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Jocelyn J. Pawcio Date

"And then the person sort of just drops off the radar...": Barriers in the Transition from Hospital to Community-Based Care among survivors of Intimate Partner Violence in metro Atlanta

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B.S., Community and Public Health, Ithaca College, 2021

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An abstract of

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Abstract

"And then the person sort of just drops off the radar...": Barriers in the Transition from Hospital to Community-Based Care among survivors of Intimate Partner Violence in metro Atlanta

By: Jocelyn J. Pawcio

Introduction: Despite the availability of many resources and services to assist survivors of IPV, there remain significant obstacles to accessing IPV resources. When survivors are admitted or choose to seek help at a hospital, IPV can be difficult to identify and, in many cases, not reported. Without a transition program that helps survivors to community care, it is up to survivors to seek care. This study explores the barriers for survivors of intimate partner violence as they transition from hospitals to community-based care in metro Atlanta.

Methods: The purpose of this study was to characterize the perceptions of IPV survivors' needs when transitioning from hospital to community-based care among a sample of staff working in community-based organizations. We used a mixed-methods study design to conduct a cross-sectional examination of the perceptions and experiences of staff working at an organization serving IPV survivors in Metropolitan Atlanta, Georgia, before and during the COVID-19 pandemic; we were specifically interested in the transition from hospital to community-based care and interactions between IPV survivors and the organizations serving them.

Results: Five inductive themes emerged from the data: (1) CBOs are challenged in meeting survivor needs in part due to financial strain with subthemes related to transportation, housing, survivor financial situations, and CBO funding; (2) CBO staff observed changes in IPV frequency, severity, and typology during the pandemic; (3) CBOs face logistical barriers supporting survivors transitioning from hospitals to CBOs inhibiting timely holistic care with a subtheme of care-seeking; (4) CBOs want to avoid survivor retraumatization and create more coordinated care for survivors; and (5) CBO staff believe that informal community and social support is important for IPV prevention and response.

Conclusions: This study provides a deeper understanding of the CBO perspective on the trajectory of IPV survivors as they transition from hospitals to CBOs. In addition, it gives insight into the gaps in providing holistic care for IPV survivors.

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List of Acronyms

CBO	Community-based Organization
IPV	Intimate Partner Violence
DV	Domestic Violence
GBV	Gender-Based Violence
IDI	In-Depth Interview
SV	Sexual Violence
WHO	World Health Organization
CDC	United States Centers for Disease Control and Prevention
COVID-19	Coronavirus disease
FJC	Family Justice Center

Chapter 1: Introduction

Introduction and Rationale

Intimate Partner Violence (IPV) describes violent and coercive behavior, such as physical, sexual, or psychological abuse, perpetrated by one person against another in a close relationship (WHO, 2012). IPV is a significant public health issue affecting individuals, families, and communities worldwide. Data from the CDC show that about one in four women have experienced IPV during their lifetime (CDC, 2021). During the COVID-19 pandemic, many US states indicated an increase in IPV/DV cases, and Georgia had a 49% increase in family violence-related fatalities from 2020 to 2021 (Georgia Family Violence Fatality Review Project, 2022). The Atlanta Police Department also reported that in 2021, over 46,000 family violence incidents were accounted for, and children were involved in almost 21% of the incidents (Atlanta Police Department, 2021). In another study, researchers in Atlanta noticed an uptick in IPV calls and cases due to COVID-19 (Evans, Hawk, and Ripkey, 2021). This increase was primarily attributed to shelter-in-place orders, social distancing measures such as isolation or quarantine, and the stresses caused by the pandemic, where survivors could not escape their situation – even for work. Furthermore, IPV has economic implications for many IPV survivors, their families, and the community. Survivors of intimate partner violence spend over $100,000 in their lifetime between medical costs and lost productivity (Peterson et al., 2018). According to a study looking at 43 million US adults with IPV history, the cost to society from this abuse exceeded $3.6 trillion annually in 2014 USD (Peterson et al., 2018). This multifaceted public health crisis can take many forms, impact survivors in various ways, and often have fatal outcomes.

Many resources in the community could potentially help survivors during a crisis; however, many are often underutilized. Several studies support the need for IPV-related community-based services for short and long-term benefits. A meta-analysis found that with an increase in community-based interventions resulted in a decrease of IPV among survivors (Mittal et al., 2023). A randomized control study found that survivor-focused outreach can decrease the severity of PTSD, depression, and fear one year after the abuse compared to IPV survivors who did not receive the services (DePrince et al., 2012). Survivors who also were connected with social support were more likely to leave an abusive relationship (DePrince et al., 2012). Having social support in the community is shown to have positive implications for survivors. Even with several studies noting the benefits of IPV survivor connection to CBO services, there lacks a connection program that links survivors from a hospital to a CBO, such as a warm handoff. Therefore, this study is aimed to characterize the experiences and perceptions of IPV survivors' needs among a sample of staff working at community-based organizations in Atlanta, Georgia.

Problem Statement

On average, nearly 20 people per minute are physically abused by an intimate partner in the United States. For one year, this equates to more than 10 million women and men" (Frieden et al., 2011). Evidence suggests CBO care has positive implications for survivors navigating through a traumatic event. There is limited evidence on programs connecting survivors to CBOs from hospitals.

Purpose Statement

This study explores the barriers for survivors of intimate partner violence as they transition from hospitals to community-based care in metro Atlanta. This study will provide insights into preventing such gaps in coordinated care.

Research Objectives and Aims

We aim to better understand survivors' experiences transitioning from hospital to community-based organizations in Atlanta, Georgia, from the perspective of staff working at CBOs. We gathered feedback from community-based organizations about their perceptions of the needs of survivors and their families during this transition. We intend to use this information to identify areas of improvement and develop strategies to better support survivors and their families in making this transition.

Aim 1: Describe health and support-seeking behaviors, specifically on domestic or intimate partner violence cases you may have seen at your organization.

Aim 2: Characterize community-based care, specifically among IPV survivors, and their use of community-based care services (social support agencies that serve domestic violence survivors, for example, by providing housing, legal aid, and other supports).

Aim 3: Characterize care transitions between hospitals and CBOs, including why survivors seek care at hospitals or medical facilities before reaching out to the community or DV agencies while others do not and how those survivors' experiences may differ.

Aim 4: Understand how to better prevent and respond to DV/IPV, especially for those referred from hospitals.

Significance Statement

There is a gap in understanding the perspective of CBO staff who communicate and help IPV survivors daily. As IPV continues to impact people daily, it is imperative to understand the barriers to help-seeking from those who interact with IPV survivors the most. With these data, we hope to create an integrated follow-up care facility for survivors and reduce or eliminate their return to unsafe environments. This will likely not be the last pandemic, and we must ensure people's needs are met in times of crisis. Moreover, we need to see how our community is supporting gender equity and stopping women from being put in harm's way. Overall, hospitals and CBOs must work together to bridge the gap between them, to ensure that survivors of IPV can access the support and resources they need.

Chapter 2: Comprehensive Review of the Literature

IPV is a significant public and global health crisis, defined by the US Centers for Disease Control and Prevention as, "abuse or aggression that takes place within a romantic relationship" (CDC, 2023). This definition includes physical, sexual, or psychological harm and threats or coercion. Data from the National Intimate Partner and Sexual Violence Survey in 2010 suggest that nearly 20 people per minute are physically abused by an intimate partner in the United States (Frieden et al., 2011). This equates to over 10 million women and men in one year. Generally, women are disproportionately IPV survivors compared to men. For example, the Georgia Commission on Family Violence (GCFV), whose mission is to end family violence in Georgia, found that 42,031 family violence incidents were reported to law enforcement in 2020; 69% of survivors identified as female and 31% were male (GCFV, 2021). Most research suggests that men are more often the perpetrators and women the survivors, yet all genders are vulnerable to violence victimization. IPV survivors commonly call 911, a 24/7 crisis line such as the National Domestic Violence Hotline or the Georgia Domestic Violence Hotline, where calls are forwarded to the caller's nearest certified shelter based on area code. In 2021, there were 114,640 crisis calls to Georgia's certified family violence and sexual assault agencies, a 20% increase from 2020 crisis calls (Criminal Justice Coordinating Council, 2022). Safety remains a significant concern for those experiencing violence, and the pandemic left many stranded with their perpetrator. A recent systematic review of domestic violence during COVID-19 revealed that several countries reported increased violence post-lockdown (Piquero et al., 2021), most likely due to survivors being isolated with their abusive partners. The GCFV found a 49% increase in family violence-related fatalities in Georgia from 2020-2021 (Georgia Family Violence Fatality Review Project, 2022). IPV can lead to economic instability, lost productivity,

increased healthcare expenses, and housing costs, underscoring the necessity for effective interventions that address IPV and reduce its economic and social effects.

The Effects of the COVID-19 Pandemic on IPV

Before the COVID-19 pandemic, one in three women experienced physical or sexual violence (Frieden et al., 2011). The pandemic only worsened matters for IPV, which became known as a "shadow pandemic" (Piquero et al., 2021; *The Shadow Pandemic,* 2022; Wyckoff et al., 2023). In some regions, calls to IPV hotlines dropped by more than 50% (Fielding, 2020). Experts in the field knew that rates of IPV had not decreased but that survivors could not safely connect with services (Evans, Lindauer, & Farrell, 2020). Researchers also described disasters such as the COVID-19 pandemic as a "perfect storm" for violence against women and girls (Usher et al., 2021). Studies dating back to the Great Depression have documented the detrimental effects of economic uncertainty on marital conflict and quality, particularly when it comes to unemployment, loss of income, and economic hardship (Komarovsky, 1940; Bakke, 1940; Elder, 1974/1998; and Liker & Elder, 1983). After social scientists found information on the Great Depression and the Farm Crisis of the 1980s, they made the "family stress model," which argues that unemployment and economic hardship lead to economic stress and strain, which can lead to marital conflict and, ultimately a decline in parenting quality and child well-being (Conger et al. 1990, 1992). The study also revealed that rapid increases in unemployment rates increased male partners' controlling behavior, even after controlling for unemployment and economic stress. These results suggest that anxiety and uncertainty adversely affect relationships which relates to the COVID-19 pandemic, where many individuals found themselves in economic hardship and uncertainty, leading to stress and strain on families (Alonzi et al., 2021).

