COVID-19 IMPACT REPORT

The New Jersey Coalition Against Sexual Assault

2023

TABLE OF CONTENTS

Acknowledgments 4
Overview 5
Rationale 11
COVID-19 In New Jersey 18
Report Findings 22
Action Items 43
Conclusion 49
Bibliography 50
Other Resources 53
Community-Care & Self-Care Practices 56
Appendix: *New Jersey Coalition Against Sexual Assault and New Jersey Coalition to End Domestic Violence Staff Experience Study COVID-19 Data* 61

© 2023 The New Jersey Coalition Against Sexual Assault
Grant funding supported the creation of this publication.
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of current or future funders. Please contact NJCASA at info@njcasa.org before reproducing and disseminating any content.

Recommended Citation:
New Jersey Coalition Against Sexual Assault (NJCASA). (2023). *COVID-19 Impact Report*. Lawrenceville, NJ: New Jersey Coalition Against Sexual Assault.

ACKNOWLEDGMENTS

The New Jersey Coalition Against Sexual Assault (NJCASA) would like to thank the members of our Community Council, Alexyss Panfile, Ashante Taylorcox, Colleen Roche, Elizabeth Schedl, Marie Jardine, Mary George, Robin Parker, Rosanna Eve, and Vimmi Surti, for their tireless support of this project and for the important work they do supporting communities across New Jersey (NJ). NJCASA would also like to thank Senator Cory Booker's Office for Congressionally Directed Funding that helped make this important project possible. Additionally, we would like to thank the Department of Children and Families for the funding provided for our new Community Council and for their continued support of NJCASA's work.

We would like to thank our member programs for their participation and, most of all, for their ongoing commitment to serving survivors of sexual violence across NJ and our Culturally Specific Partners for their unwavering support of historically marginalized communities. Finally, NJCASA would like to thank our staff for their varied and generous contributions to this project.

The challenges and disruptions caused by the COVID-19 pandemic underscore our need to work together across agencies and systems to better serve our communities. This project is a testament to such collaborations. We are grateful to all who contributed to it and look forward to continuing to work together to build a safer, more equitable NJ.

OVERVIEW

For over forty years, The New Jersey Coalition Against Sexual Assault (NJCASA) has been one of New Jersey's (NJ's) leaders in the anti-sexual violence movement, representing all county-based rape crisis centers and the Rutgers University Offices for Violence Prevention and Victim Assistance (New Brunswick). Our mission is to center anti-oppression and anti-racist principles to eradicate sexual violence and support survivors and their loved ones by working collaboratively to promote equity, justice, and healing. To understand this focus, it is important to underscore what we mean by anti-racism and anti-oppression. In his book *How to Be an Antiracist,* Ibram X. Kendi defines racism as "the marriage of racist policies and racist ideas that produces and normalizes racial inequities." These same policies and ideas are often informed by other forms of oppression (e.g., sexism, ableism, heteronormativity, etc.) that seek to privilege members of the dominant culture (defined as white, patriarchal, straight, and cisgender), to the disadvantage of those outside it. By maintaining these power imbalances, these systems continue to perpetuate harmful disparities that manifest in a range of ways, including in sexual violence, which we know disproportionately impacts Black, Indigenous, People of Color (BIPOC), members of the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) community, individuals with disabilities, and other historically marginalized groups. NJCASA's work seeks to disrupt these harmful norms and to call out their legacy of trauma as we advocate for survivor-centered policies; provide training to enhance county-based services; and outreach to law enforcement, educators, healthcare professionals, and other sectors to help provide trauma-informed care to survivors of sexual assault and promote policies and practices that reduce instances of sexual violence, particularly among those most impacted.

When the COVID-19 pandemic was declared and the State of New Jersey (NJ) issued stay-at-home orders in March of 2020, NJCASA amplified its role and worked with allies and policymakers throughout the state, as well as with all our county-based sexual violence programs, to adapt services quickly and efficiently. This included hosting weekly virtual office hours for our membership programs to troubleshoot and help transition trainings, resources, and services to digital platforms that addressed their shifting priorities. These programs have a long history of offering critical services to survivors across the state, and, in 2019 alone—just before the pandemic was declared—they: answered over 10,000 hotline

calls; accompanied 1,300 survivors to emergency rooms or police stations; provided counseling to over 7,500 clients and their loved ones; and engaged with their communities at over 1,800 events, including trainings, workshops, conferences, etc. The question of what would happen to these critical services at this unprecedented moment in our history needed to be answered, and, even during the earliest stage of this crisis, NJCASA was committed to providing survivors with continued access to services and support.

It is well documented that sexual violence spikes in times of crisis and that community crisis compounds personal trauma. In May of 2020, shortly after the pandemic was declared, *The Harvard Medical School Primary Care Review* published an article examining how “rates of sexual violence increase during states of emergency, including natural disasters, active conflict, and health crises.” For example, sexual assault increased by 45% during Hurricane Katrina and the recovery period. Subsequently, the Louisiana Foundation Against Sexual Assault (LaFASA) and the National Sexual Violence Resource Center (NSVRC) began to examine this issue and partnered to produce “Preventing and Responding to Sexual Violence in Disasters: A Planning Guide for Prevention and Response” (Klein, 2008). The guide provides recommendations for advocates, emergency responders, and others to prepare for, prevent, and respond to sexual violence during disasters, and it continues to be a useful tool today, in the aftermath of COVID-19.

Stress, anxiety, and feelings of helplessness resulting from emergency situations often give rise to risk factors for the perpetration of violence, particularly against women. As noted in a 2005 report of the

“IT IS WELL DOCUMENTED THAT SEXUAL VIOLENCE SPIKES IN TIMES OF CRISIS AND THAT COMMUNITY CRISIS COMPOUNDS PERSONAL TRAUMA.

STRESS, ANXIETY, AND FEELINGS OF HELPLESSNESS RESULTING FROM EMERGENCY SITUATIONS OFTEN GIVE RISE TO RISK FACTORS FOR PERPETRATION OF VIOLENCE, PARTICULARLY AGAINST WOMEN.”

World Health Organization (WHO), “[t]here is a pattern of gender differentiation at all levels of the disaster process: exposure to risk, risk perception, preparedness, response, physical impact, psychological impact, recovery and reconstruction.” Shortly after the outbreak of COVID-19, UN Women began to call attention to a “shadow pandemic,” referencing a global increase in violence against women, including sexual and domestic violence. Through its perspective of the statewide/macro landscape related to sexual violence, NJCASA also recognized that individuals with marginalized and intersectional identities (e.g., BIPOC, members of the LGBTQ+ community, individuals with disabilities, and undocumented immigrants), as well as incarcerated individuals, the elderly, and youth, were typically at higher risk during this crisis. For instance, in the early days of the pandemic, for the first time, over 50% of callers to the national sexual abuse hotline were minors, and most reported being abused by someone with whom they were quarantining (79%), and, according to UN Women, reports from around the world indicated an increased risk of violence against women, girls, and gender non-conforming persons with disabilities.

One report entitled “Survivors’ Concerns During the COVID-19 Pandemic: Qualitative Insights from the National Sexual Assault Online Hotline” examined National Sexual Assault Online Hotline (NSAOH) information collected through staff based on retrospective recall following one-on-one sessions with 470 victims of sexual violence who contacted the NSAOH in the first six months of the pandemic and discussed COVID-19-related concerns. The four most common ones were: (1) mental health concerns, (2) the creation or exacerbation of an unsafe living situation, (3) not being able to access services, and (4) not having access to a mandatory reporter or trusted adult. These findings demonstrate the complex ways COVID-19 quickly impacted the status of sexual violence services across the country and here in our home state. The study ends with a call for “more accessible mental health services and funding for sexual assault service providers, as well as the importance of safety planning, particularly in times of crisis”—all of which are considerations echoed in the pages of this report.

ACCORDING TO NSAOH, THE MOST COMMON COVID-19-RELATED CONCERNS WERE:

With these facts in mind, NJCASA proceeded to navigate the complex terrain of advocating on behalf of survivors and those at increased risk for assault during this unprecedented situation. In addition to expanding support for our 22 member programs across the state and working closely with policymakers and other allies, NJCASA launched a public service campaign with generous support from the New Jersey Pandemic Relief Fund that included a PSA in English and Spanish featured online, as well as on television and radio, to inform survivors about continuity of safe, confidential services. Additionally, we partnered with a range of community organizations across the state to distribute 4,000 postcards about sexual violence program services available in our communities, and we expanded our technology bandwidth to accommodate a surge in virtual meetings and digital resources and services. Data from our statewide sexual violence needs assessment conducted in 2019 indicated that only 5% of service providers offered virtual services to survivors before the pandemic. However, this quickly increased to 100% in response to COVID-19. As such, NJCASA adapted to improve accessibility (i.e., Zoom upgrade, live captioning, additional laptops to support hosting video meetings/trainings/webinars, etc.).

Later, in 2021, with rates of infections and COVID-19-related deaths decreasing, NJCASA applied for and received a Congressionally Directed Spending Grant (Byrne Discretionary Community Project Funding/Byrne Discretionary Grants Program) through Senator Cory Booker's office for a project that would explore the ongoing complex impact of COVID-19 on sexual violence services in NJ. Even at the time, we knew that the long-term repercussions of the pandemic needed to be examined in the context of lessons learned and recommendations for how to move forward. Furthermore, understanding that our field intersects with many others across the state and with the work of those who serve historically marginalized populations, including BIPOC, disability justice, and LGBTQ+ advocates, we wanted to expand our focus to include the perspectives of these professionals and examine how COVID-19 affected their programs, services, and clients.

