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# Impacts of the COVID-19 Response on the Domestic Violence Workforce

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## Abstract

Many frontline and essential workers faced increased levels of stress, anxiety, depression, and even suicide ideation during the pandemic response. These and other factors led to burnout, shifts into non-patient or client-facing roles, or leaving an occupation altogether. Domestic violence advocates experienced increases in many types of stressors as they continued to provide essential services to victims and survivors during the pandemic. However, in most cases they did so without protections offered to essential workers, like priority access to personal protective equipment (PPE) or vaccines. Executive directors of U.S. State and Territorial Domestic Violence Coalitions were identified using the National Network to End Domestic Violence website and contacted via email to schedule key informant interviews. Interviews were conducted, recorded, and transcribed using Zoom. Themes were identified using both inductive and deductive coding. Twenty-five of 56 (45%) coalition executive directors completed an interview. Three main themes related to workforce were identified, including an accelerated rate of job turnover among both leadership and staff; a lack of essential worker status for domestic violence advocates; and unsustainable

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levels of stress, fear, and exhaustion. While familiar challenges drove these outcomes for this predominantly female, low-wage workforce, such as a lack of access to childcare, other factors, including the lack of access to PPE, training, and hazard pay for those working in person, highlighted inequities facing the domestic violence workforce. The factors identified as impacting the domestic violence workforce—turnover, low status, and high levels of stress, fear, and exhaustion—made the already challenging provision of advocacy and services more difficult. Domestic violence advocates are essential first responders and must be supported in ways that increase the resilience of empowerment-based services for victims and survivors.

**Keywords**
domestic violence, workforce, COVID-19, burnout, turnover, stressors

## Introduction

Challenges faced by both patient-facing healthcare workers (Melnikow et al., 2022; Mensinger et al., 2022) and the public health workforce (Bryant-Genevier et al., 2021; Stone et al., 2021) during the COVID-19 pandemic response have included anxiety, depression, and suicide ideation. These factors negatively impacted retention of these workforces during the pandemic response. However, fewer studies have documented the impacts of the COVID-19 response on other types of frontline workers. For example, frontline, low-wage workers in health care, such as those working in food and janitorial services, were essential to keeping facilities functioning, but their needs—for sick time, better communication, and other workplace supports—were not frequently considered by health system administrators (Zerden et al., 2022). In a study of homelessness services workers in Texas, stress and depression increased, while compassion satisfaction decreased, perhaps reflecting the challenges of meeting the complex needs of those experiencing housing insecurity during the pandemic (Aykanian, 2022). Social workers similarly reported increased workloads in new settings, concern for personal health and safety, and early retirements associated with dealing with the complex needs of clients during the pandemic (Ashcroft et al., 2022).

The domestic violence workforce in the United States includes staff at national domestic violence resource centers; state and territorial coalitions; and local organizations that provide direct assistance to victims and survivors related to emergency financial needs, food assistance, transitional housing, transportation, counseling, childcare, legal assistance and accompaniment,

and shelter services (National Domestic Violence Hotline, n.d.). A total of 56 state and territorial domestic violence coalitions are represented by the National Network to End Domestic Violence (NNEDV). Each State, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa, have a federally designated domestic violence coalition (Family and Youth Services Bureau, n.d.). The coalition's membership includes the local domestic violence service providers in the state or territory (Family and Youth Services Bureau, n.d.). State and territorial coalitions work broadly to connect local member programs to training, education, partners, and victim-centered services (NNEDV, 2014).