IPV Risk Factors

IPV risk factors can vary from person to person, but some common factors are known to increase the risk of IPV in the short and long term. In the short term, a meta-analytic review found the presence of alcohol and drugs as a significant risk factor for IPV (Cafferky et al., 2018). Studies have found that alcohol abuse is strongly linked to IPV and can substantially increase the risk of physical, sexual, and emotional abuse (Catalá-Miñana et al., 2017), which also aligns with the increased alcohol intake during the COVID-19 pandemic (Barbosa et al., 2020). In addition, stress, mental health issues, and childhood abuse can also be significant risk factors for IPV in the short term (WHO, 2021). IPV risk factors can also be structural, including gender inequality and the perpetuation of traditional gender roles. Studies have found that societies with higher levels of gender inequality tend to have higher rates of IPV, as do societies with greater emphasis on traditional gender roles (Pinho-Gomes, Peters, & Woodward, 2023). In addition, certain cultural and religious norms, such as being expected to marry at a young age, can also increase the risk of IPV (WHO, 2021). Overall, IPV is a serious issue with many risk factors that must be addressed to reduce its prevalence. Therefore, it is essential to identify both short and long-term danger signs to better comprehend and prevent IPV from occurring.

Negative Consequences of IPV

There are many forms of IPV, which can have serious physical, mental, and emotional consequences for survivors and population health that impact their everyday life (Dillon et al., 2013). Many studies found that IPV survivors compared to their nonabused peers are at higher risk of gynecological dysfunction (pelvic pain), STIs, GI problems, chronic pain, and PTSD, which can continue long after the abuse occurred (Campbell, 2002) and may create further

barriers for survivors. In 2005, a national telephone poll of 1,200 workers found that 64% of IPV survivors reported that their ability to work was affected by violence (CAEPV, 2005). Not only do physical injuries result in hardship to hold a job, but fear of abusers' intrusions at work, harassment calls, keeping them up at night, and behaviors such as hiding car keys making them late for work all have a significant impact on the survivor and studies suggest they miss more days of work when compared to people who have not encountered IPV (Reeves & Kelly, 2016). Many also face financial insecurity due to the direct sabotage of their credit scores by those responsible for creating unauthorized debt. This can cause an economic disadvantage and the need to rely on the perpetrator to stay in the household. The national economic cost of domestic and family violence is estimated to be over 12 billion dollars annually (Huecker, King, Jordan, & Smock, 2022). Combining medical and mental care services related to acute DV is estimated at around $8 billion, and higher costs account for long-term care for chronic conditions (Huecker, King, Jordan, & Smock, 2022). Another study found that healthcare costs for those experiencing abuse were 42% higher than for non-abused women (Amy E. Bonomi et al., 2009). Research has shown that half of the women seen in ER report a history of abuse, and approximately 40% of those killed by their abuser sought help two years before the fatal incident (Huecker et al., 2021). Rising costs and unexpected medical bills can perpetuate economic instability with survivors and dependency on their perpetrators.

Common Weaponry used with IPV

Many weapons are used with IPV, including firearms, hands, knives, or any other household weapon. In 2021, firearms were the cause of death in 85% of all family violence-related fatalities (Georgia Family Violence Fatality Review Project, 2022). This is cause for concern considering

Georgia's loose firearm handling laws, such as residents being allowed to carry a weapon without a background check or permit (**Ga. Code Ann. § 16-11-127(c); 16-11-126(g); 16-11-125.1(5) (defining "weapon" to mean a handgun or knife) (*Concealed Carry in Georgia*, 2023)**. Statistics reveal that the presence of a gun in domestic violence situations increases the risk of homicide by 500% (Catalano, 2013). Studies also found that of women at high risk, 68-80% will experience near-fatal strangulation by their partner (Taliaferro et al., 2009; Wilbur et al., 2001). Strangulation is not only one of the deadliest forms of DV, but it has a devastating effect on children as up to 43% witnessed their mothers being strangled, and 9% experience it themselves, which may cause loss of consciousness within five to ten seconds and death within minutes (Patch et al., 2022; Fitzgerald et al., 2022). Homicide odds for those who have previously been strangled are 750% higher than those for non-strangling survivors (Glass et al., 2008). The Atlanta Police Department also found that using hands as weapons, such as strangulation, was the leading weapon in 2021 (Atlanta Police Department, 2021).

Survivor Disclosure

IPV survivors often face difficult decisions when disclosing their abuse to others. While some may seek support from the community or healthcare personnel, others may not due to fear of reprisal, shame, or stigma (Liebschutz et al., 2008). These decisions are based on personal circumstances. Survivors who seek assistance can be a crucial step towards accessing numerous resources. These may include counseling, housing, legal aid, and protective services. It is also important to note that some survivors choose not to disclose their abuse for fear of the increased risk of violence or backlash from the perpetrator (Liebschutz et al., 2008). Survivors may also choose not to disclose their abuse to protect themselves and their children or pets, avoid

judgment, and maintain privacy and autonomy. In one study, unhelpful disclosures, such as when a clinician decided to file a police report or make other well-intended decisions for the survivor, created emotional distress and alienation from healthcare among IPV survivors (Liebschutz et al., 2008). The study recommended that clinicians aim to build a trauma-informed relationship that empowers survivors to make their own decisions and not demand disclosure of their trauma (Liebschutz et al., 2008). This method was found to increase survivor satisfaction in help-seeking. The study also found that regardless of survivor disclosure, creating a space where the survivor is familiar with the clinician, acknowledgment of the abuse, respect for the survivor, and relevant referrals were beneficial to the survivor (Liebschutz et al., 2008). Another study explored IPV survivors' preferences for healthcare responses which included being treated with respect and concern, protection and documentation, autonomy with decision making, timely care, listing options of resources, and follow-up (Dienemann, 2016). Healthcare providers are given limited time with each patient, which complicates delivering this type of care requested of survivors. The literature suggests that healthcare providers include trauma-informed care for survivors to make their own decisions and include information about the available resources to decide what aligns with their needs (Kulkarni, 2019), necessitating the need for coordinated care between health and social service agencies serving IPV survivors.

Barriers to Help-Seeking

There are many reasons survivors may not connect with a community-based organization directly from a hospital. Descriptive findings revealed that around 35% of IPV survivors engaged in help-seeking behaviors, and most survivors who sought help reached out to family members (63%), whereas a few IPV survivors (3%) sought help from formal institutions (Goodson &

Hayes, 2018). Seeking assistance can take many forms, such as calling a hotline, visiting a website, attending support groups, or seeking professional counseling or legal representation. Through these methods, survivors can reach out to receive emotional support and other resources such as food, shelter, safety planning strategies, and sometimes a stipend. Survivors may also seek help from family, friends, medical professionals, law enforcement, or domestic violence support programs. Additionally, many states offer legal protection to survivors of IPV, such as restraining orders or other forms of protective orders. By seeking help, survivors can receive the necessary support to stay safe and start toward recovery. Furthermore, help-seeking provides survivors with resources to make informed decisions and remain in control of their lives. A study by Cardenas provided insight into IPV stigma regarding seeking professional services by asking participants about their attitudes toward seeking legal assistance. This research developed a scale to measure how IPV stigma is displayed in survivors' attitudes toward receiving services (Cardenas, 2022). They found that survivors who have higher anticipated and internalized stigma to seeking formal help are at higher risk of service discontinuation (Cardenas, 2022). In another study, researchers explored how help-seeking impacted Indigenous and Black women in the US. Addressing the barriers is essential to ensure survivors get the help they need in their communities regardless of their location or socioeconomic status.

Despite the availability of many resources and services to assist survivors of IPV, there remain significant obstacles to accessing these resources. When healthcare professionals treat IPV survivors, identifying cases of IPV can pose a challenge with the limited time spent with the patient and because there is no established program or personnel to link survivors from hospitals to CBOs. Many survivors may also be fearful or lack trust in the healthcare system when sharing their experiences (Wright et al., 2022), which decreases the opportunity for care connection. A

study by Dichter et al. emphasized the need for care-connected services according to IPV survivors (Dichter, 2021). This also includes the need for trauma-informed care, where the study noted that clarifying the role and scope of the CBO and the services provided is essential and valuable since many lack awareness (Dichter, 2021). In addition, they mentioned how follow-up is essential, not forcing intervention and ensuring autonomy, privacy, and confidentiality in the survivor's care (Dichter, 2021).

Agencies in Atlanta

In Atlanta, multiple agencies serve survivors of IPV, providing specialized and non-IPV-specific support services. In 2022, 48 State Certified Family Violence Agencies were recognized by the state serving counties all over Atlanta (CJCC, 2022). The Georgia Coalition Against Domestic Violence (GCADV) is a statewide coalition that provides a 24-hour hotline and services such as crisis counseling, support groups, and legal assistance and includes 53 DV organizations based in Georgia (GCADV, 2022). The GCADV coordinates with other organizations within the state and found shelter for over 5,000 survivors and their children in the fiscal year 2021 (CJCC, 2021). Although, according to the GCADV, in the fiscal year 2021, 4,200 survivors and their children were turned away from DV shelters due to a shortage of beds. This is common as shelters only have so much space for survivors. The Georgia DV hotline is connected with CJCC-certified shelters, which are then forwarded to the closest shelter based on area code. These calls also offer language interpretation for survivors. The Partnership Against Domestic Violence (PADV) is Georgia's first and most extensive domestic agency that works with individuals and the community about DV. They have two emergency shelters serving Gwinnett and Fulton County. They also provide legal advocacy support for survivors seeking legal relief (PADV, 2023). They

also partner with property owners and landlords to provide shelter for survivors. The DeKalb Women's Resource Center to End Domestic Violence (WRC) also has a 24-hour hotline, temporary housing, community support for survivors and their children, consultations with volunteer attorneys, support groups, a safe and supervised visitation for parents to visit their children (Nia's Place) and a dating violence prevention program (*Women's Resource Center to End Domestic Violence*, 2015). Other agencies like Ser Familia and The Cherokee Family Violence Center provide wrap-around services for Latinx populations. The Atlanta Police Department also has a program that partners with the Atlanta Victim Assistance Program (AVA). AVA also partners with the Atlanta Municipal Court to reduce the impact of crime and connect survivors to assistance (*Atlanta Police Department*, 2023). Last year they helped nearly 6,000 residents, most of whom are low SES and women of color. AVA also offers school-based programs that work with students in local high schools about healthy relationships, support, and resources. They have also partnered with other local wraparound services to better provide survivors with the resources they need most (*Atlanta Police Department*, 2023). Overall, accessing IPV resources can be a complex issue. To meet the needs of survivors, a collaboration between community health professionals, hospital personnel, and policymakers is necessary to guarantee that resources are both easily accessible and culturally sensitive for all individuals affected by IPV.