To incorporate these voices, we established a nine-member Community Council. Our Community Council consists of advocates representing the rich diversity of the communities we serve. Council members are: Alexyss Panfile, Care Coordinator, EDGE NJ; Ashante Taylorcox, Founder and Executive Director, You Are More Than Inc.; Colleen Roche, Disability Health & Wellness Consultant; Elizabeth Schedl, Executive Director, Hudson Pride Center; Marie Jardine, Associate Director of Public Safety/Deputy Title IX Coordinator, Bergen County Community College; Mary George, Founder/CEO, Maya's Place a Center for Healing LLC; Robin Parker, Executive Director, Beyond Diversity Resource Center; Rosanna Eve, Program Manager, Ironbound Community Corporation; and Vimmi Surti, Legal Advocate/Case Supervisor, Manavi. Members inform our work serving survivors, promoting

prevention practices, and meeting the broader needs of our communities—particularly of historically marginalized and minoritized populations. Together, we have worked over the course of a year to assess how the COVID-19 pandemic has impacted and shaped services, as well as to identify new practices and innovations for improving access to care. Additionally, we have continued our collaboration with existing partners, including a cohort of nine culturally specific partners who receive funding through the New Jersey Victim Expansion Fund: Community Affairs and Resource Center, Harambe Social Services, Hispanic Family Center of Southern New Jersey, Jewish Family Services, Legal Services of New Jersey, Manavi, Mercy Center, Partners (formally Partners for Women and Justice), and Wafa House. This expansion funding and the direction of portions of it to culturally specific partners were the results of NJCASA's advocacy that occurred during 2020, partially in response to the COVID-19 crisis and with recognition of its disproportionate impact on historically marginalized communities. Through ongoing conversations, meetings, NJCASA's annual conference, and data collecting/sharing efforts, we have pulled together disparate pieces of the COVID-19 puzzle in our state to show the pandemic's lasting effect on sexual violence services alongside the programmatic expansions and improvements that this crisis has also ultimately fostered.

Together, these facets demonstrate the adaptability and resiliency of a range of agencies and organizations across NJ serving survivors of sexual assault and communities both at higher risk for sexual violence and disproportionately impacted by COVID-19. This view of the work is essential when we account for the tremendous strain placed on service providers during and in the aftermath of the pandemic, including compassion fatigue, vicarious trauma, burnout, increased attrition, budgetary challenges, and more. The findings shared in this report point to the successes alongside the many ongoing challenges faced by nonprofits in NJ working closely with those who continue to experience the long-term physical, financial, emotional, psychological, and social toll of COVID-19. More importantly, it offers key recommendations for policymakers and community leaders across the state to help improve outcomes for those we serve and chart a path toward a healthier, more equitable NJ.

RATIONALE

According to the National Center for Injury Prevention & Control, Division of Violence Prevention's "Fast Facts: Preventing Sexual Violence, Centers for Disease Control and Prevention," sexual violence is highly prevalent but significantly under-reported. Over half of women and almost one in three men have experienced sexual violence involving physical contact, and one in four women have experienced completed or attempted rape. According to the Centers for Disease Control and Prevention (CDC), in NJ alone there are an estimated 1.8 million survivors of contact sexual violence, and it is expected that this number has grown due to the pandemic. NJ is also one of the most densely populated states in the country and one of the most diverse, with an estimated 9 million residents and a total of 21 counties and 565 municipalities, ranging from cities, like Atlantic City, Camden, Jersey City, Newark, and Trenton, to rural farming communities. Additionally, NJ is one of the highest-ranked states for LGBTQ-friendly law and policy, and it is home to many immigrants and linguistically diverse residents. Sexual violence survivors across the state include people of all ages, genders, sexual orientations, and abilities. They are members of every racial and ethnic group and social class and are both native and foreign-born. They speak over 155 languages, with various levels of English language proficiency. Thus, sexual violence programs in NJ must be equipped to address the varied needs of different survivors who call the Garden State home, particularly in the aftermath of COVID-19, which we know has compounded the risks and challenges they face.

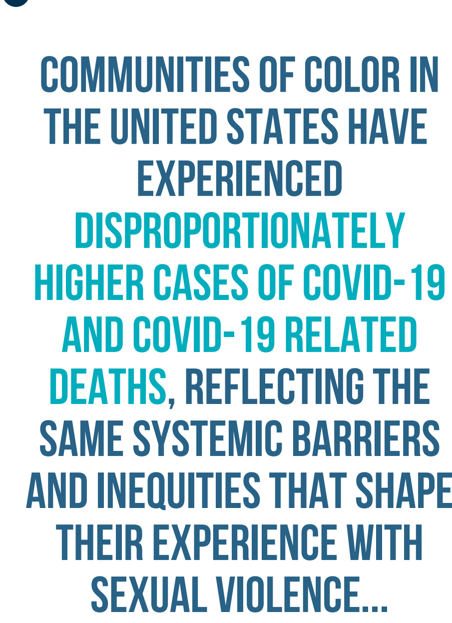
IN NJ ALONE THERE ARE AN ESTIMATED 1.8 MILLION SURVIVORS OF CONTACT SEXUAL VIOLENCE, AND IT IS EXPECTED THAT THIS NUMBER HAS GROWN DUE TO THE PANDEMIC.

As reported in "In Brief: The Psychological Consequences of Sexual Trauma, National Online Resource Center on Violence Against Women," the consequences of sexual violence may be chronic and include "depression, eating disorders, sexual dysfunction, alcohol and illicit drug use," and other chronic issues. Furthermore, the trauma resulting from sexual violence can have an impact on a survivor's employment, including disruptions that affect their economic well-being, home/family life, and more. The CDC estimates that the lifetime cost of rape is $122,461 per survivor, including medical costs, lost productivity, criminal justice activities, and other costs. Many survivors continue to experience the trauma and impact of sexual violence long after their assault, and one-third even contemplate suicide. Another factor is low rates of reporting, with lower socioeconomic status and education level linked to a decreased likelihood of reporting (DePrince et al., 2019). Even in instances where a survivor only discloses to a person they know personally, negative social reactions have been linked to self-blame, problem drinking, and post-traumatic stress disorder. Furthermore, stigmatization when survivors report often compounds mental health issues they already face. All these considerations have been exacerbated by COVID-19, and the situation is estimated to be far worse for marginalized communities, for whom health, economic, and other barriers and disparities were factors even before the pandemic and who have historically been at higher risk for sexual violence.

Many of the NJ-focused articles and reports on the impact of COVID-19 and the recovery efforts overwhelmingly focus on health factors and economic implications, without accounting for the devastating impact the disease has had on survivors of sexual violence and the providers who serve them. Yet sexual violence is an issue that intersects with health equity and COVID-19's legacy in significant ways, particularly since, as stated above, historically marginalized communities often experience sexual violence at higher rates and were also most impacted by the pandemic. For example, according to The National Alliance to End Sexual Violence, many women of color appear to be at greatest risk for rape. A nationally representative survey indicates that while almost 18% of white women and 7% of Asian/Pacific Islander women will be raped in their lifetimes, almost 19% of Black women, 24% of mixed-race women, and 34% of American Indian and Alaska Native women will be raped during their lifetimes. Furthermore,

A NATIONALLY REPRESENTATIVE SURVEY INDICATES THAT WHILE ALMOST 18% OF WHITE WOMEN AND 7% OF ASIAN/PACIFIC ISLANDER WOMEN WILL BE RAPED IN THEIR LIFETIMES, ALMOST 19% OF BLACK WOMEN, 24% OF MIXED-RACE WOMEN, AND 34% OF AMERICAN INDIAN AND ALASKA NATIVE WOMEN WILL BE RAPED DURING THEIR LIFETIMES.

the US Bureau of Justice statistics has determined that, for every Black woman who reports sexual violence, another 15 do not, no doubt due to the lack of trust the Black Community has in a system that has historically failed them. Similarly, Communities of Color in the United States have experienced disproportionately higher cases of COVID-19 and COVID-19-related deaths, reflecting the same systemic barriers and inequities that shape their experience with sexual violence, which include an understandable mistrust of these systems that are supposed to be there to protect them and ensure their safety. Additionally, as one study points out, “the spillover effects of the pandemic were more severe for African Americans, who experienced instability in employment, housing, food access, money, childcare and education” (Ray et al., 2021). Thus, the compounding effects of these and other factors have made it significantly more challenging for Communities of Color to overcome the harm and losses experienced as a consequence of the pandemic, including addressing other intersecting legacies of violence, such as sexual assault, domestic abuse, etc.



This report is designed to elucidate the co-occurring traumas of COVID-19 and sexual violence and inform broader conversations about the consequences of the pandemic in our state by expanding the dialogue to include the perspectives of sexual violence advocates and allies serving survivors and their families, both during and in the aftermath of the pandemic. It addresses a range of topics essential to our understanding of COVID-19 and its impact on NJ, such as: fostering safe and inclusive communities; supporting programmatic and service innovation; and expanding opportunities for advocacy and civic engagement for those most impacted. This lens offers an alternative view of COVID “recovery” as an opportunity for “transformation.” In other words, recognizing that recovery, by definition, focuses on a return to a normal state of health, mind, strength, etc., and that, for many residents across the state who have been most impacted by COVID-19, that “normal state” often included countless inequities, barriers, and other disparities, we need to think beyond what can be “recovered” and toward what can and must be re-envisioned altogether.

