PEOPLE'S HEALTH SOLUTIONS

HUB for URBAN INITIATIVES

Rapid-Response Policy Research

Responding to Intimate Partner Violence and Homelessness in Los Angeles County during a Time of COVID-19

October 2020

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People's Health Solutions in partnership with Hub for Urban Initiatives

ACKNOWLEDGEMENTS

This study is dedicated to those who are survivors of — or are surviving — intimate partner violence. Never forget that standing up for yourself and walking away from something unhealthy is incredibly brave. Trust that you are on the right path, and keep going.

As Maya Angelou wrote: Each time you stand up for yourself, you stand up for all of us.

We would like to acknowledge the survivors and service providers who volunteered for this study during a very sensitive time in their lives and in Los Angeles history. During a time of great uncertainty, you chose to step forward and share your story, so that it might help others. It was a privilege to engage in dialogue with each and every one of you, and we hope this report will help do justice through the experiences and solutions you shared.

This rapid-response research would not have been possible without our community partners, TransLatin@ Coalition, Positive Results Center, and Downtown Women's Center. We are also grateful to the service organizations who hosted our survivor focus groups and interviews, including Rainbow Services, The People Concern, and Jenesse. Thank you for your trust, generosity of time, and the tireless work you do for survivors.

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Rapid-response policy research team:

Melissa King, PhD, MPA, principal investigator, was responsible for study design, community engagement, research protocol and instrument development, and leading qualitative coding and analysis. She conducted key informant interviews, focus groups, and semistructured interviews. She wrote the manuscript and policy brief.

JuHyun Sakota, MPA, was responsible for project management, survey analysis, and secondary coding. She conducted key informant interviews and reviewed the manuscript and policy brief.

Sofia Herrera, PhD, contributed input to the study design and all phases of the project. She conducted key informant interviews and focus groups and reviewed the manuscript and policy brief.

All three researchers participated in development and discussion of case summary memos for their key informant interviews as part of the qualitative analysis process.

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POLICY BRIEF

Separate yet Connected: Experiences of Intimate Partner Violence and Homelessness in Los Angeles County during COVID-19

October 2020
By People's Health Solutions in partnership with Hub for Urban Initiatives

EXECUTIVE SUMMARY

The COVID-19 pandemic has led to an exacerbation of intimate partner violence and conditions that put women fleeing violence at risk of homelessness. This has created unprecedented challenges for responders and a need for solutions to promote safety for this highly vulnerable population. A rapid-response policy research study in Los Angeles County, California, uplifts survivors and service providers to identify funding, policy, and service strategies to enhance response systems and keep survivors safe.

INTRODUCTION

The fear, social isolation, economic distress resulting from COVID-19 has contributed to conditions worldwide where intimate partner violence (IPV) is more likely to occur. IPV is a major driver of homelessness: A survey of homeless women in Los Angeles County found that 53% had experienced domestic or interpersonal violence in their lifetimes (Downtown Women's Center, 2019). In the LA County setting, people of color and LGBTQ+ individuals carry a disproportionate burden of IPV, homelessness, and COVID-19 (California Department of Public Health, 2020; Los Angeles Homeless Services Authority, 2020). More than 300,000 cases and 7,000 deaths from COVID-19 have been reported in LA County (LA County Department of Public Health, 2020). With the pandemic spreading along fault lines of our most vulnerable, it is imperative to ensure responses are grounded in equity and human rights.

What is Intimate Partner Violence (IPV)?

IPV refers to any in a wide range of coercive behaviors used by one partner to establish power and control over another. It is defined as encompassing "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Breiding et al., 2015). IPV can occur whether or not two people are living together (e.g. if both people are unsheltered), something that distinguishes it from domestic violence (DV), which occurs between two people in a household and is also inclusive of child and elder abuse.

Partnering with community-based organizations and following United Nations guidelines for research with survivors during COVID-19, we addressed two primary research objectives: (1) identify policies to promote safety for people experiencing IPV and homelessness, and (2) identify solutions to create a more unified response system.

APPROACH/METHODS

We employed an exploratory research design in which key informant interviews and survivor focus groups and interviews were analyzed in parallel to generate contrasting narratives through which to identify important themes and solutions. Participants included (1) 12 key informants representing diverse IPV and homeless service providers in every service area of LA County, (2) 19 survivors who experienced IPV and housing instability before and/or during COVID-19, and (3) four survivors navigating a novel public program to help 1,000+ survivors and their families achieve safety and housing stability quickly during COVID-19. Focus group surveys were administered to assess survivor demographics, living situation, and safety and wellbeing.

Community partners (TransLatin@ Coalition, Positive Results Center, and Downtown Women's Center) and three hosts who predominantly serve black, Latino(a), and LGBTQ+ communities reviewed instruments, hosted groups and interviews, and provided feedback. Research was conducted by three female researchers trained in mental health and research ethics. Thematic content and narrative analysis were used to approach the data and involved qualitative coding in Dedoose (survivors) and development of 12 case summary memos (key informants).

RESULTS

On March 19, 2020, as Executive and Public Health Orders directed all Californians to stay at home, shelters in LA County were at a standstill: many closed their doors to new clients before reopening with limited capacity as staff sought to control the spread of COVID-19 and develop safety protocols. On April 29, the LA Mayor's Fund, Mayor's Office, and donors funded Project Safe Haven to secure additional housing for survivors and their families.

From June and July, 12 key informant interviews were conducted with leadership, directors, managers, DV Regional Coordinators, and front-line staff at IPV and homeless service providers via Zoom. July through September, three focus groups (2 Spanish, 1 English) and four semi-structured interviews (Project Safe Haven program participants) were conducted with survivors via phone in private settings following COVID-19 mitigation protocols.

A total of 23 survivors participated. Survivors identified as female (74%), transgender (17%), and transfemale (9%), and ranged in age from 24 to 66. Races/ethnicities were Latino/a or Hispanic (57%), Black or African American (30%), White/Caucasian (9%), and Other (4%). More than half had experienced homelessness on the street or in a vehicle or shelters in the past year, and nearly half had also experienced an escalation of IPV that was so bad they had to leave home or move. When asked when the last escalation occurred, 57% said before March 2020, 35% said during or after March 2020, and 9% declined to state.

Experiences accessing and navigating service systems

Project Safe Haven was described as helping to fill an existing gap in shelter and housing resources for survivors, in particular for single adults and families with older children. There was a common understanding that the IPV system of care is not a "system," but rather a network of service points. As access became almost exclusively virtual, and with no unified hotline, survivors and key informants alike described being "bounced around" between access points at IPV and homeless service agencies. Both also described how COVID-19 shone the light on longstanding health, social, and economic inequities among specific groups of survivors. Narratives suggest that those identifying as people of color, transgender, gender-nonconforming, immigrants, and/or unsheltered faced systemic challenges to access, while at the same time bearing a disproportionate burden of violence, housing instability, and COVID-19 infection.

> "Overall, the crisis has shown how quickly people can come together. We now have almost 5,000 people [housed] between Project Roomkey and Project Safe Haven together. And they're basically overlaid with the same type of programming and services. It's more standardized. There's more accountability because of all the high-profile partners involved. And I think that's a silver lining. We did that. And we could sustain it if we politically chose to do so."
> – Key informant

Maintaining safety of survivors

The strongest theme arising from survivor focus groups and interviews was mental health. Survivors described complex trauma that arose both from current experiences of IPV and housing instability and from memories triggered by shelter-in-place orders. Results suggest the need for approaches to unite 'separate yet connected' IPV and homeless service systems to keep survivors safe. Survivors sought trauma-informed services that provided sanctuary and healing during a time of social isolation and economic instability, when natural supports are less readily available. Nearly all participants described a hybrid of remote and face-to-face services as necessary to offer protection from COVID-19 while building the supportive relationships essential to recovery.

Service and resource gaps

Availability of shelter and affordable housing was named as the number-one resource gap by both survivors and service providers. Nevertheless, key informants said the complexity of the crisis had spurred unprecedented collaboration to quickly implement new housing resources using a DV Housing First model (Lopez-Zeron et al., 2019), testimony to what was possible. Key informants described how strict service specifications required by funders, limited flexible funding, and lack of federal economic relief dedicated to IPV and culturally-

> "It made a world of difference, not having to worry about where we're going to be every night… housing services is the thing that has helped me to keep my sanity…being able to take a breath, the sanctuary of having a supportive group of people."
> – Project Safe Haven participant

specific communities created barriers to meeting clients where they were at. Other resources named by survivors as essential during COVID-19 were economic or rent assistance, health and mental health care, legal services, transportation, food and household essentials, children's services, employment or career services, and technology. Overall, the ability to obtain these resources depended upon whether agencies had cultures of mental health and took a whole-person, trauma-informed approach.

> "Shelters are not equipped to support people of trans experience, and part of that is because the shelters are gender-based...there is not a [shelter] we can refer trans women to who have been victims of domestic violence." – Key informant

Creative solutions for outreaching survivors and preventing homelessness

Participants said that at a time when some are not safer at home, it is especially important for whole communities to play an active role in prevention and outreach. They recommended public education campaigns and training for law enforcement, faith community, social services, and mental health aimed at changing beliefs, increasing knowledge and awareness, and learning skills to intervene. Participants described how IPV and homeless service providers are serving the same survivors and called for integrated systems of care. This might involve leveraging technology and developing a unified crisis line and new roles to support outreach and navigation.

> "So many of the people who have connected survivors to us were lawyers, doctors, teachers, you know, concerned neighbors. [We need] more people who have a general understanding of what domestic violence, what services are out there."
> - Key informant

CONCLUSION AND RECOMMENDATIONS

Overall, while COVID-19 drew global attention to the intersection of IPV and homelessness, these systemic issues existed already. Solutions offered support policy recommendations at multiple levels to keep survivors safe both in future waves and in the longer term.

Policy and socioeconomic level

1. **Fund further implementation and effectiveness research on the DV Housing First model and Project Safe Haven intervention.** Continuation of Project Safe Haven is a means of dedicating crisis housing resources for survivors and addressing a gap in resources for single adults and families with older children.
2. **Dedicate economic relief and prevention funding to IPV and homeless service organizations for flexible procurement of resources for survivors.** Earmarking funds for flexible use toward rent, hotel/motel rooms, and community resources may be a cost-effective means of helping survivors to stabilize their living situations.
3. **Dedicate economic relief and foundation grants to programs serving those disproportionately impacted by COVID-19, IPV, and homelessness.** Native communities and communities of color and LGBTQ+ individuals have been disproportionately impacted. So too have immigrants and unhoused individuals experienced unique barriers to services.

System and inter-organization level

4. **Develop policies to ensure inclusive decision-making and create equitable access to and outcomes from City- and County-funded IPV and homeless services.** Community engagement should be required of agencies as they engage in all stages of program planning, implementation, and evaluation during and after the pandemic.
5. **Pilot and test new roles that support access and navigation.** This might include DV Housing Navigators, Housing Locators, and mobile case management and advocacy.
6. **Plan and collaborate toward integration of IPV and homeless services.** Continue to strengthen the relationship and connectedness among IPV and homeless service providers through regular communication and networking.

Organization level

7. **Support organizational cultures of mental health.** It's important to remember that trauma-informed care is not simply a skill to be taught, but rather a product of organizational contexts that foster healing for staff and clients alike.
8. **Seek to achieve a hybrid of remote and virtual services.** While survivors relied on phones, some in-face meetings are vital to relationship-building. Responders will need to provide technology to survivors to achieve a more equitable response.

Individual and interpersonal level

9. **Skills training for IPV and homeless service agency staff.** Agencies should encourage cross-training on IPV (for homeless services) and homelessness (for IPV services) to increase knowledge and awareness of these issues and develop and skills to respond.
10. **Community education on IPV and homelessness**. Public education campaigns and trainings are needed to equip the general public and diverse sectors such as mental health care, law enforcement, social services, and faith community to respond collectively.

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To read the full report: www.peopleshealthsolutions.com/covid-19

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BACKGROUND AND LITERATURE REVIEW

The COVID-19 pandemic created a climate of fear that, compounded with social isolation and economic stress, has led to growing concerns over the potential impact on survivors of intimate partner violence (Healy, 2020; Taub, 2020). Responsive policies and strategies are needed to prevent homelessness among survivors making the difficult decision between staying in an unsafe situation or fleeing to a shelter or the streets.

This rapid response policy research was undertaken to study the effects of COVID-19 on people experiencing intimate partner violence and homelessness and the challenges faced by agencies who serve them. At the time this report was completed, more than 300,000 cases and 7,000 deaths from COVID-19 had been reported in Los Angeles County (LA County Department of Public Health, 2020). We aimed to identify policy solutions that could be adopted to improve service systems and safety for this highly vulnerable population.

Intimate partner violence (IPV) refers to any in a wide range of coercive behaviors used by one partner to establish power and control over another.[1] It is defined as encompassing "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Breiding et al., 2015). IPV is a major driver of homelessness, particularly among women: A survey of homeless women in LA County found that 53% had experienced domestic or interpersonal violence in their lifetimes; among those identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ+) and/or racial or ethnic minorities, incidence was even higher (Downtown Women's Center, 2019).

Among racial minority individuals, those who are Black and/or Latino/a have among the highest incidence of homelessness, IPV, and COVID-19. While Black individuals make up 8.3% of the population in LA County, they accounted for 34%, while Latino(a) individuals accounted for 36%, of those surveyed in the Greater LA Homeless Count (Los Angeles Homeless Services Authority, 2020). In addition to experiencing homelessness and IPV at rates disproportionate to other racial groups, Black and Latino(a) individuals, who represent 6% and 38.9% of the California population, account for 7.5% and 48.6% of deaths from COVID-19, respectively (California Department of Public Health, 2020).

Violence is also a distinguishing difference between people of different genders experiencing homelessness (Ad Hoc Committee on Women and Homelessness, 2017). Among all those surveyed in the Greater LA Homeless Count who were experiencing domestic violence, 50.7% identified as female, 44.0% male, and 5.1% transgender (Los Angeles Homeless Service Authority, 2019). Likewise, while incidence data by sexual orientation and gender identity is lacking, there is ample evidence that LGBTQ+ individuals

[1] IPV can occur whether or not two people are living together (e.g. if both people are unhoused), something that distinguishes it from domestic violence (DV), which occurs between two people in a household and is also inclusive of child and elder abuse. Throughout this paper the authors and interviewees make reference to "DV shelters" and "DV services," because these are the terms commonly used to refer to agencies serving IPV and DV survivors.

have health and economic characteristics that place them at high risk of COVID-19 morbidity and mortality (O'Neill, 2020a, 2020b).

While data on changes in incidence of IPV in LA County during COVID-19 are lacking, there is evidence that factors such as stress, isolation, and economic distress create conditions where abuse is more likely to occur (Sharma & Borah, 2020). The number of LA County Domestic Violence Council hotline calls rose from 446 in February 2020 to 1,015 in June 2020 — nearly double the number in June 2019 (Office of the Domestic Violence Council, 2020). Yet it is unclear whether this reflects increased incidence, greater intensity of need among longer-term survivors, or closures among drop-in centers. Further, hotline numbers may not capture the true magnitude of a surge in violence. Prior to COVID-19, nearly half of IPV cases went unreported (Reaves, 2017). This under-reporting may be exacerbated in situations where people are unable to leave their homes or make calls for help, or who fear retaliation, due to constant oversight by their abusers.

