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Lessons Learned About Services Delivery to Victims of Domestic Violence During COVID 19 Mandatory Physical Distancing Orders

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LESSONS LEARNED ABOUT SERVICES DELIVERY

TO VICTIMS OF DOMESTIC VIOLENCE

DURING COVID 19 MANDATORY

PHYSICAL DISTANCING ORDERS

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

_____

by

Veronica Perez

May 2022

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ABSTRACT

The COVID-19 pandemic and resulting social distancing guidelines have dramatically limited or excluded in-person services to domestic violence (DV) victims. Service providers have shifted to providing services to DV victims through telehealth as part of the COVID-19 physical restriction orders. This shift in services from in-person to telehealth has impacted the DV victims accessing services and has impacted the service delivery by the service providers. This study aimed to understand the lessons learned about service delivery to victims of domestic violence during the COVID-19 mandatory physical distancing and stay-home orders. This qualitative study used interviews via Zoom to collect data. The subjects were nine service providers working with domestic violence victims. The data revealed different stages of services when delivering services to the DV victims. These stages of services reported their own barriers, benefits, and strategies when they were using their designed method of provision of services (in-person, telehealth, or hybrid). The data found that service providers and DV clients preferred telehealth services over in-person services and reported the benefits of hybrid services. The data also found an increase in mental health symptoms as an impact of the pandemic for clients and service providers. Due to the limited literature on this topic, the current study is critical for social work practice; the findings of this study can be utilized to enhance preparedness and adopt new strategies and protocols when providing mandatory physical distancing services.

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TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER ONE

PROBLEM FORMULATION

Introduction

Social workers have a history of working in person with individuals, groups, and within agencies. Face-to-face interaction between social workers and their clients is essential to conduct effective screenings, crisis intervention, counseling services, initial assessments, safety evaluations, home visits, school visits, hospital visits, and agency visits (Ferguson, 2014). In-person meetings with clients support the importance of human relationships (National Association of Social Workers, 2020). The COVID-19 pandemic and resulting social distancing guidelines have dramatically limited or excluded in-person services for many social work practitioners and service providers as part of a set of strategies to prevent the spread of the infectious virus (CDC, 2020). The new guidelines have forced many social workers and service providers to stop all in-person services and home visitations and instead shift to providing services through telephones, video conferences, and telehealth services.

An unexpected, unplanned transition to electronic and telehealth services presents challenges for vulnerable populations (Whaibeh, Mahmoud & Naal, 2020). Violence against women has been shown to increase during natural disasters and unexpected events (First, First & Houston, 2017). According to First et al. (2017), abusers demonstrate excessive control over their victims during and after the disaster. COVID-19 stay-home policies have increased the

risk of domestic and family violence in the United States due to the accessibility of alcohol by the perpetrator and due to the lack of in-home supervision by service providers (Campbell, 2020). Before the mandated physical orders, domestic violence was already pervasive. In the United States, an average of 24 people per minute were victims of physical, sexual, or harassment by their perpetrator (The Hotline, 2020). After the mandated physical orders, this number is escalating. According to the National Domestic Hot Line, they experienced an increase of 9% of calls reaching out for help compared with the previous year. Research has also found that the COVID-19 precautions have exacerbated many individuals' mental health challenges, including victims of domestic violence, by increasing anxiety, depression, and panic disorders due to isolation (Holmes, O'Connor, Perry, Tracey, Wessely, Arseneault & Bullmore, 2020). The shift in how services are provided combined with the increasing lack of protection for domestic violence victims is of crucial importance to the social work field. Third-level Heading.

Micro and Macro Implications

Current micro and macro practice policies at most social service agencies and courts require standards for meeting face-to-face with clients and maintaining regular home visitation, but these standard practices were impacted by new macro policies designed to protect against the COVID-19 virus. At a macro level, social workers are deemed essential employees, but they must deal

with other macro policies that limit or exclude in-person contact. New policies for social workers and service providers include assessing for COVID-19 at the screening call, but if the client screens positive for possible COVID-19, then the in-person services are limited (Social Services Workforce, 2020). At a time when clients are most at risk, social workers and service providers are less able to provide direct mental health assistance, crisis intervention, and other basic resources to victims of domestic violence.

The person-in-environment approach enables a social worker to understand the resources and potential risks available to a client and help the client access information networks available to help (Zastrow, Kirst-Ashman & Hessenauer, 2017). The ability to recommend possible supports in a client network is hindered by a lack of access to basic resources by vulnerable populations, such as the internet, smart devices, and phones. According to the Federal Communications Commission (FCC), an average of 19 million people in the United States have a low-speed connection, and in rural areas, 14.5 million people have no access to the internet (FCC, 2020; Weforum, 2020). Other families experience a lack of electronic devices or knowledge on how to access the services. Families who are experiencing poverty are cut off from many community-based supports, increasing the vulnerability and isolation of these families.

Purpose of the Study

The present study aims to understand the lessons learned about service delivery to victims of domestic violence during the COVID-19 mandatory physical distancing and stay-home orders. Due to the limited literature on this topic, the current study is critical to better understand the barriers, strategies, and impacts when delivering services. This study aims to enhance preparedness for future physical distancing orders by identifying the lessons learned during the COVID-related global shutdown. Domestic violence service providers know firsthand the struggles that domestic violence victims experienced when receiving services under physical distancing orders.

To better understand the problems faced by service providers and possible solutions, the present research adopted a post-positivist approach. According to Morris (2014), a post-positivist approach is based on an exploratory approach with the ultimate goal of "understanding an objective reality" (Morris, 2014, p.71). Due to the limited research on the presented topic, a post-positivist approach would lead to developing a holistic and inclusive analysis of the research question allowing the development of new theories (Morris, 2014). This approach follows a qualitative design, and data was collected through interviews and observations in the natural setting. This approach focuses on gathering data via words rather than numbers (Morris, 2014).

The present study gathered data via interviews and observations. This study utilized non-probability convenience sampling to gather data. The

interviews were via Zoom following the COVID-19 physical distancing restrictions. The participants ranged from case managers, domestic violence advocates, therapists, social workers, a program coordinator, and a program director working at a community-based social services agency. The main rationale for using this design was to give the subjects the ability to provide a wide variety of answers as part of a postpositivist approach and develop a theory from the empirical data (Morris, 2006).

Significance of the Project for Social Work Practice

Due to the limited research in the literature in regards to this topic. The findings of this study can have a tremendous impact on social work practice. Study findings can be used to enhance preparedness for future physical distancing orders, when clients are unable to meet in person, or other similar emergency circumstances whereby all in-person services and home visitations are prohibited, and instead of the provision of services shifts to telephone contacts, video conferences, and telehealth services.

The study can help build preparedness and emergency protocols and suggest best practices for delivering mental health services to domestic violence victims and vulnerable and at-risk families during mandatory physical distancing. This study addressed the research question: What are the lessons learned about the provision of services from service providers working with victims of domestic violence during COVID-19 mandatory physical distancing orders?

5

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter provides an analysis of domestic violence (DV) by describing general statistics and cultural dimensions. The analysis includes an exploration of the effects of DV while undergoing unexpected events such as natural disasters and COVID-19. Later, this chapter discusses the provision of services during the mandatory physical distancing orders. Lastly, this chapter discusses the theories that are guiding the present study, including the General Strain Theory (GST) and the Systems Theory.

General Statistics

Domestic Violence (DV) is defined as a behavior conducted by the perpetrator that causes physical, psychological, or sexual harm and controlling behavior over the victim. DV commonly occurs in married couples, couples living together, and couples in a loving relationship (United Nations, 2020). According to the National Intimate Partner and Sexual Violence Survey (NIPSVS), in 2015, 1 out of 4 women and 1 out of 10 men in the United States experienced some form of domestic violence during their lifetime (NCIPC, 2015). The same survey reported that in the year 2015, approximately 52.2 million women in the United States experienced sexual abuse in their lifetime (NCIPC, 2015). In 2010, 57.6

million women in the United States experienced psychological aggression by their partners, and 56.8% of women in the same survey reported that they experienced only physical violence by their partner (NCIPC, 2010). Men can also suffer from domestic violence, but according to the Nonfatal Domestic Violence Report between 2003 to 2012, 76% of domestic violence reported was experienced by women, compared to 24% by men (Nonfatal Domestic Violence, 2014).

   According to a data analysis conducted by the World Health Organization (WHO), from the years 2000 to 2018, approximately 35% of all the women in the world had experienced domestic violence, and 30% of all women had experienced some sort of violence in their lifetime (WHO, 2021). Domestic violence is pervasive, and it can lead to death. According to the Center for Disease Control (CDC), from the 10,018 women homicides reported in the United States between 2003 and 2014, 1,835 women died due to domestic violence (CDC, 2020). In 2005, an average of three women were murdered every day in the United States by their intimate partners (National Organization for Women, 2021), and globally, an estimated 38% of all murders of women have been committed by their partners between the years 2000 to 2018 (WHO, 2021).

Cultural Dimensions

Domestic violence is a phenomenon that does not discriminate; anyone can be a victim of domestic violence. Women and men of any socioeconomic class can be affected, but the literature indicates that women and members of vulnerable groups are more susceptible to domestic violence (WHO, 2020; West, 2012, NISVS, 2010). According to a systematic literature review by West (2012), which analyzed published articles for the last four decades, African American women reported the highest rate over the years for physical violence and perpetration by their partners when compared to White and Hispanic ethnicities in the United States (West, 2012). The 2010 data of the National Intimate Partner and Sexual Violence Survey (NISVS) reports that 43.7% of African American women reported physical violence, rape, and stalking, followed by 37.1% of Hispanic Women, 34.6% of white women, and 19.6% of Asian women in the United States (NISVS, 2010). A recent study by Steele (2020) found similar results indicating that African American and Hispanic women reported higher rates of domestic violence than white women (Steele, 2020). The racial and ethnic differences among domestic violence are also present in domestic violence homicides. According to the CDC, from the homicides reported in the United States among the years 2003 through 2014, African American women scored the highest chance of being murdered by their intimate partner, followed by Hispanic women and later white women (CDC, 2020).

Vulnerability to domestic violence is not only based on the racial and ethnic background of the victims but also is affected by their low socioeconomic status, neighborhood, and employment stability. A longitudinal study conducted by Bonomi, Trabert, Anderson, Kernic, & Holt (2014) explored the impacts of domestic violence on socioeconomic status and the neighborhood socioeconomic composition. They used police data from the year 1999 through 2001 from the Seattle Police Department to select 5,994 urban couples that reported an initial domestic violence incident. The subjects were followed for over two years. The results of the study indicated that domestic violence rates were higher in the lower socioeconomic neighborhood. The study also found that first-time phone calls to the police for domestic violence incidents occurred in low-income socioeconomic neighborhoods. Another study by Caetano, Ramisetty-Mikler, & Harris (2009) found a correlation between the lower socioeconomic neighborhood and intimate partner violence.

Domestic Violence and Natural Disasters

Over the years, the literature has reported that domestic violence victims have been more susceptible to an increase of violence during and after a natural disaster or unexpected event (CDC, 2020; Harville, Taylor, Tesfai, Xu Xiong, & Buekens, 2010). A study by Harville et al. (2010) examined the relationship between Hurricane Katrina and intimate partner violence rates. The study conducted 123 surveys with women in the years 2006 and 2007, one to two

years after Hurricane Katrina. Harville et al. (2010) found that women

experienced an increase in conflict with their partners. Reporting increased in

relation to emotional abuse, followed by physical and sexual abuse. Harville et al.

(2010) also found an increase in stress and PTSD from the victims.

A study by Schumacher, Coffey, Norris, Tracy, Clements, & Galea (2010)

supported Harville et al. (2010) findings by indicating an increased and persistent

rate of domestic violence against women subjects by 45.2% after Hurricane

Katrina. Schumacher et al. (2010) stated that the women subjects reported an

increase of 35% of psychological abuse and 98% of physical abuse after

Hurricane Katrina. Schumacher et al. (2010) also found that their domestic

violence subjects were at greater risk of developing depression and post-

traumatic stress disorder (Schumacher et al., 2010). According to the Gender

and Disaster Network (GDN), after Hurricane Andrew hit Florida in 1992, 50% of

domestic violence phone calls increased. The domestic violence persisted for the

following two months after the hurricane (GDN, 2020).

The increase and persistence of domestic violence after disasters are

visible in different natural disasters or unexpected events. Fisher (2010)

conducted a qualitative study to investigate gender violence after the Tsunami in

Sri Lanka in South Asia in December 2004. Fisher's (2010) findings reported that

the violence against girls and women increased to 4 out of 5 interviewed

subjects. The study also found an increase in sexual assault and rape on women

and girls after the Tsunami. Fisher (2010) stated that domestic violence

increased in all the provinces containing the highest numbers of low socioeconomic families. The study indicated that some of the factors that triggered the violence were lack of access to basic resources, lack of money, frustration, alcoholism, lack of employment, lack of privacy due to being in a camp, mental health, and stress.