As this report explains, such considerations need to include an in-depth examination of the intersectional nature of this crisis to foster resiliencies and greater partnerships across allied agencies and organizations throughout the state, including ones that serve historically marginalized populations, so that we can advance more inclusive, equitable outcomes, such as:

- Building a state budget that affords robust support for sexual violence service providers, including grassroots, culturally specific, and community-based agencies and organizations that have provided a range of adaptive and innovative services to clients during and in the aftermath of COVID-19 (e.g., counseling, housing, legal, referrals, etc.), oftentimes even expanding programming and services in the midst of one of the greatest public crises of our time and typically doing so with limited staff/resources;
- Focusing on a wide range of prevention and health equity initiatives that take a proactive and collaborative approach to community health and support the state's public health infrastructure; and
- Centering the experiences and perspectives of those most impacted by COVID-19 for the purpose of elevating their voices and being more responsive to their needs.

Throughout, the proposed framework for our recommendations centers on a health equity model focused on the "Social Determinants of Health" (SDOH). SDOH are defined by the federal Department of Health and Human Services as "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These determinants are grouped into 5 key areas that impact health and well-being. They are economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

SDOH are important to reference because they require responsiveness and collaboration across all sectors—from policymakers to educators, law enforcement, medical professionals, and more.

SOCIAL DETERMINANTS OF HEALTH:

ECONOMIC STABILITY

EDUCATION ACCESS & QUALITY

HEALTH CARE ACCESS & QUALITY

NEIGHBORHOOD AND BUILT ENVIRONMENT

SOCIAL AND COMMUNITY CONTEXT

Poor social conditions throughout these five areas overwhelmingly impact mental and physical health. Echoing the above-listed determinants, the CDC has identified risk factors that are associated with a greater likelihood of sexual violence perpetration. At the societal and community levels, these risk factors include:

- Weak policies concerning gender, education, health, economic, and social factors
- Poverty
- Lack of employment opportunities
- Lack of institutional support from the police and judicial system

The correlation between SDOH and risk factors for sexual violence elucidates how individuals from historically marginalized communities are more at risk for both. For instance, regarding economic instability, vulnerable communities were hardest hit by COVID-19, which, in some circumstances, eliminated employment opportunities from entire sectors (e.g., hospitality, food service, etc.). Accessibility to traditional forms of “justice” was also further reduced by the diversion of resources to address COVID-19 and/or interruption of systemic responses (e.g., delaying court proceedings, requiring virtual hearings, closing police departments to in-person reporting, etc.). These two examples resulted in increased risk factors for sexual violence, as well as caused additional ones to emerge.

The CDC also identifies protective factors that are associated with reducing the risk of causing sexual harm. At the community and individual levels, these protective factors include:

- Community support and connectedness
- Coordination of resources and services among community agencies
- Access to mental health and substance abuse services
- Connection with educational environments
- Connection with a caring adult
- Emotional health and connectedness

These protective factors were equally impacted by the pandemic, as in-person environments were replaced by virtual ones and shifted the ways individuals connected with one another. While virtual formats opened doors for connection for some, the digital deserts that exist in communities with poor internet connectivity and/or lack of access to technology left many isolated. The complexities of lockdowns and an ever-shifting landscape of public health guidance and response led to the breakdown in coordination between some essential resources and community services. Increases in demand for mental health services,

for example, created challenges in accessing a limited resource. Finally, the impacts of a global pandemic on individuals' emotional health were widespread, and, when seen as a protective factor against sexual violence, the implications for the prevalence of sexual harm become apparent.

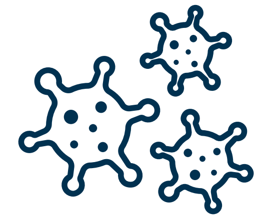
Ultimately, COVID-19 has laid bare what we already knew—that those on the margins of the margins continue to be most impacted by health, economic, and other social/community challenges, and that this fact will likely go unchanged unless we uproot the causes of the inequities and disparities that foster these conditions in our communities. The interconnection of sexual violence and the pandemic provides a starting place for this focus, since, as our colleagues and partners across NJ can attest, in both instances, those most impacted often also faced and continue to face the greatest barriers to accessing care and services and have complex needs that require more responsive, inclusive, and innovative policies and practices.

"ULTIMATELY, COVID-19 HAS LAID BARE WHAT WE ALREADY KNEW—THAT THOSE ON THE MARGINS OF THE MARGINS CONTINUE TO BE MOST IMPACTED BY HEALTH, ECONOMIC, AND OTHER SOCIAL/COMMUNITY CHALLENGES, AND THAT THIS FACT WILL LIKELY GO UNCHANGED UNLESS WE UPROOT THE CAUSES OF THE INEQUITIES AND DISPARITIES THAT FOSTER THESE CONDITIONS IN OUR COMMUNITIES."

COVID-19 IN NEW JERSEY

COVID-19 arrived in NJ in March of 2020, with the first confirmed case being reported in Bergen County on March 2. By March 9, 2020, Governor Phil Murphy declared a state of emergency, with schools and universities throughout the state closing and transitioning to online instruction, while many businesses and organizations began to ask non-essential employees to work from home. A statewide curfew began on March 16, and all casinos, gyms, and movie theaters were forced to close, while restaurants and bars were allowed to remain open for delivery and takeout. By March 21, Governor Murphy announced a statewide stay-at-home order that required all non-essential businesses to be closed indefinitely. Over time, as the number of cases of COVID-19 began to decrease, the stay-at-home order was lifted gradually, with other measures, like social distancing requirements, capacity limits, and the mandatory use of face masks, remaining in effect.

By March 2022, Governor Murphy ended the state's public health emergency. However, while the crisis has been considered over since then, the impact of COVID-19 continues to be felt across NJ in multiple ways. NJ had the ninth-highest number of confirmed cases in the country, as well as the eleventh-highest number of confirmed cases per capita. It also had the sixth-highest count of deaths related to the virus and the highest count per capita. Contributing factors include the fact that NJ is the most densely populated state in the country, the sixth most diverse, the eleventh most populated, as well as one of the earliest hit by the pandemic—i.e., during a time when very little was known about the virus, its transmission, and cause, as well as when there was no established treatment, testing, or vaccines available.



NEW JERSEY HAD THE:

9TH
HIGHEST NUMBER OF CONFIRMED CASES IN THE COUNTRY

11TH
HIGHEST NUMBER OF CONFIRMED CASES PER CAPITA

6TH
HIGHEST COUNT OF DEATHS RELATED TO THE VIRUS

HIGHEST
DEATH COUNT PER CAPITA

While the correlation between population density in relation to increased transmission is obvious, the role the state's diversity played represents a more complex connection and is worth probing further. According to current NJ Census statistics, 15.3% of NJ's population is Black or African American alone, 0.7% is American Indian and Alaska Native alone, 10.3% Asian alone, 0.1% is Native Hawaiian and Other Pacific Islander alone, 2.4% is two or more races, 21.5% is Hispanic or Latino, and 53.5% is white alone, not Hispanic or Latino. Unfortunately, while this rich diversity is something to be celebrated, it encompasses serious factors, such as structural racism, health disparities, and longstanding housing and economic inequities that have only been amplified by the pandemic. When we disaggregate NJ's COVID-19 data through March of 2021 (i.e., during the height of the pandemic) by race and ethnicity, we see how historically marginalized communities were disproportionately impacted:

CUMULATIVE PER CAPITA DATA IN NEW JERSEY, THROUGH MARCH 7, 2021

- Hispanic/Latino people were most likely to have contracted COVID-19
- Black/African American people were most likely to have been hospitalized with COVID-19
- Black/African American people were most likely to have died from COVID-19.

Given that these communities and other marginalized populations (e.g., LGBTQ+ individuals, individuals with disabilities, and undocumented immigrants) often face a host of intersecting inequities and hardships, examining the complex ways combined factors have impacted client services during and in the aftermath of the pandemic is critical to understanding the breadth of COVID-19's effect on the state, including on its public health and public education infrastructure, and to the ways in which service delivery systems have sought to remain responsive to these exacerbated conditions, often despite lack of concomitant increases in funding and other support.

Beyond higher infection and mortality rates, there are other significant ways that NJ's historically marginalized residents have been disproportionately impacted by COVID-19—many of which are likely to have long-term consequences. For instance, regarding educational outcomes, JerseyCAN, a nonprofit focused on advocating for high-quality schools for all NJ students, released the first statewide study to examine COVID-19's impact on student learning, entitled “A Time to Act: COVID-19 Academic Slide in New Jersey.” The

report cited significant drops in the number of student proficiency levels in both English language arts (ELA) and math. On average, NJ students lost 30% of expected learning in ELA and 36% of expected learning in math, but the loss was greater for Black students, who lost on average 43% in ELA and 50% in math. Similarly, Latinx students lost 37% of expected learning in ELA and 40% in math. These losses reflect the complex overlap of issues that often shape the experiences of Black and Brown youth, such as economic disadvantages and health disparities that were heightened by the pandemic. These include factors like less access to the technology needed for virtual instruction; crowded living conditions making at-home learning more challenging; and fewer resources for tutors and other academic supports.