The domestic violence workforce was impacted in similar ways to other frontline and essential workers, generally defined as certain categories of occupations or industries or by the share of workers that cannot work from home (Dingel & Neiman, 2020). In general, strains reported by frontline and essential workers during the COVID-19 pandemic included working more hours and more days in new and often challenging environments that felt overwhelming (Williams et al., 2021). However, other strains to the domestic violence workforce were more unique. For example, staff working in the Violence Against Women (VAW) service sector in Canada reported high levels of emotional distress from trying to work with clients facing the immediate trauma of abuse combined with the "uncertainty and disruption caused by pandemic-specific and -related changes" (Burd et al., 2022). This "vicarious trauma," although relatively well-studied among those working in the VAW sector, was extensive, lasting for several years over the course of the COVID-19 pandemic response (Burd et al., 2022). At the same time, factors associated with the response itself (e.g., remote services, stay-at-home orders) often limited the extent to which workers could attend to their own well-being through self-care. This study sought to document ways in which changes to domestic violence services and spaces necessitated by the pandemic were not aligned with empowerment theory, thereby breaking the link between building victims' knowledge, skills, and self-efficacy through linkages to community resources for goal setting (Cattaneo & Chapman, 2010).

Domestic violence advocates across studies consistently reported high levels of both personal and professional stressors. For example, workers in one study, 81% of whom identified as intimate partner violence or sexual assault staff, not only reported professional stressors related to client safety and client access to housing and financial supports but also reported they personally lacked access to basic resources like food or supplies in their own homes (Wood et al., 2022). In another study, advocates identified personal challenges associated with being frontline workers in essential

roles, including mental health symptoms that were exacerbated by decreased interactions with peers and a lack of ability to separate their personal lives from their clients' needs and experiences (Garcia et al., 2021). Moreover, full time domestic violence advocacy positions tend to have lower salaries than other forms of employment, despite most workers having a college degree (Wood et al., 2017). While those working in domestic violence advocacy and services are highly motivated to do this work "to make a difference" in the lives of individuals experiencing violence, the parts of the job that advocates previously felt made it all worth it, like supporting "women and children through difficult times, eating meals with families, watching children to give moms a break, and hugging women and children" were taken away due to the impacts of the pandemic (Burd et al., 2022). These types of highly valued in-person interactions were simply unavailable to advocates shifting to a virtual services environment.

While some services provided to victims and survivors were able to change from face-to-face to remote, there were many challenges in implementing this change in modalities. For example, safety planning and risk assessment could be done via video calls, but this was obviously impractical during lockdowns when perpetrators were present (Pfitzner et al., 2022). Online services could increase accessibility to and timeliness of services by eliminating the geographical and time constraints associated with receiving them face-to-face, but they could also leave victims without in-person support in places like police stations and courts (Pfitzner et al., 2022). Service providers working from home also reported negative impacts to their own mental health and well-being as they lost access to informal networks among advocates (Williams et al., 2021) or worried about exposing their own children and families to private information or distressing experiences.

The following article discusses factors associated with the COVID-19 pandemic and the public health response to it that impacted the U.S. domestic violence workforce. These factors were identified via key informant interviews with executive directors of state and territorial domestic violence coalitions. Since coalitions connect direct service providers to information about services, programs, and policies, coalition executive directors were able to provide in depth information on state- and local-level workforces and reflect on jurisdictional challenges at a broader level that contributed to different trends and patterns of service provision throughout the pandemic.

## Methods

As part of a larger project exploring the challenges to maintaining empowerment-based domestic violence services during a disaster or public health

emergency, qualitative data were collected to explore the ways in which service delivery and built environments (e.g., shelters, courts) were changed by the COVID-19 pandemic and the control measures implemented by public health authorities to mitigate its impacts. A key informant interview guide was developed to broadly explore barriers associated with the COVID-19 pandemic, and the public health response to it, that hindered the provision of theoretically sound domestic violence services. The eight-question interview guide focused on documenting increases or decreases in engagement by member programs with state and territorial coalitions (e.g., system advocacy); unmet needs throughout the pandemic (e.g., court support, visitation, batterer intervention, shelters, funding); and takeaways from the pandemic that they will be used to inform future service provision (e.g., continued use of technology, need for funding flexibility).

### *Participants and Recruitment*

Interviews were conducted with executive directors of U.S. state and territorial domestic violence coalitions between November 2021 and April 2022. Participants were recruited from the 56 State and U.S. Territorial members of the NNEDV listed on the website contacts page who received an email invitation to participate in an interview. After the initial email, executive directors received up to five additional email reminders. Upon completion of interviews, executive directors also offered to refer the research team to other coalition executive directors who had not yet completed an interview.

