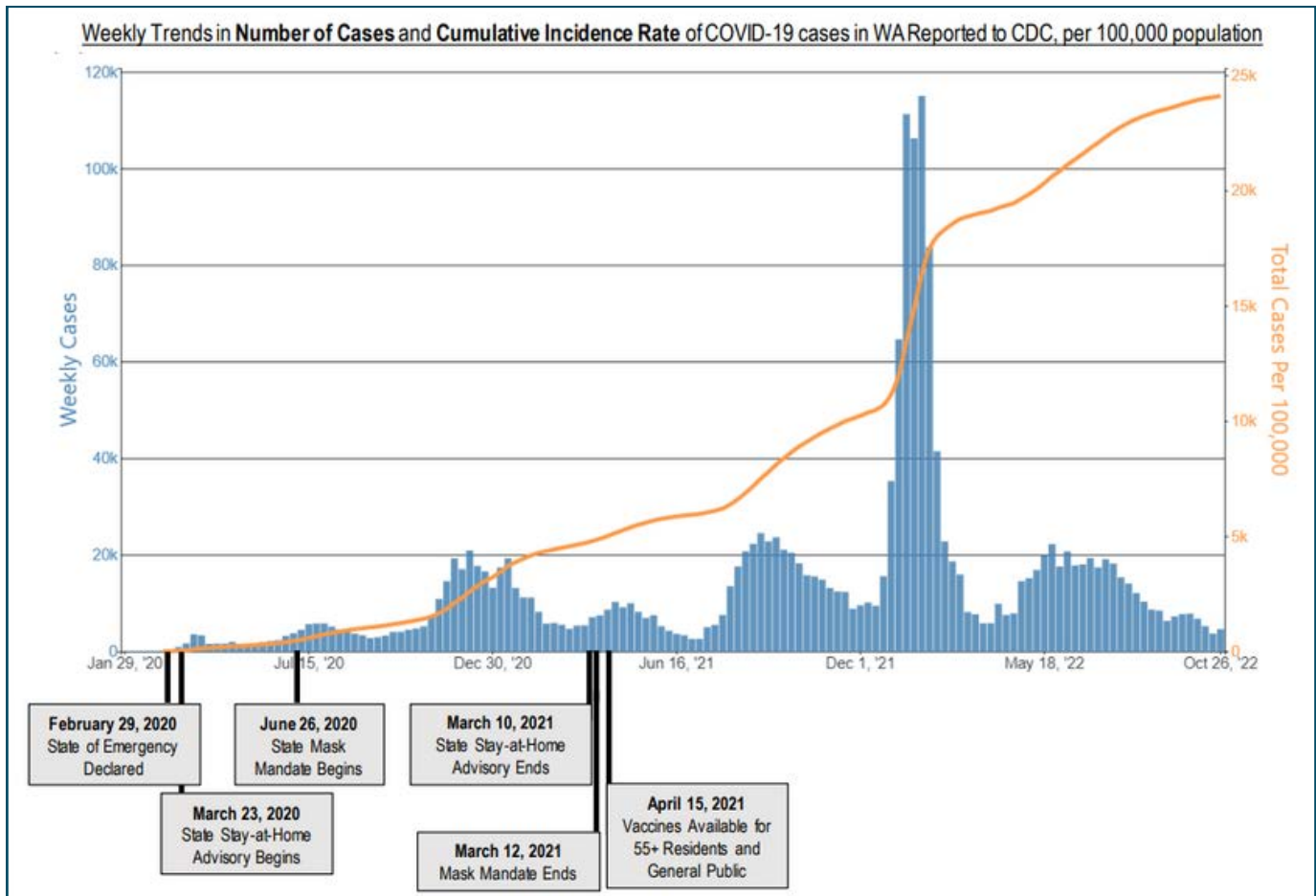# WHAT WAS THE POLICY LANDSCAPE OF WASHINGTON DURING COVID-19?

Washington implemented a variety of mitigation measures since February 2020. Of the four states included in this study, Washington was the first state to declare a state of emergency surrounding COVID-19. Washington was the second to last of the four states in this study to implement a mask mandate.

System Closures During COVID-19

Schools	State Prison Visitation
March 17, 2020 – May 24, 2021	March 13, 2020 – May 9, 2021
Courts*	**Non-essential Businesses**
March 16, 2020 – July 6, 2020	March 25, 2020 – June 1, 2020

* indicates Urban County-level mandate

Below is a timeline of Washington COVID-19 mitigation policies from March 2020 to October 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in WA Reported to CDC, per 100,000 population

February 29, 2020 State of Emergency Declared

March 23, 2020 State Stay-at-Home Advisory Begins

June 26, 2020 State Mask Mandate Begins

March 12, 2021 Mask Mandate Ends

March 10, 2021 State Stay-at-Home Advisory Ends

April 15, 2021 Vaccines Available for 55+ Residents and General Public

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This document highlights key takeaways from an individual county in our study. You can access the full report here to learn more about this and other counties.

RESEARCH OBJECTIVES

1. How did local legal, policy, and cultural frameworks impact victim service provision during the COVID-19 pandemic, and how can policymakers better support VSPs in future crises?

2. How did the COVID-19 pandemic change VSP service delivery models and practices, and to what extent have those changes been successful and/or sustained in the long term?

3. Were there patterns in the ways that victim services were impacted by COVID-19 based on victim or service provider characteristics, such as type of victims served, region, or number of staff?

Click here to read the full report.