If the COVID-19 recovery period aims to bring us back to where we were as a state prior to March 2020, then we will fail to address the systemic problems and vulnerabilities that perpetuated poor outcomes, particularly for BIPOC residents of our state before and in the aftermath of COVID-19, when we are only seeing these disparities grow. It is with this overarching concern in mind that we turn now to the findings from NJCASA's year-long study to measure the impact of COVID-19 on survivors of sexual violence and on those who have sought services across the state, both at our 21 county-based rape crisis centers and at allied programs that address a range of client needs and predominantly serve historically marginalized communities. While these clients and service providers do not represent the full scope of the devastation caused by COVID-19 in NJ, they are an important subgroup of individuals significantly impacted, and including their experiences and perspectives is essential to understanding the multitude of ways that the pandemic has shaped our lives and how we can work together to establish systematic changes that could foster healing, improve outcomes, and build stronger, more equitable communities.

REPORT FINDINGS

The COVID-19 pandemic created significant social changes that increased the risk for violence, including sexual violence, and simultaneously decreased opportunities to access care, which only compounded the experience of trauma. A BioMed Central Medicine study entitled "COVID-19 Pandemic and Violence: Rising Risks and Decreasing Urgent Care-Seeking for Sexual Assault and Domestic Violence Survivors" notes that, at emergency departments, "sexual assault and physical assault cases presenting for care decreased by approximately 50% during the pandemic." This suggests a significant impact for survivors when one considers that, in NJ specifically, forensic exams that collect important evidence following a sexual assault are conducted at emergency departments by specialized forensic nurse examiners. The study goes on to recommend that "trends in care-seeking and assault patterns will require monitoring over time, and evidence is needed to inform the provision of adequate support for individuals experiencing violence." As indicated, this is particularly critical now, in the aftermath of COVID-19, as states have reopened, and services have returned to traditional in-person operations. With many survivors of sexual violence often delaying seeking care during the lockdown period, the long-term impact of experiencing violence during a time of increased stress and isolation may only start to become apparent presently and in the months ahead.

Also, delay in seeking care was often compounded by other factors that impacted individual well-being during the pandemic, including a concomitant decrease in social supports (e.g., friends, colleagues, faith-based and other community groups, etc.) due to social distancing and increased economic stress (e.g., reduced wages and job loss). In essence, the effects were felt across the social-ecological model (SEM), particularly, as noted above, for historically marginalized communities. While these facts are not surprising, the resiliency of communities and the adaptability of the programs that serve them demonstrate opportunities for substantive changes. As the article "The Impact of the COVID-19 Pandemic on Gender-Based Violence in the United States: Framework and Policy Recommendations" indicates, "[t]he pandemic has uprooted life in a way that impacts gender-based violence prevention and response. Yet, it also presents an opportunity to define a new way forward as an alternative to returning to 'business as usual.'" It is this forward-looking perspective that NJCASA and its colleagues, partners, and allies want to underscore as we delve into the quantitative and qualitative data collected over the last year.

As a starting point, it is important to note that sexual violence policies and services in the United States (U.S.) have historically remained underfunded and are often separated from other health services that typically receive more robust resources and support. From the outset, reporting on the impact of the COVID-19 pandemic on levels of sexual violence perpetration and on disruptions in services has shed light on how greater support in both policy and funding levels is needed to improve survivor outcomes in the aftermath of COVID-19 and during the next public crisis. As one study entitled "COVID-19 and Gender-based Violence Service Provision in the United States" argues, "[e]mergency preparedness plans should include clear policy guidelines that deem gender-based violence health services essential, outline communication plans to inform survivors of service availability, and address the needs of historically oppressed populations to ensure equitable service utilization through improved service access to address inequities." Any examination of COVID-19's impact on survivors of sexual violence specifically must straddle an understanding of where we were before the pandemic, where we are in the present moment, and where we hope and need to be in the months and years ahead.

MEMBERSHIP PROGRAM DATA

NJCASA spent months gathering program statistical data to compile a comprehensive report of the work completed by our 21 county-based rape crisis centers in 2022. Unfortunately, due to the types of programming challenges discussed elsewhere in this report (i.e., staffing shortages and turnover), we were unable to gather full data sets for each county. However, a sample of 17 counties (i.e., 81% of the total number of counties) are represented in our findings. Data show that nearly 21,922 clients were served by just these programs (i.e., not counting the four remaining agencies) and that there was an increase in the following services provided in 2022 versus 2021:

- Counseling: **1%**
- Hotline Calls: **5%**
- Sexual Assault Response Team Activations*****: **13%**

***** Each County has a specially trained team of qualified professionals called the Sexual Assault Response Team or SART, who assist victims of sexual assault and work together to meet the victim's needs. SART consists of law enforcement, forensic nurse examiners, and confidential sexual violence advocates. Victims decide for themselves which members of the SART they would like to assist them. In NJ, SART services are available to individuals 13 years of age and older who disclose an incident of sexual assault within five days of when it occurred.

This increase in services is not surprising, given the long-term impact of COVID-19, including both delays in care sought by survivors particularly in the early days of the pandemic, as well as an increase in instances of sexual violence during and in its aftermath. For instance, even with counseling, where we saw the smallest increase, it is significant to note that, while levels have decreased since 2020, when they were at their highest during the height of the pandemic, in 2022 they were 14% higher than they were before COVID-19 hit in 2019. Similarly, when compared to pre-pandemic client totals, the overall number of individuals served was up by nearly 6% in 2022 over 2019, as well as over 3% from last year alone. Additionally, the increase is likely even higher, since we had more programs reporting in 2019. In fact, when we look at service totals across all four years, 2019, 2020, 2021, and 2022, representing pre-COVID and post-COVID totals, we see a steady increase in the total number of clients served, with the exception of 2020 where we witnessed a historic increase due to the height of the pandemic:

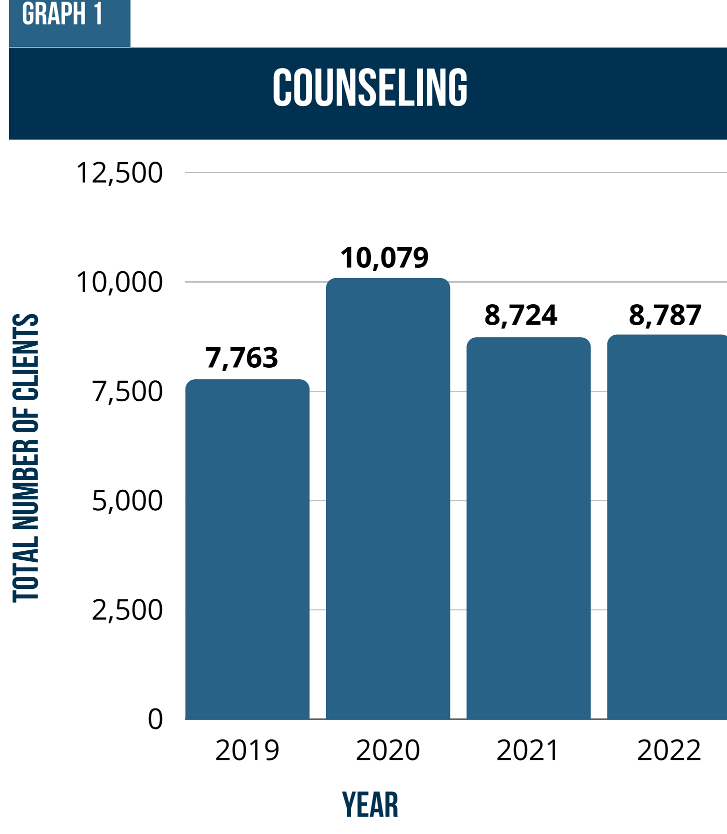
TABLE 1.

SERVICE	2019	2020	2021	2022
COUNSELING (EXISTING AND NEW CLIENTS)	7,763	10,079	8,724	8,787
HOTLINE CALLS	10,206	11,399	9,647	10,171
SART ACTIVIATIONS	1,394	878	836	942
TOTAL CLIENTS SERVED	20,792	24,316	21,228	21,922

***Note:** Program reporting totals vary as follows—2019: 100%, 2020: 100%, 2021:89%, & 2022: 81%

Again, the increase in 2022 is likely greater than what is represented in the chart above, as we have experienced lower rates of reporting due to staffing challenges post-COVID (i.e., 19% lower than in 2019, 15% lower than in 2020, and slightly lower than last year). These decreases in reporting themselves reflect the challenges programs face in meeting the broader needs of their agencies, such as data collection when it is helpful, among other things, for budget advocacy and reporting impact for grant renewals. Additionally, these same staffing challenges have created conditions where demand for services often outpaces providers' capacity.