### *Data Collection*

Interviews were conducted via Zoom (San Jose, CA, USA) by two trained researchers with prior experience in both qualitative research methods and domestic violence coalition operations. Recordings and transcripts were generated by Zoom and reviewed and edited for clarity. All materials were reviewed and approved by the University of Delaware's Institutional Review Board (1597257).

### *Data Analysis*

When interviews were complete, the research team completed an immersive review of the data using thematic analysis, in which the transcripts were read and reread to gain a thorough understanding of the narrative. Throughout this process, the researchers took note of emergent themes from the interview transcripts through both inductive and deductive coding. Two members of the

research team coded the data, one using hand-coding and the other using Dedoose software (Manhattan Beach, CA, USA). The researchers coded until saturation was achieved, which means that no new themes emerged from the data (Guest et al., 2006; Fusch and Ness, 2015). To protect confidentiality, quotes included are not attributed to a specific state or territorial coalition leader and demographic information about participants is not reported.

## Results

The final sample included 25 of 56 coalitions (45%), representing all eight of the NNEDV regions (New England [$n=5$], Mid-Atlantic [$n=5$], Gulf States [$n=2$], Southern States [$n=3$], Upper Midwest [$n=2$], Lower Midwest [$n=2$], Mountain States [$n=2$], and West Coast [$n=4$]). Three themes related to the impact of the COVID-19 pandemic on the domestic violence workforce were identified and are discussed in detail below.

### *High Levels of Leadership and Staff Turnover*

Many of the executive directors interviewed described workforce turnover during COVID-19 as a barrier to service provision. At the executive leadership level, turnover was so frequent that one respondent mentioned "seeing more open positions, more openings in leadership, and agencies without any executive" while another mentioned "long-term executive staff that are experiencing burnout and needing to exit the field, which is difficult, but understandable." These losses at the leadership level meant a loss of institutional knowledge for many coalitions and direct services programs. Another respondent mentioned that "supervisors were exhausted and trying to fill in for staff where shifts were not covered." Leaders were also frequently faced with making layoffs due to cuts to program funding while at the same time new hires were needed and difficult to recruit.

Coalition directors also described how direct services programs struggled with staff turnover, which increased during the pandemic due to elevated levels of stress, increased feelings of fear and exhaustion, limited access to appropriate personal protective equipment (PPE), and a lack of available childcare, training, or hazard pay for victim advocates whose work required them to continue working in person. Shelter staff were particularly hard hit, with one executive director describing the difficulties of retaining shelter staff, saying "I really think it's caused a really big problem for the workforces at the shelters. They've just been losing people left and right. . .so it's just been so difficult." Another respondent described the workforce turnover this way:

> People lost staff and staff resigned because they were really terrified. . . remember in the beginning it was really scary. . .the death numbers reported every day. . . especially in that first year, there was staff turnover. There were people who were like, I can't come into work. I'm afraid. I don't know what this is. I feel exposed. . .. the staffing and managing staff and staff fears w[ere] actually quite significant. And it was exhausting, really, really exhausting because then other staff would have to fill in.

Turnover issues were exacerbated for women of color and bilingual staff since they were part of communities often hardest hit by the pandemic. "We've seen a disproportionate impact on advocates of color. Our Spanish speaking, our bilingual advocates, and our advocates of color and especially our leaders of color. . .we've seen a higher impact and higher turnover there." Another executive director explained,

> a lot of the workforce was sick and there was a tremendous amount of loss of life in families of advocates who are from those [indigenous and immigrant] communities, so the grief factor is definitely one that I don't want to gloss over. We have advocates who have lost, you know, one of my board members lost four family members.

The turnover of advocates of color exerted an outsized effect on their communities as well, decreasing information, access, and resources.

Increases in staffing turnover was also attributed to other job opportunities. Several executive directors pointed out that corporations or other not-for-profit organizations recruited advocates and offered higher wages and less stress. This problem was particularly acute in some regions of the United States, such as areas with large technology companies.