This agency had a relatively peaceful shift into COVID-19, with empathy from external partners and funders as well as internal staff and leadership. Technology was occasionally troublesome, and the shift to maintaining administrative tasks remotely proved challenging, but there was little turnover and consistent services were provided throughout the shutdown.

Interviewed

8

staff members
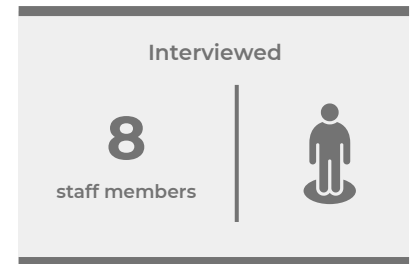
FACILITATORS

- Agency staff described how trust in new and returning leadership and a shared commitment to serving clients, allowed staff morale to stay high even during the most challenging of circumstances. Staff had very little turnover; they were patient, committed, and innovative.

- To avoid having to lay off any staff whose roles were paused as a result of state mandates and closures (e.g., legal accompaniment paused due to court closures), leadership transitioned these staff to roles that were in higher demand during the pandemic. More specifically, individuals were transferred to the crisis team to help respond to hotline calls.

- This agency leveraged their board to support decision making throughout the pandemic. Agency staff were patient and helpful in training their employees to use Zoom and other telehealth technology.

BARRIERS

- Like many agencies, this agency's staff struggled with lack of public health guidance and general knowledge about COVID-19 response at the start of the pandemic, particularly regarding courts, housing, hiring, and other tasks that had potential health risks.

- Agency staff described the unanticipated challenges that accompanied hotel housing, including the lack of case management that clients were used to having in shelters.

- Many of this agency's clients do not have consistent access to technology, creating challenges for providing virtual services.

INNOVATIONS

- All agency staff, including administrative staff, are now trained on how to answer Hotline calls. This allows more staff to provide support in the event of future service disruptions.

- Staff began meeting clients outdoors for short tasks like signing a form.

- This agency retained hybrid service delivery, which allowed clients and staff to choose options that works best for them.

Surveyed

2 agencies

> The majority of responding agencies had 11-50 staff members and 1-50 volunteers.

> Agencies that responded to the survey reported that they support victims of domestic violence and a variety of other crimes.

Nearly all agencies reported experiencing **challenges to service delivery as a result of closures to schools, courts, and businesses**. Agencies also reported mask mandates and social distancing requirements. Both responding agencies reported that mask mandates were helpful to service delivery.
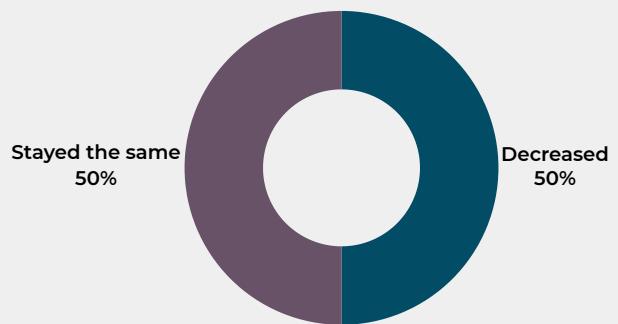
IMPACTS TO STAFFING

100.0%

Agencies reported that their **current staffing needs are being met**

Agencies reported **needing more or the same amount of staff** compared with their staffing needs at the beginning of COVID-19.

Changes in Staff Volume Since February 2020

Stayed the same
50%

Decreased
50%

IMPACTS TO SERVICE DELIVERY

Change in Number of Victims Served Since February 2020

Stayed the Same
50%

Decreased
50%

50.0%
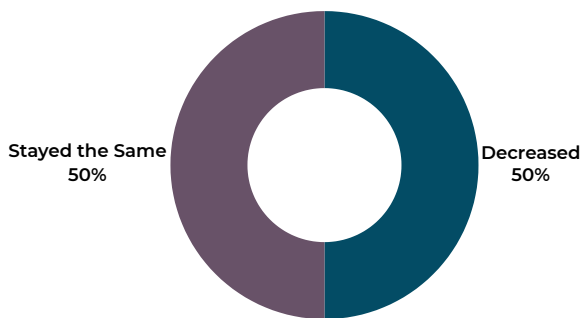
Agencies reported at least one service that experienced *increased* utilization

Services most likely to have experienced a reported increase in utilization:

- Hotline
- Crisis counseling
- Information and referrals

0.0 %

Agencies reported at least one service that experienced *decreased* utilization

WHAT WAS THE POLICY LANDSCAPE OF WASHINGTON DURING COVID-19?

Washington implemented a variety of mitigation measures since February 2020. Of the four states included in this study, Washington was the first state to declare a state of emergency surrounding COVID-19. Washington was the second to last of the four states in this study to implement a mask mandate.

System Closures During COVID-19

Schools	State Prison Visitation
March 17, 2020 – May 24, 2021	March 13, 2020 – May 9, 2021
Courts*	**Non-essential Businesses**
March 16, 2020 – May 1, 2020	March 25, 2020 – June 1, 2020

* indicates Rural County-level mandate

Below is a timeline of Washington COVID-19 mitigation policies from March 2020 to October 2022.

Weekly Trends in **Number of Cases** and **Cumulative Incidence Rate** of COVID-19 cases in WA Reported to CDC, per 100,000 population

February 29, 2020 State of Emergency Declared

March 23, 2020 State Stay-at-Home Advisory Begins

June 26, 2020 State Mask Mandate Begins

March 10, 2021 State Stay-at-Home Advisory Ends

March 12, 2021 Mask Mandate Ends

April 15, 2021 Vaccines Available for 55+ Residents and General Public