      A study by Azad, Hossain & Nasreen (2013) reported vulnerability for women and girls after a flood in Bangladesh. Azad et al. (2013) conducted a qualitative and quantitative study to explore women's vulnerability after a flood. The study stated that 35% of their subjects were harassed by their intimate partner during and after the floods for a period of 5 years; the study also reported that 34% of the subjects reported physical abuse by their husband during and after the floods. Some vulnerabilities reported in the study were the increase in mental health issues, no sanitation facilities after the floods, health conditions such as menstruation and malnutrition, no access to basic resources, lack of employment, and being homeless due to the loss of their home (Azad et al., 2013). The observed commonalities described in the literature about the impact of natural disasters on domestic violence describe women and girls as more susceptible to violence and other adverse effects during and after a natural disaster.

Domestic Violence and COVID-19

The Coronavirus Disease 2019 (COVID-19) pandemic is no exception regarding the impact of domestic violence rates; although there is little literature on the effects of COVID-19 on domestic violence victims, the known information reports that violence against women has increased after the pandemic began, and the pandemic has highly impacted vulnerable populations (WHO, 2020; VAWC, 2020; CDC, 2020). According to the WHO, the rates of domestic violence have globally escalated. In the United Kingdom, the calls to request assistance increased 97%, and in the Eastern Mediterranean region increased by 37%. Other countries, such as France, reported a domestic violence increase of 30%, and Spain reported a rise of 20% (WHO, 2020). In the United States, the domestic violence rates have also increased; according to a peer-reviewed article by Boserup, McKenney & Elkbuli (2020), the U.S Police Departments received an increase in domestic violence calls and arrests after the mandatory physical orders began. The San Antonio Police Department received an increase of 18% of family violence calls, the Portland Police Bureau experienced an increase of 22% in arrests of domestic violence perpetrators, and the New York City Police Department reported a 10% increase in domestic violence arrests (Boserup et al., 2020). Additionally, the National Violence Hot Line in the United States has reported an increase in calls, and victims are reporting COVID-19 as a reason for their call (The Hotline, 2020). The evidence of the increase in domestic violence rates during the pandemic is evident and alarming. COVID-19

is a devastating pandemic that has unique qualities different from other natural disasters; COVID-19 presents terrible health impacts and high mortality rates. As of November 30, 2020, the COVID-19 pandemic killed 1,456,687 people globally and has 62,363,527 confirmed cases (WHO, 2020).

The COVID-19 pandemic and resulting social distancing guidelines have dramatically impacted women. The stay-home measures established to protect people from being infected with COVID-19 are the same measures that are putting women and girls in situations more susceptible to violence (WHO, 2020; VAWC, 2020). The physical distancing orders and stay-home orders facilitate conditions for violence between the perpetrator and the victims because of the increase in power and control over the victim during private isolation. The literature about the causes of domestic violence reports that power and control is one of the probable causes of domestic violence; this begins when one partner has power and control over the other partner leading to power imbalance (The Hotline, 2020; VAWC,2020). According to Rauhaus, Sibila & Johnson (2020), during the pandemic, men have become more controlling on things such as finances, decisions at home (Rauhaus et al., 2020), and denying permission to see their family members and seek medical help or services (Ertan, Wissam, El-Hage, Thierrée, Hervé Javelot & Coraline, 2020). Also reported by Ertan et al. (2020) is that the stay-home measures created a high-risk environment for developing stressors that may trigger the violence. For example, spending more time in one environment, unemployment, economic vulnerability, alcohol, and

arming the perpetrators with the perception that no help is available, leading to increased controlling behavior and violence (Ertan et al., 2020).

Many women do not have the ability to leave their home due to the stay-home policies, or they experience control from their partners, or due to the complexity of not being ready to leave their offender (Kofman and Garfin, 2020). Likewise, some domestic violence victims may be in fear of being infected by COVID-19. During the Ebola pandemic outbreak of 2018 to 2020 in the Democratic Republic of Congo, women and girls did not seek services and health assistance due to the fear of being infected by Ebola (Care, 2020). An Australian qualitative study conducted by Boxall, Morgan & Brown (2020) aimed to study the effects of domestic violence during the COVID-19 pandemic. They found that 51.6% of their domestic violence survivors reported being physically and sexually abused during the pandemic and reported at least one time during their abuse, they did not seek help due to safety concerns from the perpetrator (Boxall et al., 2020). During the physical distancing orders, domestic violence victims are more vulnerable to serious physical abuse, emotional abuse, and even homicide.

Provision of Services During the Mandatory Physical Distancing Orders.

The COVID-19 pandemic and resulting social distancing guidelines have dramatically limited or excluded in-person services for many social work practitioners and service providers as part of a set of strategies to prevent the spread of the infectious virus (CDC, 2020). Not accessing the services can be prejudicial for domestic violence victims. The domestic violence support services that are essential for the domestic violence victim and their families consist of 24-hour crisis lines, emergency services, shelters, advocacy services, counseling services, case management services, support group services, family violence support services (ACADV, 2000).

Additionally, some of the best practices when intervening with domestic violence victims and their families consist of providing crisis intervention services and therapeutic services such as cognitive-behavioral therapy (CBT) (Yeager and Roberts, 2015; Iverson, Gradus, Resick, Suvak, M, Smith & Monson, 2011). Crisis intervention services aim to assist domestic violence victims and their families who are in immediate danger or in a crisis situation. This intervention consists of assessing the safety of the client, conducting safety plans, and having strategies to de-escalate the client's presenting crisis (Yeager and Roberts, 2015). One of the interventions used when a client is no longer at risk and is stabilized is CBT. This therapeutic approach is a popular evidence-based model that many counselors use when working with domestic violence victims and their

families because it helps clients treat their trauma, post-traumatic stress disorder, anxiety, and depression (Iverson et al., 2011).

These interventions and domestic violence support services are generally provided in person and are well-known to promote the domestic violence survivor's safety and well-being (ACADV, 2000; Yeager and Roberts, 2015; Iverson et al., 2011). However, the impact of COVID-19 and the associated social distancing orders have changed the provision of services by imitating in-person services, and the pandemic has also increased the need for more support and treatment services.

For example, COVID-19 has increased the mental health symptoms of domestic violence victims. According to recent literature, the COVID-19 mandatory physical orders have had a greater impact on the mental health of domestic violence victims. Sediri, Zgueb, Ouanes, Ouali, Bourgou, Jomli, R., & Nacef (2020) studied mental health effects on domestic violence victims during COVID-19. The study found that 85% of domestic violence subjects reported mental health issues; 57.3 % of their participants disclosed depressive and anxiety symptoms, and 53.1% of their participants disclosed severe stress symptoms (Sediri et al., 2020). Additionally, sources such as SAMHSA and the CDC have reported increased stress levels and mental health issues among individuals due to the impact of COVID-19 (SAMHSA, 2020; CDC, 2020).

Receiving services are essential for domestic violence victims. The literature has reported that the domestic violence victims who seek shelter

assistance are less likely to report future revictimization by their perpetrators

(Bybee and Sullivan, 2002). Shelters also represent a path to safety by offering

protection from the vulnerability to violence that they experienced at their homes

with their perpetrators. Domestic violence advocacy intervention services are

also crucial for the safety of the domestic violence victims and to alleviate the

impacts of the mental health issues of the victims. A meta-analysis study by

Hackett, McWhirter & Lesher (2015) found that domestic violence intervention

services positively impact the clients that participate in them. The invitation

services applied to the subjects in this study reveal an improvement in

psychological adjustments, self-concept, social adjustments, family relationships,

and external stress (Hackett et al., 2016). A longitudinal study by Bybee and

Sullivan (2002) studied the prevalence of revictimization of the domestic violence

victims after receiving intervention services also found a prevalence of

revictimization for two years after services in combination with the new quality of

life and social support (Bybee and Sullivan, 2002).

To alleviate the emerging mental health issues and safety concerns

brought by the physical distancing orders, women and vulnerable populations

need to access the services. However, the new guidelines have forced many

social workers and service providers to moderate or stop all in-person services

and home visitations, shifting to adapt to other strategies. One of the negative

effects of these adaptations are the limitations on the provision of services. For

example, domestic violence shelters are faced with a hard decision of refusing

new clients if they are COVID-19 positive or if they do not have proof that they are testing negative for COVID-19 (John, Casey, Carino, & McGovern, 2020). Social workers and service providers are deemed essential employees, but they have to deal with the policies that limit or exclude in-person contact. These new policies indicate assessing for COVID-19 at the screening call, but if the client screens positive for possible COVID-19, then the in-person services are limited (social services workforce, 2020).

The alternative to in-person services is the shift to providing services through telephones, video conferences, and telehealth services. The service providers are adapting to the new methods to best assist the families; there is little literature reporting the overall reaction and results of using these methods during the mandatory physical distancing orders. A study conducted by Tarzia Cornelio, Forsdike & Hegarty (2018) studied the experiences of domestic violence victims using online services and face-to-face services. The study findings indicated the benefits of providing online services, but the findings were limited to the interaction between victims and doctors (Tarzia et al., 2018). A systematic study by El Morr and Layal (2020) reviewed research studies that employ services with technology for domestic violence victims. The study found that clients with lower socioeconomic status had to overcome the inequitable access to technology, specifically digital access to services. This study also reported concerns pertaining to the increased safety risk of sharing the electronic device with the perpetrator. The study reported more favorable benefits on the

use of technology for middle to higher-economic status families due to increased

access to technology (El Morr and Layal, 2020).

The limitations for lower economic status clients open more questions on

how clients can access critical resources during mandatory physical distancing

and stay-home regulations if they do not have access to technology.

Furthermore, families who are experiencing poverty are cut off from many basic

supports, increasing the vulnerability and isolation of these families. Additionally,

service providers may be experiencing barriers to providing basic resources to

these families. Other components, such as the lack of privacy to receive the

services during the telehealth session or phone call, provide concerning factors

(Ertan et al., 2020; Slakoff et al., 2020).

Other concerning factors are the increased burnout of service providers.

Recent literature has reported an increase in occupational burnout and fatigue of

health care service providers working in intensive care units during the COVID-

19 pandemic (Sasangohar, Jones, Masud, Vahidy, & Kash, 2020). Another

article by Luceño-Moreno, Talavera-Velasco, García-Albuerne, & Martín-García,

(2020) reported increased psychological impacts for frontline workers in Spain

when they were delivering services in medical settings during COVID-19. The

study reported that 58.6% of the participants presented symptoms of anxiety,

56.6% presented symptoms of post-traumatic stress disorder, and 46% of the

participants presented symptoms of depression. Although these results do not

directly reflect the potential burnout for all types of service providers, the results

do provide the scope of the problem of burnout and the barriers that service providers can encounter while delivering services.

Due to the dearth of literature on the impacts of burnout on service providers, the present study is essential for social workers as they can gain a better understanding of the potential barriers that service providers may have when delivering services to domestic violence victims during mandatory restriction orders. Overall, accessing and providing services have become complex topics for domestic violence victims because some victims are not able to report the abuse, other victims overcome barriers to receiving services, and service providers may undergo different barriers that may not lead to the effective provision of services to domestic violence victims.

The shift in how service providers provide services combined with the increasing lack of protection for domestic violence victims is of crucial importance to the social work field. There is limited literature on the impact of accessing services and the provision of services during the mandatory physical distancing orders. For this reason, the present study is crucial for the social work field to have a better understanding of the impacts of physical distancing orders while serving domestic violence victims.

Theories Guiding Conceptualization

One of the theoretical frameworks that guide the present study is the General Strain Theory (GST). This theory reports that the experience of stressors, tensions, or strains triggers negative emotions, depression, and anger. According to this theory, these negative emotions increase the likelihood of violence and crime (Brezina, 2017). This theory reports that stressors such as losing a job, need for money, low social control, loss of property, and lack of stability let people lose control, and their way to cope with it is through crime (Agnew, 2006). This theory also states that depending on the severity of the strain and stressor, the type of violence or crime is more severe (Brezina, 2017).

This theoretical framework explains the increase in domestic violence rates and violence during the COVID-19 lockdown orders because many people lived under uncertainty. Many people lost their jobs and had financial instability, and the lockdown orders required the need to stay at home, and many people experienced a lack of control. These experiences generated strains and may increase psychological reactions and tension between the people, leading to domestic violence. This theory also explains how people's lack of control leads to an increase in mental health symptoms such as anxiety, depression, and anger wish are associated with the current increase of mental health symptoms due to the impact of the pandemic (Agnew, 2006; Brezina, 2017).

The general strain theory has been used to explain the increase in violence during natural disasters. A study conducted by Robertson, Stein &

Schaefer-Rohleder (2010) studied the effects of Hurricane Katrina and other

natural disasters on increasing violence and crime, testing the general strain

theory. The results of this study found that adverse events, life events, and

natural disasters affect the number of stressors and maladaptive coping.

According to the study, these stressors and maladaptive coping were associated

with self-ported serious criminal activity. The study also found that the exposure

to Katrina increased the violent delinquency of the subjects that participle in the

study (Robertson., et al, 2010). The finding of the mentioned study supported the

General Strain Theory (GST).