Qualitative and community-based research approaches are necessary for understanding experiences of IPV and homelessness during a time of COVID-19. As the pandemic spreads along fault lines of our most vulnerable, it is also imperative to ensure our public health policy response is grounded in human rights — eliminating barriers for our most vulnerable to remain healthy and safe (UNAIDS, 2020). We collaborated with community partners whose clients are among groups disproportionately impacted by IPV and homelessness — TransLatin@ Coalition, Positive Results Center, and Downtown Women's Center — to review instruments, host groups, and interpret findings to address two primary research objectives: (1) identify policy changes to promote safety for people experiencing IPV and homelessness and (2) identify solutions to create a more unified response system. We also collaborated with three additional agencies who hosted survivor focus groups and/or interviews: Rainbow Services, The People Concern, and Jenesse.

Prior to COVID-19, there had been significant investment in the implementation and evaluation of the DV Housing First model throughout California (Lopez-Zeron et al., 2019). Evidence for this model suggests that it may be effective in preventing violence and homelessness among survivors experiencing housing instability (Washington State Coalition Against Domestic Violence, 2020). During COVID-19, new housing resources were dedicated to rehousing vulnerable populations using this model. On March 19, 2020, as Executive and Public Health Orders directed all Californians to stay at home, shelters in LA County were at a standstill: they closed their doors to new clients while sheltering in place existing clients as staff sought to help control the spread of COVID-19 and develop safety protocols. The State launched Project Roomkey on April 3 to secure hotel and motel rooms for older adults at highest risk of COVID-19,[2] and later on April 29, the Los Angeles Mayor's

[2] From the LA County Project Roomkey website: "Hotel rooms will provide temporary housing for people experiencing homelessness who are not COVID-19 positive or symptomatic, but are vulnerable to complications should they become infected with COVID-19. To qualify to participate in Project Roomkey, individuals must be 65 years of age or older or have underlying medical conditions or be medically compromised. This group of people are significantly more likely to need hospitalization, and require critical care if infected with COVID-19. To participate in Project Roomkey, clients must be referred to the program by a homeless services provider or law enforcement." http://covid19.lacounty.gov/project-roomkey

Fund, Mayor's Office, and Philanthropic donors funded Project Safe Haven to secure up to 900 housing units for IPV survivors and their families.

With the goal of identifying and expanding upon what is known about how service systems are functioning to keep survivors safe, we identified three research questions:

Q1. How have survivors' experiences of IPV and homelessness been influenced by the COVID-19 pandemic?

Q2. What primary challenges have IPV and homeless service organizations faced in serving IPV survivors during the pandemic?

Q3. How could solutions identified by survivors and service providers inform LA City and County government policies relating to safety and systems for preventing and addressing homelessness among survivors?

While the relationship between IPV and homelessness is complex, factors such as financial instability, lack of affordable housing, and social isolation can force survivors to choose between staying with their abusers or homelessness (National Alliance to End Homelessness, 2011). Exacerbation of these conditions has created unprecedented challenges for survivors in navigating an already complex system (Futures Without Violence, 2020). It also exposes strengths and weaknesses in existing service systems and calls for rapid identification of new approaches to keep survivors safe.

RESEARCH DESIGN

We used an exploratory research design in which findings from key informant interviews, focus groups, and semi-structured interviews were analyzed in parallel to generate contrasting narratives through which to identify important themes and solutions. We took an interactionist perspective, whereby through conversations researchers, participants and partners generated and made sense of the data, eliciting insight into response systems and recommendations for policies to keep survivors safe (Miller & Glassner, 2010).

It is important not to shy away from community engagement during a crisis, when partnering with those who are impacted is essential to designing responsive programs (ARCC, 2020). We followed rapidly-evolving United Nations (UN) guidelines for collecting data on IPV during COVID-19 (United Nations Population Fund, 2020). To uplift voices of LGBTQ+ individuals and people of color disproportionately impacted by violence, homelessness, and COVID-19, providers who serve culturally-specific communities partnered in recruitment and data interpretation.

The researchers were sensitive to the lived experience of participants and were among themselves representative of some of these communities. They drew on extensive experience facilitating focus groups and interviews with vulnerable populations and practiced with a compassionate and trauma-informed approach. The study was approved as human subject research by the Fuller School of Psychology & Marriage and Family Therapy IRB (1613620-1).

METHODS

SAMPLING

Key informant interviews (n=12). A purposive sample was chosen with input and guidance from community partners and included senior leadership, directors, managers, Domestic Violence Regional Coordinators (DVRC), and front-line staff based at homeless and IPV shelters and public and non-profit service organizations. Quotas were used to ensure geographic representation of all Service Planning Areas (SPAs) in LA County and diversity in populations served and services offered by host organizations. *Focus Groups (n=3) and semi-structured interviews (n=4).* Five partners and host organizations used English and Spanish flyers to recruit survivors to participate in focus groups of 6 to 7 people (via Zoom) or semi-structured interviews (via phone) from a private place. To be eligible, survivors had to be adults ages 18 and over; live in Los Angeles County; have experienced IPV and housing instability or homelessness before and/or since COVID-19; and have comfort discussing topics of IPV, homelessness, and race- and gender-based violence. For semi-structured interviews, the additional criteria was current participation in Project Safe Haven.

INSTRUMENTS

Key informant interview and survivor focus group guides were developed to structure dialogue into four categories: (1) experiences accessing and navigating the IPV and homeless service systems (before and after COVID-19); (2) maintaining safety of survivors; (3) service and resource gaps; and (4) creative solutions for outreaching survivors and improving service navigation. A *key informant interview guide* was developed to support the systematic use of questions by interviewers. *Focus group guides* (English and Spanish) were also developed and included protocols for COVID-19 mitigation and survivor privacy and safety, as well as grounding exercises to support a safe and healing-centered space. Since semi-structured interviews were offered as an alternative to focus groups for those participating from Project Safe Haven rooms, the guide also supported these interviews. Finally, *focus group surveys* (English and Spanish) were developed to capture data on overall participant demographics, living situations, and safety and wellbeing. Surveys were anonymous; no information that could link data to participants was collected.

PROCEDURES

A total of 12 *key informant interviews* (1.5 hours each) were conducted with individuals representing diverse IPV and homeless service providers across all eight SPAs (**Figure 1**). Interviews were conducted via video conference (Zoom) by one of the three female researchers trained in research ethics from June through August 2020.

Three *focus groups* (2 hours each) were facilitated with survivors via Zoom from July through August 2020 by one of two female researchers trained in research ethics and mental health. Two were conducted in Spanish (6 participants each), and one was

conducted in English (7 participants). A second female researcher participated in each group as a notetaker and to manage technology. All participants completed an anonymous focus group survey on paper or electronically via Qualtrics.

As key informant interviews and focus groups concluded in August, it became apparent that Project Safe Haven was developing as a major theme. The team was also informed by host organizations of survivors who preferred to participate through the alternative semi-structured interview procedure, as opposed to a focus group. The research team therefore added four semi-structured interviews to accommodate those needs and to understand the lived experiences of Project Safe Haven participants. The four *semi-structured interviews* (1.5 hours each) were conducted by the PI via phone in September.

A total of 23 survivors participated in a focus group or semi-structured interview (see **Figure 2**). Survivors identified as female (74% or n=17), transgender (17% or n=4), and transfemale (9% or n=2). They ranged in age from 24 to 66 (mean: 50, median: 46). All but one who declined to state described their sexual orientation as straight. Self-identified race/ethnicities were Latino/a or Hispanic (57% or n=13), Black or African American (30% or n=7), White/Caucasian (9% or n=2), and Other (4% or n=1). More than half had experienced homelessness (as opposed to just housing instability) on the street or in a vehicle or shelters in the past year. Nearly half had also experienced an escalation of IPV that was so bad they had to leave home or move in the past year. When asked to think back to the last time they experienced an escalation of violence, 57% (n=13) said before March 2020, 35% (n=8) said during or after March 2020, and 9% (n=2) declined to state.

All participants underwent formal informed consent procedures. Interviews and focus groups were digitally audio recorded with the participants' permission, and primary data were transcribed in their entirety into textual files for analysis. Transcription was accomplished with the aid of Sonix.ai (Spanish) and Otter.ai (English) software, and transcriptions were translated as applicable to English by the research team.

Figure 1: Key Informant Organizational Affiliation Characteristics (n=12)

Criteria	Details	Organizations
Any Specific Population Focus	Youth	5
	Adult	5
	Women	8
	Men	4
	Family	4
	LGBTQ+	2
	Black or African American	1
	Latino(a) / Hispanic	3
	Asian	1
	Disability	1
Geographic Representation*	SPA1	1
	SPA2	1
	SPA3	1
	SPA4	3
	SPA5	1
	SPA6	3
	SPA7	1
	SPA8	2
Services	Hotline/ Crisis Support	5
	Emergency Shelter/ Transitional Housing/ Rapid Re-Housing	8
	Drop-In Center	6
	Supportive Services^	11
	Intervention/Prevention+	7
	Advocacy/Education	7
	Deaf & Disabled Survivors Services	1
	Permanent Supportive Housing	4

*Geographic Representation is based on physical locations of each agency's headquarters and/or drop-in centers. DV service agencies do not have predetermined geographic boundaries for service areas.

^Supportive Services: child care, transportation, clothing, nutritional support, etc.

+Intervention/Prevention: case management, legal services, counseling, violence prevention programs for youth and adults

Figure 2: Focus Group and Semi-Structured Interview Participant Characteristics

Characteristics	*N (=23)*	%
Gender		
Female	17	74%
Transgender	4	17%
TransFemale	2	9%
Sexual orientation		
Straight	22	96%
Declined to state	1	4%
Age Group		
24-34	6	26%
35-44	9	39%
45-54	3	13%
55-66	5	22%
Race/ethnicity		
Black or African American	7	30%
Latino(a) / Hispanic	13	57%
White / Caucasian	2	9%
Other	1	4%
Number of times experiencing homelessness, on the street or in a vehicle or in shelters, in the past year		
0	11	48%
1	7	30%
2	3	13%
4	2	9%
Places survivors spent their nights in the past 30 days (option to check all that apply)		
Own apartment or house	4	17%

Apartment or house of family	1	4%
Apartment or house of friend	4	17%
DV shelter	6	26%
Shelter (non-DV-specific)	3	13%
Hotel or motel	3	13%
Other	2	9%
Declined to state	1	4%
In what part of or city in Los Angeles County survivors spent the majority of their time in the past year (one response written in)		
City of Los Angeles (SPA 4)	4	17%
Downtown / Skid Row (SPA 4)	4	17%
Hollywood (SPA 4)	2	8%
Long Beach (SPA 8)	1	4%
Manhattan Beach (SPA 8)	1	4%
San Pedro (SPA 8)	2	8%
South Gate (SPA 7)	1	4%
South LA or South Central (SPA 6)	4	8%
Torrance (SPA 8)	1	4%
Number of separate times experiencing an escalation of IPV that was so bad they had to leave home or move, in the past year		
0	12	52%
1	7	30%
2	3	13%
5	1	4%
Whether last escalation of violence experienced was before or after the onset of COVID-19 (before or after March 2020)		
Before March 2020	13	57%
During or after March 2020	8	35%
Declined to state	2	9%

DATA ANALYSIS

Key informant interviews. Each researcher analyzed four interviews by developing a summary memo for each transcript, synthesizing thematic findings and arranging them with illustrative quotations into the four pre-identified categories. This represents a hybrid between a deductive "framework approach" common in policy research and inductive "grounded theory" approach common in social science research (see Pope et al., 2000, for a comparison). Each repeated this process for the other two researchers' transcripts, providing the following feedback on each memo to support reliable identification and valid representation and interpretation of themes: *Is there a theme that's missing? Is there a stated theme that may not be valid or important given my own interpretation? Is there another way to highlight a particular theme? Are there quotes that I don't think are ideal for illustrating a particular theme? Are there exemplary quotes that haven't been included in the memo?* The researchers then came together with their final memos for a series of three group discussions to collaboratively engage in narrative analysis and identify overall themes.

Focus groups. Dedoose coding software was used to facilitate thematic analysis, with the PI coding and identifying thematic content, sorting it into the four pre-identified categories, and developing a coding guide. A second researcher iteratively coded a randomly-assigned one-quarter of each transcript and discussed findings with the primary coder. This process of reflection and dialogue was undertaken to support reliable coding and valid identification and representation of themes (O'Connor & Joffe, 2020).

Focus group surveys. Survey data were analyzed in Microsoft Excel to offer descriptive statistics of overall focus group and semi-structured interview participant demographics.

Initial findings were shared and discussed with community partners to verify themes and policy recommendations and lend additional interpretation.

RESULTS

Presentation of results reflects our hybrid grounded theory and framework approach. Themes and exemplary quotations identified during discussion of case summaries (key informants) and qualitative coding (survivors) are organized into four broad policy categories: experiences accessing and navigating services systems **(p. 17)**, maintaining safety and wellbeing of survivors **(p. 24)**, service and resource gaps **(p. 33)**, and creative solutions for outreaching survivors and preventing homelessness **(p. 38)**.

For bolded topics under each theme, additional exemplary quotations are displayed at: www.peopleshealthsolutions.com/covid-19

The decision was made after focus groups and semi-structured interviews were analyzed, and similarity of themes was assessed, to display findings together with that of key informant interviews. Most themes overlapped, provided contrasting and complementary perspectives. Dialogue on community resources and creative solutions was dominated by survivors, whereas the topics of flexible funding and emergency relief and new roles for

outreach and navigation were dominated by key informants. Three subtopics found to contribute to the larger theme of trauma-informed care — (1) seeking sanctuary, (2) victim blame and insensitivity, and (3) staff health and wellbeing — arose solely from survivors (1+2) and key informants (3). Both perspectives were therefore essential to the full picture.

Throughout the results, we refer to those who participated in focus groups and semi-structured interviews as "survivors" and those who participated in key informant interviews as "key informants." However, we wish to recognize that some key informants also identified as survivors. We thank them for surviving and especially for their willingness to share their journeys and experiences during a very sensitive time.

EXPERIENCES ACCESSING AND NAVIGATING SERVICE SYSTEMS

People experiencing homelessness in Los Angeles typically seek shelter through the coordinated entry system or CES (also primary access point for Project Roomkey). People experiencing IPV in turn typically seek shelter through the DV system of care by accessing drop-in centers or DV hotlines (also primary access points for Project Safe Haven).

Although these access points did not change during COVID, a primary barrier to access named by all key informants was the **reduction in shelter bed availability** that occurred as inflows/outflows from shelters stalled at the onset of the pandemic.

> *Before COVID, if we had a survivor that needed housing, we would immediately access emergency housing programs that are available. But even those, they were limited…now with COVID, there is even more of a limitation, because for a long time people were not taking on new clients because there wasn't a sense of protocols for COVID. Should we be taking temperatures? Is that a HIPAA [violation]? [How] do we make sure everyone is keeping the six-feet distance? So I think what the upheaval was with agencies is what do we do now with this new information? How do we make sure we're protecting out staff and our clients and the new staff that are coming in? For a while we were seeing a huge influx of clients just not really knowing where to turn to, especially when a lot of agencies closed their doors. – Director at one of largest IPV service agencies in Los Angeles*

While there is a lack of data to evaluate changes in IPV incidence, providers saw evidence that reductions in bed availability were accompanied by **greater intensity of need**. One key informant described how while the volume of calls to DV hotlines lessened in the first few months after the outbreak, the urgency and severity of calls received were greater.

> *Initially, our hotline numbers did decrease. And we were concerned that again, people didn't have as much opportunity to call us safely. And then the people who did call us tended to be in higher crisis…we were receiving more calls from people who had already fled. They had already left the home because the situation escalated. Now they're calling. 'I'm outside. I'm not really sure where to go.' – Service manager of large DV organization*

Survivors described how they coped by drawing on natural supports such as friends and family or staying in hotels while searching for a more stable living environment. However, **COVID-19 placed stressors on natural supports** that made them less available to help, and staying in hotels indefinitely was untenable given unemployment and job insecurity.