Examining new versus existing clients also sheds light on the state of sexual violence service provision across NJ. Overall, programs experienced an 8% increase in existing clients served, coupled with a 25% decrease in new clients. This is likely due to a lack of capacity to accept new clients at agencies, given ongoing post-pandemic staffing challenges. This is highlighted by the fact that a total of five programs did witness an increase in new clients, and these increases were significant, ranging between 15% to over 800%. Of the programs that saw an increase in new clients, 60% did not experience a waitlist at all or did not have one for most of the year. While the sample size is small, this demonstrates a likely correlation between stable capacity and an increase in new clients, thereby potentially illustrating a rise in the need for services among all clients (existing and new) that were able to be met by some



OVERALL, OUR 2022 SERVICE DELIVERY DATA SHOW:

942
SART ACTIVATIONS

1,091
OUTREACH REQUESTS FULFILLED

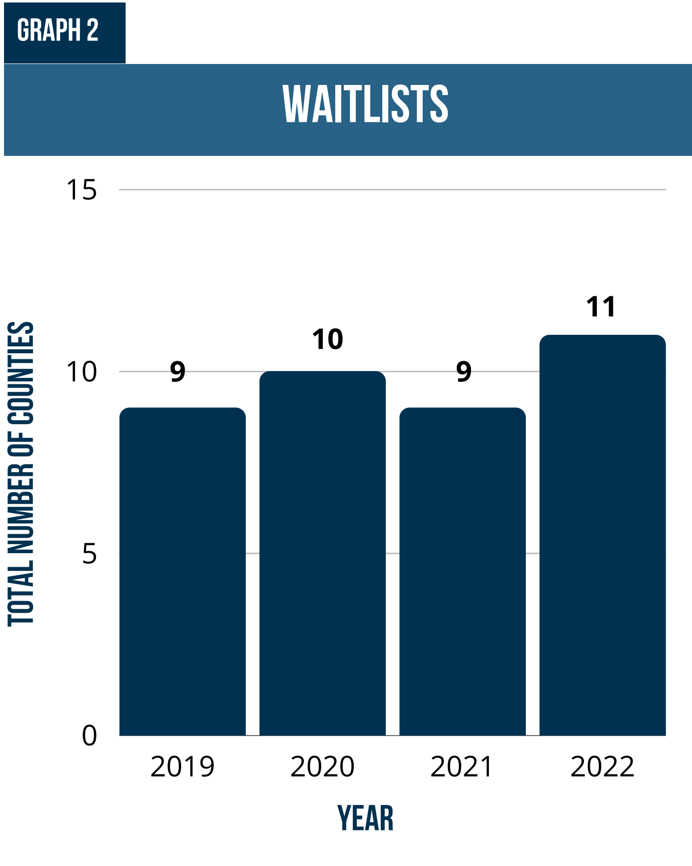
OVER 10,000
HOTLINE CALLS

8,787
COUNSELING CLIENTS SERVED

programs but, unfortunately, not by others. Also, of the 12 programs that had decreases in new clients, only two did not have waitlists.

Specifically with regard to waitlists, 11 counties had them, representing 65% of those reporting, as well as over half of all county-based rape crisis programs in the state. Significantly, the majority of those with waitlists cited staffing issues as the reasons for delays in service, including a lack of bilingual/multilingual counselors. This problem reflects barriers to care among historically marginalized groups, as referenced throughout this report. While waitlists have been a long-term challenge for sexual violence programs across NJ, the current rate is approximately 10% higher than it was just a few years ago, in 2019, before the pandemic hit. Furthermore, the reasons given to explain the waitlists are also different, as in 2019 counties mostly noted that closed groups and clients' schedules were the primary causes for waiting lists, while in 2022 programs cited lack of capacity or staffing limitations. More alarmingly still, waitlists were up 22% in 2022 compared to 2021. This includes Camden, Essex, and Mercer counties, all of which have major cities that were disproportionately impacted by COVID-19, as well larger concentrations of historically marginalized individuals.

With over 50% of all reporting programs noting waitlists over the course of the year, the stress service providers face daily in meeting the needs of clients is significant.



> WHILE WAITLISTS HAVE BEEN A LONG-TERM CHALLENGE FOR SEXUAL VIOLENCE PROGRAMS ACROSS NJ, THE CURRENT RATE IS APPROXIMATELY 10% HIGHER THAN IT WAS JUST A FEW YEARS AGO, IN 2019, BEFORE THE PANDEMIC HIT.

This, along with vicarious trauma, inflationary pressures, and traditionally low pay have led to burnout and attrition, particularly at a time when services are most needed. No doubt, vicarious trauma and the impact of COVID-19 on service provision are serious factors for providers. A report entitled "Burnout and Intent to Leave During COVID-19: A Cross-Sectional Study of New Jersey Hospital Nurses" indicates that, of a total of 3030 nurses responding to a survey, "64.3% report[ed] burnout and 36.5% report[ed] intent to leave the hospital within a year." Additionally, there was a significant correlation between high levels of burnout and intent to leave. While a similar study of sexual violence service providers has not been conducted, it is safe to say that we can draw parallels between the experience of nurses and other service providers who have been managing increased workloads, vicarious trauma, and compounded stress.

Pay is also a significant factor, especially when considered alongside the increased challenges that frontline workers are facing. The SOAR Collective and the Survivors Know Anti-Violence Solidarity Circle, which are "composed of frontline anti-violence advocates who are committed to providing trauma-informed support, changing the existing systems to reflect the needs and wants of survivors, and ensuring that our profession is sustainable," conducted the "We Deserve Better: Anti-Violence Advocates Assessment" in the fall of 2022. There were 265 respondents, with 80% indicating that "better pay" would help them stay in the field. This is especially critical in NJ, where the cost of living is 12% higher than the national average, housing is 32% higher, and utilities are 8% higher. When we recognize that decreases in services are related to staffing shortages, rather than to a decrease in need for services, we can achieve a better understanding of how important more robust funding is to support survivors across the state.

80% OF ANTI-VIOLENCE ADVOCATES INDICATED THAT "BETTER PAY" WOULD HELP THEM STAY IN THE FIELD

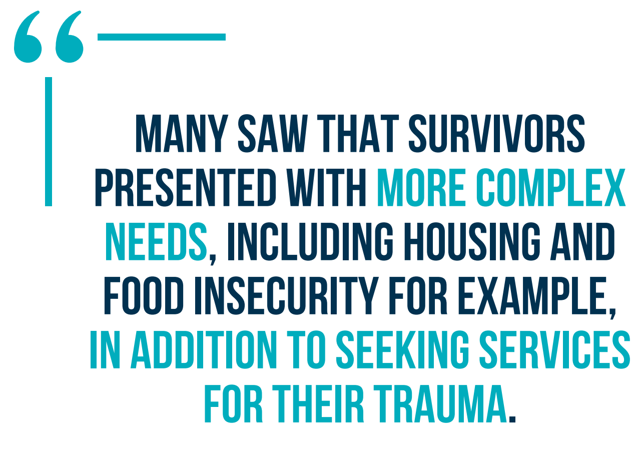
"WHEN WE RECOGNIZE THAT DECREASES IN SERVICES ARE RELATED TO STAFFING SHORTAGES, RATHER THAN TO A DECREASE IN NEED FOR SERVICES, WE CAN ACHIEVE A BETTER UNDERSTANDING OF HOW IMPORTANT MORE ROBUST FUNDING IS TO SUPPORT SURVIVORS ACROSS THE STATE."

According to The National Alliance to End Sexual Violence, when rape crisis centers are underfunded, they cannot adequately meet the needs of sexual assault survivors, and prevention programs are sidelined. When employees are not adequately paid and waitlists grow, survivors are left to defer their care, which only exacerbates their trauma. Furthermore, systems of support are, in turn, weakened across sectors due to the lack of staff bandwidth needed to provide advocacy and grow partnerships and collaborations.

In addition to collecting program statistics from our county-based providers, we welcomed them to participate in a twenty-question COVID-19 impact survey to gather further details about their experience during and after the pandemic and to glean deeper insights into program challenges, innovations, collaborations, and more. Below, we share those findings representing a total of nine county-based programs (i.e., 43%), which we believe further elucidate the quantitative data above.

With regard to service provision in the early days of the pandemic, some programs noted that they experienced a decline in in-person activations due to hospital restrictions and fewer clients reporting to emergency rooms. Hotline calls were also reported to have temporarily decreased for some, along with outreach for support group requests. This is likely due to many survivors not having privacy/safe space to call hotlines during the lockdown. Yet, despite these decreases, there were areas where agencies tracked increases. Specifically, four programs noted higher crisis counseling requests, likely due to remote services being more convenient for some clients. Also, it was noted that there were more frequent sessions or check-ins for existing clients, and demand for emergency shelter was an area where programs struggled, as requests outweighed supply. One program saw a roughly 35% increase in services. Another cited an increase in telehealth sessions.

Regarding service adaptations, many programs switched to virtual/phone counseling or a hybrid model for services that were more readily available to clients. One agency was able to provide tablets for live video counseling. Many saw that survivors presented with more complex needs, including housing and food insecurity for example, in addition to seeking services for their trauma. In light of this, the focus of treatment shifted to reducing anxiety and discussing ways to cope with the ongoing pandemic, in addition to aiding with meeting basic needs. For existing



clients, while it was noted that some reached out more frequently for services, others discontinued them due to other, more pressing needs. It was further noted that, for both clients and staff, there was loss experienced in myriad ways—loss of loved ones, jobs, freedom, and more. As this was experienced by all—clients and providers alike—it clearly created greater challenges for those providing care and services at this time.

When sharing challenges, it was noted that, while programs shifted to online services, there was a pause in the rollout to ensure HIPAA compliance and determine best practices for telehealth. Other difficulties that were referenced included one program that saw an influx of survivors expressing a desire to come forward and formally report sexual violence they experienced to law enforcement. This agency spent a significant amount of time connecting survivors to community partners versed in civil legal litigation and options, serving as a conduit during a time when there was a significant strain on the legal system. Generally, the pandemic made it difficult to engage with some partners, including the courts, many of which were closed or did not allow non-court personnel to be present in their facilities. Hospitals were also, of course, extremely challenging to navigate, as they did not permit non-hospital personnel in their facilities. Providers focused much of their time on meeting the needs of their communities while traversing these systems under new conditions and staying abreast of protocols and procedures. One agency noted that there were no volunteers to respond to activations, court processes were delayed, and advocacy had to be provided completely over the

FOR BOTH CLIENTS AND STAFF, THERE WAS LOSS EXPERIENCED IN MYRIAD WAYS—LOSS OF LOVED ONES, JOBS, FREEDOM, AND MORE.