Overall, the general strain theory explains the increase of domestic

violence during the COVID-19 restrictions orders due to the impact of external

strains such as financial stability, lack of control, loss of property with the

increase of maladaptive reactions leading to an increase of violence from the

abuser to the victim. The general strain theory is an important theoretical

framework that service providers can use to understand how maladaptive coping

and violence increase due to the effects of natural disasters or uncontrolled

behaviors.

Another important theory that guides the present study is the Systems

Theory, which is the idea that behavior is manipulated by social structures that

work together as a system, such as economic status, social constructs, and the

home environment. The systems theory explains the individual behaviors or

outcomes as a relationship with other systems (Social Work License Map, 2020).

This theoretical framework relates to domestic violence and the impact of COVID-19 for several reasons. One reason is that the actions of one family member can impact other family members and has an impact on the family system.

This theory also explains the impact of environmental systems on family dynamics. Environmental stressors can impact the family unit; systems such as mandatory physical orders, loss of a job, health issues, economic hardship, and isolation can break a family's homeostasis, which refers to the equilibrium and balance of systems generating family violence (Zastrow et al., 2019). When these external systems contribute to someone being in a potentially dangerous situation, then the service providers must try to impact them to promote a safer situation for the client by bringing equilibrium and balance (Zastrow et al., 2019). Overall, the interconnection of each system is related to the current effects of the mandatory physical distancing restriction orders.

CHAPTER THREE

METHODS

Introduction

This chapter provides an overview of the methods that were used to conduct this study. The chapter begins with a description of the study design and will proceed with the description of the sampling. This chapter describes the process of data collection and the interview method used in the study. Lastly, the chapter describes the procedures of the protection of human subjects and will discuss the qualitative data analysis.

Study Design

The purpose of this study is to understand the lessons learned about service delivery to victims of domestic violence during the COVID-19 mandatory physical distancing and stay-home orders. This study aims to identify the barriers experienced by service providers who delivered services to domestic violence victims under mandatory physical distancing orders and their strategies to address these. This study also aims to understand the barriers experienced by domestic violence victims when receiving services under mandatory physical distancing orders, as described by the service providers and based on their perceptions and opinions.

The research study adopted a postpositivist approach to obtain data. According to Morris (2014), the postpositivist paradigm employs a method that

follows an exploratory approach and begins with a generic question, and after the completion of the data analysis, a focused understanding of the data evolves, allowing the development of new theories and can bring concrete answers for the research question (Morris, 2014). The postpositivist approach uses a qualitative method to collect the data, and the methods used with this approach are interviews and observations (Morris, 2014).

The present study collected data via interviews in a natural setting. The interviews were via the Zoom video conference platform and followed the current COVID-19 physical distancing restrictions, which allowed the data collection to be in the actual setting where the services were provided to the domestic violence victims. The participants were service providers who delivered services to victims of domestic violence. Participants were informed about confidentiality and completed the informed consent prior to their interview via Zoom.

The interviews encouraged the participants to express their thoughts about the barriers, experiences, and perceptions about providing services to domestic violence victims while following physical distancing protocols. The interviews consisted of seventeen questions. This approach was an effective way to ask open-ended questions and allowed more interaction between the interviewer and interviewee. The main rationale for using this design was to give the participants the ability to provide a wide variety of answers as part of the exploratory research. Other advantages of research interviewing are that the interviews can be spontaneous and natural, allowing the participants to feel

comfortable and express their thoughts and knowledge about the questions (Grinnell and Unrau, 2018). Research interviewing also allows for more flexibility in the answers provided. The researcher can change the way the questions are phrased for the interviewers to understand the questions better, allowing for accurate answers and for more information about the research question (Grinnell and Unrau, 2018).

The limitation of using the interviews was that it was time-consuming; the average time for each interview was forty-five minutes. According to Grinnell and Unrau (2018), when conducting interviews, participants may have the pressure to stay with the interviewer until the end of the interview, and this may result in discomfort, fatigue, and anger that may well influence their responses (Grinnell and Unrau, 2018). Another limitation is that interviews only allow having one person present during the interview. This results in being time-consuming for the researcher. Another disadvantage of the interview process involves the loss of anonymity from the participants because the researcher meets with the participants (Grinnell and Unrau, 2018). The inaccessibility of obtaining new participants is another limitation because participants may not want to participate in the study for different reasons due to the time consumption, the loss of anonymity, or because they may feel uncomfortable in participating (Grinnell and Unrau, 2018).

Sampling

This study utilized non-probability convenience and snowball sampling. Non-probability convenience sampling refers to a procedure that relies on obtaining participants who are convenient and available to the researcher. This sampling method does not use random selection; for this reason, this method is not a representative sample of the population (Grinnell and Unrau, 2018). Snowball sampling refers to using the networks between key individuals that have a relationship with the research topic. After each participant is interviewed, the participant is invited to identify other members that have a relationship with the research topic; this process continues until the desired sample is obtained (Morris, 2014).

The sample consisted of (n=9) female participants. Due to the current situation of COVID-19 protocols and social distancing, not many participants agreed to be interviewed for the study. The participants in this study were service providers working with domestic violence victims. The participants were (n=3) case managers with the roles of providing resources and case management services to domestic violence victims and their families. Case managers have the role of domestic violence advocate, providing crisis interventions, legal aid assistance, housing assistance, and links to services such as shelters, mental health care, medical assistance, and any resource that the client and family may need. The sample also consisted of (n=3) therapists with the role of providing individual and group counseling to domestic violence victims. The sample

contained (n=1) a Master of Social Work service provider who had the role of

providing individual and family therapy services to the clients who stayed at the

emergency shelter. The sample also contained (n=1) a program coordinator, who

oversees all the domestic violence programs at the interviewed agency, including

the first responders' team. The sample also contained (n=1) the program director,

who oversees the domestic violence programs, emergency shelter, housing

assistance program, first responders' program, and the family and violence

program at the interviewed agency. The participants were employees at a

community-based social services agency in San Diego, CA.

The racial demographic of the participants were (n=4) Hispanic

participants, (n=3) White participants, (n=1) African American participant, and

(n=1) participant that identified as Mestiza. Their ages ranged from 26 to 62

years old. The years of experience in the field of domestic violence ranged from

1 year to 20 years of experience. The rationale for selecting different service

providers working with the domestic violence population was to better understand

the barriers experienced and strategies to overcome them from different

professional orientations, allowing them to have a wide perspective on how to

help domestic violence victims.

Data Collection and Instruments

The study was conducted via one-on-one interviews using the Zoom video

conferencing platform. Participants were informed about the purpose of the

study, confidentiality, any potential risks and completed the informed consent prior to their interview via Zoom. Participants were reminded about confidentiality at the beginning and end of the interview process. All participants provided their consent on being recorded via an analog tape recorder. The interviews lasted approximately 45 minutes to 1 hour. The researcher followed a post-positivist approach when intervening with the participants. An open-ended interview questionnaire was used to guide the interviews, but the researcher was flexible on modifying the questions and the content of the conversation. The discussions progressed with the ultimate purpose of searching for new ideas and patterns that led to the development of a theory (Morris, 2006).

The open-ended interview questionnaire contained six demographic questions and seventeen open-ended questions. The questionnaire was created by the researcher (see Appendix A). The interview included six demographic questions focusing on gender, age, ethnicity, job title, length, and time working with the domestic violence population. The main interview asked open-ended questions about barriers encountered and suggested strategies for providing services to domestic violence victims while undergoing a mandatory physical order. The interview questionnaire also asked about the service provider's experiences and their observations on how the vulnerable populations were impacted by the restrictions. The interview questionnaire also focused on the mental health aspects observed for the domestic violence victims and the mental health of the service providers. The questions were designed to gather

information about the lessons learned from the service providers. The combination of using the open-ended interview questionnaire, the flexibility in modifying the questions, and asking new questions could lead to creating a theoretical approach.

Procedures

The research preparation began by gathering information about the research focus. The researcher gathered information about service delivery to domestic violence victims during COVID-19 (barriers, strategies, and news), domestic violence facts and statistics, mental health effects for domestic violence victims during natural disasters and during the pandemic, and burnout for employees. The information was gathered through peer-reviewed articles, government websites, and news. After the information was gathered, the research question was developed among the interview questions. The purpose of the study and the research questions were reviewed with the researcher's advisor. A structured set of questions were developed to ensure that all the participants were asked the same questions and to have the research foci addressed by the questions (Morris, 2006).

After the research question and structured set of questions were reviewed with the research advisor, then the Institutional Review Board (IRB) application was submitted to the California State University, San Bernardino

30

Institutional Review Board (IRB). The application was submitted on December 08, 2020. The application contained a proposal describing the steps on the recruitment of the participants, a description of the research project, and steps on maintaining confidentiality. A copy of the informed consent was provided on the application. The second step was to obtain the approval of the community-based organization to conduct the interviews with their service providers who work with domestic violence victims. The organization provided the approval letter on January 10, 2021.

The IRB approved the study on February 09, 2021. The third step was the recruiting of the participants. From the months of February to March of 2021, the study was presented at a community-based monthly team meeting, inviting the service providers of the domestic violence team to participate. An email was also sent inviting them to participate in the research project; A description of the study, a copy of the informed consent document, a phone number, and a school email were included in the email. Four participants were recruited due to the monthly team meeting invitation; two participants replied to the email invitation, and three were recruited via snowball sampling.

The sample consisted of nine volunteers. The recruited participants were informed that their participation was confidential and voluntary. They were informed about the informed consent and that they could refuse to participate in the study or discontinue their participation at any time without any consequences. The researcher collected the informed consent prior to beginning the interviews.

The interviews were conducted in a one-on-one interview via Zoom, using open-ended interview questions.

Preparing for the interviews included the researcher's preparation of the research topic and having the structured set of questions and consent forms available. Preparing for the interview also included being conscious of the researcher's own biases regarding the research topic because it could have influenced the data-gathering process (Morris, 2006).

The researcher was neutral during the interview process and did not provide opinions or comments, and was properly oriented to the interview. The recording stage was one of the steps for data collection. The postpositivist aims to obtain the most accurate information, and records of everything said during the interview process (Morris, 2006). The present study used the method of voice recording and note-taking to gather data. All participants provided their consent on being recorded via an analog tape recorder, allowing the data collection's accuracy.

During the interview process, the researcher asked the essential set of questions as well as the extra questions focusing on the main idea of the research topic. The essential questions addressed the research topic and were obtained from the structured set of questions. The extra questions focused on new findings and were slightly different from the essential questions; they were also used to check the consistency of the responses (Morris, 2006).

The interviews lasted approximately 45 minutes to 1 hour. At the end of the interview, the participants were thanked for their time and participation. Then the researcher took time to reflect on the interview and evaluated the question, "What worked and what did not work?" during the interview. The researcher also assessed its values and bias and thought about the question, "What can be improved next time?" (Morris, 2006, pg. 100). After each interview, the data was stored on Google Drive through a CSUSB school account. The data will be destroyed after the project ends.

Protection of Human Subjects

The researcher took adequate measures to protect the confidentiality and well-being of the participants. The interviews were anonymous and did not ask for any identifying information to protect the participants' confidentiality. No data was presented in a format that allowed the identification of a participant to be discovered. Participants were informed about confidentiality, the purpose of the study, and any potential risks. Participants completed the informed consent prior to their interview via Zoom. Participants had the ability to terminate the interview at any time without any repercussion. With the permission of all the participants, the audio of the interviews was recorded via an analog tape recorder. At the completion of the interviews, the researcher transcribed the words spoken by the subjects.

The participants were differentiated by coding numbers 1–09, depending on the total number of subjects. The researcher was the only person in charge of the data collection to maintain confidentiality. The interview answers were assigned a numerical code. The data will be destroyed after the project ends. The notes taken regarding the participant's interviews were shredded. The data was stored on Google Drive through a CSUSB school account. This ensured the data was protected from any data theft or accidental erasure.

Data Analysis

The subjects were differentiated by coding numbers 1-9, depending on the total number of subjects. In order to interpret the data, a "Bottom-Up" approach was used. This method allowed the researcher to be more inductive and open-ended when analyzing the data (Morris, 2006). The first level of coding began by repeatedly reading the transcripts to identify "open codes," which meant identifying units, concepts, and potential interpretations of the data (Morris, 2006). During this process, the researcher used a constant comparison method to select meaningful units within the same characteristics and meaningful units that had different characteristics. Then, the researcher highlighted all codes on Microsoft transcripts and color-coded all the open codes. Later, a Microsoft word document was created and contained all the open codes allowing the data to be more visible for further analysis.

The second level of the data analysis consisted of creating "axial coding." This type of coding consists of analyzing all the data to create categories and subdivisions of the data (Morris, 2006). During this step, all the open codes were reviewed again to create bigger categories and concepts with their own dimensions, and after the review of the open codes, axial codes emerged. To make the categories more visible, all the axial codes were also color-coded and were added as the main subcategory for the matching open codes.