Connections to services

With a high volume of calls and incidence of IPV, this raises concern for the well-being of women in Georgia. On a typical day, local domestic violence hotlines receive approximately thirteen calls every minute (National Network to End Domestic Violence, 2020). When survivors

are admitted or choose to seek help at a hospital, IPV can be difficult to identify and, in many cases, not reported. Healthcare workers are often among the first professionals that can treat and identify IPV survivors. Warm handoffs have been evaluated as a quality improvement tool for physician-to-physician end-of-rotation handovers and have been shown to be a safer means of transitioning care (Saag et al., 2017). Healthcare specialists can use warm handoffs to ensure secure and efficient referrals to specialized IPV services while also maintaining continuity of care by making healthcare providers aware of any potential risks or concerns the patient may have. Furthermore, several studies have examined the efficacy of self-help interventions for IPV. According to Ogbe et al., a systematic review examined the scope of IPV interventions and their ability to improve the mental health outcomes of survivors (Ogbe et al., 2020). They discovered evidence of IPV interventions through advocates who had a relationship with a CBO (Ogbe et al., 2020). Grady Memorial Hospital in Atlanta, GA, implemented an Emergency Department Observation Unit (EDOU) to provide extended social work support during shelter placement for IPV survivors. This included partnering with a local IPV shelter manager to build more shelters and enhance communications for Emergency Department social work staff (Clery, et al., 2023). The study found that a "warm handoff" tool was created to maintain the quality-of-care planning across shifts; 70.5% of survivors found safe dispositions after this intervention (Clery, et al., 2023). Overall, evidence suggests that self-help interventions may be a practical approach to combatting IPV.

Conclusion

The consequences of IPV and domestic violence (DV) are far-reaching and devastate survivors, their families, and communities. Although the city has implemented various initiatives and

programs to combat DV in metro Atlanta, Georgia still ranks 31st nationally for women killed by men (Violence Policy Center, 2021). Further research is necessary to fully explore the impact of self-help interventions on IPV survivors and identify best practices for implementation. This project will aim to investigate the barriers and facilitators CBO staff face when supporting IPV survivors.

Chapter 3: Methods

Design

We used a mixed-methods study design to conduct a cross-sectional examination of the perceptions and experiences of staff working at an organization serving IPV survivors in Metropolitan Atlanta, Georgia, before and during the COVID-19 pandemic; we were specifically interested in the transition from hospital to community-based care and interactions between IPV survivors and the organizations serving them. This study supplements the parent study examining perceptions of healthcare providers serving IPV survivors during the COVID-19 pandemic (Hendrix et al., 2021). While the study design was the same, this study focused on the perspectives of individuals working in community-based organizations, their experiences serving IPV survivors, and their perceptions of 'warm handoffs' from the hospitals to their community organizations, including their own.

Power and organizational dynamics could arise in focus group discussions, so in-depth qualitative interviews (IDIs) were appropriate for the study. IPV is also a sensitive topic, and IDIs as they help build rapport and elicit perceptions and experiences from community-based workers who may provide examples of experiences they have had serving survivors which might not be disclosed in other settings.

Instrument

The in-depth interview guide (IDI) used in the parent study among healthcare professionals providing hospital-based care to IPV survivors in Metropolitan Atlanta during the COVID-19 pandemic was adapted for use among the staff of community-based organizations serving IPV survivors (Hendrix et al., 2021). The IDI guide consisted of questions to gather perceptions and

experiences about several domains: 1. IPV survivor experiences; 2. Survivors' needs when transitioning from hospital to community-based care; 3. Barriers and facilitators for IPV survivors transitioning from hospital to community-based care; and 4. ideas on how to improve transitions from hospital to community-based care.

The guide was divided into six sections and included 23 questions, including probes. The first section included quantitative demographic information. The second section asked qualitative and quantitative questions about social service employment history to see how long individuals had worked in their current position and the social service field. The following section consisted of health and support-seeking behaviors with quantitative and qualitative questions about IPV and the training CBO workers have received. We also asked for an estimate of how many IPV survivors the CBO staff saw within one day. Section four revolved around community-based care, the support CBOs offer their clients within 48 hours of intake, and any barriers they may face in serving survivors. This included probes around the severity of violence, changes during COVID-19, and the social-ecological model (SEM) of barriers depending on the interviewee's response. The following section consisted of questions about care transitions and the main barriers to care connection from hospitals and CBOs; we asked participants to estimate the proportion of IPV survivors that they serve who come directly from a hospital to their CBO. We also asked for their insights into any differences between IPV survivors that receive care at a CBO following hospital discharge versus those who do not. In the closing section, participants were asked for suggestions to better respond to IPV and if there were any additional topics they would like to discuss.

The primary interviewer pilot-tested the revised IDIs with members of the research team and public health professionals unaffiliated with the study to gather feedback from practice

interviews (n=8). Critiques and edits were incorporated into the final guides, including probing techniques to extract additional information from participants and clarifying questions to avoid confusion.

Participants

To be eligible for study participation, participants must have worked at a community-based organization serving IPV survivors for at least six months. Participants were recruited using an electronic flier containing participant eligibility requirements, study information, and contact information for the study team.

Initial recruitment occurred in March 2022, following a quarterly meeting of the Georgia Coalition Against Domestic Violence (GCADV), where the senior author presented findings from an earlier study. Subsequently, the study team emailed those attending the recruitment flier and contact email. Next, using a publicly available list of agencies serving IPV survivors in Metropolitan Atlanta, the study team sent recruitment emails to the Executive Directors of each agency, asking that they share the study recruitment flyer with their administrative staff. Finally, we used snowball recruitment, asking each participant to recommend up to three individuals they believed could contribute to the study via email referrals. All recruitment took place over email. Once participants expressed interest in participating via email, they were asked to schedule an interview for a day and time that worked for them. Next, participants were sent a verbal consent form to review before the interview; the consent form explained the study's purpose and was approved by Emory's Institutional Review Board (IRB). They were also sent a Zoom link for the interview and a calendar invite. Email addresses referred by a previous interviewee who did not respond were contacted via email a total of four times before being excluded.

Data Collection

Data collection occurred from June through December 2022. Following pilot testing and training a junior research team member, two study team members conducted 14 in-depth interviews. After the junior team member was sufficiently trained, they continued interviewing independently. An additional research team member was also present to take field notes for most (n=4) interviews. To ensure privacy and safety were maintained, the verbal consent form was reviewed prior to the start of the interview. Interviews were conducted and recorded remotely with permission via Zoom, lasting between 20 and 60 minutes. Following each interview, verbatim transcripts were produced using Happy Scribe (Happy Scribe, 2017); the primary interviewer performed a quality review of each transcript to maintain confidentiality. Names and other identifying information were removed from the transcript during the fidelity check. The Emory University's Institutional Review Board deemed this study exempt from review based on its nature as a public health practice.

Data Analysis

A thematic analysis was utilized to review 14 transcripts with CBO participants serving Metropolitan Atlanta. Coding central themes was done using MAXQDA Analytics Pro 2022, according to Braun and Clarke (2006), which refers to, "the method for recognizing, analyzing, and reporting patterns (themes) within data." These phases involved data familiarization, creating initial codes for searching themes, reviewing themes, defining them, and producing a final report (Braun and Clarke, 2006).

Through the analysis process, memoing and comments were first added to make sense of the data and develop theme ideas. During the coding process, the research question was kept in mind to

focus on *Barriers and in the Transition from Hospital to Community-Based Care among survivors of Intimate Partner Violence in Metro Atlanta*.

A codebook was developed using a set of codes applied to all transcripts with 16 deductive and two inductive codes, later added and reviewed with each transcript. Codes were developed deductively based on questions from the IDI guides, literature, and memoing. Examples of deductive codes include; “injuries,” “emotions (anger, sadness, fear, and depression),” “Barriers to care-seeking connection (help-seeking),” and “care transition.” Codes were then analyzed with the summary page to narrow down themes. Following the initial coding of the first transcript, additional inductive codes were added and reviewed by a team member. These included “general/routine survivor support” with the subtheme as “prevention” and “care transitions” with the subtheme as “number of survivors from the hospital.” Once coding had been completed, various methods were employed during primary data analysis and theme development, such as memoing, case summaries, reflections, matrices, along with comparisons across data sets. Lastly, descriptive statistics were identified using Qualtrics and Google Sheets.

Results

Participants (n=14) included 13 females and one male-identifying staff of Atlanta-based CBOs. Of the 14 participants, 50% (n=7) were Black or African American, 29% (n=4) were white, and 21% (n=3) identified their race as Other. The mean age of participants was 48 years. All participants completed higher education, with 14% (n=2) completing a professional degree (MD, JD, etc.), 35% (n=5) a bachelor's degree, 42% (n=6) a master's, and 7% (n=1) a doctoral degree. Participants saw an average of 16 IPV survivors per day. Participants worked at community-based organizations in six counties: Cherokee, Clayton, Cobb, DeKalb, Fulton, and Gwinnett, all in Metropolitan Atlanta. Professional titles included: Executive Directors, Program Directors, Managers, Program Coordinators, Legal Advocates, and one police officer. Participants had an average of 14.5 years of experience ranging from less than one year (0) to 39 years. All but one CBO professional worked directly with IPV survivors; the outlier previously worked directly with survivors and at the time of the interviews served in a leadership role at a CBO.