Yeah, so my sister is kind of like [my] main support person. You know, with COVID, [she] was laid off from work. And so with her not having a job, you know, when all of this happened, you know, of course, the financial, the idea of, you know, having to either rent a hotel room, or, you know, try to find some sort of Airbnb long term, was what I was facing. And I know she was quite upset at the fact that she didn't necessarily have a job, so that she could help me if I needed it. – Project Safe Haven participant

COVID affected everything. I was living motel to motel. I was paying $450 a week out of my paycheck, every week, for [a] hotel. – Project Safe Haven participant

Project Safe Haven fills DV shelter resource gap for survivors

Key informants said the most significant change to accessing IPV services as the pandemic progressed was **Project Safe Haven, which filled a DV shelter availability gap.** The program is a collaborative effort to secure housing for survivors of DV or human trafficking who sought safety and protection during safer-at-home orders (City of Los Angeles, 2020).

Prior to COVID-19, IPV survivors relied primarily on DV shelters and motel vouchers were limited. Project Safe Haven provided access to an immediate resource that didn't require COVID-19 testing results, provided privacy and isolation for individuals and families, and helped address shortages creatively — by repurposing vacant hotel and motel rooms.

One of the benefits that I've seen [is] that the DV shelters have partnered with the Mayor of Los Angeles [through Project Safe Haven], and so there's actually more beds than there was before there was COVID, because we have the ability to place clients in hotel rooms. In homelessness, placing a client in a hotel room is very normal; it's something that agencies do and they know how to do. And they've already built relationships with hotels and motels. – DV Regional Coordinator based at housing agency in her SPA

Survivors who participated in Project Safe Haven described the relief they experienced when a hotline was able to move them to safety at a time when they were exhausted, vulnerable, and scared. As one participant recalled of her encounter with the program,

I was a single individual, with no nowhere to turn, no place to go. No family. No friends. And it took me a couple of days to get ahold of an organization…I was on the phone maybe five hours a day [for] two days, looking for someplace to go…but because of COVID, there was always the turnaway…there was no place to go, you know, they had no place for me. And the COVID made homelessness a more vivid and more real and more bigger problem for those who are homeless, you know, compounded the situation.

[So] the phone was a real big thing, calling for hours and hours for those days, until finally, [the] third day of desperately trying to find somebody to help me, [she] didn't say, 'I think I can help you?' with a question mark. She said 'I think I can help you!' [And] they took me and scooped me up and put me in a hotel during COVID. And I finally am in a stable environment now after six months…The help that came now with the COVID, with the new programs, was a godsend. From my experience, if it had come at any other time, I might not have had the support that I did have.

Key informants too said Project Safe Haven not only helped fill a large housing resource gap, but also met the needs of **survivors who sought non-congregate-living situations**

during COVID-19. They said it also allowed for creative and flexible use of rooms, e.g. to provide safety to those who are en route to their final housing destination.

> *It makes sense [that Project Safe Haven gives survivors] their own [space]. In the past I've heard, even when working on the hotline, people would say, 'Well I don't want to go to a shelter. I don't know about living with other people. Am I going to leave one unsafe situation to then go into another unsafe situation? I don't know who's around my kids. That's going to be added stress.' And that's another real concern…I do believe that having their own space is helpful and allows them time to really process…I've had a lot of clients who would try to take on other people's problems in an effort to avoid their own stuff. - Service director at a large DV agency*

> *I think there is more opportunity in Los Angeles to support survivors, especially through the Project Safe Haven…I mean, we built this program in a matter of weeks…it was to house survivors in hotels, recognizing that the homeless service system wasn't necessarily going to be able to have the same kind of considerations for survivors…I think what we've learned from this is that this could be another way to be able to house survivors when our shelters are full, which is a hotel program that's specifically for survivors. – Executive Director of large DV agency*

> *It's helpful for survivors who might have an exit plan but don't have that interim stay, particularly in the time where we have to be very cautious of who's in our social bubble. – Manager at a public agency overseeing DV and homeless system coordination*

Overall, the magnitude of what was accomplished through Project Safe Haven was acknowledged as having national and global implications. The executive director of an agency serving DV survivors stated that LA has recognized the need to protect survivors during COVID-19 unlike any other city or jurisdiction: *"Los Angeles has invested more money in housing survivors through COVID or because of COVID than any [city] in the world."*

Experiences of being 'bounced around' access points

Nearly all survivors and frontline service providers described **multiple access points to the IPV service system** as especially challenging during COVID-19. Rather than calling one number that could route them to the most appropriate services, many called multiple hotlines before being offered help. About a dozen agencies within the City of Los Angeles were contracted to enroll clients in Project Safe Haven, each with their own hotlines. This presented a challenge to survivors at a time when all communication was virtual and they didn't know which agencies to call. As a service manager at a DV organization said,

> *It's mostly calling down the list and every shelter may have a slightly different intake process. It can lead to a lot of frustration when you're calling around all these places and being told they don't have space right now. And these shelter spaces are already limited…around like the fifth shelter and nobody has space…What am I supposed to do?*

Funding restrictions and strict service specifications added further confusion for survivors and service providers alike as they end up going through multiple wrong doors.

> *We're a domestic violence agency, and domestic violence is a broad term. But when I'm talking about our services, it's intimate partner violence we are funded to [work with], versus*

all the other meanings that also fall under domestic violence. Yeah. And it's confusing for the service providers, nevermind for people who are trying to access [services]." – Service manager at DV organization

A service coordinator working at a child- and family-serving homeless service agency said that survivors sometimes hide the fact that they've experienced violence when they come to her agency, because they fear being "bounced back" to the DV system:

One thing I saw within our agency was that survivors sometimes felt that they had to lie about actively fleeing, because within homeless services, anytime domestic violence is mentioned, [we're] a little scared [that] we don't have the capacity to keep that survivor safe, she said. We recommend they go into the domestic violence silo, or the domestic violence system, however the survivor's already been through [that] side; they've probably already done their 30 days and weren't able to find transitional housing, so they're looking just to find any services available to them. So I feel that sometimes they get bounced around between the systems.

COVID-19 shines light on inequities in shelter access

COVID-19 shone light on inequities in shelter access that people of color, transgender, gender-nonconforming, and unsheltered individuals face when fleeing IPV. Key informants described the dehumanization felt by clients who were denied shelter due to perceptions relating to skin color, community of origin, gender, and being unhoused during COVID-19.

A CEO of an organization serving transgender and gender-nonconforming individuals experiencing IPV and homelessness described clients, many of whom immigrated to the United States to escape targeted violence and persecution, as being systematically denied access to safe shelter. She said the **biggest barrier to accessing safe housing for her clients is gender identity,** since the majority of DV shelters only allow cis-gender women:

Shelters are not equipped to support people of trans experience, and part of that is because the shelters are gender-based, or they're basically set up in a binary system. They're based on genitals. If you have a particular set of genitals, then you do to one side or the other…or to the one specific place based on genitalia. For trans women, even if they are self-identifying as a woman, [if] they have not gone through gender reassignment surgery, then they're placed in men's facilities… shelters [are] denying access to trans people…the system is not equipped to deal or accommodate people who are trans.

There is not a specific place that we can refer trans women to who have been victims of domestic violence. And when we obviously have attempted to, we have over the years tried to work with [name redacted], and the shelter that they have is usually full. People have to go through a screening process, and oftentimes, trans women [don't] qualify.

Taken as a whole, the focus group made up primarily of transgender Latina survivors revealed an acute crisis among a population who experience disproportionately high rates of violence and substantial barriers to accessing housing and IPV resources. One survivor described how discrimination has made her housing search challenging:

[If] one applies, they ask 'what [kind] of work do you do?' Why? Because [of] one's physical characteristics. Those were the difficulties for me. So that is my fear right now, because

when I lose my room [it] will cost me, [it will be even] worse with the way the situation is right now, with the social distancing and all that, it will be more difficult to find a place.

Access issues were seen as exacerbating existing disparities relating to the fact that people of color, LGBTQ+ people, and undocumented immigrants face multiple health, economic, and social vulnerabilities to COVID-19. Key informants saw the dangerous combination of health vulnerability, job loss, and an inability to qualify for government relief intensifying a climate of instability and fear.

What's happening now with COVID-19 is that more and more people are calling because they're facing homelessness because they [lost] their jobs. Our calls here at our organization have increased up to 500% from people calling in fear of becoming homeless. So we anticipate that more people are going to be homeless who are trans. And unfortunately, with these relief efforts, many trans people don't necessarily qualify for any type of relief…we know that trans people have been impacted even more than other communities, but the challenge is that through some relief efforts, trans people are not even thought of. And so it's really putting this tremendous burden on our community.

A few transgender survivors described situations where they had been forced into prostitution since COVID-19 after losing their jobs in the service industry or construction. As one recounted:

I think it is harder for us, well, I say for being transgender and at the same time for not having documents [to obtain] a work permit to work. In my case it is being very difficult for me to find a job because most of the places where I have applied require a work permit. It has become very difficult for me, I repeat, thank God, [agency name redacted] has supported us with the rent. But it [pandemic situation] has led many of us astray and we have come, I believe, to find the easiest way and there is only one that is really getting most of us out of trouble, which is to practice prostitution, although with some fear for X or B reason, but there is no other option, for us transgender women. We have to do sex work, even if we do not like it or we are afraid; but it is the only option because it helps us at least to be financially stable to [pay] rent and to buy food you need daily, in this country everything is expensive. I think this work has been a very important factor in the health of all of us transgender women, and we lack much help.

A CEO at an organization that leads culturally-specific programs and training focused on prevention and healing from IPV in black communities described how systemic barriers and racism have prevented families in communities of color from accessing shelter during COVID-19. She recounted one survivor and her children being barred from entry to a shelter due to stereotypes regarding the type of clothing the child was wearing:

When they got there [to the shelter], they looked at the kids, and they were in clothing that they weren't accustomed to. And the people wouldn't let them in because they said that the kid — and the oldest child was nine years old — was a gang member because they had on red. Like, wait. What? Because a kid wears red? If a white kid showed up in red, would you perceive them to be a gang member? No. And this is a nine-year-old. Yes, true: There are nine-year-olds that are in gangs. But this child was not in a gang. And this mother was not gang-affiliated, although she came from a community that has a high population of gangs. So you automatically look at me and make an assumption that because of the color that I

have on or my kids have on, that we're gang-affiliated. That is so discriminating. That is…that is just horrific.

At last, there was a sense that **negative implicit bias toward unsheltered individuals** has persisted and made it more difficult for people on the streets to seek safety.

Many did not have masks, they did not have gloves. So they weren't readily welcomed into an establishment that may have been open. So that prohibited them from even getting support. People looked at them — people have a tendency to look at people that are homeless or poor as less than and unwanted. And as a victim of abuse, you already feel unwanted and less than, and so people weren't going out of their way to seek support, because they didn't feel that there was support readily available. – CEO of organization leading culturally-specific programs and trainings on prevention of and healing from IPV

Key informants working in homeless services expressed the need for **a systematic approach to outreaching unsheltered individuals who are experiencing IPV**. A manager for a large public agency working on coordination between DV and homeless systems described how Project Roomkey has brought attention to IPV occurring among people living on the streets:

With Project Roomkey, we're taking everybody that's in the streets and bringing them indoors. And there has been an increase of DV instances, at least that you know. I want to say that they've been happening for a long time, but nobody has been around to see and experience it…It feels like DV agencies were made for survivors that are housed, and believe it or not people that have been homeless need to leave [DV]. So that's a challenge. And that's something that I hope at some point in time we work on, because we do want an aligned system. Both systems have to be able to meet the needs of survivors wherever they are.

Anecdotally, one key informant described how the crisis spurred her agency to develop the following decision tree for unsheltered clients: If a crisis bed is available, they immediately shelter the survivor and verify their housing status later. If a crisis bed is not available, and the survivor has children, a DPSS motel voucher is sought to provide a temporary place to stay. If a DPSS voucher is not available or if the survivor isn't eligible, 211 is contacted for a one-night motel voucher. At last, they may transfer the survivor to another SPA.

Key informants felt that equity of access during COVID-19 could be improved by **including community members and those with lived experience in planning and decision-making**, thereby making response systems more culturally-informed. As a CEO of one culturally-specific organization pointed out, *"It's not about what I want, it's about what is needed. I can't come in and say 'Oh, I'm going to do this because I see…' I need to talk to those that I'm serving…people who have gone through the shelters, who have been victims that are now on the healing side, or those that may even still be in abusive relationships."* A staff member at another culturally-specific organization described how they have approached outreach differently for each community they serve:

During COVID-19, we've been fortunate to bring on two virtual outreach specialists…one of our specialists is fluent in Japanese and one in Thai. They are looking at not just in-language services, but really, how do I best connect to the Thai community in LA? How do I best

connect to the Japanese community in LA? And they've had very different approaches in doing what they do.

Key informants said effective community and stakeholder engagement is necessary to ensure survivors are at the table when it comes to decisions about how resources are allocated and what programs are prioritized. The CEO of a large homeless service organization, reflecting on operations during a crisis, pointed out how easy it was to become disconnected from survivors:

> *I feel out of touch with people with lived experience outside of the DV Homeless Services Coalition advocates who, thankfully, still I get to meet with…So I'm really interested in the lived experience [focus] groups…Because anytime you do something like this [referring to this study], there's always a disconnect between the service provider and the consumer.*

Unique experiences of single adults and transition-age youth versus families

Just as access to IPV and homeless services has differed by race, gender, and housing status, so too have experiences differed by demographic group. Survivors who were single versus mothers with children described different barriers and facilitators to access.

In both the IPV and homeless service domains, survivors who were single described greater difficulty accessing resources, since many programs earmark funds for families. One focus group participant described her experience calling a DV hotline specifically:

> *I do remember making a phone call off of a number that I found in the phone book, [and] the person over the phone saying to me, 'Are you married?' And I said, 'No.' And the person said, 'Do you have children?' And I said, 'No.' They said that 'Well, then you don't need help.' And that has been basically the continuation of what I've heard as a single woman [when] my life has been precarious, is that 'You're single, you don't have children, you just need to pull yourself up by your bootstraps.' That was basically the underlying message.*
> *– Focus Group participant*

Other single individuals, in particular those who were older, experienced a heightened sense of loneliness due to COVID-19. As one Project Safe Haven participant described:

> *Many people are experiencing the loneliness and the depression of the COVID and the isolation. But I think it was emphasized more so in my situation due to my age and what I've seen, what I've been through my entire life, and what I've seen this country go through. And more so I feel that the impact was greater for a person my age and being all alone. You know what I mean? Somebody younger might have kids, friends, you know, whatever, a job, God only knows. But at the time, I had nobody, you know, no family, no friends, nobody.*
> *– Single unaccompanied woman who had enrolled in Project Safe Haven*

Key informants echoed survivors, recognizing a lack of resources and **experiences of social isolation, particularly among immigrants** and transition-age youth.