The third level of coding began by creating "selective coding." This process was developed by refining the axial categories and the relationship between these categories (Morris, 2006). This level of coding is completed after the intensive review of the overall open codes and their axial categories to develop main categories. This process allows the development of a compressive statement and connects the main categories to develop the theoretical research framework, the overall research story (Morris, 2006).

CHAPTER FOUR

RESULTS

Introduction

The following chapter discusses how the qualitative data was analyzed and will present the data findings. This section will begin with the explication of the data analysis, then it will present the study's interpretation by reviewing the open and axial codes, and lastly, it will discuss the selective codes leading to a theoretical statement (Morris, 2006).

Data Analysis and Interpretation

To analyze the qualitative data, a "Bottom-Up" approach was utilized to develop a theory from the data findings (Morris, 2006). The first stage of data analysis was through open coding, which allowed the identification of meaningful themes and concepts from the data (Morris, 2006). Then, the second stage consisted of analyzing the relationship between the meaningful themes and concepts, creating the category of axial codes (Morris, 2006). The last step of the data analysis consisted of integrating the meaningful categories to develop the study's theoretical statement (Morris, 2006).

Open Coding

The first step began by transcribing the nine interviews utilizing word processing software; then, each transcription was analyzed. The next step was identifying open coding. Open codes are narratives in the data that are grouped into meaningful themes and concepts (Morris, 2006). The analysis revealed thirty-four open codes.

The open codes were: calls, cases, type of abuse, reasons for DV during COVID-19, type of DV population, engaged clients, need resources, responding to a crisis, connecting clients to services, first responders' barriers of telehealth, benefits of telehealth for officers, barriers of in-person services, strategies of in-person services, benefits of providing telehealth services, barriers of virtual services, strategies providing telecommuting services, court /legal aid, court strategies, benefits of providing telecommuting services for clients seeking therapy, strategies of telehealth, barriers of telehealth, barriers of group services strategies of group services, hybrid services, strategies implemented in the shelter, barriers encounter at the shelter, fear of COVID-19, anxiety/depression, situational stress, burnout, emotional affected, benefits of hybrid services, choice of services, the use of telehealth, and flexibility.

<u>Calls</u>

The open code of "calls" is defined as the increase of domestic violence calls that the interviewed agency received by police seeking first responders to accompany them to the domestic violence scene that occurred during the

37

COVID-19 lockdown orders and physical restriction orders. This code was selected because Participant 8, the program director, highlighted an increase in police calls during the COVID-19 lockdown orders. Participant 8, mentioned: "The response team had a high volume of calls from dispatch (law enforcement) sometimes; we had to respond to 45 calls or more in one weekend" (Personal communication, July 2021).

Cases

The open code of "Cases" is defined as the increase of domestic violence cases and the waiting list process to access services at the interviewed agency during the COVID-19 lockdown and physical restriction orders. All service providers reported an increase in cases to access services. Participant 2, a case manager, reported: "There have been more and more cases. We had like 400 cases between two staff during the whole year….and we were two case managers for the DV team; we never experienced anything like this before, but later on, more case managers were hired due to the high volume of cases" (Personal communication, May 2021). The increase of cases was reflected in all the sectors of the stages of DV services. Participant 1, a therapist, reported: "Many of my clients did report that things were getting worse after the pandemic hit. What I know is that the FVSS (Family Violence and Support Services) referrals spiked after we went back into more restrictive tears, and we ended up having higher cases. We had a waiting list of over 40 people waiting for therapy services in late June 2020" (Personal communication, May 2021).

Participant 3, the group therapist, also reported a high increase in cases for group participants. She reported, "we had a waitlist of over 15 people or more for group services; I mean, we had enough people to run multiple groups at that point because we've had so many referrals coming in" (Personal communication, May 2021). The agency's shelter was also affected due to the high volume of referrals. Participant 4, the Shelter's therapist, reported: "We had an increase on referrals. I don't have the numbers; specifically, I know that it has never stopped; we always have been full in the shelter units" (Personal communication, June 2021).

Type of Abuse

The open code of "type of abuse" is defined as the type of abuse reported by the victims. This code was selected because Participant 6, the program coordinator of the DVRT (Domestic Violence Response Team) program, highlighted an increase of severe injuries reported by the police. Participant 6 said: "We started to notice really severe injury cases, very severe strangulations, very severe felonies" (Personal communication, July 2021). Participant 9, a therapist, also collaborated with the increase of violent cases as the pandemic progressed, reporting: "I also notice an increase in severity in the type of abuse as the lockdown progressed. There was a marked difference in the severity of cases; the cases were more violent cases like strangulations" (Personal communication, July 2021).

<u>Reasons for DV During COVID-19</u>

The open code of *"reasons for DV during COVID-19"* are defined as the most popular reasons reported by the services providers of why the DV cases increased during the COVID-19 lockdown orders and physical restriction orders. All the participants reported that the main factor driving the increase in domestic violence calls was due to the pandemic restrictions and impact of the pandemic. The main themes reported were financial situations, no place to go, losing jobs, unable to leave home, unhealthy relationships, lack of privacy, lack of child care, and homeschooling.

Participant 6 reported: "I think one contributing factor was when finances started to take a pretty huge hit; kids were out of school and most were homeschooling, families had more stress, the abuser had easy access to abuse the victim—lots of strain on families and finances were a factor" (Personal communication, July 2021). Participant 5, a case manager suggested finances as a contributing factor for violence. She reported "the loss of income—the level of fear. You know you got families who lost all their income. I had a client who lost her income, and the loss of the income has resulted in domestic violence. It's just like 'my kids are hungry, we don't have any money, so we're yelling.'" (Personal communication, June 2021).

Another common factor reported for violence was the pandemic restrictions of not allowing people to leave home, Participant 7, a case manager, reported: "I think that this is because of the pandemic restrictions; people were

40

not able to escape. There is no escape. Because of the pandemic restrictions, people had no place to go. People were not able to visit their support system... We are also in a housing crisis. It's very hard to find housing, and a lot of people are requesting housing" (Personal communication, July 2021).

The combination of the lockdown orders and unhealthy relationships generated violence. Participant 8 reported: "Well, people were living under lockdown, now to imagine if you already have an unhealthy relationship. You go to work every day, and you probably have other things in your life. You are only together a couple of hours during the day; things can be scaled in those couple of hours, now, put COVID-19 into the mix of an unhealthy relationship. Lockdown is a recipe for disaster for many people; you have different stressors such as job loss and lack of child care. People were under lockdown and were living with the perpetrator" (Personal communication, July 2021).

Type of DV Population

The open code "type of DV population" is defined as the type of population that was served during the COVID-19 lockdown orders and physical restriction orders. All the services providers reported that due to the demographic location of the agency, the majority of the clients are Hispanic women. Participant 6, the program coordinator, reported that the populations' average age are women between 25 to 35 years old. However, service providers reported an unusual increase in domestic violence for different populations. Three service providers reported an increase in elderly domestic violence, and two service providers

reported domestic violence for military males. One service provider reported an increase in violence with immigrant women. Two service providers reported an increase for younger women between the age of 18 to 25 years old, and two service providers reported an increase in domestic violence for professional people.

Participant 6 reported: "We saw a high, higher than the normal number of military males. So, males in the military, and elderly folks, 60s to 80s. I don't know the reason for the bump in the military males… So, military finances stayed fairly consistent throughout the pandemic, but we usually don't get a ton of military males in our program; they do on base but not in our program" (Personal communication, July 2021). Participant 7, added: "One of the things that came out on the reports was an increase in violence for elderly people and for males. I don't know the reason for the increase of cases in this population, but it was an increase" (Personal communication, July 2021).

Participant 9, a DV therapist, also reported: "I did see an increase in professionals getting referred to services. For example, for some reason, I had a few real estate agents, which I only saw maybe once a year; I had like six or seven of them.I had several nurses who were very worried about anything like this being reported on their license because they would lose their license. I had a few people who were arrested that were in the medical field. That, unfortunately, they did lose their professional licenses because of the felony." (Personal communication, July 2021).

Engaged Clients

The open code for "engaged clients" refers to internal referrals (people wanting services) that were more engaged in services than the police referrals. Participants reported that clients from self-referrals were able to complete the tasks and were more eager to participate in the intervention services. Participant 7 reported: "I noticed that some internal referrals were more motivated to participate in services than non-internal referrals" (Personal communication, July 2021). Participant 2: added: "Most of the self-referred cases wanted the services and followed through with the services; as for the 911 calls, some did not follow through with the services" (Personal communication, July 2021).

Need of Resources

The open code for "need of resources" refers to the self-referrals that were in need of resources. Some clients called to receive shelter services, rent assistance, housing assistance, food, and other basic resources. Participants reported that most of the self-referrals were also requesting resources besides the intervention services. Participant 2 reported: "Self-referred cases were also struggling; some of them had issues with their rent or need its emotional support. For self-referred cases, they need more resources or assistance with rent, etc. I guess it was a combination between the DV and then they couldn't afford their rent and utilities, you know, people lose their jobs, and that was a whole situation on why they started struggling with rental assistance, employment, and mental

health. Most of the self-referred cases wanted the services and followed through with the services" (Personal communication, May 2021).

Responding to a Crisis

The open code of **"**responding to a crisis" is defined as the immediate response from the response team to police and dispatch calls due to a domestic violence crisis. Participant 7 reported: "the DVRT team goes out to the scene when a 911 call is placed to provide crisis intervention support. Participant 8 added: "The beauty of the response team is that you are there in the moment of the crisis, and you are offering a different level of support than law enforcement can." (Personal communication, July 2021).

Connecting to Services

The open code of "connecting to services" refers to the links and referrals that the DVRT team does with the clients when responding to a DV call. The support services provided were from case management service, legal aid, therapy, support groups, shelter and more. Participant 7 reported: "the DVRT team goes out to the scene when a 911 call is placed to provide crisis intervention, support, and resources to the victim. They do a safety plan with them and see how they are, and later on, the assigned advocates will follow up with that case" (Personal communication, July 2021).

First Responders' Barriers to Telehealth

The open code "first responders' barriers of telehealth" refers to the barriers that the first responders encountered when providing telehealth services.

The most common theme reported was the lack of engagement of the clients in services after the responders' call. Participant 8 reported:" It was very hard! It was not…. easy... You know... The beauty of the response team is that you are there in the moment of the crisis, and you are offering a different level of support than law enforcement can…. But, when it's over the phone, you know, there's a disconnect like you're not in person, feels a little bit cool, there were not many people connecting to the follow-up services, or answering the calls for the follow-up, or maybe their perpetrators were not arrested. Many things came up and presented challenges" (Personal communication, July 2021).

Participant 6 added: "We were not out in the field with the officers. It was challenging not to respond in person. Clients were not engaging because many people did not follow up with our calls or services." Another mentioned barrier was not completing as many CWS reports due to the lack of in-person services and the lack of disclosure of information from the victim to the response team member. Participant 6 reported:" We were not doing the CWS report because we weren't talking straight to the victim, we were putting that back on the officers, the officers were the ones that witnessed everything, they talk to the victims, so we made the officers do the CWS reports. So that change, we weren't filling as many CWS reports in our team" (Personal communication, July 2021).

Benefits of Telehealth Services for Officers

The open code "benefits of telehealth services for officers" refers to the benefits encountered by the police when contacting the client response team.

Some of the benefits registered include the easy process to contact the response team to assess the victim instead of waiting a long time for the response team to arrive at the scene. Participant 6 reported: "The officers seem to be more willing to call us (client response team) to provide us over the phone information versus waiting for us to be in person. It takes a lot longer for them to wait for an advocate to get to the field, out to the scene, so the officers really don't have to stay off the call rotation for as long when they're out there versus when they're calling it into us, so it takes a big chunk of their time, it takes about an hour and a half out of the officer's day when they call the DVRT team. So, suppose they can call us and spend 10 minutes on the phone giving us follow-up information versus an hour and a half when they can't go out and answer calls" (Personal communication, July 2021). Participate 6 also reported that the accessibility of telehealth services might contribute to having a high number of police calls because it was more convenient for the officers (Personal communication, July 2021).

Barriers to In-Person Services

The open code of "barriers of in-person services" referred to the barriers encountered by the response team when they transition to providing in-person services. Some of the common themes reported were that the response team was not able to enter the victims' home, lack of confidentiality, needed to complete a COVID-19 screening, were not able to transport the victims, were not able to access the hospital. Participant 6 reported: "We weren't allowed to go

inside the house, so confidentiality was challenging for us. It just feels weird to talk to somebody that just has been strangled out on their front lawn vs. being in the comfort and privacy of their home" (Personal communication, July 2021).

Participant 8 added: "And the one thing that remained difficult was that they were still not allowed to go into the home. So, they were having these very sensitive conversations with the victims outside. So, you can imagine, maybe the neighbors are, you know, being nosy, or it's cold, or, you know there's a lack of privacy being on the site, or in a busy apartment, lack of confidentiality." Some other barriers were the COVID-19 screening. Participant 8 reported: "Some other issues were that we needed to do a pre-screen for COVID-19, and if the families scored positive, then we could not respond in person; we responded by phone" (Personal communication, July 2021).