All participants discussed safety planning for IPV survivors within the first 48 hours of the crisis as a mandatory process at their CBO. Five inductive themes emerged from the data: (***1) CBOs are challenged in meeting survivor needs in part due to financial strain*** with subthemes related to transportation, housing, survivor financial situations, and CBO funding; (2) ***CBO staff observed changes in IPV frequency, severity, and typology during the pandemic; (3) CBOs face logistical barriers supporting survivors transitioning from hospitals to CBOs inhibiting timely holistic care*** with a subtheme of care-seeking; (4) ***CBOs want to avoid survivor retraumatization and create more coordinated care for survivors*** with a subtheme of prevention work in IPV; and (5) ***CBO staff believe that informal community and social support is important for IPV prevention and response.***

All participants indicated that safety planning as essential in prioritizing the survivor's immediate needs, such as; shelter, legal services, support groups, a translator, filing temporary protective orders (TPOs), rest, eating, and talking to a therapist, or health care. Within this process, a few participants noted leaving space for survivors to tell their stories, if they wanted, without judgment or shame. With most organizations, participants described how survivors are placed with case managers that will guide them through their stay/service as a part of the safety planning process. One participant spoke about having a space for a vision plan where survivors look past their trauma and envision how they want to show up in the world. The participant explained that requests range anywhere from signing up to complete a degree, gaining financial independence/improving financial status, getting new identification documents, building a resume, and job hunting. Participants noted how that was essential to support survivors in feeling that they have a space to stay and trustworthy people they can talk to:

> *"We have safety planning because we know stats have shown us that the most difficult, scariest and dangerous time for an individual leaving a violent relationship is just that—is when they're leaving."*

Theme 1: CBOs are challenged in meeting survivor needs in part due to financial strain

Participants shared examples of limitations on using money in their organizations which limited the use of funds in the ways staff felt was most fitting. Some participants noted their organization's status as a non-profit, which receives grant money from federal and/or state government sources where most funding is allocated for specific purposes with limited flexibility in usage.

Sub-theme 1.1: Housing

Almost all participants described temporary and long-term housing availability — including at shelters and hotels — as a significant barrier to IPV care provision.

> *"Money, honestly, people need cash, and so much financial assistance is tied to certain requirements, and there's hoops people have to jump through, and people really just need money... food, shelter, and clothing. When you have your basic needs met, it makes everything else much easier to navigate. And we're seeing more and more situations where people's basic needs are not being met, but they don't have health insurance. And there's a lot of people with mental health issues out here that aren't glaring, but they create challenges for them when they're trying to navigate the system or deal with police or any of that."*

Participants explained that IPV severity is situational. If survivors do not have friends or family nearby, they have fewer housing options. One participant described that many survivors served by their organization are uninsured or immigrants who fear going to the hospital. They may also be denied housing due to their immigration status, creating another barrier. Participants explained that some shelters do not have enough space to house survivors. One participant noted that their organization's shelters housed survivors for up to 90 days during the pandemic. If the shelter was at capacity, funding was needed to relocate survivors to a hotel or a family or friend's house. Further, some participants explained that although survivors may look for long-term housing, the housing may be unaffordable, especially if they have children or pets, which may increase housing costs or availability. Some participants mentioned that it is easier for single women to find shelter; however, many survivors have children, making it more difficult with the

limited space available for temporary housing, including shelters and apartments. COVID-19 exacerbated the lack of available housing for IPV survivors; as one participant explained,

> *"Our biggest challenge right now is housing. The market. As it stands, the access is quite limited and the rents have gotten so expensive. And the people that we serve — obviously people who don't have a lot of resources, otherwise they would just go rent a place or they would get a hotel. So it's been very challenging to find the next best step for people, which has added a tremendous layer of stress. So people are always already worried about their safety. Am I going to get COVID? If I get COVID, am I going to get long COVID and many of the people that we work with are people who are front line workers. We're front line workers in a different way, but we're talking about people who are very closely involved with large numbers of people in public, facing grocery stores, fast food, those kind of places. And so there was a lot of fear around how safe they were going to be. So many of them were reluctant to work. But it wasn't just the fear, it was also the lack of daycare, which was a big big obstacle. There's the housing challenge and then there's the ability to afford housing because there's not enough child care."*

Sub-theme 1.2: Transportation

Participants described that many survivors need basic necessities such as transportation to a safe place (e.g., family or friends' house, temporary housing), gas cards, money for rent, hotels, food, and other material needs when experiencing an immediate crisis. Participants shared that when a crisis occurs and the survivor calls a hotline, they connect with a CBO that serves their geographic region/county. The participants described the first 48-hour window as crucial for the survivor to reach a safe space. Some participants explained that they could assist survivors with transportation up to a certain radius of the CBO, but this was problematic and limiting for

survivors whose needs required them to travel outside of that radius (i.e., to a relative out of state). One participant explained,

> *"I think sometimes transportation can be an issue because to do a protective order, we need to have a couple of pages have to be signed and notarized, so sometimes people that are a lot of times in financially abusive situations don't have access to transportation, and a lot of times that can be problematic. Sometimes they can get someone to help bring them. But I think a lot of times the transportation issue can be a huge impediment."*

Participants noted that they try to support survivors with their organizations' available resources or refer them to another CBO who can better help meet their needs.

Subtheme 1.3: Survivor Financial Situations

Participants explained that IPV survivors often have insufficient credit or low income, which frequently results from perpetrator financial control; this complicates housing and transportation procurement for survivors leaving violent relationships. IPV survivors may also struggle with employment stability since IPV-related injuries may have prevented them from working, leading to financial instability. Some of the reasons for the differences CBO staff see with their survivors have to deal with credit scores, the severity of the injury, needed medical care, children or pets involved, and whether they want to press legal charges or not.

Subtheme 1.4: CBO Funding

In addition, the COVID-19 pandemic exacerbated organizational challenges in meeting survivor needs due to limited funding, insufficient staff, reduced or eliminated hours of in-person interaction, and overfilled shelters. Participants expressed that the primary barrier to best-helping survivors and their immediate needs in a crisis was the availability and allocation of money.

Although, one CBO participant did not note finances as a barrier since they felt their organization had funds have allocated for flexible use the funds allocated to do so:

> *"We call them emergency line assistance. So that includes financial assistance to support housing and utilities, bills, anything that really is a barrier for them to safety and stability."*

Some of the reasons for the differences CBO staff see with their survivors have to deal with credit scores, the severity of the injury, needed medical care, children or pets involved, and whether they want to press legal charges or not.

Subtheme 1.5: Temporary Protective Orders

Participants mentioned challenges in obtaining temporary protective orders (TPOs) as another logistical barrier in serving survivors. Survivors may need support navigating the legal system if they wish to press charges, which is often a long, tedious process. Participants mentioned that some CBOs have connections to free legal services, but because the process is long, follow-through is difficult. Participants discussed how some survivors avoid interaction with law enforcement or the justice system since it often requires that they tell their story to strangers or for other personal reasons like a lack of trust in police and fear of the perpetrator's arrest. One participant noted the limitations in arresting perpetrators,

> *"Some of the barriers are kind of due to the victims and their perception, I think of maybe police or their scenario. A lot of them tend to be reluctant as far as reporting is concerned, especially after the fact…Sometimes the primary breadwinner in the house and they don't want that person to go somewhere. There's just a change of heart.."*

On the other hand, one participant who partnered with law enforcement reported success with their referral program, akin to a warm handoff. The participant explained the police are called to

a crisis, and the survivor is linked up to the CBO for follow-up care unless they need to go to the emergency room.

Theme 2: IPV Frequency, Severity, and Typology

Most (57%) CBO workers saw an increase in IPV frequency, and three out of 14 participants also acknowledged that the severity occurred sooner than usual in a relationship:

> *"...What we saw was earlier acts of violence in the relationship, whereas in the past we may have seen more of emotional abuse or financial abuse, but lately there has been earlier acts of violence that we wouldn't have otherwise seen until later on in the relationship."*

Participants also found that weapons were often used as forms of violence, but the most common weapon was a person's hands, specifically strangulation. One participant mentioned observing more strangulation cases during COVID in the community:

> *"But we are seeing an increase in strangulation, which is a high indicator. And unfortunately, one of the things that we're really trying to do is educate our clients because what we're hearing is he choked me or he tried to choke me out. And we know it's not choking, we know it's strangulation, right?...Got a very high reality indicator and we're hearing, "he choked me out, I was unconscious for a little bit." Which we know that could be close to death."*

Another participant reported on the impacts of potential escalation of violence after previous acts of strangulation:

> *"So for the most part, I'm seeing strangulation being a top one. And that's very alarming because there's some data that shows that if you strangle someone, there's a strong*

likelihood that you will commit some great harm to that person in the future. It only gets worse from there."

In addition to the increased severity of IPV during COVID-19, many participants noted that the mental health of IPV survivors took a toll and impacted their decision-making skills:

"Yeah. So there were people who had experienced more severe physical abuse and also people are experiencing more anxiety and depression. So we're noticing that people are just having less emotional capacity and even around things like being able to decide on the next best step. I think that's always been true. And of course, that's what you would expect if you're dealing with a lot of trauma, it makes it difficult to think clearly. But I think that it was exacerbated by the interruption of people's social networks. So there just wasn't really a place really for anybody to hold space for you. People were coming to us with holding so much because they didn't really have any places or spaces to share that before they got to us."

Increase in IPV severity:

Ten out of 14 participants observed increased IPV during the COVID-19 pandemic. Four participants experienced a lull in calls during the enactment of movement restrictions since there was no way to report abuse to enforcement. Many knew IPV was still occurring, but the survivors were in proximity to the perpetrator, ineligible to call for help.

"When COVID hit and everything shut down, what was March 17, 2020? Our lines went pretty quiet. Eerily quiet...um and quiet for probably a couple of months, much quieter than certainly any kind of normal. And we also have a pretty close contact with [inaudible]. And of course, their lines were also very quiet. And we pretty much knew it was not because it wasn't happening."

Theme 3: CBOs face logistical barriers supporting survivors transitioning from hospitals to CBOs inhibiting timely holistic care.