> *Women that come from other states or countries and don't have a lot of support, they're isolated. They don't have a whole lot of support. And single women are probably the most difficult to place — single women, single men. Because there are a lot of programs that are funded for families, for women with children. But when it's a single woman, it's very difficult.*
> *– Director of large IPV agency*

> *We have a 17-year-old survivor who is fleeing an abusive relationship and the DV shelter is like we can't take them unless they're an adult, because we're not a youth shelter. There are fewer DV programs that have a youth shelter; I can think of one actually. – Service manager of culturally-specific IPV agency*

For survivors with children, experiences were different in the IPV and homeless service systems. In keeping with Housing and Urban Development and LA County Continuum of Care policies, homeless shelters prioritize those who are chronically homeless as a vulnerable population. And while homeless family shelters typically allow adults to be accompanied by children under age 18, DV shelters do not accept families with older boys. **Narratives of survivors with children were dominated by how the decision to seek help was intertwined with fears of losing their children**. The following is one excerpt:

> *If the child is 14 years old and a male, many times they don't want that 14-year-old in the shelter with a mother, and she may have to have her child separated. That is another fear that mothers have, and I also want to say we have to meet the mother where she is, because she may have children, and she may be thinking 'I can't break up my family.'*

Another survivor described how she had to separate from her 16-year-old in order to access shelter and transitional housing, immediately before the pandemic outbreak. She had escaped to Mexico and then had been living at a shelter in the Catholic Church prior to receiving help through a domestic violence hotline:

> *Now I'm back and I'm here at [agency name redacted]. But I'm also still separated from my children. Because right now here at [name redacted] I was not accepted with my other son and I miss him very much. He is 16 years old and he wasn't accepted with me here.*

During COVID-19, **Project Safe Haven provided an option for survivors with older children** and allowed them to stay together and achieve some normalcy in a tumultuous time. One participant described the challenges she faced having one younger child, as well as being the caretaker for two dependent transition-age youth in their twenties:

> *All of my time with [Project Safe Haven] has just absolutely been like [sound of a deep breath in and out], I mean, it sounds dramatic, but like Thanksgiving. Because it really, it kind of just threw my world upside down and just, you know having to deal with COVID, my son, and you know, homeschool my adult children…I'm still the main caretaker, you know, making sure that their life isn't kind of completely turned upside down. A lot of things were going on at the same time, which was very overwhelming.*

MAINTAINING SAFETY AND WELLBEING OF SURVIVORS

Survivor safety during the pandemic was in part a function of avoiding exposure to COVID-19, and in part about protecting survivors from their abusers. IPV and homeless service agencies took numerous precautions to mitigate exposure, developing protocols for staff and clients following the Center for Disease Control and Prevention (CDC) and LA County Department of Public Health (DPH) guidelines. Drop-in service centers closed or offered appointment-only intakes, saw clients in parking lots, and provided lunches "to go." Support groups and public meetings were uniformly remote. Some suspended street

outreach or restricted home visits. Staff worked from home, rotated on- and off-site, gave a few days' notice before making office visits, or came in only if a client was in crisis.

Common mitigation protocols shared by multiple IPV and homeless agencies were:

1. Providing new masks, face shields, gloves, and pens to clients;
2. Taking temperatures of and reviewing COVID-19 symptoms with clients;
3. All parties use disinfecting hand sanitizer;
4. Plexiglass between clients and staff during one-on-one meetings;
5. Shift to use of larger meeting and conference rooms with good ventilation;
6. Spraying and wiping meeting areas down with disinfectants after every use; and
7. Larger staff gatherings occurring via social distance in outdoor areas.

When the COVID-19 outbreak began, certain opportunities that survivors had to escape an abuser were lost due to shelter-in-place orders and business closures. Drop-in service centers throughout the County closed and later began reopening with limited capacity. The CEO of a culturally-specific organization offering IPV services painted a picture of the time:

> *Oftentimes people knew where services were if they had been in abusive relationships, because they've either been informed or someone shared that information, or they sought it out. But maybe the time wasn't appropriate. When the time is right, they have an opportunity to say 'I'm leaving now. I'm going — I'm going to make a call.' But when COVID came up, and we had the stay-at-home order, I'm no longer able to go to the store. I'm no longer able to get out of the house for any plausible reason. And so now being safe at home is not necessarily safer at home, because I'm now stuck with my abuser…that's how it became different, that they just didn't have an opportunity to freely step out into a safe zone to do what they need to do to seek services.*

Remote communication emerged as an essential approach to seeking safety during shelter-in-place orders, but brought with it a myriad of privacy and equity considerations. Social isolation also created a situation in which fear and uncertainty were exacerbated, necessitating heightened sensitivity and healing-centeredness among providers.

Hybrid of remote and face-to-face response services

All key informants described how their agencies have adapted how they communicate with survivors to ensure their safety. For example, a coordinator at a child- and family- serving agency pointed out, *"when we're on the phone and safety planning, it's different because their potential abuser is home now all the time. You have to coordinate with that person to make sure that they're safe on the phone."* Others explained how this in turn forced agencies to bring their technology up-to-date.

> *Technology is something [we] were not comfortable with. I mean, we still had agencies that don't have WiFi in their shelters, who don't email or text survivors…I do think that COVID threw a lot of these agencies into the tech worlds, sort of forced them to finally meet survivors where they are. – Coordinator of DV and homeless services for large public agency*

Likewise, the vast majority of survivors described how technology took learning, but was ultimately their "lifeline" to connect with service providers and leave abusers during COVID.

> *Initially, all of my contacts were just literally over text messaging between the family who works at my son's after-school program. You know, it was as simple as, you know…here's the address of where you need to go. – Project Safe Haven participant*

> *I don't know if everybody's experience is like that, but I will say that the technology saved my life because I was able to contact [IPV agency name redacted] randomly as a list of organizations that had helplines. – Project Safe Haven participant*

The question of what services should remain remote as restrictions are lifted, and which should be face-to-face, was posed in all survivor focus groups and interviews. All survivors who responded said they appreciated accessing various services and appointments from the convenience of their homes. However, in-person services were vastly preferred for counseling and therapy sessions that require trust-building and therapeutic rapport.

> *At first I didn't like the remote because I'm not tech-savvy. But then when I realized I had so many doctor's appointments the tech-savvy kind of went out the door, and I said I think I can learn this! So I, and seeing as I have this trouble with my back, I just really love the phone appointments. And so I'm taking full advantage of them. And at this point, I think that's really great. And I hope that there'll be a lot more transitioning into that. – Project Safe Haven participant*

> *I cannot imagine not being able to be face-to-face with the therapist that I had during that time. I did five years in support groups, sometimes four days a week. And I cannot imagine not being able to have that experience in person. I just couldn't imagine it. And right now, I do talk therapy over the phone. I don't get to see this man. I've never met this man…And I'm pretty sure I would be having a different experience face-to-face. – Project Safe Haven participant*

Likewise, key informants said the building of relationships and trust between survivors and service providers is something that takes multiple meetings and that is harder to establish remotely. They described beginning to offer a combination of remote and on-site services for intakes, follow-up assessments, and case management. A director at an IPV and homeless service organization explained how they resumed in-person intakes in June 2020:

> *We're showing that we <u>can</u> do a lot of stuff remotely, <u>but</u> at the same time, there's nothing that can take the place of an actual face-to-face interaction. When you have somebody in person, and you're face-to-face, there's a whole different feeling to an intake, on top of the fact that now you know who they are, and you're starting to create that rapport. And that's the critical thing of any type of case management is what relationship you create with this individual in terms of trust and follow-through on both ends. And I think that's something that can never be replaced.*

Likewise, a DV Regional Coordinator based at a homeless service agency described how in-person meetings were crucial to survivors for psychological reasons during COVID-19:

> *A lot of our clients that are DV are asking to meet with us in person and as a means of verifying their experience. And I know that DV survivors do experience a lot of psychological abuse, and a lack of believing their experience, especially with narcissistic abusers, and*

that's something that I've noticed has influx is this need to see someone I need you to see what I'm going through.

Key informants spoke positively of more widespread use of mobile case management as a means of meeting survivors at a safe location and decreasing frequency of on-site visits. It balanced the need for relationship-building with the priority of keeping survivors safe.

> *I feel like the homelessness world has become more comfortable with mobile case management…our DV/IPV Rapid Rehousing providers do mobile case management where they meet with the survivors in their homes or a coffee stop or wherever they feel comfortable. With COVID, it threw all the other [DV] agencies into doing this model. And I want to say it has been fairly smooth where they go to the hotel rooms instead of having the survivors go to their main offices. – Coordinator of DV and homeless services for large public agency*

Overall, consensus was a hybrid of remote and face-to-face services would be beneficial and take into account the need to meet survivors where they are at.

> *But like what's already been shared, we don't know someone's situation. How can you talk on the phone when your abuser's right there? Or going to be right there? Or any other room. You're in your secret closet, or whatever, the bathroom. I just don't see it at all. So there has to be a solution. Kind of like when you can you can, and when you can't you can't. Like I will do this over the phone unless I cannot, then I will come in. – Focus Group participant*

> *I feel that there should be an option available. Like right now, I'm going through the issue of I have paperwork that [my] psychologist helped me fill out last year, and I don't have access to her this year to help me. it's created a lot of anxiety for me. And it triggers a lot, and so I feel that, you know, post-pandemic, I feel that the option should be available whether or not we want to meet in person. Maybe sometimes we do want to meet in person, but then maybe other times we'd maybe like to just have that phone call from home. So I think options. – Focus Group participant*

Finally, both survivors and key informants expressed concerns that **reliance on electronic communication could lead to inequitable access to services**. For example, the main point of access to DV services since COVID-19 has been through hotlines, but unsheltered survivors are less likely than housed survivors to have access to technology. If they have a phone, they may have trouble finding places to charge it when public places are closed.

> *I think seeing the challenges has been, it is like, literally physically harder to get into people's buildings. You don't just like drop in anymore. So, we're sort of created an environment where folks really need a phone and to know who to call and hopefully people can call them back and hope that they can keep their phones charged; which has also been harder with the closure of public places like libraries, public parks, and coffee shops not letting you sit inside for long periods of time anymore. – CEO of large agency providing homeless services*

Survivors suggested the possibility of offering phones and computers, or private kiosks to meet with IPV/homeless service providers, in public places such as supermarkets, public agencies, or libraries if they were open at specific times for this purpose. It would also be helpful for those for whom it was possible to make calls from home.

I could think of feeling comfortable, in most cases, you know, of doing remote, but I think to speak to the larger problem of what does that mean for people who are living with someone right there who may or may not have access to their own phone, or maybe he's constantly checking it…[If] there was a kiosk with some sort of privacy screen and headphones [at] laundromats, the supermarket, DPSS…something that would only maybe be pointed to by a worker…if there could be some kind of privacy area where they could have that, because I guarantee you that I would not have a moment to myself and I my phone was scrolled through. – Focus Group participant

Narratives suggest the importance of acknowledging that the ability to access remote services is a privilege that excludes those without access to technology or phone/internet, in particular individuals with low incomes, older adults, and those who are unsheltered.

Pandemic compounds survivors' struggles with mental health and trauma

Mental health and trauma was the theme most frequently raised by survivors. This included dialogue relating to substance use, anxiety or depression, the stress or emotional toll of COVID-19, and therapy or support groups. Nearly all survivors described a history of trauma leading up to their most recent experience of IPV and housing instability.

The following are just a few examples from dozens of similar excerpts from survivors. Each is from one of the four Project Safe Haven participants interviewed:

COVID has really affected me a lot. I was drinking so much before I came here. I was drinking so much. I was the devil. Honestly, alcohol transformed me.

You don't know how many times I have cried in the park. I just go sit down to the park and I just cry, like you have no idea how I feel, emotionally, because I'm so stressed out…I'm losing my hair…

And people — not people — my partners just abuse me. Not only abuse me physically, but emotionally. Both. Physically and emotionally. It's like sometimes, you know, I'm out here by myself. I don't have family out here. My family is in Mexico. My mom's in Mexico. I feel sometimes in a deep, dark hole.

[Sleep], I wasn't getting none. So I would have to sit at the table, at the dinette table, until they leave, the company leaves. And then once the company leaves, he's still got the music blasting. I'm like, uh, can you cut it off? Cuz I need some rest. And I felt like I was just – I didn't have no energy. I won't lie, I went to the hospital so many times for a nervous breakdown.

For those who had transitioned to a stable living environment when the pandemic began, **social isolation and stay-at-home orders were described as triggering traumatic memories**. Coping with complex trauma was discussed at length in all focus groups.

I went from the emergency shelter here to the transitional shelter [on site], exactly when the pandemic was about to start. And yes, it is practically having to deal with double [loads], because we are dealing with domestic violence and then there is the pandemic. So, uh, well, in my case that is very stressful, yeah; though at the same time I thank God that I found a place to be with my daughters before the pandemic, right? But it is emotionally double

because we're dealing with the violence and the pandemic at the same time. – Focus Group participant

A survivor who had immigrated to escape violence described her feelings since COVID-19:

> *My image of this whole pandemic is (a little) very hard, very sad, as I suffer from anxiety and depression, panic attacks. Being locked up brings me much suffering and many images of what I went through coming to this country. [Sheltering in place] causes me to [have] very sad and uncomfortable thoughts…I still cannot forget what COVID has done and it has caused me a lot of nervousness, a lot of uncertainty. It has been scary. I still can't forget the first day when I started seeing the lines of people buying food at the markets, and the [stores] closing down, and it felt like the end of the world…We were free and now we're not. – Focus Group participant*

While survivors sought compassion and emotional support, the fifth most common theme that arose in focus groups and interviews was experiences of **victim blame and insensitivity**. This topic most commonly arose in reference to interactions with law enforcement, mental health, and IPV and homeless service providers. One survivor described the lack of sensitivity she experienced when visiting her counselor during a crisis:

> *So I went up to the front window, and I asked her what does this word mean? And with the Plexiglas in between us, she leaned down and she said, 'basically, that you're a drama queen.' And so I really feel that there's a real need for people who are treating trauma survivors, women who have been displaced to the streets, to [be sensitive]. This one person has their master's from a very pristine school and all of that. But, you know, a textbook can't teach you how to be compassionate and empathetic. And if this person were looking to show humility and compassion and empathy, understanding that I'm out here in the world alone, they would say, 'You've been through a lot and I want to help you. Can you trust me to help you?' And then they would do the work of then trying to build that trust…Not thinking that you just automatically have that. And then that is how you become trauma-informed. – Project Safe Haven participant*

Building cultures of mental health

Trauma-informed care, which is built on a foundation of trust and relationship-building, was named by key informants as well as survivors **as a promising service approach**. Key informants said providers need the knowledge and skills to build relationships with survivors and problem-solve with them, as well as to facilitate warm handoffs as a best practice. Examples include hotline staff transferring survivors directly to IPV and homeless service agencies, and agency staff linking survivors to legal and mental health services.

Key informants described how the crisis spurred shifts toward more trauma-informed care. For example, a DV Regional Coordinator based at a homeless service organization described how she was stationed with frontline staff for the first time. The result was regular interaction, where she and staff, as a group and in conversation with clients, began to rethink practices on the fly.

> *Before they would just give the clients the National Domestic Violence Hotline number, and then we talked. Now I'm able to forward them the availability for the DV shelters for that*

day. I feel that helps them because they're giving clients an actual number for a DV agency within LA County that potentially has availability. And they've told me that they feel better about providing that resource because it's something substantial.

We homeless service agencies don't have the ability to provide that immediate intake for crisis housing the way that a domestic violence shelter does. And so I feel like if we [have] the ability to give them over to a domestic violence agency, and it's a warm handoff, that would be more helpful for the survivor than just giving them the number for the Domestic Violence Hotline. It would be very beneficial [if] it was more systematic, that each homeless service agency was connected with one or two domestic violence shelters, and we literally just did the warm handoff.

The desire for warm handoffs was echoed by survivors. One described asking her counselor for help when her housing situation became unstable, and being told to call 211:

Basically she directed me to 211. And that's one of the things that [is] disconcerting to me is that, you know people want to give you a flyer, they want to direct you to a phone number, and that to me is not being trauma-informed. To me [that's] cognitive dissonance. That's really being very, like, 'I don't want to have to deal with your circumstance.' I mean, it's extremely triggering.

Supporting healing-centered cultures of mental health was described as being of critical importance to clients and staff alike as COVID-19 led to a climate of fear globally. Key informants said it is important to remember that in many DV and homeless service agencies, staff have lived experience and many are IPV survivors themselves. They expressed the need for **services and resources to support the physical and mental health and wellbeing of staff**.