> People are quitting right and left because they can go get a higher paying job and a less stressful job at one of these places, and so we are at quite diminished capacity and the folks that are left are exhausted.

Even in more rural areas, "for-profit businesses were recruiting people from non-profits because they can pay them more money. . .all I hear from our shelters is the few staff they have left are overworked and stressed out."

In addition to paid staff, many domestic violence programs rely extensively on volunteers, who were often unavailable due to pandemic restrictions or concerns about exposure. As one executive director pointed out, "What I head from our shelters is the few staff they have are overworked (and) even volunteers don't want to come to the shelter anymore out of fear of COVID-19." Several directors mentioned that volunteers could no longer

help as court advocates or liaisons since procedures were virtual, and expressed concern that once things were back to in person, the pool of trained volunteers would have diminished considerably.

### *Lack of Essential Worker Status for Domestic Violence Advocates*

From the start of the pandemic, domestic violence service providers and advocates were not designated as essential workers like some other frontline workers. There was some advocacy work being done nationally—and in some states—to obtain frontline status for domestic violence advocates and raise awareness of what domestic violence advocates were doing in response to the pandemic (Domestic Violence Awareness Project, 2021). One state coalition executive director stated:

> We advocated really hard for the for the advocates to be considered essential workers, because that also opened up opportunities for them. There were some benefits. . .they could move around the community (and) there were also some monies attached to (receiving) childcare and so we wanted them to be able to have access to that.

However, without being designated as essential workers, domestic violence advocates had less PPE access, less access to testing in shelters, and later access to the COVID-19 vaccine than other essential workers.

Programs faced barriers to implementing mask or vaccine mandates for staff, and many programs in various states received pushback from individual staff members who would not adhere to these mandates. Many advocates feared the unknown of the pandemic and the uncertainty of the information being disseminated to shelter staff. Advocates were concerned with how to keep shelters safe amidst social distancing guidelines, and clean with decreased access to cleaning and other supplies. As one executive director explained, "a lot of medical services are centralized in the state and transportation was disrupted, (so) the outlying areas struggled with capacity and supply chain disruptions." Another pointed out, when shelter workers "kids got COVID, or they were exposed, it was difficult." In states with large tribal populations, these problems were intensified as tribal communities had little access to supplies and were disproportionately impacted by COVID-19 cases, hospitalizations, and deaths.

Fear and anxiety also increased in shelter staff around the rapid spread or outbreaks of COVID-19 in shelters and the need to alter sheltering approaches. One executive director asked, "How do we keep people happy and healthy

(when) in the last few months we have seen several shelters have to close or limit capacity because of COVID outbreaks?" Another stated, "There was rapid spread and outbreaks from communal environments, and this was very scary to both shelter staff and clients." When some shelter residents were moved to hotels to limit the potential spread of COVID,

> programs had to provide them with all the things they would get in shelter. So. . .meals, diapers, personal care supplies, phones, you know all these things, and also doing completely different kinds of safety planning. And this went on for months. For months.

These ongoing efforts challenged an already depleted workforce who were "exhausted from tracking down PPE, cleaning supplies, and items to facilitate remote learning (for children) in shelters." Disparities between those who could work from home and those who could not were immediate. The lack of clear status as an essential worker left staff, particularly shelter staff, "being told they have to come in. . .that you are going to be placed in a dangerous situation. So, agencies needed to do something to compensate them for (being) in jeopardy, especially in the beginning" but without the essential designation, providing hazard pay for victim advocates was not possible.

### *Unsustainable Levels of Stress Among Domestic Violence Staff*

For many advocates, the source of their stress during the pandemic was not limited to their work lives, but was also present in their personal lives as well. Advocates had children, friends, or other family members that they did not want to spread COVID-19 to from increased exposure at work. Along with increased COVID-19 exposures, parents who were required to report in person to provide services faced challenges with also needing to stay home with their children for homeschooling and child care due to school and daycare closures. As one executive director put it:

> I think that added to staffing issues, because parents had to stay home with their kids and do homeschooling. It was just "Hey, everybody gets out of school right now." You had a lot of parents who were expected to be teachers, which just added to the staffing problems.