Most participants noted that only a few survivors connect from the hospital directly to CBOs, and almost all CBO staff find the most significant barrier being one clear way of a warm handoff with the hospital to the designated CBO. All participants mentioned roughly 20% of their survivors come from the hospital. When asked why this might be, most participants said there needed to be more communication and follow-through between hospital and CBO organizations and bidirectional communication. Participants mentioned that hospitals use fliers with the national hotline number but that survivors may not know the plethora of community resources available. One participant noted how she wished the hospital would call her shelter immediately rather than go through another "unnecessary" line. Many participants mentioned that survivors often avoid health-related follow up care for personal reasons such as not having insurance or preventing not wanting to retell their story. One participant explained,

> *"I'm going to just talk about my clients, which are immigrant victims of domestic violence, so it looks different than Americans. And with that said, I think during the pandemic, we just received like one client coming from the hospital and after the pandemic, we haven't received any directly from hospital. Now why? Because our immigrants victim, they usually don't want to go to the hospital because they are undocumented most of the time and they don't have insurance, medical insurance. So they're always worried about the bills. So even though sometimes they come with us and we really encourage them to go to the hospital after the incident, for example, in strangulation cases they refuse to just because they fear of the bill. We explained them*

that with compensation would be able to provide a financial assistance and things like that or even sometimes we can find some financial assistance to pay the bills. But still."

Multiple participants mentioned 'siloing' as a significant reason hospitals and CBOs are disconnected. One participant explained that the hospital's main priority is to provide care for the injury and that they are not responsible for not following up to ensure survivors are connected with a CBO. One CBO with a warm handoff program in a hospital said it was adequate, but sometimes they receive "incorrect referrals" though they did not define the meaning of this term. The same participant explained that they want to help as many people as possible but sometimes get referrals for people outside the scope of their organization's means:

"...We really want to be able to provide services to everyone who doesn't have a place to live and who doesn't feel safe. But we are designed to provide services specifically for survivors of domestic violence and partner violence, trafficking, those kinds of things. And I think what's true is that everyone who provides care services cares about the people that they're working with. And so sometimes they want us to be able to accept people who are not appropriate for us to accept."

Subtheme 3.1: Survivor Care-seeking

Many participants mentioned most survivors only go to the hospital if it's a critical emergency, such as a gunshot wound or severely broken bones; participants noted that verbal and 'minor' physical abuse was viewed as less severe by survivors and were more likely to call a hotline and thereby connect with a CBO. Most participants expressed concern that survivors unconnected to community care would return to unsafe environments with their perpetrator, on the street, or otherwise be left to find help independently. Participants expressed frustration at the coordinated care and were hopeful for a program that allows a smoother transition into CBO care, such as a

warm handoff. Although, as a few participants mentioned, survivors sometimes do not want to follow up and may want to return to their homes. Some participants noted that when survivors come to CBOs directly from hospital care, it sometimes creates a challenge since CBO staff are not medically trained for follow-up care. Some participants explained that survivors may have critical issues that require constant supervision, which they are unable to handle:

> *"So the biggest challenge or barrier obstacle we see when they're coming from the hospital is just what the extent of their injuries are. So we've you know, bruises to broken backs, um, to vision issues, to concussions. It really just depends on what injuries were sustained, what kind of care is really needed. You know, we don't have our hotline workers and our advocates that work on site don't have a medical background, so we don't have the capacity to medically care for someone."*

One CBO had a warm handoff program where their survivors are linked to another CBO from the hospital. Some participants have a relationship at the hospital with someone who works there and links the survivor with the CBO case manager. However, the participant noted room for improvement with the warm handoffs to serve those in their designated counties. Participants also noted a problem with handoffs and the importance of having consistent people:

> *"Honestly, I think it's a warm hand off. So like the idea of having an individual who doesn't receive referrals and then who would follow up with the referring agency and then the person who would internally follow up with that client or that client. That becomes that they provide that support to that's probably like the biggest barrier is having somebody that's consistent and it comes without being almost without being said. But just said with community-based care there's always things that are changing. I think that it's hard for agencies to have somebody be in that position long enough for other*

agencies to really feel the effect of having a consistent person, you know what I mean? Whether it's because it's a nonprofit and so folks move around or other reasons. But I think what I have found to be most difficult, challenging, but also has been rewarding for some experiences is when there was somebody I could call and say hey, I have somebody who would benefit from your services and they were like either really quick to be like oh yes, let's start an intake or let's start a phone call or whatever the process was".

One participant spoke about internal or informal resources being necessary for the IPV survivor. They mentioned how it is essential to be patient and allow the patient to feel like they have control in the moment to get the care they want and need:

"Well, I think sometimes people are in the moment, they're in a crisis in the moment. And I would say that there's a percentage of our clients that have to go to the hospital in the moment, but once their initial needs are met, then depending on what their situation is, they maybe will return to the abuser. They maybe don't have a lot of internal resources. And so I would say I've had clients definitely that went to the hospital, and I was expecting to see them, somebody in their family might have advocated for them, and I was expecting to see them in my office the next day to try to do the next steps, to try and do a protective order or try and find transitional housing or whatever it is. And then the person sort of just drops off the radar. And so I think it sort of just depends on the person. I think we have to provide as many resources as we can, but the person has to be willing to be at that point in their life when they're willing to be able to move forward instead of staying in their current situation."

Theme 4: CBOs want to avoid survivor retraumatization and create more coordinated care for survivors

Participants desired a 'one-stop shop' where survivors could rest and take care of all their needs. A few participants mentioned a family justice center (FJC) where the survivors could get TPOs, shelter, therapy, career counseling, conduct a job search, gain transportation to a safe place, get official documents, and help for children and pets. When asked why this was needed, many participants spoke about avoiding exhaustion and retraumatization to the survivor by telling their story multiple times to people they had just met. Many participants expressed the hardships of trusting a stranger with their story, especially with other stressors going on at the same time, such as money, transportation, kids, and simply a path forward after the crisis. Participants mentioned that outside referrals require additional paperwork and that survivors must go through the intake process at each CBO since the intake documents differ. Some participants also mentioned that survivor recordkeeping is linked to CBO funding, sometimes resulting in competition between organizations. Participants noted that they could only do so much to change these processes and procedures. Participants noted a potential benefit of a one-stop shop and a reduction in appointments, less survivor transportation needs, reduced time away from work for children requiring care, and most importantly reduced retraumatization. Participants articulated passion for their work and wanted to reduce friction for the survivors to get the help they needed. However, referral comes with its own challenges, namely the potential retraumatization of survivors. Some participants described how referral often requires survivors to tell their stories repeatedly. One participant shared,

> *"Sometimes we'll say, well, we have a client who's here, we've done the full intake. They've been burying their souls the last 2 hours. We've taken so much from them sharing*

so many personal issues and we just need to get them into a shelter. And then the shelter will say, oh, well, have them call us and we need to do our own intake again. And they won't even tell us if they have space. So even after going through that whole intake, or they will not also tell the client, well, let me say, they will not tell us beforehand, but they will want to go through the whole other intake. And I just don't think that's in the best interest of the client. Best interest client is just to deal with their immediate needs and not retraumatize them."

Theme 5: CBO staff believe that informal community and social support is important for IPV prevention and response:

Several participants spoke about the importance of community efforts for IPV prevention and identification. One legal advocate spoke about involving places of worship and religious leaders to identify IPV and create a community for help and resources. Two participants spoke on the influence community members had to educate and explain the dangers:

"We can't make them come in. We can't make them leave him, but we can educate them while we have either contact on the phone or if they come and have case management with them explain how dangerous it looks, at least we know at the end of the day, we gave her all of the information we could give her. At least she made somewhat we would hope an informed decision."

Another participant talked about teachers in grade school getting more training on identifying Adverse Childhood Experiences (ACEs) in young people, which would allow for opportunities to teach young children about healthy relationships or refer them to someone who can help them stop generational cycles of family violence. Along these lines, one participant emphasized the difference between choking and strangulation and how to recognize signs of strangulation. Many

participants also mentioned the importance of financial literacy for survivor empowerment. Participants revealed that many survivors stay in relationships or situations because of financial dependence, noting that it often takes survivors multiple attempts before successfully leaving an abusive relationship. Some participants recommend having a mentoring program for young people by getting out and socializing with the community to create connectedness and resources with others. One participant stated,

> *"I would really like to see more community in [inaudible], more compassion, more mentoring with young people, getting out in the community, talking to folks. We used to spend a lot of time training police and training systems people."*

Several CBO staff touched on how elders passing away during the pandemic negatively impacted survivors. Two participants specifically spoke on behalf of the community, 'hollowing out' due to elder folks passing away from the virus. One individual spoke on behalf of informal support and the elders in the community:

> *"[The elders] typically were the kind of the glue that was holding families together. So not just intimate partner violence, but family violence in general is happening because people have less resources, they're having to go into a pad split situation or everyone was staying at grandma's house and now Grandma has passed away and we're all fighting over the property. That kind of stuff happens too, quite a bit, as well as just sort of the mental health crisis of going through a pandemic as a population and feeling abandoned by your government and all the people that are supposed to help you. And that's certainly given people a shorter rope. So I'm seeing situations that used to not be such a flash point, becoming that in a lot of domestic violence situations and that's continuing to evolve."*

Participants observed that uncertainty during COVID-19 caused many people to lean on family and friends for support. Unfortunately, with the loss of key family members, many were left without adequate resources for assistance. This was expressed through various means such as individual assistance with housing or childcare needs. One participant spoke about the important role of African American grandmothers and their roles in the community and their families:

> *"It is I think it's it's it is not appreciated, really, the role that grandmothers play, especially the African American community in our cities. And they're just overstretched. They have their own health needs and they're taking on whole other families, right? And so I would love to see more support for grandparents and grandmothers in particular somehow. Then I was also thinking about the young women that we see. We really need to intervene and assist these young women before they get to this point. There needs to be earlier intervention before they get to these. They become young victims and survivors of domestic violence. I keep saying, why are we failing them? Why is society failing them? We have young kids who have five, six, seven children. They have two, three partners. Some of their children have two, three parent fathers. Some of them come to us with their victims, and they're pregnant when they come to us. They haven't finished school. They're not able to even focus on their own lives, their own futures, their own careers, because they're busy just dealing with now they're busy dealing with all the children that they have. They're moving their families from house to house, trying to get away from the abusive partner who's just stalking them."*