Another barrier was the lack of transportation. Participant 6 stated: "We were used to transporting quite a few clients to the bus station, airport, shelter, and hotel. But we couldn't transport anyone anywhere around; that was a big one because we were usually able to take people to hotels and to the shelter. So, that kind of threw us for a loop because a lot of people needed help; they needed those services.." She also commented on the restrictions to enter the hospitals to serve the victims. She said: "We were not going to be able to go into the trauma center into the hospitals. People had been severely injured and needed information on restraining orders, on shelters, on where to go when they got

released… They had high lethality situations, and we weren't able to talk with them" (Personal communication, July 2021).

Strategies of In-Person Services

The open code for "strategies of in-person services" refers to the mentioned strategies that the response team implemented during their transition to in-person services. The reported strategies were to pre-screen for COIVID-19 before responding to a call, wearing the PPE equipment, and asking the police officers to transport the victims to the locations. Participant 6 said: "So, we would ask dispatch (Police Department dispatch) if there were any COVID-19 symptoms in the home, and if there were, we were not responding in person…we would go to our car and call them to do the follow-up. We had to wear PPE equipment; we wore two face masks, gloves, face shields" (Personal communication, July 2021).

Benefits of Telehealth Services

The open code for "benefits of telehealth services" refers to the benefits of telehealth services for clients during COVID-19 lockdown and physical restriction orders. According to the case managers, the clients reported that telehealth services were convenient for them due to the lack of transportation, no need for childcare, and for being time convenient. Participant 7 said: "Many people work and can't make an appointment until after hours, and a lot of case managers work from 8 to 5:00pm. Honestly, the telehealth services helped the clients to have sessions during their lunch break, or go to their room, or go into

their car and have a session ..Some people live far; others don't have transportation. They only have a short window per day, and they can only do a quick call…" Participant 7 also added that another benefit for telehealth resulted in serving more people. She said: "More people were able to get services during the pandemic." Participated 6 agreed with this information by saying. "I think it helped our numbers… we were able to get more people enrolled into services and get our information to them" (Personal communication, July 2021).

Another reported benefit was no need to drive to the case managers' offices and police departments. Participate 6: "So, if you think about it, we're asking DV clients to come to the Police Department to do an intake, to do the paperwork to be able to get services. Some people may not like police, some may be undocumented, and may not trust being around a police department. Some people may not have the financial resources to be able to come here. So, I think clients responded very well to the option of telehealth and being able to do their intakes and a lot of their paperwork and stuff over the phone" (Personal communication, July 2021).

Barriers of Telehealth Services

The open code for "barriers of telehealth services" refers to the barriers encountered by the clients and service providers by the use of virtual services. The common themes reported by the case managers were learning and teaching the clients how to use the devices, the safety of the client, paperwork, not seeing the clients in person, and overworking. Participant 5 reported: "The first couple

of months, we needed to learn how to use GoToMeetings, then Zoom, telehealth, we could not see each other physically, but we had to meet with our clients, we had to do it over the phone or by Zoom, we need it to figure out, and everyone was like.. What? What? How? So, we didn't know what to do. Now, imagine how the victims were feeling with these changes" (Personal communication, May 2021).

Participants 7 reported…" All of them had questions. How do online services work? How does Zoom work? We explained the process, but they all had questions, especially at the beginning of the pandemic. Especially how does it happen? How does telehealth work? We explained that it happens by sending the Zoom link via safe email. And if they feel safe, then we send them the email" (Personal communication, July 2021). Not all the service providers reported the clients' lack of technical equipment as a big barrier. Participant 7 said: "I heard that some advocates experienced some barriers with their clients. Like if they don't have cell phones or any access to the internet. But I did not have that problem with my clients" (Personal communication, July 2021).

<u>Strategies Providing Telehealth Services</u>

The open code of "strategies providing telehealth services" refers to the case managers' strategies when providing telehealth services. The primary strategy reported by all the case mangers was assessing for safety and implementing safety plans during the initial session. Participant 2 commented the same and added about adding a safety code. "Safety, Safety first!! …. When we

50

begin the session, we discuss the safety plan…they tell me a code word that they'll be using when they are with the abuser " (Personal communication, July 2021). Participant 7, added the importance of following safety regulations even when initiating the first call. "When we screen a call, I say my name, and then I ask if "this is a safe time to talk." That is the first thing I say, and many people will say, "no, this is not a good time to talk" and I hang up and try to call them another time. So, I really ensure that the client is safe before I explain the details of why I am calling" (Personal communication, July 2021). Participant 8 also reported that the families that do not have the technological devices were provided with resources to obtain a device, and the victims' children were provided with computers to continue with their homeschooling (Personal communication, July 2021).

Court /Legal Aid system limitations

The open code for "court /legal aid system limitations" referred to the changes implemented at the court system and how these changes affected the services of provision to the clients. One effect was the no in-person courts and not detaining the abusers for an extended period. One of the limitations was the lack of in-person court support from the service providers to the victims. Participant 7 said: "There are people who need support and do not have anyone or any emotional support when going to a court day. They need that extra in-person support to hold their hand or be there with them; when you are there physically, they feel a little bit of comfort, and being there via telehealth is

51

not as comforting as being in person with them" (Personal communication, July 2021).

Another limitation reported was that the court system changed due to the impact of the pandemic, and prosecutors were not staying in jail for a long period of time which became a safety risk for the victims. Participant 6 said: "Court and jails were not keeping people locked up for a long period of time; they were not prosecuting out of custody cases so if the offender was released. They were not prosecuting the cases; they would just kind of continue them until whenever....So, you can imagine if they were letting people out early because of the pandemic and they were not in custody, and they were being released at higher rates, but they weren't prosecuting or moving forward with anybody that wasn't in custody, LOTS of DV perpetrators were out way earlier than normal, and could come right back out, matter than they went in because they got locked up. And then, like, the cycle would start again, they were out" (Personal communication, July 2021).

Court Strategies

The open code for "court strategies" refers to the strategies established by the advocates to assist their clients in gathering evidence that they were/are at risk of violence by the perpetrator. The number one strategy was to continue to report the abuse and on obtaining restricting orders. Another reported strategy by the case managers was the provision of cameras to the victims to record evidence of their abuse and present it to court.

Participant 6 said: "We're buying people ring cameras for their home so it could capture the perpetrator coming to the home because the judge was like .. mmmm, I don't see enough data, police officers wouldn't show up to the reports for whatever reason to take the report, or they would take it over the phone, and then not having both parties statements, so it wasn't as strong as a report, and the judge was like .. "I don't know… it's your word against theirs." So, we were getting people with ring cameras so that they had data and documentation to be able to take it to court and say "No, they were here, and on this video, they threatened to kill me" (Personal communication, July 2021).

Benefits of Providing Telehealth Services for Counseling Clients

The open code of "benefits of providing telehealth services for counseling clients" refers to the benefits of providing telehealth services to clients in therapy services during the COVID-19 lockdown and physical restriction orders. The therapist reported the same benefits of telehealth services as the case managers and added new benefits, such as the clients having a high level of comfort when having therapy sessions at home. Other benefits were access to the home environment and allowed the opportunity to observe the family dynamics and relationships, the benefits of Zoom to show clinical interventions and using telehealth to provide therapy services anywhere in the state.

Participant 1, a therapist, reported: "I was able to see their home environment, which when you are working with a DV client that is valuable because you can see and hear what is going around home. So, I can see how

53

she/they were interactive with their children, I can see if they were in a safe place, or their body language of when the perpetrator was at home. So, it helped me to understand other areas that I would not normally have an insight into if they were coming into the office" (Personal communication, July 2021).

Other benefits were the benefits of Zoom by sharing the screen to show clinical interventions. Participant 4, a therapist, said: "This is the same for clinical interventions; you can share the screen and review information with your clients.. like the power and control wheel. And other clinical resources, many people are visual, and seeing the clinical tools has been helpful for them" (Personal communication, July 2021).

The other benefit reported was the accessibility to join therapy for people who normally do not come to therapy. It can open the door for everyone to access therapy services from anywhere in the state. Participant 1 said: " I think telehealth opened the door for people who normally do not come to counseling due to accessibility….Some telehealth opportunities...it's opening it up. It's not for local clients, I mean, I can treat anyone in California, and we know there are many communities like eastern California that don't have many therapists. They don't have a ton of resources, and suddenly, we have this great ability to provide the services so that it could be really helpful" (Personal communication, July 2021).

Barriers of Telehealth

The open code for "barriers of telehealth" refers to the barriers encountered by the clients and therapist by the use of virtual services. The therapist reported the same barriers as the case managers but highlighted safety concerns, lack of confidentiality, not being able to see the clients in person, and some clients prefer in-person services. Participant 9, reported a combination of a safety concern with a lack of confidentiality. She reported: "Virtual sessions can bring safety concerns. For example, the lady that I mentioned earlier, her husband was home, and she was in her children's bedroom, and he was in the living room. And he at some point became very upset that she was not in the living room with him. He came to the room and was listening outside of her door. And he, like, threw open the door, and I, he was at some point he was listening outside of the door. When he opened the door, he addressed me personally, that he said that is not true what she just said it didn't happen that way" (Personal communication, July 2021).

Participant 3 reported the importance of seeing clients in person to observe them physically for any physical violence. She said: " I think just kind of the obvious barriers for me would be, not being able to see them physically in person. I can see a part of you but I can't see from here down. I think for me, having a domestic violence, a lot of these women are still with their perpetrators, so being able to be in person and being able to say hey like "where's that scratch from?" "hey I noticed like you're limping "or like, "Hey, I noticed you're feeling like

55

you're a little more standoffish today." Those are all things that are really hard to notice virtually" (Personal communication, July 2021).

Another important barrier mentioned was treating clients outside the state or country by accident, leading to ethical implications. Participant 1 said: "Asking if they are still in California and not another state or country when providing virtual sessions, because I accidentally was providing services to somebody who was in Mexico, and I did not know that, I noticed many similar situations with other counselors, but the clinical team needs to approve this due to ethical and safety reasons, there's a lot of rules about where we can and can't treat and a lot of my clients moved around a lot, to stay with family like they needed that support" (Personal communication, July 2021).

<u>Strategies of Telehealth</u>

The open code for "strategies of telehealth" refers to the strategies for telecommuting that the therapist used when providing services to the clients during the covid-19 physical distancing orders. The therapist reported strategies as case managers to of establish a safety plan at the initial session, including a code word, and asking to move to a private place to have the session. Participant 4 said: "We would come up with the code word during our safety plan, and after if the client was in danger or any safety concern, then she would use the code word. I mean it was not like pizza or a random word, but it was something that they could use, and it was not a suspicious word" (Personal communication, July 2021). Participant 9 also added: "I do ask if there's anybody else present, and if

there are other people present, I asked if they could meet in another room, or if we could maybe step outside if there's like a bench separated from everybody else that they can hear us talk" (Personal communication, July 2021).

<u>Barriers of Telehealth</u>

The open code for "barriers of telehealth" refers to the barriers encountered by the group counselors and clients when providing and receiving group sessions. Some of the common themes were lack of confidentiality due to be doing a group in public or at home with other family members; other common themes were not able to bond as a group because it's not in person services. Participant 3 the group facilitator said: "I think in almost every way, having virtual versus in person I think in person would be more beneficial; possibly they would be more engaged in the sessions.

The women tried really hard to be able to kind of bond. And I think it would have been a lot easier to do if we weren't virtual…..if we weren't in person, these women will be able to comfort each other" (Personal communication, May 2021).

<u>Strategies of Telehealth</u>

The open code for "strategies of telehealth" refers to the strategies used by the group counselors when providing group sessions. Some of the common themes were reviewing confidentiality, using headphones, having the camera on, reviewing safety plans, finding a confidential place to join the group session, and following up with participants if they were absent from the group. Participant 3 said: "We tried to talk a lot about confidentiality before we started; we talked

about the importance of being somewhere where you feel comfortable and safe to talk. And we always encouraged our clients to also use headphones. That was something that we really, really, really encouraged, especially because, since it was virtual and I mentioned that there's a lot of moms, there's a lot of kids around. And there's a lot of triggering stuff that's talked about in our group"(Personal communication, July 2021).

<u>Hybrid Services</u>

The open code for "hybrid services" refers to the services in person and via telehealth enforced by the shelter during the COVID-19 lockdown and physical restriction orders. Program Director, Participant 8**,** reported that "we had half of our staff working from home and half-staff working from the shelter" (Personal communication, May 2021). Staff members were not allowed to have in-person services even with the clients that were staying at the shelter and hotel. Participant 6 reported: "They would be knocking on the window, and the client will waive, or maybe they didn't hear, it wasn't like face to face, "everything ok, can we get your signature"- so it was more like they're gonna knock on the window and if they open they open if they don't''(Personal communication, July 2021).