The CEO of a large organization providing IPV prevention and response programming in all SPAs recalled leaving the office on March 13 because she was at high risk of COVID-19. Her team closed up the office the following week, and no one had been physically back at the office since. She instituted flexible schedules with time off, lunch meetings in large outdoor spaces where staff could gather safely every two weeks, and virtual self-care workshops.

Now we're home operating kind of virtually in isolation with this thing here called the internet that is supposed to be a lifeline, when most of us that are healers heal through touch and connection. And so we're not able to touch and connect in this way. There have been people on my team who come home and now they're providing for their parents. They're providing for someone sick. They have become sick. They're worried, but they don't want to go somewhere else, because now if I go someplace else and maybe engage with a client, and maybe that client has been exposed, [or] now I got to come back home and now worry about my mom who may be going through breast cancer treatment. [So] now the way we treat people has become completely different. We're not supporting people the way we used to, the way that we need to. But we're also not getting the support that we providers need as well. So how do we move from this space? People say it's not social isolation, but it very much is, because the work that we do is really about healing work. And we don't heal in isolation. We heal in community.

Survivors too sought environments characterized by sanctuary and support. While a lack of resources is a key reason many survivors stay with their abusers, cycles of violence are complex, and as one survivor said, an innate need that people have when they make the decision to leave is to feel emotionally supported and cared for. When asked to reflect on what would have made her journey easier, one survivor described,

> *Anything that would take away the reasons that we don't leave. So it could be financial, because sometimes this person is our financial support. It could be housing. We just don't know where we are going to live. Even the emotional attachment, this person is meeting a need, and to have other things to replace that need, you know, whether it's some type of oasis that's just full of self-care and love [where] we replenish ourselves with whatever we think that we need from this person.*

Another survivor participating in Project Safe Haven described how beneficial it was to find a sense of sanctuary and support at a time when she was feeling fearful and exhausted:

> *It made a world of difference. To be quite honest, not having to worry about where we're going to be every night, or the cost and how am I gonna make this continue to work, you know, the single mother. The actual housing, those housing services is the thing that has helped me keep my sanity throughout all of this. And just being able to take a breath a little bit, the sanctuary of having a supportive group of people, you know, with a case manager who kind of checks in and makes sure everything's okay and if there's anything that I need. So the support has been so beneficial.*

'Separate yet connected' IPV and homeless service systems

The complexity and urgency of the COVID-19 crisis meant that IPV and homeless service providers had had to "relearn" how to coordinate among themselves. It became crucial that they knew who to contact to connect survivors to new services. *"I think that since COVID hit there's been an increase in our ability to coordinate with one another. People drop their egos a bit and say, you know, let's try and figure this out,"* said a DV agency director.

A director at a homeless service agency likewise said that relationship-building was especially important during COVID-19, given the lack of unified service systems or technology for matching survivors with housing. He said his staff relied heavily on their own social networks. *"We're housing clients based on relationships — just the quick work of locating units in the community*."

Prior to COVID-19, the Domestic Violence Homeless Services Coalition (DVHSC) had been advocating for policymakers and funders to recognize that **IPV and homeless service providers are serving the same survivors**. One DVHSC member said that future work to prevent homelessness or violence among survivors had to happen at the intersection of these two systems, with common understanding of what it means to be fleeing violence:

> *One of the things we've been working on for a long time is trying to help people see this very real intersection between domestic violence and homelessness, and not as separate. We do have separate systems right now, but they overlap and interact all the time. Homeless [agencies] don't have enough funding to be able to serve everyone that comes to them. So if someone's staying with a friend, but they're fleeing violence, that is a category of*

homelessness…they're safe somewhere right now. So I got to move on to this other person who's living on the streets. And I think that's where the disconnect is between DV and homeless services and how we approach this. That person may not be in danger in that moment, but things can change really quickly.

The flip-side is the DV field saying well, this person is really just homeless. They're not in danger right now. So we need to move on to someone who is in danger. And so I think that if we can try and help people before they get into that dangerous situation [and provide] options for safe housing, that are beyond shelter, then we wouldn't see so many [survivors] homeless.

Survivors too described how experiences of IPV and homelessness were intertwined and struggled with how labels such as these oversimplify the complexity of their situations.

You know, it just kind of helps me to see things broader. I was helping my son with a project about homelessness, and he was looking up, like, what are the different types of homelessness? And I was like, wow, I never thought of, like different [types]. He was just figuring out like, 'oh, there's, you know, chronic and transitional and all these.' And so, when I think about, you know, what domestic violence looks like, it's, you know, knowing that everybody doesn't kind of fit into one or two categories and being open and aware. – Project Safe Haven participant

Some key informants described a need for alignment of the IPV and homeless service systems, inclusive of new services developed in response to COVID-19.

Most of the Project Roomkey service providers don't have much understanding about Project Safe Haven, and all of the Project Safe Haven providers I'm talking to, except for those of us who are also DV coordinators, they don't know about Project Roomkey. So again, we have these two very different systems that have evolved separately. – Manager at culturally-specific DV service organization

Key informants working in IPV services almost universally said a technical challenge to this alignment is a **struggle to figure out whether and how to safely link survivors to housing through the CES**. As the executive director of a large DV organization explained,

I think that the domestic violence field has always had a level of coordination, though it is not as formal as the CES, but it is coordinated. And there's been a struggle thinking about, well, how do we fit into that CES, really wanting to continue with our autonomy to be able to accept people that we screen versus being told by a coordinated entry lead, this is the next person in line. And so, we've remained separate and yet connected to the homeless service coordinated entry system.

On the homeless services side, key informants made a complementary observation that the CES Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) does not prioritize survivors or guarantee a housing match. They said DV service providers had always been reluctant to participate for autonomy and safety reasons.

DV providers are a little bit apprehensive about utilizing the system, because that doesn't guarantee that their survivor will be matched to a housing resource…if a DV survivor comes in through the CES, they won't score high enough on the assessment tool just based on the

fact that they have a history of DV or are actively fleeing DV. So, that poses a challenge in linking them or their being prioritized or matched to a specific housing resource…

Being a survivor, it should be enough. And I feel like it's not enough just based on the fact that someone is a survivor of violence, like that should have them score high on the VI-SPDAT. That's something that should be up there with, you know, chronic mental health or substance abuse. – Coordinator of DV and homeless service systems for a SPA, based at a homeless service agency where she holds expert knowledge of CES

LA Homeless Services Authority (LAHSA)'s Interim Emergency Transfer Plan (ETP), developed in compliance with the Violence Against Women Act (VAWA) and implemented during COVID-19, was named a promising link between DV and homeless service systems.

LAHSA has been working on creating a VAWA emergency transfer policy, which allows for people to move out of public, HUD-funded housing and be assisted into new housing, if they're experiencing domestic violence. And that was moving forward, but COVID actually made that move faster and they've given out interim guidance to everyone. So now that is more, it's more implemented than it was before. – CEO of a large homeless service agency

One of the Project Safe Haven participants interviewed had just benefited from an ETP, noting that before the interview, she had received the call that they had found a more permanent housing placement, and she would be transferring out of her hotel room.

I have got a call today, because I have put emergency transfer in where my old house is at, because it's low-income, so I did put emergency transfer when my son first passed away…So I finally hear something today from the manager [saying] that they have an opening…What they do is they make you write a statement out of what happened [and] then I had to bring my restraining order on [name redacted]…they approved [the ETP] right away. – Project Safe Haven participant

SERVICE AND RESOURCE GAPS

Resource needs during COVID-19 described in focus groups and interviews, in order of the number of survivors who named them, were shelter and housing, economic or rent assistance, health and mental health care, legal services, transportation, food and household essentials, children's services, employment or career services, and technology.

Shelter and affordable housing

Survivors and key informants named a general **lack of availability of shelter and housing** as the primary resource gap for survivors. As one focus group participant explained, housing instability was common as unemployment soared and rents stayed the same.

When the pandemic started you started seeing less work, less money. The rent didn't go down, but it always stayed the same…That's what you're worried about. Being homeless. Being without a place to sleep. You're used to feeling good about [a] safe place. And losing it like that overnight.

With the program concluding in December 2020, key informants described an urgency to **connect clients enrolled in Project Safe Haven to long-term transitional housing** to

give them time to adjust and attain independence, and to identify permanent housing when they are ready.

> *Thirty to 45 days can go by really quickly…and then you're like, you know what, let's work to get you an apartment and they might not be ready. There are so many different layers to unpack. Maybe they need counseling, and 30 days of counseling, it's really not a lot of time. To find employment, that takes time…if the abuser has been controlling all of the financial assets…they don't know what it's like to be independent. So just putting them into an apartment sometimes can set them up for failure…I wish there was some type of permanent supportive housing for DV survivors that DV agencies can [refer to] and [say] this is a good candidate. – DV Regional Coordinator*

Since DV programs don't have the same pathways and funding structures as homeless service programs in CES, IPV providers said they have had to develop new relationships and workflows to ensure clients are discharged to safe housing destinations.

As the executive director of a large homeless service agency said in July 2020, *'Shelters [are reaching] capacities super quickly, and even now our permanent housing funds that we have for survivors, they're depleted. And we still have [about] 200 households in Project Safe Haven that still need those resources."* She said Housing Choice Vouchers (also known as Section 8) are an essential resource for survivors who are low-income and reaching the end of their stays. *"[They] provide more long-term stability for survivors. So how do we get more vouchers that are dedicated specifically for survivors of domestic violence and other types of trauma, such as sexual assault and human trafficking?"*

Key informants offered anecdotes that due to the recession and unemployment, their agencies had gained some negotiating power with landlords. A director at an agency serving people experiencing IPV and homelessness said that landlords have a *"fear of renting to somebody that may not be able to pay the rent, you know, four or five months down the line when the program is no longer providing that monetary support."* Since COVID-19, they had been able to negotiate with landlords who wouldn't partner in the past, because they had assurance that the rent would be paid by the sponsoring agency/program.

Resources to support recovery and safe shelter-in-place

Economic and rent assistance was described as essential to preventing homelessness among people experiencing IPV. After mental health and trauma, this was the second most common theme brought up by survivors in focus groups and interviews. As one stated,

> *When I was asked to move out — when I was evicted, right — it's because of a $100 rent increase that I could not afford, and he was not willing to participate for $100. I'm about to be homeless because you don't want to give me $100? And the reason that I didn't have it is because my unemployment was ending from a job I got fired from also as a direct result of this relationship.*

Another described how cash assistance helped her transition into Project Safe Haven.

> *I came here with nothing but some clothes. So they gave me a card [and] the money come on every Friday $100. And that's how I pushed through to feed me and my son.*

Health and in particular mental health was again the most common topic arising in interviews and focus groups, and mental health care was named with the same frequency as housing as a key resource that survivors had relied upon during COVID-19. Many survivors shared similar stories of the value of counseling, support groups, and advocacy:

> *That's what I was looking for, to get out of my house, a shelter, and that when I got to the shelter, seek help, help in parenting classes, domestic violence classes, support group classes, because all of that helps you get rid of your fear a little bit and feeling guilty like me. He was hitting me because it was my fault; you feel that you are always the guilty one and I wanted help getting that out of my head. Or that I could also look to other people who went through the same thing as me, because when I left my house I thought I was the only one who had been beaten, [but] no, there were many women [when] I went to my first domestic violence class. – Focus Group participant*

> *I think most importantly, I think if any organization could have some kind of therapist, psychologist or have an area specifically for people who suffer from domestic violence. Because when I have heard from most people that are going to put their cases before the authorities, they are mocked or they do not take the problem seriously. I think that if some organization had a specific area for this or some accompaniment [advocates to walk the journey with the survivor] it would be very useful. – Focus Group participant who identified as transgender*

Another major resource gap during COVID-19 was **legal and court services**. Seeking an emergency protective order or restraining order, often a time-sensitive step to keeping survivors safe, was challenging as courts closed and judges were held to strict COVID-19 mitigation protocols that restricted how many requests could be processed and court hearings could be held each day. In October 2020, there was still great variability across court systems in availability of remote hearings and when operations were expected to resume. Key informants described having to advocate for survivors to protect them in the time between the emergency or temporary order being issued and the court hearing:

> *The officer has to inform the survivor, so then the survivor has to request it, [saying] 'I need a 30-day emergency protective order.' The officer has to write up the order that way, but then it needs to be approved by a judge. [What] we were finding on those weekly calls was LAPD was informing survivors and requesting that, but then there was a kink with the judges who said they don't really need to approve 30 days. They'll do 10 days or whatever. So we had to also work with the courts, making sure that judges understood how important it was to issue as much time as possible during this time when the courts are closed. You can't just walk into a courtroom [and] get that permanent restraining order. – Executive Director of DV and homeless service agency*

> *Yeah, I think it's all, all of the above but even more, especially in the criminal justice side, like courts are closed…child custody cases have been delayed. Just like figuring out how [to] communicate to the right people is really challenging when all these buildings are like, literally closed…the services not meeting the need are probably about the same [post] COVID, but the court criminal justice systems [are now] even worse, in COVID. – CEO of large homeless service agency*

Key informants also described how they saw reduced service offerings at agencies during COVID-19, making it harder for survivors to fulfill court requirements such as participating in parenting or DV groups and classes to seek custody of children:

> *Now that agencies are going remote, they don't have the capacity to provide 100% of the resources they had before. So we're getting a very high number of people requesting groups, because that's still a requirement for DCFS. So it's a requirement for parents to get custody back of their children. So if there aren't resources, it sort of starts to trickle down and delays other things. If agencies are closed, and they're not providing the services that you need, it's going to delay your court hearing because there's nothing available for you to enroll in. – Director of IPV service agency*

Transportation has presented a unique challenge, with some public transportation closing during the stay-at-home order. Rideshare companies commonly used today have accounts that perpetrators may be able to access, requiring extra safety planning. One DV Regional Coordinator said new confidential transportation options would be beneficial to survivors during the pandemic. "*We have survivors that don't have transportation to stay at a shelter or go anywhere else,"* she said. *"[If] someone has the ability to leave their house, and then someone could swoop them up and take them [to the shelter], I think that would be beneficial."*

Survivors and key informants alike named **food as a primary need more generally**, alongside **household essentials** such as clothing, diapers, and detergent. As one survivor said: *"Thank God, as we have all said, the only organization that has really supported us financially, emotionally, and with basic food has been [name redacted]. And we are very grateful to it because it has given us a little bit of respite and [helped us] to see the light in the tunnel as we sometimes say."* Some cited a specific need for meal delivery, since waiting in long lines in front of stores could be dangerous for those escaping from abusers.

As the pandemic continues, survivors will continue to need resources to enable safe and equitable shelter-in-place. One specific resource mentioned by multiple survivors was **children's services** such as childcare and tutoring and assistance with schoolwork:

> *Well, not having social security, not having a stable job and even more so now with the pandemic, that you can't work because nobody wants to take care of the children, you don't know where to leave them. I had many plans, to drop my daughters at school and from there I would go to a program for them to help them with their homework and everything. I already had all my time [figured out], in the morning, I would go to the English school and [then] I was about to go to a job and at 5 or 6 I would go to pick up my daughters, but this happened, the pandemic took place, all my plans have fallen apart. – Focus Group participant*

Survivors said they sought also **employment or career services**. They named for example "referrals for employment" and management of "finances and money." For most this was mentioned in the context of losing jobs due to layoffs or lack of childcare.