Table 1: CBO Staff Demographic Information

Characteristics	Overall N=14
Age in years Average SD	 47.86 9.5
Gender, n (%) Female Male	 13 (93%) 1 (7%)
Race, n (%) Black or African American White Other	 7 (50%) 4 (28.6) 3 (21.4)
Marital or Relationship Status, n (%) Married Never Married Widowed Divorced Separated	 5 (38.5) 3 (23.1) 2 (15.4%) 2 (15.4%) 1 (7.7%)
Highest Level of Education Achieved, n (%) Bachelor's Degree Master's Degree Doctoral Degree Professional Degree (JD, MD)	 5 (35.7%) 6 (42.9%) 1 (7.1%) 2 (14.3%)
Years in social service Average SD	 14.5 11

Discussion

Allocation of CBO funds

Participants identified several themes during interviews that highlighted the need for a revised follow-up care protocol for IPV survivors after they receive care at a hospital. This begins with the allocation of money CBOs receive and how it can be utilized so IPV survivors can get transportation to appointments and shelters to escape dangerous situations. Survivors of IPV who seek to break free from an abusive relationship often face housing instability and homelessness due to elevated housing costs, economic insecurity, damaged credit, and poor tenant history. In 2003, a California Women's Health Survey analysis found that a correlation between IPV and housing instability was nearly four times the odds of women who did not experience IPV (Pavao et al., 2007). Another study of 110 survivors receiving service from shelters, criminal justice agencies, and/or welfare programs in Georgia found that around 40% percent reported homelessness after fleeing abuse, and 25% were forced to leave their homes due to financial problems or partner harassment (Charlene K. Baker et al., 2003). This also aligns with Macy et al.'s 2010 findings related to DV services in North Carolina where funding was a top challenge similar to our findings (Macy, 2019).

Changes in IPV frequency, severity, and typology during COVID-19

With the increase in COVID-19 cases during 2020-2021, many participants noted a rise in IPV cases to their CBO, and nearly all participants also noted an increase in severity. These findings support increased IPV severity found sooner among COVID-19 (Wyckoff et al., 2023). However, not all participants observed an uptick in cases during this time and noted how the phone lines seemed 'eerily silent.' Participants knew abuse was happening and also expected that many survivors were trapped with perpetrators and thus unable to reach out for help. This finding

aligns with a study in Boston, which found a decrease in the total number of intimate partner violence (IPV) survivors seeking hospital care during the pandemic (Gosangi et al., 2020). This contradicts Piquero's systemic review and where they also found an increase in cases during the pandemic (Piquero et al., 2021) the study by Evans et al., which found an increase in Atlanta IPV calls during COVID-19 (Evans et al., 2021). An overarching amount of evidence suggests an increase in IPV during the pandemic.

Many participants also saw increased severity in IPV cases such as strangulation among IPV survivors during the COVID period. Many participants also saw this as problematic since many noted they were unconscious for a bit, which means they were close to death. This aligns with research on strangulation as a risk factor for femicide (Glass et al., 2008; Campbell et al., 2003).

Barriers supporting survivors transitioning from hospitals to CBOs

Participants mentioned how many IPV survivors were unaware of the available resources even when leaving a hospital. A systemic review noted how warm handoffs are used more commonly with mental health and substance use, and other services were not as popular (Taylor & Minkovitz, 2021). Overall, they suggested that warm handoffs would be helpful for mothers and their children to connect with child and maternal health homes or other CBOs (Taylor & Minkovitz, 2021). Many participants also mentioned the lack of communication between hospitals and shelters. This is a problem for the survivors to get timely and coordinated care. Not only was there miscommunication between the hospitals but also between the different CBOs suggesting a better communication method be utilized. Additional studies found inadequate organizational resources, staff burnout, lack of training, and poor integration with other community services interferes with quality services to IPV survivors (Portnoy et al. 2020; Kulkarni, 2019).

Creating more coordinated care for survivors

Participants mentioned the importance of keeping the survivor at the center of care. This aligns with the findings in Kulkani's thematic categories related to enhancing IPV services, such as providing empathy, supporting the empowerment of survivors, individualizing care, and maintaining ethical boundaries (Kulkarni, 2019). Participants desired a 'one-stop shop' where survivors could rest and care for their needs. A few participants mentioned a Family Justice Center (FJC) where the survivors could get TPOs, shelter, therapy, career counseling, conduct a job search, gain transportation to a safe place, get official documents, and help for children and pets. Duncan et al. highlighted the importance of an FJC, noting that this center brings a "multitude of organizations under one roof and eliminates the hurdles so many survivors must jump through" (Duncan et al., 2021). The first Family Justice Center began in San Diego and saw a reduction of 95% in domestic violence homicides after 15 years (*The President's FJC Initiative Best Practices*, 2007). Congress later recognized the importance of family justice centers in Title 1 of the Violence Against Women Act (VAWA) in 2005 and got funding to create more FJCs, which are also considered best practice in DV by the US DOJ Office on Violence Against Women (*The President's FJC Initiative Best Practices*, 2007).

A study done in 2006 found that FJCs "reduced homicides, increased victim safety, increased autonomy and empowerment for survivors, reduced fear and anxiety, increased prosecution of perpetrators, and increased effectiveness with CBOs" with the family justice center model (Gwinn & Strack, 2010; Hoyle & Palmer, 2014; Kennedy, 2013). This organization addresses the challenges when survivors travel to multiple locations to file police reports, obtain TPOs, receive counseling, and obtain other criminal justice-related services (Townsend, Hunt, &

Rhodes, 2005). Atlanta is modeling their FJC after the Tennessee Department of Finance-Administration Office of Criminal Justice Program. Tennessee has opened over a dozen Family Justice Centers with similar technical assistance and funding structure that Atlanta is planning. Three counties have begun the intensive planning process, including Marietta, Macon, and Waycross, GA, although there are no current efforts to develop an FJC serving metro Atlanta (*Family Justice Center Initiative,* 2020).

Informal community and social support

Two participants touched on behalf of the community, 'hollowing out' due to elder folks passing away from the COVID-19 pandemic. One individual spoke on behalf of the informal support elders in the community provide. This supports the findings that most individuals disclose their situation to at least one informal support person (Tiura et al., 2010). Research shows that informal and formal support can have different reactions from different people (Tiura et al., 2010). While we did not interview IPV survivors, it is assumed that having elders to support them was a positive support system for the community.

Limitations

There are many limitations to this study. As with qualitative research, results cannot be generalized to the entire population of IPV survivors. Additionally, a majority of survivors identified as cis-gendered, heterosexual, and Black or African American. Therefore, we are missing perspectives from other racial, gender, and sexual identities. Although the codebook was created collaboratively with all research team members, only one coder analyzed data. Furthermore, only one team member interviewed and took notes during most interviews. Findings from this study should be complemented by expanding data collection to incorporate more IPV CBO staff voices from Georgia and other regions of the U.S. Though we were unable

to interview all CBO staff representing all counties in Atlanta, we do not anticipate different results. The only distinction would be the distance between organizations. This study only looked at IPV and did not include a holistic look into family violence. Although, the reality is that violence often happens when children are around.

Chapter 6: Conclusions and Public Health Implications/Recommendations

Conclusions

The findings in this study provide information and recommendations for future IPV community planning. This study applies to Atlanta, GA, and may apply to other US cities. Although, additional research is recommended to understand the range of CBO and IPV survivors' gaps depending on one's location. This section summarizes how findings from this study apply to community and educational settings and how they can be used to inform PH professionals, future pandemic responders, and other community health workers.

As mentioned above, there was an increase in IPV during the COVID-19 pandemic. Public health action must integrate a more comprehensive approach to lockdowns to protect survivors as a part of public health preparedness. As IPV continues to be a pervasive issue, this analysis suggests that integrating a warm handoff program for IPV survivors from hospitals to a designated CBO could alleviate survivor retraumatization. Participants warned about maintaining survivor autonomy by listening to survivors and their needs during this traumatic process. However, warm handoffs for IPV have not been well documented or rigorously evaluated, and more research needs to be done in this area. During the peak and lows of the pandemic, CBO staff found a gap for IPV survivors to get the holistic care they wanted. Many who received care have to bounce around to different community-based organizations. An FJC would minimize the instances where they must redo intake forms for each service they receive. There has been early discussion and planning of an FJC serving Metro Atlanta, but it requires a lot of resources and community buy-in and is not fully implemented yet. Until a societal approach, such as an FJC, is finalized, a more effective way of communication is necessary to minimize survivor retraumatization. Even with many CBOs expanding safe places for survivors would benefit the

community. Many participants mentioned places of worship as safe places for prevention and support.

Prevention

Many participants mentioned incorporating education for young girls and women about healthy relationships. Some CBOs currently visit grade schools and educate adolescents as part of their preventative approach to IPV. Expansion of education can reach more children and women to the services available to them and empower them towards healthy relationships.

The findings from this study also support expanding mental health resources to the survivors. More mental health services can allow an opportunity for better short and long-term health.

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Appendices

Appendix I: In-depth Interview Guide

Qualitative Instrument- In-depth Interview guide

Inclusion Criteria:
18+ years of age
CBO staff in metro-Atlanta
Works with IPV survivors for more than 3 months

Demographics
1. What is your gender <open-ended>?

2. What is your age? <## years>

3. What is your race? <checklist-choose all that apply>
   White
   Black or African American
   American Indian or Alaska Native
   Asian/Pacific Islander
   Other Race: _____ <Open-ended>

4. What is your marital or relationship status? <choose one>
   Never married
   Married
   Widowed
   Divorced
   Separated
   Member of an unmarried couple

5. What is the highest level of education you have achieved?
   Did not complete high school
   High school graduate, diploma or the equivalent (for example: GED)
   Some college credit, no degree
   Trade/technical/vocational training
   Associate degree
   Bachelor's degree
   Master's degree
   Professional degree
   Doctorate degree

Employment

Now I'm going to ask a few questions about your role at your organization.