<u>Barriers Encounter at The Shelter</u>

The open code for "barriers encountered at the Shelter" refers to the barriers that the staff members encounter while providing services to the clients during the COVID-19 lockdown orders and physical restriction orders. One of the

barriers was extending the time to stay for all clients at the Shelter, there was no limit of time, this limited the units available for other victims, they were no evictions due to the COVID-19 lockdown orders. The shelter has a total of 12 units. Participant 8 reported: "We begin by not giving any client an exit day…There was no limitation on their stay, typically it's 60 days into they need to find their next housing, and we support them with that process. But, yeah, we moved to have indefinite shelter for the clients; this was very hard because we have a high call volume and people were not moving out and freeing units, so we had a lot of people waiting for a place, and others staying for a long period of time" (Personal communication, July 2021).

Another limitation was having no in-person contact with the clients and leaving everything outside of the client's units. Participant 8 added: " We also had families at the shelter that came positive for COVID-19 and others families at the transitional housing that also had COVID-19, but we just leave everything that they need it at their door, and the rest of the services were virtual."
Another limitation reported was the misconception about how the shelter operated. Program Director, Participant 8 added: "There was just a lot of misconception from families coming into the shelter, like they thought that the shelters were closed. Many perpetrators kind of like used the pandemic to manipulate their victims and, like, encouraging them not to flee right, they were telling their victims that the shelters were closed, or they were using fear tactics of like well, you are going to be with all these people at the shelter and they were

telling them that "you're going to get COVID or things like that" (Personal communication, July 2021).

Strategies Implemented in The Shelter

The open code for "strategies implemented in the shelter" refers to the strategies implemented by the staff members to overcome the barriers of the physical distancing orders. One strategy was on providing hotels to members, even if clients were COVID-19 positives. Participant 8 reported: "We handle it by providing a lot of hoteling. That was a big challenge for the shelter! We were blessed to have a lot of CARE founding that came into the agency, so we were able to hotel a lot of families, but we also had to case manage a lot of families in the hotel that were not able to see to face" (Personal communication, July 2021).

Another strategy was to provide reassuring to the clients that the COVID-19 protocols were being followed. She also reported "we were providing every family with thermometers, and they need them to report their temperature to us every single day, and if any of the families had COVID-19 symptoms, we need it to let HR know. she also added: "client who came to the shelter without a phone, we provided them with smartphones to have the online sessions and court sessions" (Personal communication, July 2021).

Fear of COVID-19

The open code for "fear of COVID-19" refers to the fear encounter by the staff members when working at the shelter and hotel to provide services to the clients. Participant 8 reported: "We were one of the only programs from the

60

agency that was still alive during the pandemic; we were at a high alert for staying healthy; this can bring anxiety….My three staff at the site were doing everything! It was exhausting work! So, it was very challenging, and the fear of COVID was another concerning factor for staff and for the clients…She added: "There were two times where we have to swap because someone on the one from the team that was on site got COVID-19. And everyone on-site with that team needs it to be quarantined and working from home; the backup team needs it to come in. So, you need to be prepared. It was super scary the first time that it happened; we had 20 minutes to pack up our stuff and leave the office, and.. you know, is also keeping that person's health information confidential" (Personal communication, July 2021).

<u>Anxiety and Depression</u>

The open code for "anxiety and depression" refers to the mental health symptoms that the clients' reported during the COVID-19 lockdown orders. Services providers reported that all of their clients reported an increase of mental health issues. Participant 9 reported: " Yes, it was definitely a sudden increase in severity of a severity of depression. And it was exacerbated with some of my clients" (Personal communication, July 2021). Participant 6 collaborated the information reporting and increase on Suicidal Ideation" We have suicidal clients all the time, but they don't necessarily verbalize it, so, is usually when we assess the questions "Do you have any thoughts of hurting yourself? Then, they'll let us. But, this time, we notice an increase with. "I just can't do this anymore" "I don't'

want to be here anymore" "I want to die" (Personal communication, July 2021). Participant 1, reported "Some clients report high rates of anxiety, one of my clients were very anxious about getting COVID, and unfortunately, she contracted COVID. Her anxiety was definitely increasing as a result of the pandemic" (Personal communication, May 2021). Participant 7, added: "I think that the cases increased because of mental health. There are things that haven't been addressed and are not being addressed, like PTSD; there are many people who have PTSD. And people can't get out of their homes because of the pandemic restrictions" (Personal communication, May 2021).

Situational Stress

The open code for" Situational stress" refers to the mental health symptoms that the clients' reported during the COVID-19 lockdown orders. Service providers said that most of the clients reported situational stress related to the effects of the pandemic. Such stress for unable to pay the bills, rent, and for the adjusting to the effects of the pandemic. Participant 6 added: "Yes, they reported more depression, anxiety, PTSD. I mean, a lot of people with DV situations have a lot of anxiety, PTSD, but these symptoms were more situational than trauma-related; it was kind of compounded, like trauma and the situation. So, people feeling very stuck, people, feeling like they could not leave the relationship because there was nowhere for them to go" (Personal communication, July 2021).

Burnout

The open code for "burnout", refers to the burnout reported by the employees due to working during the pandemic restrictions. Most of the service providers reported burnout, they reported a lack of self-care due to be overworking. Participants reported having a high caseload and no breaks due to having extensive work, cases, meetings, and multiple sessions in one day. Participant 6 said: "I noticed burnout on the employees; well, I can also speak for me, like working from home, never leaving home, hearing all of this trauma in your home, not having the ability to leave and go, not having that downtime. I know I worked so much harder from home. I started working after I woke up, woke up at seven every time, and started working. I did not have that drive home that time to kind of decompress, release everything, like put it out of my mind reset for home life. It was like I worked clear up until six o'clock or more and didn't have that time for me. It was burnout; many case managers were experiencing fatigue and burnout. You could tell they were tired because it was like one day after another with no end" (Personal communication, July 2021).

Emotional Affected

The open code for "emotional affected", refers to the employees' emotional and mental health impact reported by the employees due to working during the pandemic restrictions. One staff member reported the impact of vicarious trauma due to be working in an intensive crisis. Four services providers reported being emotionally impacted due to being working from home with vulnerable populations during the pandemic restrictions. Participant 7 said: " We

63

work with vulnerable populations, we need to be very empathetic, but sometimes we heard traumatic events, and we .. feel fatigued, like "wow that was a lot." (Personal communication, July 2021).

Participant 3 said: "Yeah, I mean, it's hard. We know we need to create boundaries with our clients; we know we shouldn't be taking things home, but how can you not?, right, How can you not? I mean that there was an instance where I had a client who was on the phone with the police during the whole group because she was waiting for the police to come home to come, as you know, check her out because her husband had just hit her. You know, like how can I just shut that down after my group and not think about it?. And so yeah, I think I've definitely been triggered through some of that, and I've definitely had some countertransference for sure. And I think for as a therapist working with this population, I get emotionally affected" (Personal communication, July 2021). yes

 Benefits for Hybrid Services

The open code for "benefits of hybrid services", refers to the benefits of providing hybrid services (virtual and in-person services) to the clients. Participant 1 reported: "Like my clients are more open to other things virtually and others in person, like support groups and case management, all of those things that they feel like okay I can do that counseling online, I can do this in person, you know, and I feel that we empowered them by letting them navigate these systems as they want" (Personal communication, May 2021). Participant

6 said: "We saw our case management numbers rise because of our flexibility to be able to meet the client's needs. Possible continue with services via hybrid can be beneficial for the clients' needs now that we moved to in-person services gain" (Personal communication, May 2021). Participant 7 said: "I think that it depends on the client; I think that we need to be more flexible with the clients' needs. I feel that, now that we can meet them in person, we need to ask them about their preferences. I feel that not everyone would like to meet us in person; they would still like to meet us via telehealth. And that's perfectly fine. Some people live far; others don't have transportation. They only have availability for a short window per day, and they only can do a quick call" (Personal communication, May 2021). The program director also reported the exploration of other agencies to implement hybrid services. Participator 8 said: "One thing that other agencies' DV programs are asking to each other is "how are you moving forward" Are you having a hybrid program? Or are you fully in person? Because we have seen how helpful it can be for online services for some people with transportation barriers, childcare, or just comfort level to have virtual services. So, the quiet of few agencies that are reformatting the way that they are offering services and are offering hybrid services" (Personal communication, May 2021).

Choice of Services

The open code for "choice of services", refers to the choice that should be provided to the client to receive the services virtual and or in-person. Participant 1 reported the importance of giving the client a choice to decide what system

they want to use because it empowers them. She said: "I feel that we empowered them by letting them navigate these systems as they want" (Personal communication, May 2021).

<u>The Use of Telehealth</u>

The open code for "the use of telehealth", refers to the benefits of using telehealth and keep this method to provide services to clients. Participant 1 reported the opportunity to provide therapy services to clients anywhere in California and the opportunity to expand the services to any place in the country. Participant 1 reported: "I would like to retain some telehealth opportunities because it's opening it up. It's not for local clients, I mean, I can treat anyone in California, and we know there are many communities like eastern California that don't have many therapists. They don't have a ton of resources, and suddenly, we have this great ability to provide the services so that it could be really helpful. I think that's kind of my main message" (Personal communication, May 2021).

<u>Flexibility</u>

The open code for "flexibility" refers to the adaptation and flexibility that the staff members and program had during the provision of services and highlights the importance of being open to any possible changes to better meet the clients' needs. Participant 6, the program coordinator, said: "One good thing that came from the pandemic was our ability to be more flexible regarding paperwork, intakes, and meeting clients. I think having the flexibility to do it the

right way. When we identify that there's a true need, I think some people will take advantage of it, but really kind of flexibility to do it." She also said: "Be flexible, try to meet the client's needs, do what you can to meet their needs so that they stay engaged, your staff stays motivated. So being open, not doing something the same way, consistently, just because that's how it's always been done. Being flexible and able to pivot with the times, not just in a pandemic but technology age, we have a much different way of communicating now, so evolving with time, evolving with current world affairs, and just being able to evolve with the current climate so that you can meet your client's needs and stay effective."

Participant 7 added: "the lessons learned are that "We can do it." We have the capability to be flexible and adapt; we were able to do telehealth, we were able to serve more families in need, we have adapted to their needs. I think that the lessons learned are that we need to continue having that flexibility. Each case is different; we also need to see the complexity of things that are not black and white. We need to service clients in a more diverse way, where people can receive services, "what if a client does not have the time to drive and see me, but what if I can see her in her lunch break by having a telehealth session, and we save some one's life" (Personal communication, May 2021).

Axial Coding

The second stage in the qualitative analysis consists of identifying axial coding (Morris, 2006). Axial codes are the major categories that emerge from the

relationship between themes and concepts of the data (Morris, 2006). The analysis consisted of connecting the data's open codes, which were the main themes and concepts. The data analysis revealed fourteen axial codes, which were the main categories of the thirty-four open codes.

The axial codes were categorized into the various stages and continuum of domestic violence services that emerged from the data. The axial codes were: DV cases, self-referrals, first responders' team, first responders via phone services, first responders in-person services, case management services, legal aid, therapy Services, group services, shelter services, clients' mental health, employees' mental health, adaptation, and the need of hybrid Services.

DV Cases

The axial code of "DV Cases" represented the overview of domestic violence cases that received services during the COVID-19 lockdown and physical restriction orders. The open codes for DV cases consisted of "calls," "cases, "type of abuse," "reasons for DV during COVID-19," and "DV population served."

Self-Referral

The axial code of "self-referral" refers to the referrals that came to the agency due to clients calling themselves for services or from clients that were already participating in the agency for other programs but were also requesting domestic violence services due to a current incident or a history of domestic

violence. The open codes for self-referrals were: "Engaged clients" and "Need of resources.

First Responders' Team

The axial code "first responders' team" was defined as one of the groups into the various stages of services that emerged from the data. The first responders' team responded to police calls and dispatch calls whenever 911 domestic violence calls were generated. This team plays an essential stage in the various stages of services because it makes the initial contact with the police referrals and assists in linking the clients to services and providing crisis intervention services. The open codes for the response team were: "responding to a crisis" and "connecting clients to services."

First Responders' Telehealth Services

The axial code of "first responders telehealth services" was defined as one of the methods used by the first responders team to provide services during the COVID-19 lockdown orders and physical restriction orders. Telehealth is defined as the use of telecommunication technologies such as phones, computers, emails, tables, texts to communicate with service providers (Investopedia,2021). For first responders,' telehealth consisted of responding to police calls by phone; no in-person contact was established between the service provider and clients. First responders provided telehealth services until August 2020. The open codes from this category were "first responders' barriers to telehealth" and "benefits of telehealth for officers."

First Responders In-Person Services

The axial code of "first responders in-person services" referred to the transition of the first responders to respond to the calls in person again. The transition to in-person services occurred after August 2020. The open codes for first responders and in-person services were **"**barriers of in-person services" and "strategies of in-person services."

Case management services

The axial code of "case management services" was defined as another stage of services that emerged from the data. Case management services referred to the services that the advocates provided to the DV victims during the COVID-19 lockdown and physical restriction orders. Some of the services consisted of assessments, planning, care coordination, legal aid, advocacy, and linkages that meet the clients' needs. Case management services were provided solely via telehealth. The telehealth methods used by the service providers consisted of phone calls, Zoom sessions, texts, virtual court sessions, and email communication. The identified open codes for case management services were "benefits of telehealth services," "barriers of telehealth services" and "strategies providing telehealth services."