The final resource gap named was **technology** (phones, tablets, internet, etc.) needed to help survivors navigate in a remote world and for children to continue their schooling. It's

notable that WiFi was expressed as a need for *both* shelters/agencies and clients. As the CEO of an IPV response organization serving all SPAs pointed out:

> *Part of the problem with being virtual is we have to also remember that to be virtual is to be privileged. How many people do not have internet? How many people do not have a laptop or a computer or even a cell phone that is accessible for internet? So if we're going to have a portion of us that are virtual, who are we serving?*

Flexible funding and emergency relief targeted to IPV agencies and programs

All key informants described the need for **flexible funding for homelessness prevention and emergency relief targeted to IPV programs**. As a Family CES Coordinator said, *"I do see as next steps to be able to serve survivors more immediately, is to be able to have accessible funds that they can use flexibly in order to establish their own safety based on what they need."*

The executive director of a large DV agency in a different SPA concurred.

> *We need emergency shelter for those who are in super dangerous situations that need to leave right now. And, if we can provide flexible funding to those that have a little more time, or maybe the person that's harming them has left, and now they are looking for some support on the housing side, then that's a great scenario to be able to support someone.*

Two sources of flexible funding were identified by key informants: (1) DPSS cash assistance accessible through an EBT card, which is available to CalWORKS clients and can be used flexibly for different accommodations, and (2) Problem Solving Intervention (PSI), which is available through LAHSA and involves helping a survivor stay in their home or seek an alternative within their social network and may include financial assistance. PSI was described as an essential resource as agencies' funds ran out in June 2020.

Four key informants specifically named the DV Housing First model – which includes financial assistance, mobile advocacy, and community engagement as core components – as a promising approach to using flexible funds to meet survivors where they are at:

> *I think the practice of the Domestic Violence Housing First Model is and continues to be promising…it helps prevent the mindset that someone has to be removed from their house and go to a secluded shelter in order to resolve their matters. When really so much of domestic violence can be resolved with financial help…many survivors stay because they can't afford to pay rent somewhere else or afford a legal process. So I think that [is a model] that allows for people to either stay where they're at by addressing some financial concerns or stabilizing, you know, helping them find employment or supportive them through legal processes, as well as helping them find housing, if they've lost housing. And it's a practice that helps get people out of an old model of like the person has to come to you at your office, and the staff person goes to the person where it's safe and accommodating for everyone. – CEO of large homeless service organization*

On April 24, 2020, the City of LA Economic and Workforce Development Department (EDD) was awarded emergency relief funds from the California Employment Development Department to provide supportive services to DV and human trafficking survivors affected by COVID-19. This included for example up to $800 per participant, equipment necessary to

telework, and housing, utility, and childcare assistance. All funds had to be used by contracted agencies for support services and expended by June 30, 2020. Key informants noted that to be effective, emergency relief should be dispersed considering the time that it takes program staff to find eligible survivors and the anticipated long-term impact of the crisis. They also expressed safety concerns for survivors, since assistance came with the condition of enrollment in a public program.

> *[We had] two months. So I mean, we spent most of the time trying to find qualified people. In addition, [we] needed to enroll them in Workforce [Innovation and Opportunity Act] Centers, which is a little complicated for DV survivors, they have to enter into a very public system. We didn't spend all of the money either. If it was longer, we would have been able to support more people. – CEO of a large homeless service organization*

Key informants stressed the need for additional federal economic relief funds that can be purposed toward IPV response. They emphasized the need to direct these funds to organizations led by and serving culturally-specific communities disproportionately impacted by COVID-19.

CREATIVE SOLUTIONS FOR OUTREACHING SURVIVORS AND PREVENTING HOMELESSNESS

Survivors and key informants both said that the greatest impact in outreaching survivors and keeping them safe could be made through public education campaigns aimed at promoting knowledge and awareness of IPV and teaching community leaders and the general public skills to respond. To support trauma-informed organizations, they described a need for IPV and homeless service provider education to improve understanding of each other's worlds. And to streamline systems, they called for new roles to support coordination among service providers and the development of a unified crisis line.

Community education and awareness

Survivors and key informants spoke about the need for a **community approach** whereby community members — across sectors including mental health, schools and universities, faith community, the arts, law enforcement, social services — work collectively with IPV and homeless service agencies to respond. Dialogue clustered around general public awareness; dispelling harmful beliefs and stereotypes; and professional roles and skills.

First, key informants recommended **community education campaigns** to promote knowledge and awareness of IPV. They said that action ultimately boils down to *"what is that person's mindset"* when they interact with a survivor, either responding to cues or not.

> *There's been times where people have gone into different restaurants and said 'Hey, I want to order something,' and wrote on a piece of paper 'I need help.' Sometimes those pieces of paper have been thrown in the trash, and other times people have read it. It depends on the mindset of the person. So then it goes back to how do we continue to educate community?*

A coordinator at an IPV service agency reiterated the value of general public awareness:

So many of the people who have connected survivors to us were lawyers, doctors, teachers, you know, concerned neighbors. [We need] more people who have a general understanding of what domestic violence, what services are out there, being able to provide some immediate emotional support, even if it is just affirming that it's not okay to do that to you.

While key informants overwhelmingly called for a community approach, they also acknowledged the tension it created. They worried the need (in terms of number of survivors) was far greater than the resources they had to respond with, and struggled with how much to advertise or promote so as to not disappoint or raise people's expectations. As the executive director of one IPV agency recalled of when media campaigns began,

We were asked early on, can we take on additional survivors and I had to really work with my staff to ask how many more survivors can we serve because this is on top of who we were already serving. And at first, they were like, maybe eight. I am like, how about 15 [laughs]. Eventually, I got them up to 45. But it is an issue because we don't have more staff. And eventually we got more funding to be able to hire more staff, but how do you hire staff during a pandemic?

Community education and awareness was the fourth most commonly mentioned topic in survivor focus groups and interviews, with many describing how it was through word-of-mouth from friends or family that they were able to access help. One woman described how it was a friend and director at her son's school who first intervened and gave her resources, something that was illustrative of this community approach:

My initial call was to one of the directors at my son's after-school program who knew about [agency redacted]. And so she gave me the number and I contacted…All of my contacts were [then] just literally over text messaging. It was as simple as, [here's] the address of where you need to go.

Survivors said there are stereotypes about what IPV and homelessness look like, and that public education could help people recognize its different forms and break down the stigma that stops survivors from accessing services.

I think we should put more advertisements out there to have courage and have pride and don't let no man abuse you physically or mentally. I suffer that. I suffered domestic violence for a whole year. Like, it's horrible to have bruises all over your face. People have to have courage. Women have to have courage and speak out. And don't let no man put no hands on you. Don't let no man push you around. – Focus Group participant

This sentiment was echoed by a key informant who was a service director at a large DV agency and said that the reasons people do not leave are complex and require awareness not just on the part of the people around the survivor, but also by the survivor themself:

[Not] everyone is in [the same] situation. [There is a] stereotype that the only folks that [experience IPV] have no income, and that's just not the case. We have a lot of gray area with folks that have a career already, that have these life skills, but are just needing that support…They're just making enough to live off of, [and] there's so many layers to intimate partner violence and it's not just there is psychological abuse, but also the dependency… having space for that and saying yeah, that's a real thing. Sometimes people don't leave because there are other practical reasons.

At last, participants described how homelessness or IPV might have been prevented if **community organizations were equipped with the staff, knowledge, and skills to intervene**. The topic was most often brought up in reference to interactons with **law enforcement and faith communities**.

> *Most of the time there were several police officers that would come – 4, 5, 6. I mean, [if] they could have put some of those funds and connected me to some social service, you know, some kind of service organization, and then that person could have joined the team. We didn't need six police officers. We needed however many, but at least one person for me. All of them were for him. Nothing was for me. – Focus Group participant (on law enforcement)*

> *What would have been the most helpful would have been any kind of resources provided by the police, because the police were called numerous times in my case…I'm hoping it's better now, but there was kind of a disrespect and a disregard for me, like, condescending. [It] was all [very] focused on [abuser]. And all I ever got was one pamphlet one time. If there had been some, if they had someone on the team who could [have] talked to me and told me about [what] domestic violence looks like, what it is, and then explained to me what a typical progression is, and then could have offered me some kind of resources, something that I could have had in the back of my mind. You know, a seed that could grow, a way to reach out. Because, you know, domestic violence directly led to me being homeless. So I could have avoided all that I'm pretty sure if I had gone into the domestic violence system, but I didn't. [To] be honest, I did not even know about it…I think that for many people, the police is the first sort of external entity that interacts with people who are surviving domestic violence, and that would have been a key moment to have done some kind of support, some kind of offering of services. – Focus Group participant (on law enforcement)*

> *I think what might have helped was if the church I was in would have been more helpful in wanting me helping me get a place to stay and helping me deal with my homeless issues, and not saying 'You're not a Christian. You got to stay. You're married, and the church says…' I'm a Pentecostal minister's daughter, and they preach a lot that you have to stay through abuse. And I remember being told if you don't stay, God is gonna punish you. And you're the wife. So I think it would have been help from the church, more services to go, and a welcoming community when I even became homeless in different shelters, someone saying to me, 'You're not wrong. You're not a bad mother. You're just trying to make it.' – Focus Group participant (on faith community)*

The need for new roles and skills training was also commonly expressed in reference to **mental health and social service providers**. Survivors said that if they were "heard" earlier, further violence or homelessness may have been prevented. The following are excerpts from two different focus group participants said:

> *I didn't get services or a specific case manager after I've been checking the box for many years, it didn't take them seeing that that box was checked to give me the match to the services, it took for me to have my purse stolen, and not have an ID, and not have my benefits card, and to be sitting in the lobby in tears because I was trying to figure out how would I get my next month of cash aid and food aid that will allow for me and my children to stay in the home of somebody else for a little bit longer without them harassing me about what am I contributing to their home…and not having access to these cards, for me to be in this lobby crying for the supervisor to come out and say, 'This is not normal. What's*

happening here?' And then further see my case for many years that I've been checking that box of having the run-ins with domestic violence, and then she asked at that point, 'Well, what services have you got?' I mean, none.

I really would have appreciated if the psychiatrist or the therapist or somebody in my support group would have told me 'you are in a domestic violence relationship. This is a power and control wheel. Would you like some help?' It's something I had to figure out on my own. And only if somebody would have said something that they saw, like I do good when people are straightforward, it would not have hurt my feelings, I would have had to wrestle with it, thought about it, you know, however it would have played out, but nobody ever said anything. And I needed it to be said outloud because I was completely out of touch. That would have really helped me. Because [a] year after that is when I became homeless and everything else. It would have bought me some time if I were to deal with that relationship, and then I would have been connected to resources, and possibly not have to experience homelessness.

IPV/homeless provider education and awareness

All key informants described the existence of two systems serving the same survivors but operating from different paradigms. They pointed to the need for a holistic approach and **common understanding among providers of what it means to be fleeing violence**.

An executive of an organization leading programs on preventing and healing from IPV in black communities pointed out that this requires centering IPV as part of whole health:

One of the things people need to do is listen. Listen to the needs of the community. People don't do that enough. When you greet someone, do not greet them from where you think they need to be, but accept people for who and where they are. Also understand that when a person shows up for whatever kind of service, whether it's domestic violence, homelessness, or substance abuse, they are not walking in that door as just a victim of domestic violence. If I'm walking into a shelter and I'm seeking service, and I'm trying to get away from my abuser, very often I may also be homeless, very often I may also be dealing with mental health challenges, very often I might be dealing with abandonment and hunger and poverty and hypersexuality and sexual assault. We have to build a system of care that really cares for the survivor and their needs.

Survivors emphasized that this education should involve knowledge and awareness of cycles of trauma and what it means to be fleeing violence. This takes a coordinated approach where service providers work together to meet survivors where they are at.

I would like to see workers more educated on what domestic violence is, being understanding, and helping that woman get into a place with her children. A domestic violence shelter where she can get help. Not always a crowded shelter, because you're going through a lot of trauma anyway. But the understanding, and just being there and saying I understand you and not being condemning. – Project Safe Haven participant

IPV agencies were seen as sometimes offering a level of assistance that doesn't fit the survivors' needs at the time. For example, DV shelters often require survivors to give up their current employment due to safety concerns, which puts survivors on the spot to

choose between safety and livelihood. It has been an even harder choice to make during COVID-19, when unemployment rates are at a record high.

> *The help doesn't always match the need, once it's discovered, namely that DV shelters require you to remove yourself from your community, to not use your phone or risk any GPS tracking potentially not go to work, potentially take your children out of their school systems. That seclusion is not always the necessary intervention. – CEO of a large homeless service agency*

All key informants emphasized the need for IPV and homeless service agencies to break down silos and create a unified response system, centering IPV as part of whole health. They described the **need for cross-training and education among IPV and homeless service providers**. One key informant recalled discussions of this early in the pandemic:

> *We were like, let's create a training so that Project Roomkey agencies know how to address DV when it comes up, how to identify it, and how to tell who's the victim…and we didn't roll that out quickly enough…[and] I think getting the education to people before they realize that they're going to need it is something else that would have been helpful. – Coordinator at large public agency*

Another emphasized the specific need for training on VAWA and survivor rights:

> *The other challenge that I have seen is, you know, the violation of VAWA by shelters that are not DV…because based on VAWA, [you] cannot evict somebody from permanent housing based on domestic violence. You can also not deny somebody from going into a shelter that's not DV because they're DV, and I've seen that happen many times. I've had [to be] educating them because they're not aware that they cannot do that. – Director at IPV and homeless service agency*

Leverage technology and develop unified crisis line

Key informants sought ways to communicate with survivors when they were sheltered in place with abusers or abusers were within hearing range. Mobile phones offered the ability for survivors to communicate with emergency responders, service providers, or hotlines via text. IPV and homeless service providers described developing text code systems and adding digital communication safety tips and chat features to their websites.

> *That was something that I made sure that all of our staff knew — that if they had someone who was stuck at home for long hours, they could reach out to someone via text. I thought that was really crucial after COVID, because sometimes it's easier to talk to someone by texting them. – DV Regional Coordinator based at family-serving agency*

> *It's been hard for survivors to even reach out. I heard from my case manager maybe six weeks ago or so she created a texting code system with her client, of safe words that can be texted to communicate various things. Because in a time when we're supposed to be at home, of course survivors are more likely to be near abusers. And if everyone is at home then late, the survivor has no opportunity whatsoever to make a phone call and [are] more and more monitored. – CEO of large homeless service agency*

> *When we started doing virtual, everything remotely, we had to assess some of those things. [Are] you in a safe space? Is anyone monitoring your email? And finding creative ways. So,*

> *some of our clients, what we discussed is creating a safety plan. Even [for] therapy, creating a safe word so that [they] would say 'Oh, I'm not interested in Avon' or whatever, we knew that it was our code to hang up. So we allow room for phone sessions, we do sessions over Zoom over Doxie.me, and also aside from my work at [agency name redacted] I am a provider on Talkspace. Talkspace is a system where you can do therapy over text messages or over video chats. Some of my clients have used that as a resource because they can log in, and they may not even ever have to see me, or me see them. It's all through text messaging. – Service director at large IPV agency*

Early on in the pandemic, the LA City Attorney's Office and LA County District Attorney's Office, in partnership with California Grocers Association and LA Unified School District, launched a "Behind Closed Doors" public education campaign. Posters placed in locations survivors still frequented — such as school lunch pick-ups and grocery stores — enhanced exposure of DV hotlines, shelters, and legal services. Public agencies also coordinated social media blasts across offices so that messaging was uniform throughout the County:

> *We try to coordinate with other offices [in LA County] just to make sure that we were all blasting the same 'if you are experiencing DV, you can get help on, you know, here here and here.' So we tried to do a big social media push. The Domestic Violence Council did see an increase in calls… when that social media blast happened, we did get survivors calling that particular line more. – Representative of large public agency*

The Domestic Violence Council hotline referred to by this key informant acts as an electronic pass-through, where the caller enters their zip code and is connected to a live DV agency hotline in their service area. She said the call forwarding is no guarantee that the agency they are connected to has capacity to help.