6. What is your current job title? <Open-ended>

7. How long have you worked in your current position? <##> years. If less than one year enter 0.

8. How long have you worked in the social service field? <##> years. If less than one year enter 0.

Health & Support Seeking Behaviors

Now I would like to focus specifically on cases of domestic or intimate partner violence you may have seen at your organization. **< Screen share the Qualtrics survey for SSPs.>**

9. Do you work directly with clients experiencing violence in their relationships? <Y/N> <enter in Qualtrics during interview>

10. Do you have any special training working with clients experiencing violence in their relationships? <Y/N> <enter in Qualtrics during interview>
a. If yes, what training? <Open-ended>

11. In a typical workday at your organization, how many clients do you encounter who are experiencing violence in their relationships? <##> cases <enter in Qualtrics during interview>
<Turn off screen share>

So now I will ask more open ended questions.

12. Have you noticed that domestic or intimate partner violence cases have presented differently during the COVID period, and if so in what ways?
a. Probe: Attempted killing, types or severity of injury, changes to victim profile (i.e. gender, age, SES)
b. Have you noticed differences in other health issues, specifically among clients experiencing domestic or intimate partner violence?
c. How does this differ from before?

Community-Based Care

Now I would like to focus specifically on survivors and their use of community-based care services. When I say community-based care I am referring to social support agencies that serve domestic violence survivors for example by providing housing, legal aid, and other supports.

13. What kinds of support do you typically provide to your clients experiencing domestic or intimate partner violence in the *first 48 hours*?

a. How has this changed if at all during COVID?
b. Please describe any new methods or resources that emerged out of COVID-related changes.

14. What barriers, if any, do you face in providing support to IPV survivors in general?
a. What personal barriers do you face in providing support to these clients?
b. What interpersonal barriers do you face in providing support to these clients?
c. What institutional barriers do you face in providing support to these clients?

Care Transitions

Some survivors seek care at hospitals or medical facilities before reaching out to community or DV agencies while others don't. Now I'd like to ask about how those survivors' experiences may differ.

15. Approximately what percentage of the survivors come directly from hospital care (for example emergency departments)?

16. **How do the needs of survivors from hospitals or health care settings differ from those from other places?**
a. In what ways are they similar?

17. What are the main barriers to care connection between hospitals and CBOS?

18. Now I'd like you to think of a survivor who first received care at a hospital and then received care or services in the community. What do you think is important for us to know about that kind of experience?
a. What contributed to or supported the person in successfully connecting with community care?

19. Now I'd like you to think of a survivor who received care at a hospital who **did not** receive care or services in the community. What do you think is important for us to know about that kind of experience?
a. What kept them from successfully connecting with community care?

Closing:

22. What would you suggest to prevent or better respond to domestic or intimate partner violence, especially for those referred from hospitals?
a. Specifically at their organization

23. Is there anything else that we have not yet covered that you feel is important?
<Make sure to be quiet for at least 30 seconds>

Thank you for your time and all the important work you do. Can you share the names and contact information of at least **three** people who work at your organization or other organizations who might be willing to participate in this study?
If yes – What are their names and contact information?

In addition, if you'd like I can share a recruitment flyer with you.

<If YES, record individuals' email addresses in Qualtrics AND say "Great, I will also email you the study's informational flyer with my contact information for you to distribute among your network.>

Thank you again for your time today.

Appendix II: Codebook

Community-Based Organizations (CBO) Codebook

Determining Barriers and Facilitators in the Transition from Hospital to Community-Based Care among survivors of Intimate Partner Violence in metro Atlanta

Purpose: Explore how IPV survivors are safely discharged from hospitals to CBOs in the first 48 hours following a traumatic injury as a result of IPV

DV= Domestic Violence, IPV= Intimate Partner Violence

Parent Code Name	**Sub Code Name**	**Definition**	**Example**
Emotions-Anger, Sadness, Fear, & Depression		Mentions of feelings of fear or anxiety among DV and IPV survivors to disclose violent incidents to others including healthcare providers, law enforcement, family and friends and fear of seeking in-person health or supportive services. Includes: - Fear of contracting COVID-19 among DV and IPV survivors and general patients. - Financial instability as a result of leaving the relationship - Fear or anxiety among shelters to accept new patients	I: "Was there an increase of severity, would you say, with some of these issues?" P: "Yeah. So there were people who had experienced more severe physical abuse and also people are experiencing more anxiety and depression. So we're noticing that people are just having less emotional capacity and even around things like being able to decide on the next best step. I think that's always been true. And of course, that's what you would expect if you're dealing with a lot of trauma, it makes it difficult to think clearly. But I think that it was exacerbated by the interruption of people's social networks. So there just wasn't really a place really for anybody to hold space for you. People were coming to us with holding so much because they didn't really

			have any places or spaces to share that before they got to us.”

Injuries		Mentions of injury including intentional and/or unintentional injury as a result of IPV. Includes: - Descriptions of cases that CBOs have seen including severity [ED3] increases, decreases, or no change in amount of injury observed by CBOs at the CBO/ER - Mentions of strangulation, weapons (firearms, or knife stabbing) - Mentions mental health effects (depression, PTSD, headaches, GI effects)	I: "So how do the needs of survivors from hospitals or healthcare settings differ from those of other places?" P: "We usually it's more severe of a situation if it's resulted in hospitalization. So we're talking possibly somebody's lost their ability to breathe temporarily from strangulation or has been severely, severely assaulted or assaulted with a weapon of some sort. Those are more typical for those situations that come out of, like, an emergency room setting. If we're talking mental health clinical settings or hospital settings, that's much more complicated. There's really not a system for that cohesive system for that here in Georgia, at least as far as I can tell. It's crisis center. If you don't have insurance, you're back on the street in three days. The jails have now become a substitute for inpatient mental health services, which exacerbates trauma and stress and all of those things. And for many victims, they don't want the person to go to jail necessarily. They want them to get medicated. They want them to get stabilized. And we're seeing a whole lot more of that, like people who might have had latent mental health issues, that this pandemic and everything going on in the world has triggered some pretty severe responses."

Barriers to care seeking connection (help seeking)		Any help seeking (formal or informal) including hospital, health, police, social support, shelter, legal Includes: - Includes barriers and facilitators to help-seeking - Mentions successful transition from hospitals to CBOs - Unstable housing/ transportation	I: "What barriers would you say, do you face in providing support to intimate partner violence survivors in general?" P: "Our biggest challenge right now is housing. The market. As it stands, the access is quite limited and the rents have gotten so expensive. And the people that we serve ___ obviously people who don't have a lot of resources, otherwise they would just go rent a place or they would get a hotel. So it's been very challenging to find the next best step for people, which has added a tremendous layer of stress. So people are always already worried about their safety. Am I going to get cold? If I get COVID, am I going to get long? COVID and many of the people that we work with are people who are front line workers. We're front line workers in a different way, but we're talking about people who are very closely involved with large numbers of people in public, facing grocery stores, fast food, those kind of places. And so there was a lot of fear around how safe they were going to be. So many of them were reluctant to work. But it wasn't just the fear, it was also the lack of daycare, which was a big big obstacle. There's the housing challenge and then there's the ability to afford housing because there's not enough child care."

Care Transition		Descriptions of transitions from hospital to CBO (positive or negative) Includes: - Mention of transition experience in survivors from hospital or health care setting to a CBO - Barrier /facilitators - Positive or negative experiences	I: "What would you say are the main barriers to care connection between hospitals and community-based organizations?" P: "I think we have a pretty good connection with [hospital] [PJ8] in particular. So there are a couple of social workers there and we have an assigned staff person who takes cases from them. So when they have someone that they need to connect with us and that relationship is already in place."

Social support needs-survivors		Refers to mentions of social issues that have been observed by CBOs among general patients and those experiencing DV or IPV. These include food security/access, financial strain, unstable housing, lack of transportation, experiences of police violence or racism, shifting parenting responsibilities, employment changes, substance abuse, childcare and others. Includes: - Mentions of social issues Excludes: - General mentions of social issues experienced in the world that are not explicitly/specifically connected to survivors' personal situation or plights of those experiencing DV or IPV.	I: "I'd like you to think of a survivor who first received care at a hospital and then received care or services in the community. What do you think is important for us to know about that kind of experience?" P: "It's like, now my financial situation is completely upended, I'm going to lose my house. He refuses to pay the mortgage because I filed a TPO. And there may have been other ways to address that or figure that out, even if it means going into a shelter for a little while, just to give yourself space to decompress and figure out next steps. It's very hard to ask people to come up with a plan when they're in the middle of a crisis."

	Reasons for care-seeking	Mentions of care-seeking for IPV survivors Includes: - Mentions of children that factor into decision-making for the survivor - Mentions of severe injury - Mentions of financial strain	I: “So now I'd like you to think of a survivor who first received care at a hospital and then received care or services in the community. What do you think is important for us to know about that kind of experience?” P: “So it's one thing and then when I think about a survivor from the community, that's an individual who is emotionally right, hurt, and that doesn't mean that he or she still couldn't be battered... But so then when you think about those two individuals now, community served and hospital served, hospital individuals have a little bit more need for assistance. Right. Because it's one thing that I need. I need funding, transportation, housing, and let's say mental health services and maybe even food. Right. As a community person. Now for a hospital, can you add on that now? Also need additional medical or dental services? I may need different aids for walking or lack of so yeah, so I feel like the medical component definitely makes that hurdle just a little bit higher, hands down.”

	Financial Strain-CBOs	Mentions of financial strain experienced among CBOs. Includes: - CBO workers expressing financial struggles that impact the care they deliver - Barriers and facilitators to providing care among CBOs Excludes: - General mentions of financial strain experienced in the world that are not connected to patients or those experiencing DV or IPV.	I: "What barriers do you face?" P: "We try to meet every need possible, but we are nonprofit agency. We get a lot of perks because we're so tied to the city. But one of the first things that people need are resources, right? So that is financial a lot of times. So how can we have a system set up to where there is an emergency fund just for this category? That would be phenomenal. That's my dream one day, right? That you can go to an app and fill out a very short application and have emergency funds to transportation to travel to where you need to be or that your car just pulls up for you. Many, many years I worked at a domestic violence program and the only way that we were able to transport women and children. And this particular agency did service for men a little differently and it wasn't as popular. So that's why I say women. But the only way to transport them if they did not have their own car, ___, is by police car. And we know that could be revictimization. Totally feel of it in so many ways. So transportation huge. That's my number two. And I think we can say this for so many other social service needs, but housing. Housing. Housing. If I could just have all these little tiki torchy little houses on one road in one

			community, right, that I can just say go live and be violent-free and happy, that's exactly what I would do. Because, yeah, I want to leave this relationship. I want to be safe, I want my children to be safe. But how do I do it? How do I financially carry it? How do I travel to where I need to be and then how do I live in peace and harmony? So those are three big ones. I know you've heard them with every conversation that you've had with individuals, but I have a road map in my mind. I just need some people to help me get there."