THE PANDEMIC MADE IT DIFFICULT TO ENGAGE WITH SOME PARTNERS, INCLUDING THE COURTS AND HOSPITALS.

PROVIDERS FOCUSED MUCH OF THEIR TIME ON MEETING THE NEEDS OF THEIR COMMUNITIES WHILE TRAVERSING THESE SYSTEMS UNDER NEW CONDITIONS AND STAYING ABREAST OF PROTOCOLS AND PROCEDURES.

phone. Post-pandemic, this agency has continued to struggle to rebuild its volunteer pool, despite many efforts, and, therefore, it still cannot respond to activations in person in hospitals or law enforcement agencies—just one more example of the long-term impact of COVID-19 on service providers.

Coupled sometimes with decreases in staff, delays in addressing the needs of clients under the “new normal” impacted agencies’ abilities to maintain level services, even as they endeavored to adapt practices quickly and remain responsive to emerging needs. In essence, programs noted that they sought to adjust to changes as they came, supporting staff and assisting clients by providing technical assistance to reduce barriers and ensure continued access. Additionally, given that county-based programs also offer prevention education programming including at schools, one agency’s prevention outreach team worked with schools and continued presenting to students once they were set up with Zoom. Most were able to continue outreach virtually and also had their hotlines available 24/7 if a student needed crisis/intervention counseling.

“POST-PANDEMIC, THIS AGENCY HAS CONTINUED TO STRUGGLE TO REBUILD ITS VOLUNTEER POOL, DESPITE MANY EFFORTS, AND, THEREFORE, IT STILL CANNOT RESPOND TO ACTIVATIONS IN PERSON IN HOSPITALS OR LAW ENFORCEMENT AGENCIES—JUST ONE MORE EXAMPLE OF THE LONG-TERM IMPACT OF COVID-19 ON SERVICE PROVIDERS.”

Finally, as we recognize that historically marginalized groups were most impacted by COVID-19, we asked programs how they sought to increase program inclusivity during the pandemic. Trainings were outsourced to consulting organizations with specific experience in racial, ethnic, and LGBTQ+ concerns in several agencies. One focused on the transcreation of new content, primarily into Spanish, which they indicated promoted access to their highest non-English-speaking client population. Another updated their intake forms to be more inclusive and underwent an agency name change, while yet another team conducted extensive research and used YouTube, webinars, and consultants to assist them in reducing barriers.

When asked what they need most now to address future crisis situations, programs indicated emergency and flexible funding to increase staff pay, as well as hiring incentives to address counseling, shelter, technology, and other related needs that could improve response rates. Specifically, flexibility with demands from funders to allow a greater focus on the work given emergent community needs was cited as a priority, as was continuing remote counseling services that will allow clients to receive services even if we experience another disruption. Well-established plans for remote work and hybrid schedules would also be valuable to address the complex needs of providers (i.e., vicarious trauma). All noted that continuing a hybrid form of work has allowed for greater accessibility, regardless of the pandemic, and that it is integral for providing services while fostering self-care. Seeking ideas and needs from the communities they serve was also requested, along with continued support from COVID-19 funding—recognizing its lingering impact on clients and services.

As funding is a major consideration for programs, feedback about program budgets also yielded helpful considerations. A couple of participants noted shortfalls in funding across their agencies. Base contracts for certain federal funding streams have not increased (e.g., Violence Against Women Act and Victims of Crime Act funding). At the same time, staffing, benefits, utility, general and professional liability insurance, and other operating costs have sharply increased. Specifically, over the past year alone, staffing costs have increased significantly due to the need to remain competitive in today's job market. One program noted that they have experienced an increase in clients being served without additional financial support to match. Another noted that, no matter how many people they hire, the waitlist never ends, demonstrating a need for even more service providers, which requires additional funding.

One program noted that the bulk of additional funding that was received was for personal protective equipment, sanitation supplies, and increased cleaning/sanitation of facilities during each of the pandemic years. This same program noted that they have experienced a 28% turnover rate in approximately the last year and a half. Prior to this, they had a 2-3% turnover rate. New hires' salaries to replace those staff that left are much higher, given the demands of the current job market, which also pushed up the salaries of existing staff to retain them and promote greater equity. Therefore, all staffing costs have gone up sharply. Staff health insurance has also increased by as much as 30%. While one-time Covid-related funding is helpful, and in a few cases could be used for staffing, it is not sufficient to keep pace with these increased costs. In addition, all operating expenses have gone up at the same time due to inflation.

This, unfortunately, coincides with general decreases in fundraising, also due to the same economic pressures. In the meantime, many funders, both government and private, do not cover various essential staff functions, such as human resources, finance, executive/management, and data and technology/IT. Yet, these positions are ones for which nonprofits compete with corporations, universities, hospital systems, etc. for hires, thus making these professionals increasingly more expensive both to hire and retain. In particular, human resources (HR), finance, and technology needs have increased sharply as a result of the pandemic and continue to be critical to the performance and support of organizations and their staff. Yet, funding for these essential functions is generally not provided in adequate amounts. Overall, this indicates that there is a need to step up general fundraising and execution of grant proposals to compensate for additional needs and funding challenges. The consensus among all participating programs is that they are searching and applying for more funding, while programs also recognize that one-time funding cannot sustain ongoing staffing costs. Thus, at a time when programs are already stretched thin, they need to allocate more time and resources to development activities.

In addition to increased funding, this report calls for the creation of stronger, more responsive networks of services among a range of providers, including culturally specific and community-based agencies that traditionally do not receive adequate levels of recognition and funding. In the next section, we include more about the impact of our community partners during and in the aftermath of the pandemic and of the challenges they continue to face, as we propose greater collaboration with and support for these providers and those they serve.

COMMUNITY PARTNERS DATA

NJCASA shared our twenty-question survey with community partners, including our nine-member Community Council. Council members are:

ALEXYSS PANFILE

CARE COORDINATOR, EDGE NJ

Alexyss Panfile began her advocacy for sexual assault survivors as a volunteer Certified Crisis Counselor for Crisis Text Line in 2016. In 2018, Alexyss participated as a Staff Writer for the advocacy journalism program Writing Wrongs. She worked with other advocacy journalists and survivors to create a published book that shines a light on the issue of domestic and sexual abuse and represents people not as victims, but as resilient survivors. Alexyss is now a Care Coordinator for EDGE NJ, serving the Living with HIV/AIDS community and the LGBTQ+ community in addition to being a Community Council Member for NJCASA.

ASHANTE TAYLORCOX

FOUNDER AND EXECUTIVE DIRECTOR, YOU ARE MORE THAN INC.

You Are More Than Inc. is a survivor-led organization supporting marginalized survivors of trafficking nationally. Over the last nine years, Ashante has worked to enhance support services for BIPOC and LGBTQ+ survivors within the mental health, education, and economic empowerment sectors of care. Ashante is a licensed professional counselor with advanced certification in LGBT health, education, and social services from New York University. In 2022 she was granted the Visionary Voice Award by the National Sexual Violence Resource Center and Arbor Rising 2021 - 2022 Leaders of Color Award. She was also a 2021 Echoing Green Fellow.

COLLEEN ROCHE

DISABILITY HEALTH & WELLNESS CONSULTANT

Colleen Roche, a Certified Community Resource Specialist, is a regional training coordinator, program developer, and subject matter expert on disability health and wellness. Certified by the New Jersey Victim Assistance Academy, her work centers on raising awareness of and increasing access to domestic violence and abuse-related supports and services within the disabled community. She holds a Bachelor of Science in Biology and Spanish Literature from St. Peter's University. A disabled activist and organizer, Colleen is also the co-founder of the New Jersey Disability Collective, and she is the board chair of both the Alliance Center for Independence and the New Jersey Statewide Independent Living Council.

ELIZABETH SCHEDL

EXECUTIVE DIRECTOR, HUDSON PRIDE CENTER

As the Executive Director of Hudson Pride Center, Liz raises awareness about LGBTQ+ issues, strengthens and grows the center's services and cultural programs, and develops partnerships with agencies, businesses, organizations, and individuals. She chairs the Early Identification of Individuals with HIV/AIDS Committee and is a member of numerous local and regional committees. In 2022, she was appointed to the Governor's Age-Friendly State Advisory Council, joined the Advisory Council of Healthy NJ 2030, and became a council member for NJCASA. In 2023, she became a commission member of the Hudson County Commission on the Status of Women and Girls.

MARIE JARDINE

ASSOCIATE DIRECTOR OF PUBLIC SAFETY/DEPUTY TITLE IX COORDINATOR, BERGEN COUNTY COMMUNITY COLLEGE

Marie Jardine is a thirty-year public safety servant, working her way up from Public Safety Officer to the Associate Director of Public Safety. She has created policies and operating procedures, organized security for high-profile visitors, assists in Title IX compliance, and coordinated the first COVID-19 drive-thru testing center in the state. Marie strives to have a positive impact in creating a safe, secure environment for all at the largest community college in NJ.