Key informants nearly universally agreed that having multiple DV hotlines that survivors must "call down" in a time of crisis was problematic. One participant described Day One as a promising solution coming out of Minnesota that uses one unified crisis line to support survivors of IPV, sexual assault, and human trafficking: *"It's a one-on-one call. And then within the network of DV agencies, they say 'do we have a room,' instead of having the survivor go through many calls and get traumatized and retraumatized all over again."*

New roles to support outreach and navigation

Key informants spoke frequently about three particular roles that cross-cut the IPV and homeless service systems and support a holistic, trauma-informed approach to outreach.

First, LA has eight **DV Regional Coordinators** (one position currently unfilled) that serve to bridge IPV and homeless services in their SPAs. Four were represented among key informants and said their roles differed according to the setting in which they are embedded, the level at which they focus (coaching case managers, vs. building relationships between agencies, vs. influencing policy) and professional background. When embedded within a multidisciplinary team that wraps around the client, they were able to help coach the team and serve as a liaison to DV resources.

> *We have intake days at our agency, which means it's like one day where the client comes in and they meet their case manager and they meet all of our staff that's co-located, so they would meet a DSS worker, they would meet a substance abuse counselor, they would meet our mental health person, they would meet someone who's in child care, and then our education person. And then our agency has felt the need to also place me there, because we have seen an influx of domestic violence survivors coming in through the CES, to have me there as a resource for them and to work alongside the [housing] navigator to help them with anything domestic-violence-related that comes up. – DV Regional Coordinator*

> *It's really hard as case managers who really aren't trained in human behavior [to] understand where people are coming from and what we're seeing and where it stems from. And so having the DV coordinator has really been helpful. – Coordinator based at homeless service organization*

> *A lot of what our DV coordinator does is work with us around language, how to present information to someone who's experiencing domestic violence actively, how to present information to someone who has experienced DV, abuse around self-sufficiency, whether it's finding assistance or the ability to work or maybe psychological abuse with their belief system...and being able to bring in this strength-based approach to the housing dynamic and what you need to talk about and how you need to talk about it. – Family CES coordinator for SPA*

DV Regional Coordinators described their efforts to link DV agencies to the CES Regional Coordinators and homeless service system during COVID-19. *"We kind of all partner together through each SPA to help each other out. [We] really stay together and brainstorm so we can help our survivors out."* A representative of a county-wide agency observed the same:

> *They're the most trained in the concept [of DV] and they help, they liaise. They spend most of their time making sure that the homeless services understand how to get the housing resources through a DV agency, and that on the DV side that they're also not just giving up on the housing side.*

Second, two key informants specifically mentioned co-location of specialized case managers known as **DV Housing Navigators** at access points like the regionally-based Family Solutions Centers, which remained open for drop-ins even at the outset of the pandemic. *"So they have somebody that knows domestic violence, knows housing, so that when a survivor walks in through the door they [say] great, you have this person here that can help,"* said the coordinator of IPV and homeless services for a large public agency. Another explained how homeless service agencies in one SPA had hired housing navigators who had completed 40 hours of domestic violence training:

> *One of the SPAs has a Domestic Violence Housing Navigator. And I think that is really interesting and really beneficial because our role isn't to case manage. And I think sometimes, because our case managers do not know a lot about domestic violence, having a housing navigator that does have that experience would be immensely beneficial to the survivor that's being housed. Anything that comes up, they would be able to advocate being able to offer different resources to the client if they had that background in domestic violence. Red flags would be easier to spot than for someone who doesn't have experience*

in domestic violence. So I think that would be beneficial [to be] embedding more people with experience in domestic violence within homeless services. – DV Regional Coordinator

Third, four key informants pointed to the need for **case managers** trained in both DV and homeless services who could support a holistic approach to addressing the needs of survivors. Some specifically mentioned mobile case managers and advocates who meet survivors where they are, accompanying them in navigating systems such as housing, law enforcement, courts, or health care. Ultimately, key informants envisioned a day where DV and homeless service agencies case manage the same clients together. When asked what would be helpful to serving survivors during COVID-19, one DV Regional Coordinator said,

Having the ability to place someone in a hotel for a couple of days while you help them figure out what they're doing. And if we were connected, [the] DV agency and the homeless service agency could work together with the client…that way they're already connected to the coordinated entry system and the domestic violence agency, and they're just case managing together…I think that would be amazing if we were able to get to that point where we could case manage together.

DISCUSSION

Survivors described how experiences of IPV and homelessness were influenced by the COVID-19 pandemic (Q1). Many experienced compounding mental health needs, as well as the need for resources to support safe shelter-in-place. They sought trauma-informed programs that provided sanctuary and healing during a time when natural supports were less readily available. Nearly all described a hybrid of remote and face-to-face services as necessary for protecting themselves from COVID-19 while building the supportive relationships essential to recovery.

COMPOUNDING MENTAL HEALTH AND RESOURCE NEEDS

The strongest theme that arose from focus groups and interviews was **mental health and trauma**. Survivors described fear that arose both from current experiences of IPV and housing instability and from memories triggered by social isolation. These feelings were particularly strong among survivors who were immigrants. A climate of fear and complex trauma combined to create an emergent need for **emotional support and sanctuary**.

Survivors described how during COVID-19, it was harder to reach out to natural supports who could lend monetary aid or a place to stay, due to rises in unemployment and the need for social distancing. This narrative is validated by news reports describing how survivors who once sought refuge with neighbors when violence escalated have had to find other options (Sullivan, 2020). Those who participated in Project Safe Haven in particular described their relief at receiving housing support and resources from program staff.

Other **community resources** deemed increasingly essential to survivors during COVID-19 were economic or rent assistance, health and mental health care, legal services, transportation, food and household essentials, children's services, employment or career services, and technology. Survivors particularly sought in-house services and warm handoffs. Overall, their ability to obtain these resources depended upon the extent to which agencies had **cultures of mental health** and took a **trauma-informed approach**.

ACHIEVING A HYBRID OF REMOTE AND IN-PERSON SERVICES

All survivors interviewed who experienced housing stability during COVID-19 said they had accessed services remotely. Key informants described how agencies had developed new protocols for communicating with survivors, creating safety plans and text messaging systems. Agencies now had the task of deciding how to adapt protocols in the longer-term. Ultimately, participants recommended a **hybrid of remote and face-to-face services**.

Many survivors specifically described the telephone as their "lifeline" to accessing help. Yet most also acknowledged how **in-person services are essential to establishing trust and therapeutic rapport**. There were also concerns that shifts from in-person to virtual services could have serious consequences in terms of health equity. Survivors and key informants alike emphasized that remote services are a privilege, citing a need to equip both survivors and shelters with technology. A study on the impact of COVID-19 on social

services validated these findings, recommending increased client access to technologies such as smart phones and expanded public Wi-Fi access (Holliday et al., 2020).

While COVID-19 drew global attention to the intersecting issues of IPV and homelessness, these systemic issues did not arise from the pandemic — they existed already. And in many ways the crisis exacerbated existing issues that were not being addressed adequately. Key informants revealed some of the **challenges tIPV and homeless service organizations faced in serving IPV survivors during the pandemic (Q2).** These included being able to access affordable housing, flexible funding, and emergency relief. Key informants also stressed how COVID-19 shone a light on already-existing inequities in service access.

ACCESS TO SHELTER AND AFFORDABLE HOUSING

Availability of shelter and affordable housing was before and has remained the number-one challenge facing IPV and homeless service providers. Key informants described how the complexity of the crisis spurred unprecedented collaboration to quickly implement large-scale initiatives to mobilize new shelter and housing resources and move survivors to safety. While Project Safe Haven and Project Roomkey were implemented independently of one another, together they were described as critical to filling housing resource gaps for survivors and unsheltered older adults. As one key informant concluded:

> *Overall, the crisis has shown how quickly people can come together. We now have almost 5,000 people [housed] between Project Roomkey and Project Safe Haven together. And they're basically overlaid with the same type of programming and services. It's more standardized. There's more accountability because of all the high-profile partners involved. And I think that's a silver lining. We did that. And we could sustain it if we politically chose to do so.*

Project Safe Haven alone has provided temporary shelter to nearly 500, and meals and other services to more than 1,100 survivors and their families (Mayor's Fund for Los Angeles, 2020). With the program set to expire in December 2020, survivors and key informants alike described the challenge of searching for other **longer-term transitional and permanent supportive housing options**. Even prior to COVID-19, it was a struggle to find affordable housing with rents that survivors could sustain. To that end, Housing Choice Vouchers (Section 8) were named as an important resource for survivors with low income.

Interventions similar to Project Safe Haven have been implemented during COVID-19 in other U.S. cities. **In Austin, Texas, a "Shelter Away" model** has involved stabilizing survivors in DV shelters before transitioning them to hotels, which have faced high vacancy rates in the wake of travel restrictions (Sullivan, 2020). Globally, state governments across the world, including for example **France and various states in Australia**, have broadly implemented strategies of providing public funding to rent empty hotel/motel rooms for survivors to keep them safe.

NEED FOR FLEXIBLE FUNDING AND TARGETED ECONOMIC RELIEF

Responding to a crisis of the magnitude of COVID-19 required bringing complex service systems together in new ways to outreach survivors and bring them to safety. One of the greatest challenges to this was strict service specifications (who can be served and how) required of agencies by those entities who fund them. Key informants described a **lack of flexible funding as a barrier to meeting clients where they are at**.

One particular source of existing flexible funding that key informants said was an essential resource during COVID-19 was Problem Solving Intervention, available to homeless service providers through LAHSA. It is notable that flexible funding of this nature has proven to be essential to the effectiveness of DV Housing First models (described below).

Key informants expressed **concerns that federal Coronavirus Relief Funds could not be earmarked for DV housing**, requiring the City, County, and philanthropists to fill a resource gap. Participants who identified as transgender and/or undocumented immigrants described the further challenge of not qualifying for most forms of state emergency aid. Representatives of culturally-specific agencies, in particular those serving transgender individuals and communities of color, said that the historical lack of funding for their programs and leadership was exacerbated during COVID-19, as they struggled to respond to high need with a disproportionately low share of resources.

COVID-19 EXACERBATES HEALTH, SOCIAL, & ECONOMIC INEQUITIES

Narratives from key informants and survivors illustrated how systemic racism and gender discrimination shape not only how a survivor is perceived by others, but also what resources are available in their communities and which they have access to.

It is important to consider that this research occurred against the backdrop of a national social movement to demand action in ending violence and racism toward people of color. Decades of research show how **racism and poverty shape health outcomes among people of color** (Alang et al., 2017). During COVID-19, The Committee for Greater LA (2020) advanced a roadmap for policy and structural changes to address racial disparities. Prior to the pandemic, the LAHSA Ad Hoc Committee on Black People Experiencing Homelessness (2018) developed a series of recommendations for dismantling institutional barriers to racial equity and eliminating racial disparities within the homeless crisis response system.

So too did narratives reveal a human rights crisis of significant magnitude among **transgender and gender-non-conforming survivors**. Many LGBTQ+ adults have health conditions that make them vulnerable to COVID-19 (O'Neill, 2020b), and they are overrepresented in the service industry, where job loss has been concentrated since the pandemic outbreak (O'Neill, 2020a). Yet they described experiences of being denied shelter and housing before and during COVID-19 as a direct result of their gender identity.[3]

3 It is notable that housing providers receiving federal funding are forbidden to ask about gender identity or sexual orientation, and in the case of a shelter housing men and women separately, clients have the right to be housed according to

Immigrants and **unsheltered survivors** were final groups who, based on survivor and key informant narratives, faced barriers to shelter and resources before and during COVID-19. A particularly high intensity of social isolation, complex trauma, and health vulnerability was conveyed among these groups, with immigrant experiences often intersecting with identities as trans people and people of color. Key informants described a need for formalized processes for bringing survivors who are unsheltered to safety.

Results suggest the need for models to better unite IPV and homeless service systems to keep survivors safe during COVID-19. At a time when people are more socially isolated than ever, it is especially important that whole communities — from social services to law enforcement to faith leaders to neighbors — play an active role in prevention and outreach. Participants offered the following **solutions to inform government policy (Q3):**

COMMON VISION FOR ENDING VIOLENCE AND HOMELESSNESS

Narratives of key informants and survivors described two systems with separate structures, cultures, and technologies that are serving the same people. This begs the questions: What is the common vision for a future without violence and homelessness in Los Angeles City and County? And what strategic steps would it take to achieve this vision in the short- and long-term? Results point to a need to consider **what it means for someone to be fleeing violence or experiencing housing instability and how systems could be better aligned to intervene**.

Overall, results suggest a need for key stakeholders and leadership from the fields of homelessness and violence response and prevention to come together for important conversations regarding the relationships of these systems and the roles that each play in housing survivors. Groundwork for this discussion has been laid by the Domestic Violence and Homeless Services Coalition, as well as a community scan that gathered feedback on approaches to integrating the parallel DV and homeless response systems (Billhardt, 2017).

ALIGNING 'SEPARATE YET CONNECTED' SERVICES SYSTEMS

There was a common understanding that the IPV system of care is not a "system," but rather a network of service points. Some service providers expressed the desire for a unified service model and standards for collaboration across DV and homeless service agencies. Ultimately, implementing new interventions will require **laying the groundwork for an integrated, trauma-informed service system**. This includes addressing barriers/facilitators to change at multiple ecosocial levels and across different stages of implementation (Aarons et al., 2011; Damschroder et al., 2009; Greenhalgh et al., 2004).

At the staff level, participants described a need for **cross-training among IPV and homeless service providers**. For IPV providers, this could mean developing an

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the gender they identify with. Proposed HUD updates to the 2016 Equal Access Rule announced July 1, which would return this decision to shelters and effectively end protections for transgender and gender-non-conforming survivors, could be overridden by state laws in California.

understanding of different forms of homelessness and skills to proactively respond to housing instability (Fowler et al., 2019). For homeless service providers, it could mean understanding power and control wheels and developing skills and tools to help survivors identify and break out of them (YWCA, 2020). At the organizational level, this means **building cultures of mental health** with shared norms that are healing-centered and trauma-informed for staff and clients alike (Kulkarni, 2019).

In LA County, people experiencing homelessness primarily access shelter and housing (permanent supportive housing, rapid-housing, or subsidized or affordable housing) through the CES, which involves screening and prioritization via the VI-SPDAT and entry into the Homeless Management Information System (HMIS). People experiencing IPV primarily access DV-specific shelters and rapid re-housing programs through DV hotlines.[4] The paradox revealed by key informants and survivors is that these are often the exact same people who in their crisis are going through multiple front doors.

Both key informants and survivors described the experience of being "bounced around" when searching for shelter availability. Without a unified crisis hotline/intake, they would make multiple calls, sometimes over the course of multiple days, to find who is able to provide services. Turnaways were a result of agencies having no remaining funding or shelter availability and program restrictions that disqualify a survivor based on the type of violence encountered, their age, their children's ages, or being unaccompanied.

At the inter-organization and service environment level, achieving an integrated system of care will require **work to support relationship-building between agencies across systems and new technologies for collaboration**. With input from the Domestic Violence Regional Coordinators and Domestic Violence and Homeless Services Coalition, LAHSA has begun to develop a "system alignment process map" of pathways by which survivors access and navigate homeless and survivor (IPV/DV, sexual assault, and human trafficking) services. This includes where the systems are separate or connected at the stages of referral, access, assessment, prioritization, and matching. They are also working with survivors to develop new approaches for entering survivors into HMIS so they may benefit from housing matches available only through that system. This might include entering de-identified information into HMIS (homeless service providers) or using a non-HMIS prioritization portal (survivor service providers).