Again, as a predominately female, low-wage workforce, domestic violence workers, like women in all types of caregiving work roles during the pandemic, were significantly disadvantaged. Overall, although women make up less than

half of the U.S. labor force, they accounted for the majority of lost labor force participation during the first year of the pandemic (Kochhar & Bennett, 2021). For advocates who could work remotely, some did not have a designated office space in their homes for administering services virtually while maintaining privacy and confidentiality, creating elevated levels of stress for advocates who worked from home. One executive director summed this up, saying

> Not only were they dealing with heavier caseloads and fear at work, in addition to a second shift with children at home, but they had to master new technologies. When working remote, the lack of information technology support and the need for immediacy created even more staff exhaustion.

Many of the executive directors spoke about the extreme fear that staff had about being exposed to COVID-19 because they could not require women and children entering shelters to be vaccinated—nor could they even ask them if they were—due to federal funding mandates. In some states, there were no mask mandates, which increased staff stress and fear. As one executive director said,

> I think some of the tensions that came up, especially initially, were around masks and social distancing. And you can't require people to wear masks in shelter. Because then you're mandating something. You're not supposed to mandate anything. Especially if you're trying to be trauma-informed, but also (because you are) trying to follow regulations around federal funding. So, they were strongly recommending people, like shelter residents, to wear masks and some didn't want to do it because again, misinformation was enormous in the beginning. So, staff are wearing masks or there were just disparities and a sense of "Am I safe or not?" among staff. So, the level of stress that staff were experiencing in the direct services was quite significant, especially in the beginning.

Under normal conditions, empowerment-based services are used to build victims' knowledge, skills, and self-efficacy (Cattaneo & Chapman, 2010). However, the social context of COVID was influencing nearly every aspect of programs and negatively impacting program's ability to use empowerment-based approaches or access community resources. As one executive director put it:

> In our programs, they want to provide an empowering environment. But they also have to keep people safe. I think that was a barrier, and it's like, how do we keep everybody safe and also how do we also know when to say "I'm sorry?" This is what we have to do, this is our trajectory, and if we don't do this we could be jeopardizing other people's lives and health. . . It's a hard conversation to have with people.

The murders of George Floyd and Breonna Taylor and the subsequent protests and demonstrations against systemic racism attended by more than 20 million people in the United States during the Summer of 2020 (Roberts, 2021) compounded the unsustainable stressors faced by domestic violence workers, more than 40% of whom identify as a racial or ethnic minority (Wood et al., 2017). One executive director summarized the need to address the impacts among Black, Indigenous, and people of color advocates, stating "Survivors and advocates of color were watching everything going on in our country and calling on the coalition not only to address the pandemic, but to continue work around racial equity."

In addition, during the first 2 years of the COVID-19 pandemic, 100 major disaster declarations were issued by the President of the United States for events other than COVID, including wildfires, floods, hurricanes, and severe storms (Federal Emergency Management Agency, n.d.). These disasters that occurred concurrently with the COVID-19 pandemic also exacerbated stress for domestic violence staff and systems. Interviewees mentioned severe storms, power outages, and other disasters, with one executive director pointing out that a natural disaster's "compounding effects meant that we needed to reduce census in our shelters across the state." One executive director discussed shelters moving "clients to hotels in advance of a major snowstorm because they worried they wouldn't have any staff over the weekend."