General/ Routine survivor support		Mentions of ways in which CBO offers support within first 48 hours Includes: - Increases, decreases, and no changes in the support available to general patients and DV or IPV survivors in relation to COVID-19 movement restrictions and infection control measures. - Mentions to the "outlets" that general patients and survivors have in relation to COVID-19 movement restrictions and infection control measures. - Any changes with routine post pandemic Excludes: - Mentions of support that are not related to COVID-19 movement restrictions or infection control measures. - Excludes mentions by CBOs of the types of support they offer to patients experiencing DV or IPV	I: "Okay, and then how was that different with COVID?" P: "It was not in person. Okay. So it was FaceTime or zoom or sometimes just to call. We tried to do zoom or something where at least they could see the case manager. Um and um, then when we started meeting with clients, it might have been wearing a mask, which right now we're back to masks as of Friday."

COVID Effects		Mentions of the impacts of COVID-19 on experiences of IPV and care provision, including movement restrictions and infection control measures on survivors experiencing DV or IPV. COVID-19 related movement restrictions include Georgia statewide and Atlanta city shelter-in-place orders, isolation for confirmed COVID-19 cases, and quarantine for confirmed contacts of COVID-19 cases. Infection control measures include social distancing and mask requirements. Includes agency specific measures, policies and effects. Includes changes to IPV experience, severity, mental effects, frequency Includes: - References to self-imposed movement restrictions such as self-quarantine or self-isolation.	I: "So have you noticed that domestic or intimate partner violence cases have presented differently during the COVID period? And if so, in what ways?" P: "...A couple of things have happened. Um, sort of the fabric of community has been hollowed out to some degree with a lot of elder folks dying of COVID who typically were the kind of the glue that was holding families together. So not just intimate partner violence, but family violence in general is happening because people have less resources, they're having to go into a pad split situation or everyone was staying at grandma's house and now Grandma has passed away and we're all fighting over the property. That kind of stuff happens too, quite a bit, as well as just sort of the mental health crisis of going through a pandemic as a population and feeling abandoned by your government and all the people that are supposed to help you. And that's certainly given people a shorter rope. So I'm seeing situations that used to not be such a flash point, becoming that in a lot of domestic violence situations and that's continuing to evolve. I mean, I've never seen a housing crisis like this, and that includes the 2008 2009 crisis and gentrification happening

			in [county] and there's a lot of displacement going on. And so all of that just sort of leads to more flash points. I guess the best word I could say where people who may have walked the other way or found a different solution to their problem just snap."

	IPV severity	Refers to how COVID-19 related movement restrictions and infection control measures have impacted the severity of all forms of IPV. Includes: - Anecdotal mentions of increased severity of IPV related to COVID-19 movement restrictions (ie. not personally observed by healthcare providers but heard about through colleagues, family, friends, news, and other sources). - Increases, decreases, or no change in IPV severity. Excludes: - Mentions of severity of IPV that are not related to COVID-19 movement restrictions or infection control measures.	I: "Have domestic or intimate partner violence cases presented differently during the COVID period, and if so, in what ways? P: "Yeah, after the COVID period, I would say that we have been receiving more clients that have been strangled. So, a lot of strangulation cases."

	IPV frequency	Refers to how COVID-19 related movement restrictions and infection control measures have impacted frequency of all forms of IPV. Includes: - Mentions of increases, decreases, or no change in IPV frequency that are anecdotal (ie. not personally observed by healthcare providers, but heard about through colleagues, family, friends, news, and other sources) and those that are personally observed by healthcare providers. Excludes: - Mentions of IPV frequency that are not related to COVID-19 movement restrictions or infection control measures.	I: "So have you noticed that domestic or intimate partner violence cases have presented differently during the COVID period, and if so, in what ways?" P: "I can speak to our research and what I've been observed from that. I'd say the impression we have to research is that the severity in the violence that people experienced during COVID increased, meaning the episodes were occurring more frequently and they tended to be more violent, and that was what our research indicated."

	Exposure to abusers	Mentions of the exposure to abusers that those experiencing DV and IPV have as a result of COVID-19 related movement restrictions and infection control measures. Includes: - Mentions of increased exposure, decreased exposure, and no changes in exposure. - Mentions of being forced to be at home with abusers due to COVID-19 related movement restrictions and infection control measures. Excludes: - Mentions of exposure to abusers that are not related to COVID-19 movement restrictions or infection control measures	I: "Have you noticed that domestic or intimate partner violence cases have presented differently during the COVID period? And if so, in what ways?" P: "I would say when COVID first started and everything was locked down, we were getting less calls because people were isolated with their abuser. And so it made it very difficult for a period of time for them to be able to make 911 calls or be able to call our shelter. So I think that once things open back up a little bit and that's sort of when the floodgates open back up and we saw a market increase because people were not isolated as much as they had been in the past."

New Support/ Support Changes		Mentions of new methods of support for DV and IPV survivors that have arisen during the COVID-19 period (January-June 2020) including increased use of technology and telehealth, increased partnerships with social services or community organizations, and others. Includes: - Mentions of how support has changed due to COVID Excludes: - Mentions of support offered before the COVID-19 period	I: "Did you see that it changed with COVID at all? I know you mentioned doing some more online work. Were there any other barriers with your normal response with COVID?" P: "Yeah, absolutely. In the beginning it was really scary because the system didn't really have preparations for transitioning to digital from in person. And so there was a period of time where it could take over a week for a person from the time they petitioned the court for relief to when they talked to a judge. And so obviously, in emergency situations, that created a situation where we needed to put people in hotel rooms more often or had to look at shelter more often. That's improved quite a bit since the beginning, but it still takes 24 to 48 hours after filing to get a hearing with the judge, and then it takes another day for that signed order to be filed and for the sheriff's office to go out to serve it. So safety planning has changed as a result of that. And same with law enforcement. Just kind of seeing the lay of the land and how they're responding to things gives me more information to tell victims like this is what to expect if you call the police, and don't worry if they don't do what you think they need to do. We have options and we have

			ways that we can try to help you facilitate that. That's been brand new. As far as safety planning goes, helping them plan to deal with the system is part of it now more than it used to be. It always was, but now more so than ever."

	Barriers to CBO support	Mention of institutional, practice-related, personal, and general barriers faced by healthcare providers in the support they offer to survivors experiencing DV or IPV. Includes: - Mentions of barriers and facilitators both before and during the COVID-19 period	I: "So overall, what barriers would you say, do you face in providing support to intimate partner violence survivors in general? P: Our biggest challenge right now is housing. The market. As it stands, the access is quite limited and the rents have gotten so expensive."

Support resources needed		Mentions of additional resources that are needed by healthcare providers to give support to DV and IPV survivors during the COVID-19 pandemic such as more money, more social services, more research into DV or IPV during pandemics. Includes: - What we need to support care transitions Excludes: - Mentions of resources not related to support for DV and IPV survivors.	I: "What do you think is important for us to know about that kind of experience? I know you touched on a little bit, but is there anything else you'd like to expand on?" P: "Yeah, no, I think that's the goal, I think, is for us to try and to transition people from the hospital to community-based care and provide support to them. I think certainly there's always with grants and everything, trying a need with some of our clients, a need for more resources to be able to assist because a lot of our clients do not have access to Medicaid or any kind of care of that nature. And so to be able to have the financial resources to be able to seek some of the care, it can be kind of an impediment, but I think just to try and provide that support system, to try and help advocate for next steps towards their continued care, definitely."

CBO Suggestions		Mentions of ways to prevent or better respond to DV or IPV in general Includes: - Suggestions that are personal to the CBW - Policy suggestions	I: "What would you suggest to prevent or better respond to domestic or intimate partner violence, especially for those referred from hospitals?" P: "Yes, I would like to see less of a systemic response and more of a community-based response like you're talking about, because forcing people into a cruel system that people attempt to bend towards, just towards good. But generally it's harmful in its own ways. I would really like to see more community in period, more compassion, more mentoring with young people, getting out in the community, talking to folks. We used to spend a lot of time training police and training systems people. It doesn't really seem to make a whole lot of difference in terms of the numbers we're seeing. I think it's good for those individual officers or people there to know more and to have a more comprehensive understanding of domestic violence. But it doesn't change the way that women are experiencing those entities when they're trying to get help and they're the ones who have to call them the most. I don't necessarily have to call the police if I get into a conflict. I feel like I have options of places to go or things like that. You're just stuck somewhere and now you're

			really stuck because rent is going up like crazy...But yeah, I see the needs being more community-based. Definitely mental health assistance is huge. Just even having a pathway for people to get what they need in that regard is going to make a huge difference in getting people's basic needs met. Again, I can't emphasize that enough and I don't know what kind of coordination could happen in that regard with health care system and nonprofits and domestic violence agencies, um but that's definitely something to think more about now than ever before."

Inductive Codes			
General/ Routine Survivor support	Prevention		I: “What would you suggest to prevent or better respond to domestic or intimate partner violence, especially for those referred from hospitals?" P: “What we do have school advocates and we're in the schools doing prevention work. We have a program called Safe Dates where we talk about relationships and healthy relationships. And so that's part of our prevention stuff. We also have V to V, which is a victim to Victor. And we're in inner city schools...And what we found, even at the high school level, we're too late, which is why we wrote the grant for [Middle School].”
Care Transitions	Number of Survivors from hospital		I: “Approximately what percentage of those survivors come directly from hospital care, for example, like emergency departments, would you say?” P: “I'd say a small percentage.”