MARY GEORGE

FOUNDER/CEO, MAYA'S PLACE A CENTER FOR HEALING LLC

Mary is the Founder and CEO of Maya's Place A Center for Healing, LLC, located in Ewing, NJ. Mary was born in Las Vegas, Nevada, and was raised in Trenton NJ. She attended Trenton Public Schools and graduated from Granville High School. Mary obtained a Bachelor's Degree in Criminal Justice from Delaware State University in 2009 and attended The College of New Jersey to attain a Master's Degree in Clinical Mental Health Counseling in 2016. Mary specializes in trauma-informed care, addiction treatment services, and community development. She takes pride in serving her community by providing counseling and therapy services to address and support good mental health and overall wellness. Mary is passionate about serving adults, adolescents, and families to support family healing from trauma and addiction.

ROBIN PARKER

EXECUTIVE DIRECTOR, BEYOND DIVERSITY RESOURCE CENTER

Robin Parker is the Executive Director of the Beyond Diversity Resource Center. His work focuses on using anti-oppression tools to build a more just society. Parker was formerly a Deputy Attorney General in the New Jersey Division of Criminal Justice and Chief of the Office of Bias Crime and Community Relations. He is the recipient of the Rachel Davis Dubois Human Relations Award and the “A World of Difference Award” from the Anti-Defamation League of the B’nai B’rith. He is a graduate of the University of Illinois Law School and Rutgers University.

ROSANNA EVE

PROGRAM MANAGER, IRONBOUND COMMUNITY CORPORATION

Rosanna is a Domestic Violence Program manager at Ironbound Community Corporation with a BA in Forensic Psychology and sixteen years of experience working in the Social Services field. Currently, Rosanna is pursuing her MA. Rosanna has experience working with underserved populations, such as People of Color, undocumented, and the LGBTQ+ community. Rosanna is responsible for managing the program, providing case management, legal and housing advocacy, supervising staff, working directly with clinicians and lawyers, assisting with grant writing, and submitting reports to funders.

VIMMI SURTI

LEGAL ADVOCATE/CASE SUPERVISOR, MANAVI

Vimmi joined Manavi Inc. in February 2019. She is a legal advocate and case supervisor at Manavi. Vimmi has a B.A from SUNY ALBANY, NY, LLB from Gujarat University, India, and MSW from Rutgers University, NJ. She is passionate about working for survivors of gender-based violence. She brings the perspective of social work, therapy, and law to her work. Her uniqueness lies in understanding transitional marriage abandonment, especially when cases are between U.S. and India.

Our Community Council has been gathering over the course of nearly a year to discuss and address the impact of COVID-19 on clients and service providers. While these partners do not exclusively work with sexual assault survivors, many do serve them in the context of wrap-around and/or culturally specific supports that they provide. Also, council members are advocates for a range of historically marginalized populations that often experience higher rates of sexual assault, along with increased barriers to accessing services, and they represent communities most impacted by the pandemic. Additionally, two culturally specific community partners, Harambe Social Services and Community Affairs and Resource Services, also participated in the survey, for a total of 11 community partners. Below are key findings across specific topic areas.

INCREASED DEMAND

Overwhelmingly, these providers surveyed identified an increased demand for services, with mental health/behavioral health services representing the most significant increase. The rise in requests for mental/behavioral health support reflects a corresponding increase in stress factors during COVID-19 (i.e., fear of getting sick, loss of loved ones, job loss, physical isolation, etc.), coupled with an increase in violence, including sexual assault. Additionally, like our county-based programs, these providers witnessed an increase in requests for financial assistance, technology access, and legal services, and two noted addiction relapse rate increases, all of which point to the intersectional nature of the impact COVID-19 had on our communities—physical, financial, social, emotional, etc. Other examples of requested services included rental assistance due to job loss/not being able to collect government benefits, interpretation services in medical settings, and food, hygiene, and personal protective equipment/materials. Despite these increases, some programs did report decreases, such as one program which specifically reported a decrease in sexual violence/interpersonal violence outreach attributed to clients who were sheltering in place with their abuser and were afraid of risking homelessness. The latter also demonstrates parallels to what we witnessed among participating county-based rape crisis centers.

PROVIDERS IDENTIFIED AN INCREASED DEMAND FOR SERVICES INCLUDING:

MENTAL & BEHAVIORAL HEALTH SERVICES

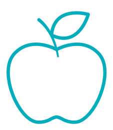
FINANCIAL ASSISTANCE

TECHNOLOGY ACCESS

LEGAL SERVICES

RENTAL ASSISTANCE

INTERPRETATION SERVICES



FOOD, HYGIENE, PPE MATERIALS

ACCESSIBILITY

One prevalent issue programs cited was that, while transitioning to online services helped fill a critical gap during the height of COVID-19, it exacerbated challenges for many clients. For example, survivors quarantining with the person who caused them harm often could not avail themselves of virtual counseling for fear of their safety, while other clients experienced digital barriers. Another difficulty that agencies experienced with the delivery of telehealth counseling specifically, for example, was staffing, which created waitlist issues during a time when clients felt most at risk. Also, one provider noted that linkages for LGBTQ+ individuals were particularly a challenge, as there are not many organizations that are inclusive of all genders and sexual orientations. This made it difficult to find housing, counseling services, and support services (case management specifically) for LGBTQ+ clients. It is important to note that the LGBTQ+ community is disproportionately impacted by sexual violence, increasing concern about significant barriers to services in the midst of this public crisis. For example, in a 2015 study of over 27,000 respondents who identified as transgender, genderqueer, non-binary, and other identities on the transgender identity spectrum, the National Center for Transgender Equality found that nearly half of the respondents had been sexually assaulted. See Sandy E. James et al., The Report of the 2015 U.S. Transgender Survey, National Ctr. for Transgender Equality 198 (Dec. 2016). Furthermore, gay and lesbian individuals are

WHILE TRANSITIONING TO ONLINE SERVICES HELPED FILL A CRITICAL GAP DURING THE HEIGHT OF COVID-19, IT EXACERBATED CHALLENGES FOR MANY CLIENTS.

THE LGBTQ+ COMMUNITY IS DISPROPORTIONATELY IMPACTED BY SEXUAL VIOLENCE, INCREASING CONCERN ABOUT SIGNIFICANT BARRIERS TO SERVICES IN THE MIDST OF THIS PUBLIC CRISIS.

more than twice as likely to experience rape or sexual assault than straight individuals, according to Jennifer L. Truman and Rachel E. Morgan in their report "Violent Victimization by Sexual Orientation and Gender Identity, 2017-2020." Also, gay men are almost twice as likely as heterosexual men to experience sexual violence other than rape, according to the National Center for Injury Prevention & Control, Division of Violence Prevention. Finally, according to The Trevor Project, 28% of LGBTQ+ youth reported experiencing homelessness or housing instability at some point in their lives—a figure that has been compounded by COVID-19 stay-at-home orders which created more risks, particularly for LGBTQ+ youth who were sheltering in place with unaccepting parents and/or other relatives.

A few providers surveyed did, however, indicate some unique advantages in services that arose, such as increased accessibility for many individuals with disabilities who often experience barriers to in-person services, as well as expanded services to new clients outside of the geographic area/region of certain programs. This was particularly useful for groups who typically experience more limited access to local services, such as members of the LGBTQ+ community, as cited above. For example, one provider that typically serves their local community hosted a virtual LGBTQ+ youth prom with 87 youth participants from 19 different states and one international attendee (31 participants were from NJ). In states with fewer LGBTQ+-friendly laws and policies, it is even harder to come across LGBTQ+-affirming care and services, making reaching resources and opportunities virtually an even greater advantage to anyone seeking support. Just under 50% of attendees were in homes that were not LGBTQ+ affirming, and 40% had never been a part of an LGBTQ+ safe space prior to this. Also, over 33% did not feel safe expressing themselves/LGBTQ+ identity at previous school events (like prom). While these positive outcomes do not outweigh the overwhelming risks and challenges faced by these communities, they underscore actions and practices that can be incorporated as we seek to create better resources and systems of care to address the unique needs of historically marginalized populations.

ADDITIONAL CHALLENGES

One program indicated that a crucial aspect of the impact of COVID-19 on low-income, marginalized communities was an inability to adhere to CDC guidelines and recommendations that placed them at higher risk for exposure. This was mainly due to having to work to avoid homelessness and afford basic needs. Another important challenge

that was mentioned was the impact of the pandemic on staff, one of which was the loss of clients. We have heard a lot about increased vicarious trauma and compassion fatigue, but acknowledging the tremendous loss of life, including the loss of clients, is a significant factor that likely requires more in-depth analysis when we consider the feelings of providers when a client/patient dies. In this instance, these feelings were compounded by the overwhelming sense of helplessness and confusion caused by the pandemic.

SERVICE EXPANSION

Typically, one would think that the pandemic would lead to a reduction in services, but one of the most interesting findings from the survey was that many programs adapted and even expanded services at this time. Given the factors cited above, programs aimed to address the evolving needs of their clients, for example, by sharing more community resources, such as information about local food banks, job listings, childcare services, survivor services, and more. Others grew their social media presence, recognizing it as a prominent tool for reaching survivors and the larger community. Others still did more than just build awareness about available services; they created new programs and resources themselves to meet emergent needs. Some of these included securing emergency funding to cover phones and sim cards for clients who did not have access to phone/internet which allowed them to stay connected with agencies for support, hotel stays for young adults needing emergency housing because they were kicked out of their homes (i.e., a significant issue for LGBTQ+ youth during the pandemic), and Uber Eats and Uber Rides to increase access to food and transportation for at-risk individuals and families. One agency also created memorandums of understanding (MOUs) with mental health providers and covered co-payments, such as for youth/young adults who were uninsured, underinsured, or under their parents' insurance. Another agency focusing on supporting the local South Asian community provided clients with a South Asian therapist, peer support counseling, and virtual support groups when needed. These adaptations and innovations not only filled critical gaps but enhanced existing programs and helped providers see the potential for reimagining their services beyond the pandemic.