Legal Aid

The axial code for **"**legal aid" was defined as another of the various stages of services that emerged from the data. Legal Aid is part of one of the case managers' services; it consists of assisting the clients in filling out restriction orders, linking them to legal aid assistance and court accompaniment. The open codes for this axial code consisted of "Court /Legal Aid system limitations" and "Court Strategies."

Therapy Services

The axial code "therapy services" was defined as one of the groups into the various stages of services that emerged from the data. Therapy services were defined as the counseling services provided to the domestic violence victims during the COVID-19 lockdown and physical restriction orders. Therapy services were provided solely via telehealth. The telecommute methods used by the service providers consisted of phone calls, Zoom sessions, texts, and email communication. The identified open codes for case management services were "Benefits of providing telehealth services for counseling clients," "Barriers of telehealth," and strategies of telehealth."

Group Services

The axial code "Group services" was defined as one of the groups into the various stages of services that emerged from the data. Group services were defined as group counseling services provided to domestic violence victims during the lockdown and physical restriction orders. Group services were provided solely via telehealth. The telecommute methods used by the service

providers consisted of Zoom sessions and emailing the zoom link. The identified open codes for case management services were "Barriers of telehealth" and "strategies of telehealth."

<u>Shelter / Hotel</u>

The axial code of "shelter / hotel" was defined as one of the groups into the various stages of services that emerged from the data. Shelter / hotel was defined as the shelter or temporal hoteling provided to the clients to the domestic violence victims during the COVID-19 lockdown orders and physical restriction orders. Even clients that tested positive for COVID-19 were placed at the shelter or hotel. The services were provided via hybrid services and via telehealth). The identified open codes for case management services were" "hybrid services," "strategies implemented in the shelter," "barriers encounter at the Shelter" and, "fear of COVID-19."

<u>Clients' Mental Health</u>

The axial code of "Clients' Mental Health" refers to the mental health symptoms that the clients reported to their service providers when receiving services during the COVID-19. The open codes were "Anxiety / Depression" and "Situational stress."

<u>Employees' Mental Health</u>

The axial code of "Employees' Mental Health" refers to the mental health symptoms that the employees reported due to the provision of services during

the COVID-19 lockdown orders. The open codes were "Burnout" and "Emotional affected."

<u>The Need for Hybrid services</u>

The axial code of "the need for hybrid services" refers to the suggestion reported by the services providers to provide services to the DV victims. The open codes were "benefits of hybrid services" and "choice of services."

<u>Adaptation</u>

The axial code of "adaptation" refers to the adaptation of the new methods used when providing services and the lessons learned from these adaptations and changes. The open codes were "the use of telehealth," "flexibility."

Selective Codes

The data analyses revealed six selective codes. These codes were the main categories of the axial codes and led the theoretical framework of this study. The selective codes were: "DV referrals," "initial contact," "telecommuting DV services," "hybrid DV services," mental health," and "lessons learned."

<u>DV Referrals</u>

The selective coding of "DV referral" is the core category of the axial codes of "DV cases" and "self-referrals." After the analysis of the data, this code revealed that domestic violence referrals increased and were complex and diverse. The data also revealed that self-referred clients were more engaged in services than the police referrals.

The data revealed that the domestic violence referrals increased and included unusual populations such as males, younger women, elderly people, professionals, and military males and most of the overall cases had a severity in physical violence. The data revealed that the violence was complex but was related to the COVID-19 lockdown orders and physical distancing restrictions. The reported factors were situations such as financial problems, no place to go, losing jobs, inability to leave home, unhealthy relationships, lack of privacy, lack of child care, and homeschooling. The data also revealed that self-referred referrals (clients asking for services) were in need of basic resources and were more engaged to participate in services than police referrals (DV Cases).

Initial Contact

The selective coding of "Initial contact" is the core category of the axial codes of "first responders' team," "first responders telehealth services," and "first responders in-person services." This selective code is the core category for "first responders' team," which is one of the various stages of services that emerged from the data. The data analysis found that the first responders' team, which receives the initial contact from the police, encountered the barrier of lack of engagement with the clients' when responding to the first call via telehealth; the data reported that some clients did not engage in services after the initial contact. The data also reported that police officers found it beneficial to have first responders' team assessing the victims via phone instead of waiting a long time for the team to arrive at the scene because it was a faster process for the

officers. The data also found barriers when the first responders responded to the

initial call-in person; some barriers were lack of privacy, lack of confidentiality, no

access to the hospitals, no transportation, and not responding if the clients

screened positive for COVID-19. The data revealed that some strategies

implemented by the first responders consisted of completing a pre-screen for

COIVID-19 to the clients before responding to a call, wearing the PPE

equipment, and asking the police officers to transport the victims to the

locations.

Telecommuting DV Services

The selective coding of "telecommuting DV services" is the core category

of the axial codes of "case management services," "legal aid," "therapy services,"

and "group services." These axial codes are part of the various stages of

services that emerged from the data.

Telecommuting DV services refer to the stages of services that only use

telehealth services to provide services to the clients. The data analysis revealed

that case managers and therapists reported benefits for the provision of services

via telehealth. The reported benefits were no need for childcare, accessible, time

convenient, no need for transportation. The therapist also reported a high level of

comfort for the client, access to the home environment, observation of family

dynamics and relationships, Zoom allowed to show clinical interventions, and

using telehealth allows therapy services to be provided anywhere in the state.

The barriers reported for the use of telehealth services were learning and teaching the clients how to use the devices, the safety of the client, paperwork limitations, not seeing the clients in person, and overworking. Therapists highlighted safety concerns and a lack of confidentiality. The data analysis reported that the mentioned strategies were establishing a safety plan at the initial session, including a code word, and asking to move to a private place to have the sessions. The group facilitators also included reviewing confidentiality, using headphones, having the camera on, reviewing safety plans, finding a confidential place to join the group session, and following up with participants if they were absent from the group. The data also revealed that the provision of cameras to the victims to record evidence of their abuse and present it to court was another strategy to assist the clients in gathering evidence for their court hearing.

Hybrid DV Services

The selective coding of "hybrid DV services" is the core category of the axial code of "Shelter and Hoteling Services." This axial code is part of one of the various stages of services that emerged from the data. The data revealed that this stage of services provided hybrid services to the clients that stayed at the shelter and hotel. Families stayed at the hotel in person, but the staff members could not see the clients in person. The data revealed that half of the service providers worked from home providing telehealth services to the shelter and hotels clients and the other half of the staff members worked at the site.

The data revealed that the service providers experienced the barriers of not interacting in person with the clients, and they left food or things outside their door and knocked on their windows to check on them. Another reported barrier from the shelter was being overbooked and not having an exit day for the families to leave the shelter. The data also revealed that the strategies reported were the use of hoteling to place clients due to the no units available at the shelter and also placed clients that were positive of COVID-19. The data also revealed that other strategies were to complete daily COVID-19 screens and provide families with thermometers, and they needed them to report their temperature. Additional strategies consisted of providing the families that did not have electronic devices with smartphones to have the online sessions with their service providers and access their court sessions.

<u>Mental Health</u>

The selective coding of "Mental Health" is the core category of the axial codes of "clients' mental health" and "employees' mental health." The data found an increase in the clients' and employees' mental health symptoms due to the impact of the COVID-19 lockdown restrictions and physical distancing orders. The data revealed that clients displayed depression, including suicidal ideation (SI) and an increase in anxiety. The data also revealed that the clients' displayed situational stress related to the impact of COVID-19, stress for not being able to pay the bills, rent, and for adjusting to the effects of the pandemic. The data also revealed an increase in mental health symptoms among the employees. The

77

data reported that the service providers reported an increase in burnout due to the lack of self-care and for being overworking. The data also found being emotionally affected due to the exposure to intense cases.

<u>Lessons learned</u>

The selective coding of "lessons learned" is the core category of the axial codes of "the need for hybrid services" and "adaptation." The data revealed that the lessons learned reported from the service providers is implementing hybrid services (virtual and in-person services) to serve the clients because it meets the clients' needs. The data also indicated that providing the clients the option of how they want to receive the services (virtual/in-person) empowers them. The data also reported that the adaptation and flexibility that the staff members had during the pandemic helped them to adapt to the new program changes and help with the provision of services. Another important lesson learned reported to maintain telehealth services for the provision of therapy services to allow clients to access services at any location and expand therapy services to any location in the State and Country.

<center>Summary</center>

The present study analyzed the data using a "bottom-up" approach, and open, axial, and selective codes emerged, helping to develop a theory. The study's theoretical framework reported that the different stages of services were impacted differently in the provision of services to domestic violence victims when delivering services during the COVID-19 lockdown orders and physical

<center>78</center>

distancing orders. Each stage of services reported their own barriers, benefits, and strategies when they were using their designed method of provision of services (in-person, telehealth, or hybrid). Clients and service providers reported an increase in mental health symptoms as an impact of the pandemic. The reported lesson learned is the implementation of hybrid services (in person and telehealth) to meet the clients' needs and empower them.

CHAPTER FIVE

DISCUSSION

Introduction

The following chapter discussed the study's major findings and the limitations of the study. This section also discusses the recommendations for social work research and practice at the micro and macro level. Then, this section discusses the termination section of the study and the dissemination plan of the study.

Discussion

The present study aimed to understand the lessons learned about service delivery to victims of domestic violence during the COVID-19 mandatory physical distancing and stay-home orders. This study aimed to identify the barriers experienced by service providers who delivered services to domestic violence victims and aimed to understand the barriers experienced by domestic violence victims when receiving services under mandatory physical distancing orders, as described by the service providers and based on their perceptions and opinions.

The present study's data revealed important and complex information about service delivery to victims of domestic violence during the COVID-19 lockdown orders. The data showed an increase in calls and referrals from the

police department and an increase in self-referrals seeking assistance. This finding supports the Boserup et al. (2020) study reporting an increase of U.S police calls and reports after the mandatory physical orders began. This increase of referrals and calls also supports the information provided by the National Violence Hot Line and the World Health Organization (WHO), which reported an increase in domestic violence cases in the United States as part of the impact of the pandemic.

The data also found an increase in domestic violence cases in males, younger women, elderly people, professionals, and military males. The reason for abuse was complex but was related to the impact of COVID-19. These reasons reported were: financial problems, no place to go, losing jobs, inability to leave home, unhealthy relationships, lack of privacy, lack of child care, and homeschooling. The reason for not having a place to go and the inability to leave their home due to their abuser were common reasons and supported the study of Kofman and Garfin (2020), indicating that they were the common reasons for the increase of domestic violence during the pandemic. The data also revealed different stages of services when delivering services to domestic violence victims at the interviewed agency. These stages were: first responders, case management services, legal aid services, therapy services, group services, and shelter/housing services (Please refer to Figure 1).

The present study's theoretical framework suggested that the different stages of services had different impacts on the provision of services to domestic

violence victims during the COVID-19 lockdown orders and physical distancing orders. The service providers of each stage of services reported their own barriers, benefits, and strategies when they were using their designed method of provision of services (in-person, telehealth, or hybrid).

The data found that first responders encounter the barrier of lack of engagement with clients when delivering services via telehealth, affecting the continuation of services of the clients. First responders' also encounter barriers when delivering services in person, but using the strategies of assessing a pre-screening for COVID-19 to the clients before responding to a call, wearing the PPE equipment, and asking the police officers to transport the victims to the locations. These strategies can be used as guidance for first responders or other service responders whenever they need to respond in person, and there is the limitation of physical distancing orders.

The study also revealed different barriers experienced by the case managers, therapists, and group facilitators when providing services via telehealth. Some barriers were teaching the clients how to use the devices; clients experienced safety situations, paperwork limitations, not seeing the clients in person, lack of confidentiality, and overworking. The strategies implemented by the service providers were establishing a safety plan at the initial session, including a code word, reviewing confidentiality, using headphones, having the camera on, reviewing safety plans, finding a confidential place to join the sessions, and following up with participants if they were absent to services. The

strategies implemented by these service providers can be observed as lessons learned from the provision of services and can be suggestions to be followed by other service providers whenever they need to implement telecommuting services.

The data also found that service providers and families preferred telehealth services over in-person due to being time convenient, accessible, no need for transportation, and no need for childcare. Telehealth also can open the door for everyone to access therapy services from anywhere in the state. The benefit of telehealth services supports the findings of Tarzia (2018), which indicated the benefits of providing online services to domestic violence victims, but Tarzia's findings were limited to the interaction between victims and doctors (Tarzia, 2018). The present study found new data that reports the benefits of telehealth services for clients and service providers.

The study also found that the agency's shelter and hoteling services encounter their own barriers and strategies when using hybrid services. The data reported that staff members could not see the clients in person, and half of the service providers worked from home providing telehealth services to the shelter and hotel clients, and the other half of the staff members worked at the site. Some barriers were that the shelters were overbooked because they did not have an exit day for the families to leave the shelter due to the impact of the pandemic.