One promising interconnection between the IPV and homeless service worlds described by both key informants and one survivor was the **Interim Emergency Transfer Plan (ETP)**, which LAHSA began implementing during COVID-19 (Robinson et al., 2020). Compliance with the ETP is required of all covered programs that are part of the CES and funded by LAHSA. It stipulates that participants/tenants can request an emergency transfer to safe housing in a comparable unit, even if it's classified or funded as a different type of shelter

4 While there is no IPV/DV equivalent of the CES, two informal technologies for DV inter-agency collaboration were named by key informants. First, about 20 DV agencies in Southern California have networked to form the Domestic Violence Information and Referral Center (DVIRC), which provides an emergency shelter census among members. Second is a database that provides a DV housing census.

or housing, when they believe there is "imminent threat from further violence." They don't risk losing existing benefits or "starting over," and the burden is not on the survivor to prove they need a transfer; a verbal or written request is enough to initiate it.

IMPLEMENT INTERVENTIONS USING DV HOUSING FIRST MODEL

Participants described the need to achieve a "no wrong door" approach to service access that does not place the burden on the survivor to choose the most appropriate entry point. Among the solutions named to achieve this were developing a unified crisis line, new roles within IPV and homeless service agencies to support survivor outreach and navigation, and flexible funding to be used as cash assistance for survivors to achieve housing stability.

It is notable that these themes arose organically, because **flexible mobile advocacy, financial assistance, and community engagement are considered the three pillars to the existing DV Housing First Model**. This model was directly named by four key informants as a promising approach. An evaluation of the model in California identified four processes that may be keys to successful implementation in LA City and County settings: flexible funding to obtain housing; survivor-driven, trauma-informed advocacy to maintain housing; agency relationship-building with community partners; and organizational culture shifts (Lopez-Zeron et al., 2019).

Interviews and focus groups revealed that Project Safe Haven was a complement to such a model, providing rooms that could be flexibly and creatively deployed to assist survivors with and without families in their unique journeys. The program was also described as filling a resource gap when DV shelters had reached capacity and agencies' Rapid Re-Housing dollars were exhausted. **Project Safe Haven uses an Rapid Rehousing (RRH) approach, which is a subset of the Housing First model** that involves more time-limited stays and scattered-site versus congregate living arrangements (National Alliance to End Homelessness, 2020). Survivors described how they were able to achieve housing stability quickly and safely. Some benefited from community linkages, cash assistance, and onsite services, core components of a DV Housing First model. However, nearly all recounted experiences of victim blame and insensitivity and emphasized the need for more trauma-informed and culturally-relevant care.

PRIORITIZE A COMMUNITY APPROACH TO IPV AND HOMELESSNESS

Community education and awareness was the fourth most commonly mentioned topic in survivor focus groups and interviews. Many described situations where violence or homelessness might have been prevented if, for example, teams responding to 911 calls included social workers, or their faith communities had advised them to leave an unhealthy situation. Survivors and key informants alike also described the value of campaigns through social media, school lunch kiosks, and grocery stores to promote public awareness of IPV, homelessness, and related resources during COVID-19. Together, they called for a **community approach in which "non-traditional" responders work in tandem with IPV and homeless service providers to respond as a community with greater urgency**.

We would be remiss not to acknowledge the tension that promoting services through community education creates for service providers given limited resources. Key informants and survivors described how a shortage of shelters, affordable housing, legal resources, mental health care, and culturally-specific services especially meant that not all those who needed services were able to obtain them. They advised investing more resources in culturally-specific services to help ensure that City and County programs more equitably reach communities disproportionately impacted by violence, homelessness, COVID-19.

Given what participants described as an **acute exacerbation of a human rights crisis among transgender and gender-nonconforming people during COVID-19**, results suggest the need for public education programs designed to generate knowledge and awareness of the contributions and rights of trans and gender-nonconforming individuals, change beliefs about their right to seek shelter that matches their gender identity, and increase understanding of the impact of violence and discrimination on trans people.

STRENGTHS AND LIMITATIONS

Primary strengths of our study are our rapid-response and community-based approach. We completed this human subjects research study in an expedited four months, navigating many system complexities and barriers to outreach during COVID-19. We worked closely with community partners at all stages — from research design, to adapting our research protocols, to interpretation of findings. As safety and supporting an equitable response to COVID-19 were utmost priorities, we followed UN guidelines for engaging with survivors.

Another strength was inclusion of participants from communities disproportionately impacted by IPV, homelessness, and COVID-19. We practiced with a trauma-informed approach, seeking to provide a brave space for survivors that helped to elicit authentic insights into their experiences. Many expressed to the team how the spaces created for one-on-one and group dialogue fostered a sense of safety, grounding, and positivity.

A final strength was the qualitative nature of our study. Exploring experiences of IPV and homelessness from diverse community perspectives was essential during a crisis when public health statistics could be at worst misleading and at best challenging to interpret.

A primary limitation of our study is the caution that must be exercised in generalizing results outside of LA County. Perspectives on accessing and navigating the service system and challenges faced by providers were specific to this setting. That said, the call for unified response systems with a common service paradigm, and for equitable access to services systems, would seem universal. Other narratives that are more generalizable include the existence of compounding mental health needs; the value of rapid rehousing in non-congregate hotel settings; achieving a hybrid of remote and in-person services; the need for COVID-19 economic relief earmarked for the intersection of IPV and homelessness and for communities disproportionately impacted; and the urgency of a community approach.

We relied on host organizations to recruit survivors/clients, and our sampling frame was agencies who served communities disproportionately impacted by IPV, homelessness, and COVID-19. We did not turn away interested survivors who met the study criteria. Thus, a final limitation is that our sample was dependent upon which clients volunteered. We notably did not have any men, Asian & Pacific Islanders, or Native Americans represented. Our host organization serving Asian communities was unable to host a focus group due to the community being extremely overburdened by COVID-19 at the time. We recognize that Asian & Pacific Islanders have faced unusually high COVID-19 case fatality rates (Yan et al., 2020). Future studies should seek to explore the unique experiences of these three groups.

POLICY RECOMMENDATIONS

Policy and socioeconomic level

1. **Fund further implementation and effectiveness research on the DV Housing First model and the Project Safe Haven intervention**

   Project Roomkey and Project Safe Haven have together done what many said felt impossible prior to the pandemic outbreak: quickly housing nearly 5,000 individuals who are most vulnerable to severe illness or are survivors of DV/IPV or trafficking. Still, a continued upward trend in COVID-19 infection is predicted in coming months (Best & Boice, 2020). Should new federal COVID-19 relief legislation (Health and Economic Recovery Omnibus Emergency Solutions Act or "Updated HEROES Act") be passed, further investment in these programs could help match eligible individuals still on wait lists with hotel rooms. Extending Project Safe Haven through CARES Act Emergency Solutions Grants (ESG) (Federal), Measure H (County), and Mayor's Fund for Los Angeles (City) dollars could also help promote survivor safety. Continuation would allow for effectiveness studies of longer-term outcomes and sustainability of the DV Housing First model. It is also a means of earmarking crisis/transitional housing resources for survivors and addressing a gap in resources for single adults and families with older children. ESG funds could also be purposed toward rental assistance and connecting survivors to permanent and affordable housing.

2. **Dedicate economic relief and prevention funding to IPV and homeless service organizations for flexible procurement of resources for survivors**

   What survivors described as life-saving during moments of crisis and fear were resources whose price tags were often shockingly less than a few hundred dollars: meal delivery, cash assistance to cover a discrepancy in rent, clothing and household essentials, legal advice for restraining orders or child custody, access to a cell phone, and transportation to safety. Earmarking funds for existing IPV and Rapid Re-Housing programs for flexible use toward these and other preventive measures may be a cost-effective means of helping survivors to stabilize their living environments and find calm and sanctuary. Should new Coronavirus Relief Funds become available, any cash assistance program to assist eligible DV survivors should be designed with survivors in mind; it should not require survivors to register with public systems or workforce databases that can place them at risk. Continued funding of motel vouchers through the DPSS and 211 remain of particular importance to unhoused survivors unable to secure crisis beds.

3. **Dedicate economic relief and foundation grants to programs serving those disproportionately impacted by COVID-19, IPV, and homelessness**

   Our results support the value of intentional investment of Coronavirus Relief Funds (e.g. Updated HEROES Act) and CARES Act Emergency Solutions Grants (ESG) into IPV and homeless service organizations serving these communities and leadership from

these communities to support their existing capacity to serve and to lead. Native communities and communities of color and LGBTQ+ individuals have been disproportionately impacted by COVID-19, IPV, and homelessness. So too have immigrants and unhoused individuals experienced unique barriers to service access. The magnitude of the human rights crisis described by transgender participants revealed a need for new shelters and IPV programs, and dedicated programs within existing shelters, that are designed to respond to the unique needs of LGBTQ+ and especially transgender and gender-nonconforming survivors.

4. **Develop policies to ensure inclusive decision-making and create equitable access to and outcomes from City- and County-funded IPV and homeless services**

   To promote a just and equitable response, community members disproportionately impacted by IPV, homelessness, and COVID-19 must be represented in planning and decision-making among agencies who serve them. To that end, community engagement should be required of all agencies with City- and County-funded programs as they engage in all stages of program planning, implementation, and evaluation during and after the pandemic. Survivors with lived experience should be involved in these processes in meaningful ways and compensated a wage for their expertise. Examples of lived experience and advocacy groups include the LAHSA Lived Experience Advisory Board and Homeless Youth Forum of Los Angeles and the DVHSC Advocates Program. To address perceived inequities in service access, new policies and regulations including for example quality improvement and assurance activities and reporting requirements should address indicators of equity in access and outcomes by gender, race, ethnicity, and housing status. Another approach to promoting equity is a policy requiring all staff at IPV and homeless service agencies that receive federal HUD funding to participate in training on shelter and housing protections for survivors and LGBTQ+ individuals, including for example the Fair Housing Act, HUD regulations, Violence Against Women's Act (federal); Fair Employment and Housing Act (state); and LAHSA Continuum of Care Policies (local). Such a training could be implemented by County or Continuum of Care authorities.

System and inter-organization level

5. **Pilot and test new roles that support survivor access and navigation**
   Train and situate DV Housing Navigators into DV and homeless service organizations to assist front-line staff with screening, referral, and warm handoffs. Establish a dedicated team of Housing Locators to identify units and build relationships with landlords whose housing can be added to existing stock/portfolio. Continue to fund DV Regional Coordinators to continue to build relationships between the IPV and homeless services systems. At last, ongoing deployment of mobile case management and advocacy can assist survivors who are sheltering in place. Implementation and efficacy research would be needed to understand the comparative

advantages of these roles in supporting outreach and navigation, and to develop performance specifications and workforce development training.

6. **Collaborate toward integration of IPV and homeless services**

   Continue to strengthen the relationship and connectedness among IPV and homeless service providers through regular communication and networking. Given the likely continuation of the COVID-19 pandemic, it is vital to consider bringing key stakeholders and leadership from the fields of homelessness and violence response and prevention (i.e. IPV/DV, sexual assault, and human trafficking) together to have important conversations in LA County about philosophical assumptions, vision, values, cultures, and approaches to service delivery. Critical to the dialogue and in-depth discussion would be to clarify the roles of homeless and DV service providers, and at what points in the survivor journey their services and technologies may or may not intersect. There is also a need to revise the VI-SPDAT to better prioritize DV survivors for permanent housing placement.

   Overall, it may be essential to envision what it would take for the fields to become more "seamlessly connected." One planned outcome of these discussions might be to fund and develop an RFP through Los Angeles County to implement one or more waves of a learning collaborative intervention to support capacity-building and training around integration of DV and homeless service agencies within and across SPAs to create a more unified system. DV and CES Regional Coordinators are already well-positioned to help manage and lead an effort of this kind. Core components should address *organizational cultures and climates* to be more healing-centered and trauma-informed; *organizational processes* to include workflows for coordinating referrals and warm handoffs; *technologies* to support collaboration such as a unified hotline, housing census, and resource directory; and *staff knowledge, skills, and motivation* to identify and address violence and homelessness.

Organization level

7. **Support organizational cultures of mental health**

   IPV and homeless service organizations alike would benefit from working to change their organizational cultures to be more supportive of mental health. This might include an organizational inventory to understand the current culture and designing programs to help influence norms to be more healing-centered and trauma-informed. It's important to consider that trauma-informed care is not simply a skill to be taught, but also a product of organizational contexts that foster qualities such as sanctuary and mental health (Bloom & Farragher, 2013; Brown et al., 2017). During COVID-19, dedicated programs to support the health and wellbeing of program staff are needed to combat the stress and isolation that those who work in healing professions are feeling. Ideas might include outdoor meetings and lunches, flexible on/off schedules, mask-making and other creative workshops, trauma-

informed yoga, Tension, Stress, and Trauma Release ("TRE"), and other activities that support connection and healing and that can be done with social distancing.

8. **Seek to achieve a hybrid of remote and in-person services**

   Service providers would benefit from achieving a blend of remote/virtual and in-person services to support relationship-building during the pandemic. For survivors who are sheltered in place with their abusers, having text or chat options on websites and developing text coding systems for ongoing communication are crucial. For survivors who are able to leave home and would prefer in-person services, CDC and LA County DPH provide COVID-19 mitigation guidance for opening of offices for scheduled face-to-face meetings. Having an in-person option for therapy is helpful to some survivors given the exacerbation of mental health crises. In anticipation of future waves of the pandemic, develop and adopt emergency plans and technical infrastructure needed to convert services to virtual as needed. Prepare and allocate resources to provide technologies such as mobile phones and Wifi to survivors to support a more equitable response. If plans are to continue services remotely post-COVID, anticipated effects on equity of service access and delivery should be carefully considered through dialogue with community members. Consider establishing best practices for staff working with survivors remotely, including guidelines for communicating safely with survivors, and provide ongoing support to staff who are learning new processes and technologies.

Individual and interpersonal level

9. **Skills training for IPV and homeless service agency staff**

   IPV and homeless service agencies should encourage cross-training on IPV (for homeless services) and homelessness (for IPV services) to raise knowledge and awareness of these issues and develop skills to respond. For homeless service agencies, this might look like mandatory all-staff trainings providing background on cycles of violence, reviewing warning signs, and developing basic skills to maintain survivor safety, such as safe communication and resource-sharing. For IPV agencies, this might look like recognizing different forms of homelessness, tenant and housing rights, and navigating housing resources. For both types of providers, there is a need for ongoing trainings on disaster preparedness and crisis response — including COVID-19 mitigation protocols — given the "caution fatigue" that people experience over time. Numerous human service resource and referral platforms such as OneDegree and Aunt Bertha exist as tools for agencies and the public to navigate resources. Such platforms could be leveraged to help streamline and crowdsource development and maintenance of a Countywide resource directory.

10. **Community education on IPV and homelessness**

    IPV and homelessness are a product of opportunities, relationships, and experiences that begin in early childhood and require prevention and early

intervention (Centers for Disease Control and Prevention, 2020). As such, a community approach is needed whereby community members and leaders across sectors work collectively with IPV and homeless service agencies to respond. Certified IPV/DV workers or counselors would be a valuable addition to homeless outreach teams, law enforcement response teams, and other "non-traditional" IPV responders to help deliver resources and provide warm handoffs. There is also a need for skills training and education among mental health and social service staff to be able to recognize cycles of violence and housing instability. Finally, public education campaigns designed to raise knowledge and awareness among the general public could help ensure that cycles of violence and housing stability are recognized early on by survivors and that others know how to respond when they see it. Continue to disseminate information about IPV and homeless services in places that survivors might still frequent during the pandemic, such as grocery stores, laundromats, and school lunch kiosks. Finally, given the magnitude of violence and discrimination described by transgender and gender-nonconforming survivors in particular, results suggest the need for public education to help dispel myths and generate awareness of their rights.

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