## Discussion

Victim service professionals always considered themselves essential workers, regardless of their official classification (Voth Schrag et al., 2023). In fact, domestic violence advocates are in many ways "the ultimate essential workers" whose "innovation, steadfast advocacy, and commitment make their communities safer every single day" (Domestic Violence Awareness Project, 2021). In many cases, challenges associated with adapting services and advocacy to COVID-19 were simply more complex or difficult versions of their pre-pandemic challenges (Wood et al., 2019). For example, for many who work as part of the domestic violence and advocacy workforce, the COVID-19 pandemic compounded pre-pandemic challenges, including high stress, low pay, and a lack of resources to unsustainable levels, leading to burnout and turnover. A 2013 study identified high workloads and having little control over work as factors associated with burnout and secondary traumatic stress (Kulkarni et al., 2013); these and other factors were exacerbated by the pandemic. Similar to other female-dominated direct care professions, including nursing, the stress of providing services beyond one's normal scope of practice during emergencies can be damaging to both physical and mental health (Shalala et al., 2010).

The main difference in the findings from this study conducted during the COVID-19 response included a lack of access to coping and support. Because the response to the COVID-19 pandemic required the use of non-pharmaceutical interventions to protect both victims' and advocates' health and safety, access to the types of collaborative supports essential for coping with these challenges is in many cases no longer available. Quality of supervision has also been associated with lower levels of staff retention in prior studies of the domestic violence workforce (Cortis et al., 2021). In this study, coalition executive directors identified leadership turnover as a major challenge, which likely left many direct service providers without access to the type of supportive supervision needed to cope with the increasingly stressful workload and restrictions of the pandemic response. Emotional intensity, resource scarcity, and the expectation of being able to help victims have also been associated with turnover and advocate burnout (Merchant & Whiting, 2015) and were identified by our key informants as issues exacerbated by the pandemic. Resource scarcity was particularly intense during the COVID-19 pandemic, with domestic violence victims and advocates dealing with very limited access to appropriate PPE and a lack of flexibility in funding that was needed to allow them to meet the most critical needs.

For many decades, advocates and service providers have balanced the protection of their own mental health with a dedication to their clients (Garcia et al., 2022). Thus, the need for more training, infrastructure, and supports for occupational stress and overall well-being has been well-documented for some time, with factors such as burnout, compassion satisfaction, and secondary traumatic stress predicting turnover (Wood et al., 2019). The COVID-19 pandemic could potentially present some new approaches to addressing these stressors, should the necessary funding and policy support be available to put them into place. For example, the transition to virtual services created challenges for both providers and clients—including a lack of trust, concerns about privacy, and depersonalization of services—but also opportunities such as increased ability to access services regardless of a lack of transportation (Garcia et al., 2022). However, going forward, it is clear that victim services professionals need more support for dealing with occupational stressors and more training to enhance their skills and abilities in providing ongoing virtual services as an option for victims and survivors in the future when appropriate (Voth Schrag et al., 2023).

While the impacts on frontline advocates have been the focus of much of this article, the turnover among leaders in the domestic violence advocacy and service sectors is also crucial to highlight. Changes in leadership are disruptive at any time, but greater negative impacts on agency effectiveness are typically observed when there is leadership turnover during an emergency

(Ward et al., 2022). In the case of COVID-19, many more experienced—and older—leaders who were at higher risk of severe morbidity or mortality from COVID-19 left the workforce and did not return. More specific information is needed on domestic violence leadership turnover during the pandemic. Some fields, including education (Cheung & Gong, 2022) and business (Mattis, 2001) have proposed programs to develop coalitions and networks to support female leaders and leaders of color to reduce professional isolation and bolster mentorship opportunities. These fields may provide models that should be considered among leadership networks, including executive directors of state and territorial domestic violence coalitions, as a new generation of leaders enters these positions following the pandemic.

## Conclusion

Frontline and essential workers, including domestic violence advocates and service providers, faced increased levels of stress and burnout during the response to the COVID-19 pandemic without the protection of essential worker status. These factors, and others, led to high levels of turnover among both staff and leadership. Control measures implemented to limit the public health impact of the pandemic often resulted in the joint effects of increasing risk to victims and reducing access to shelters and other services, compounding pre-pandemic challenges to service provision, infrastructures, and other systems that provide theoretically sound services to survivors. Domestic violence advocates experienced increases in many types of stressors as they continued to provide essential services to victims and survivors during the pandemic. Support for advocates must be prioritized post-pandemic to ensure their well-being, which is essential to survivors as well.

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