Some implemented strategies were using hotels to place new families until a shelter unit had an opening. Hoteling was also used to place families that were COVID-19 positive. Additional strategies consisted of providing the families that did not have electronic devices with smartphones to have the online sessions with their service providers and access their court sessions. The strategies implemented at this agency's shelter can be seen as guidance and can be used as protocols whenever is required due to a mandatory physical distancing order.

The study found an increase in mental health symptoms from the domestic violence victims and service providers while receiving and providing services during the pandemic. These findings support Sediri, et al., (2020) in their study reporting an increase of mental health symptoms on domestic violence victims. The present study found an increase in anxiety, depression, and situational stress among the victims. The present study also found new data reporting the increase of mental health symptoms for service providers due to the impact of the pandemic. The symptoms reported were burnout and being emotionally affected due to the DV cases. New studies are needed to understand the effects of the pandemic on the clients' and service providers' mental health.

Other lessons learned from the present study were the benefits of using hybrid services when serving the domestic violence victims because it meets the clients' needs. Data reported that hybrid services allow the clients to obtain the same benefits of telehealth and provides the clients the option on how they want

to receive the services (virtual or in-person), these decisions can help empower the clients. This type of empowerment can be very useful, especially when working with DV victims.

Limitations of the study.

Although the present study gathered significant data that is valuable for the social work practice, the study encountered several limitations. One of the limitations of the study was not obtaining a diverse sample and large sample. The sample was a convenience sample and was not representative of all service providers working with domestic violence victims. Many service providers refused to participate in the present study, and the sample consisted of nine service providers. All the participants were female service providers and did not contain a diverse sample of gender and ethnicity. Another limitation was that the results from the present study were based on the experiences of the service providers working in the same agency. Additionally, the present study only interviewed the service providers, and no domestic violence victims, which meant this study did not include domestic violence victims' actual experiences.

Recommendations

Based on the research findings, the following section provides recommendations for social work research and provides guidance for better practices at the micro and macro levels.

One of the recommendations for social work research is to replicate the present study using a larger sample of service providers and domestic violence victims to obtain a more accurate response to the problem. This would allow the development of better practices and evidenced-based material that can be used as strategies or protocols for delivering services to domestic violence victims and vulnerable and at-risk families during mandatory physical distancing orders. Another recommendation is to conduct more research that focuses on the impact of telehealth services and hybrid services through domestic violence victims' perceptions.

Additional recommendations suggests studying the effect of the COVID-19 lockdown orders on mental health, focusing on the mental health of the clients and employees. The present study found increased mental health symptoms from clients and employees, but the study did not find considerable information about this situation. Exploring the mental health effects of the clients and employees is valuable for the social work practice.

To improve social workers' effectiveness in providing services to domestic violence victims during physical restriction orders on a micro level, service providers must assess for safety and conduct safety planning at the initial contact. The limitation to seeing the clients in-person may increase the safety risk as discussed in this study, but assessing for safety and conducting safety planning with the victim and having first responders attend to the initial call may reduce the safety risks.

At the micro level is also important to assess the comfort level of using telehealth services and provide the option of having hybrid services to empower the client about their decisions. At a micro level it's also important that service providers provide the clients with the required devices to access services such as phones, tables, computers and internet services. This will alleviate the problem of not having access to technology.

At a macro level, the recommendations are to implement policies similar to the CARES act funding, where the main focus was on helping people with economic relief during the pandemic (CDE, 2021). This study found that the Shelter utilized the CARES funding to providing hoteling for DV victims who needed housing assistance. At a macro level it is important to implement policies that solely assist the domestic violence victims financially because it can help victims gain financial independence and it can provide a solution for the housing crisis that many domestic violence victims encounter when they leave their abuser.

Termination of the Study

After the individual interviews were completed, the researcher answered questions that the participants had about the present study. The participants were thanked for their time and participation in the study. Participants were also notified that they would have access to the research project after May 2022. The researcher provided information on how to access the project through the

CSUSB Pfau Library Database. The participants were also notified that their

voice recorder interviews and transcribed interviews would be deleted after the

completion of the study. This stage of termination includes reporting the findings

of this study and includes the reflection of each stage of the study, and

celebrating the completion of the project (Morris, 2006).


Dissemination Plan

In order to disseminate the results of the present study, the researcher will

share with the agency's participants, via email, the steps to access the CSUSB

Pfau Library Scholar Works database to access the results. Additionally, the

researcher will present a poster containing the study's research findings at the

California State University, San Bernardino, annual social work research

symposium.

Summary

The current chapter focused on disclosing the research findings and

reported the limitations of the present study. Due to the limited literature on the

impacts of service delivery to domestic violence victims when undergoing

physical distancing orders, the findings of the current study is critical for the

social work practice; the findings of this study can be utilized to enhance

preparedness and adopt new strategies and protocols when providing mandatory

physical distancing services. This chapter also discussed future social work

research recommendations and provided recommendations at a micro and

macro level. This chapter also discussed the termination process of the study

and the dissertation plan.

Figure 1. Stages of Services
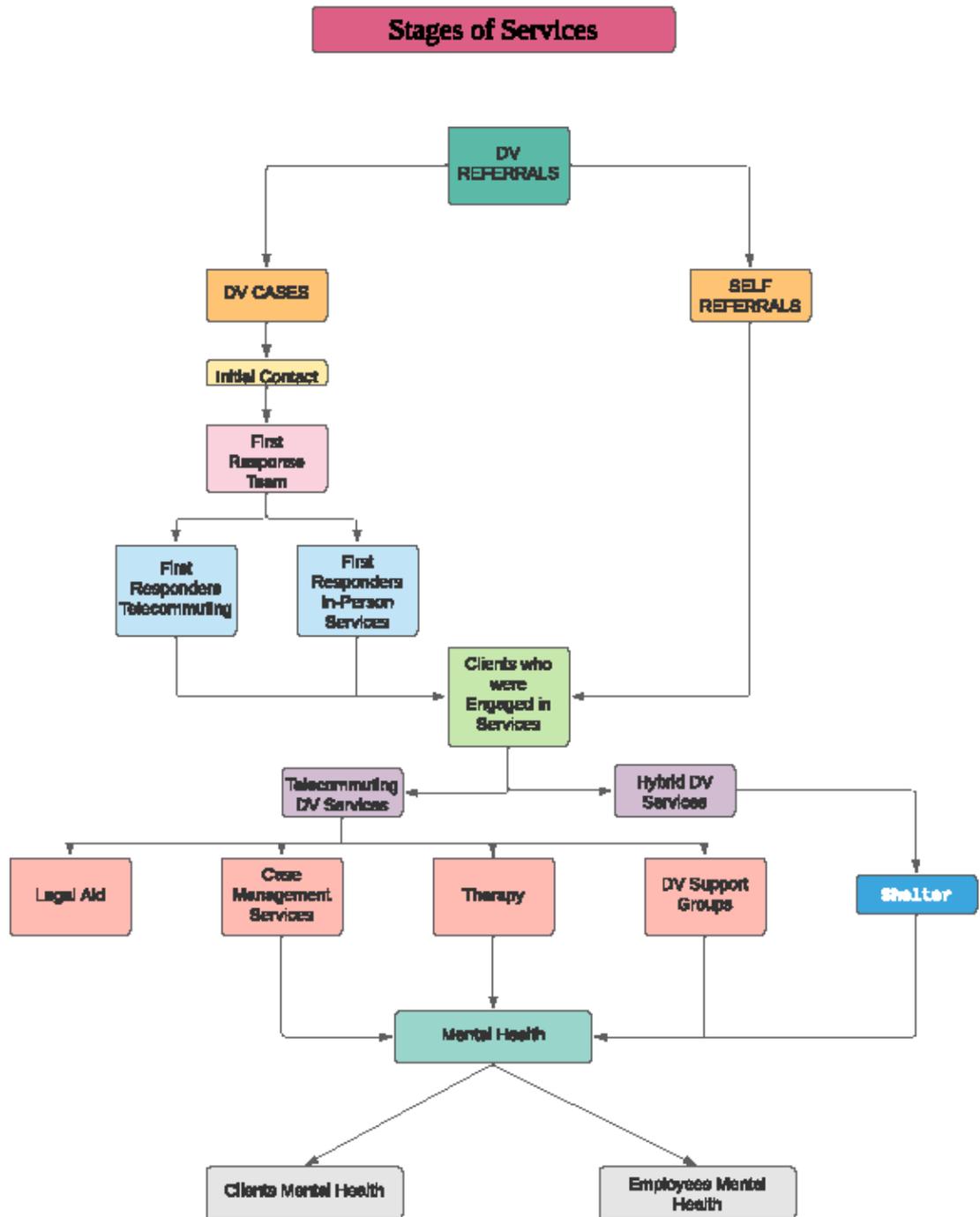
APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

February 9, 2021

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2021-128

Teresa Morris Veronica Perez
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Teresa Morris Veronica Perez:

Your application to use human subjects, titled "Lessons learned about service delivery to victims of domestic violence during mandatory physical distancing." has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at https://www.csusb.edu/academic-research.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-128 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
CSUSB Institutional Review Board

ND/MG

APPENDIX B

INFORMED CONSENT

School of Social Work

INFORMED CONSENT

The study that you are invited to participate in is designed to examine the impact of delivering services to domestic violence victims while experiencing mandatory physical distancing restrictions. The study is being conducted by Veronica Perez, a graduate student, under the supervision of Dr. Teresa Morris, Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to examine the impact of social workers and service providers on delivering services to domestic violence victims while experiencing mandatory physical distancing restrictions.

DESCRIPTION: If you decide to participate, you will be asked to participate in one interview. You will be asked several questions about the impact of service delivery to domestic violence victims while undergoing physical distancing restrictions. With your permission, I will tape-record the interviews so I can give my full attention to our interview. You will not be asked to state your name on the recording. The recording will be destroyed as soon as it has been transcribed.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without consequences.

CONFIDENTIALITY: Your responses to interview questions will be confidential. At no time will your actual identity be revealed. Your information and interview answers will be maintained confidentially, and no information will be provided to the agency. Your answers will be assigned a numerical code. The recording will be destroyed as soon as it has been transcribed. The transcribed data will be saved on Google Drive through my CSUSB school account. This will ensure that the data is protected from any data theft or accidental erasure. The data will be destroyed three years after the project ends.

DURATION: The interview will take approximately 30 minutes.

RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You are not required to answer and can skip questions or end your participation. Your information and interview answers will be maintained confidentiality, and no information will be provided to the agency.

BENEFITS: There will not be any direct benefits to the participants. The study's findings would benefit to the work environment.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Teresa Morris, at CSUSB Informed Consent.docx tmorris@csusb.edu.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after July 2022.

I agree to have this interview be audio recorded: _____ YES _____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

_____ _____

Place an X mark here Date

APPENDIX C

INTERVIEW QUESTIONS

DEVELOPED BY VERONICA PEREZ

Short Demographic Questions

1. What is your age?

2. What is your gender?

3. What is your ethnicity?

4. What is your job title?

5. Length of time in that role?

6. For how long have you been working with domestic violence victims?

Interview Questions

1. Varied news sources suggest there has been an increase in domestic violence (DV) cases since the pandemic. What has that been your experience? Explain.

2. Why do you think cases have increased or decreased (based on your experience since the pandemic/mandatory physical distancing restrictions)?

3. Since the mandatory physical orders began, is there any group that has been the most affected (in terms of ethnicity, age, income level, and other factors)? Why do you think this is happening?

4. What methods are you using to provide services to your clients (Telehealth, in-person, hybrid)? How often do you see your clients (daily, weekly, monthly)? Are these methods working? Do you feel comfortable with these methods? Explain.

5. Discuss how working with domestic violence victims during the mandatory physical distancing orders has been. What have you observed?

6. How are your clients dealing with the new physical restriction orders?

7. Have your clients reported an increase or decrease in their stress or anxiety levels, or have they experienced other mental health issues? If so, how are they managing them?

8. How do you think the current physical restriction orders resulting from the pandemic have impacted your clients' emotional well-being?

9. What obstacles have you encountered since the pandemic began (i.e., your agency, yourself, your clients, the government)?

10. Have you been able to work around these issues? What solutions have you used?

11. What barriers do you suggest to better service the domestic violence clients during the mandatory physical distancing of the pandemic?

12. As a service provider, how do you think the current physical restriction orders resulting from the pandemic have impacted your emotional well-being? If so, what have you done about this?

13. Have you experienced any vicarious trauma or compassion fatigue in the work you do due to the new employment adaptations as part of the mandatory physical orders?

14. How do you feel about the transition from providing in-person services to the current alternative that you have in your position?

15. Imagine a scenario in which you had unlimited funding; what would you do to improve domestic violence services during a mandatory physical distancing order?

16. What lessons have you learned as a service provider on providing domestic violence clients services under mandatory physical distancing orders?

17. Is there anything else you want to tell us about how services have changed after the pandemic?

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