BUDGETARY CONCERNS AND EMERGENCY PREPAREDNESS

Today, many of these providers, like our county-based ones, are still reeling from the financial impact of COVID-19. Ongoing higher rates of requests from clients for things like

rental assistance, for example, continue to put a strain on their budgets. They also indicate the challenges of paying staff equitable wages and of covering overtime. The fear of losing funding is also high among providers, with all respondents saying that they have concerns about funding decreases. This has led to uncertainties about how to sustain programs and to challenges around identifying and applying for other sources of funding with limited staff and bandwidth. Also, many programs conduct fundraising events and activities, and it has become more difficult to identify donors with so many individuals impacted by the economic fallout of the pandemic, a consideration that was also shared by participating county-based programs.

Overwhelmingly, providers reported that more funding and more staff are needed. Case managers and particularly bilingual/multilingual case managers are in high demand, as is ensuring that existing staff are adequately paid—particularly during a period of high inflation. Additional funding would also enable programs to roll out more robust services, as new community needs have and continue to emerge post-COVID-19. Furthermore, providers discussed funding for emergency services, which would be helpful in future disruptions to allow them to better support clients with housing, food, internet access, transportation, mental health service, personal protective equipment, and more. Additionally, programs cited a need to better train staff in how to interact with individuals virtually and to better understand the complex impact of isolation on clients. Resources that are most needed for future events include laptops and tablets to increase client access to online services and reduce the effects of isolation. Furthermore, providers cited a need for greater collaboration among agencies and community allies, as well as utilization of state and federal resources, such as the National Crisis Hotlines that provide 24-hour support.

ADDITIONAL FUNDING WOULD ENABLE PROGRAMS TO ROLL OUT MORE ROBUST SERVICES, AS NEW COMMUNITY NEEDS HAVE AND CONTINUE TO EMERGE POST-COVID-19.

Housing was another area of high concern cited by providers, due to the challenges of communal living during pandemic conditions. Housing costs in NJ are some of the highest in the country, and with homelessness rates impacted by COVID-19—particularly as stay-at-home orders made living situations dangerous and ultimately untenable for many individuals in abusive home environments—emergency housing was and continues to be a significant need. In general, providers indicated that safe houses and other forms of housing/shelter need to be more accessible during public emergencies. Suggestions shared include having dedicated quarantine/isolation rooms/areas. In events where rapid testing is not available, this would allow clients to receive the services they need, while protecting the health of others. Additionally, hotel aggregator programs—which started in 2020 to help agencies place domestic and sexual violence survivors in area hotels instead of shelters due to spacing issues during the pandemic—have been successful for some, but costs are exorbitant. One program surveyed is working to get a safe house specifically dedicated to emergencies, which may help with overcrowding.

Furthermore, providers indicated that efforts to address crisis situations must have more unified responses across sectors, such as the medical and education systems and law enforcement. Greater trust needs to be built by partners to ensure that clients feel safe turning to these services when needed, and doing so requires more proactive efforts on the part of these systems to embody more inclusive and affirming approaches. When individuals and systems are in crisis, it becomes even harder to overcome barriers and mitigate harm. However, if providers across these sectors adopt policies and practices that help shift how community needs are perceived and supported, we can all be better prepared to assist in more collaborative, constructive ways that do not overwhelm staff or cause greater anxieties and risks for those seeking services. Given that historically marginalized communities are most often negatively impacted by these systems, working with culturally specific providers, advocates, and community leaders to reach a deeper understanding of how the pandemic exacerbated disparities and disproportionately affected BIPOC, the LGBTQ+ community, individuals with disabilities, incarcerated individuals, and more could underscore how institutionalized racism and other systemic forms of oppression have shaped responses to community crisis.

ACTION ITEMS

The recommendations shared below are informed by NJCASA's own membership data, current research, partner and membership program survey responses (20 organizational respondents), and other reporting on the relationship between sexual violence and community crisis, and the systemic inequities that shape outcomes from these experiences, particularly for historically marginalized/minoritized populations. There are significant lessons to be learned from survivors and the providers who serve them, as well as opportunities for making substantive changes to help improve outcomes for all impacted. As the National Sexual Violence Resource Center's "Sexual Violence in Disasters," notes, "[t]he work of achieving racial and socioeconomic equity, preventing sexual violence, and preparing for and recovering from disasters is inseparably intertwined." Similarly, the health, economic, and social impacts of both COVID-19 and sexual violence represent overlapping factors. As we look ahead, we must apply an intersectional lens to what has been gathered from this crisis to strengthen systems, support services, and advance equity.

KEY RECOMMENDATIONS

1 ELEVATING THE VOICES AND PERSPECTIVES OF THOSE MOST IMPACTED

As articulated throughout this report, one of the main findings of our research (consistent with a wide range of academic articles and other reports) is that COVID-19 disproportionately impacted marginalized and minoritized communities in various ways. First, many of these communities did not have a strong safety net to begin with, meaning that reductions in income levels, job loss, increased medical expenses, etc. often had an immediate and grave impact from which communities are still struggling to rebound. Addressing this problem requires more than what is typically proposed under "recovery" efforts, as by definition the practice of recovery focuses on returning to a previous state or condition, whereas what is required at this moment is a transformational approach that will result in better outcomes for communities now and in the event of future public crises. This effort demands a deeper understanding of how systems fail historically marginalized

communities and an examination of the root causes of these failures, which go far beyond the stress placed on systems during periods of alarm and crisis. The inherent mistrust felt by communities of the very systems they were asked to turn to during COVID-19 points to problems that existed long before the pandemic and that were only made worse during and now in its aftermath.

Addressing these underlying issues will take many years, as there are no quick fixes. Additionally, these efforts will require centering the voices and perspectives of those impacted to ensure that recommended policies and practices are guided by their experiences. Not only will this approach improve trust and build collaboration, but it will also result in actions that are responsive to and informed by those individuals our systems are most called upon to support. Essentially, when we serve those on the margins of the margins, we create programs and systems of care that are trauma-informed, compassionate, and fully invested in the well-being of our communities. Without such approaches, systems will inevitably continue to struggle, particularly during periods of public crisis that place a greater strain on them. Improving community outcomes before the next pandemic or disruption in services will ensure that the systems communities most rely upon during periods of crisis are less overwhelmed and better equipped to address their needs. The creation of task forces, councils, charettes, and other community groups is one way to promote greater representation of those most impacted. However, it is important to note that such groups are not in themselves an outcome. Instead, their creation is just one

> **WHEN WE SERVE THOSE ON THE MARGINS OF THE MARGINS, WE CREATE PROGRAMS AND SYSTEMS OF CARE THAT ARE TRAUMA-INFORMED, COMPASSIONATE, AND FULLY INVESTED IN THE WELL-BEING OF OUR COMMUNITIES.**

> **IMPROVING COMMUNITY OUTCOMES BEFORE THE NEXT PANDEMIC OR DISRUPTION IN SERVICES WILL ENSURE THAT THE SYSTEMS COMMUNITIES MOST RELY UPON DURING PERIODS OF CRISIS ARE LESS OVERWHELMED AND BETTER EQUIPPED TO ADDRESS THEIR NEEDS.**

important step towards meaningful transformation. Community members participating in such groups must have an unwavering commitment from public leaders, lawmakers, and those with power to enact recommended changes. Also, participants should be paid for their service to such groups to ensure that we are not replicating harmful norms but are instead empowering those whose insights are most needed.

2 CROSS-SECTOR COLLABORATION

COVID-19 drew back the curtain and exposed how systemic racism and other forms of oppression create inequities and how these disparities are exacerbated during times of public crisis, touching every aspect of a person's life—physical, mental, financial, and social. This, in turn, increases a range of risk factors, including sexual violence, putting a greater strain on the systems that must remain responsive to the needs of our communities. Policymakers, community leaders, medical professionals, and other providers and advocates must come together to advance health equity and foster cross-sector engagement that will help improve health outcomes across the various systems through which individuals connect regularly—e.g., the education system, healthcare system, law enforcement, etc. Over time, these interactions can help build trust to change attitudes and perspectives about historically marginalized and minoritized individuals and create more inclusive programs, agencies, and services that feel welcoming and affirming to those who have a deep mistrust of them based on their lived experience and a long history of their communities being failed by them. Clearly, this is not something that will happen overnight. Instead, it will involve a long-term, coordinated effort, and accountability will be required.

However, we cannot wait until the next public health crisis to begin building better practices. With COVID-19 only shedding a brighter spotlight on how racism and other forms of oppression and discrimination inform the complex interactions between individuals and their environments, systems cannot turn a blind eye to these facts. Instead, cross-sector action plans must be created to establish greater cooperation in addressing community needs across the foundational attributes that help build healthier lives and stronger, more vibrant neighborhoods—healthy foods, safe living environments, quality education, thriving wages, mental health resources, physical activity, social engagement, and much more.

WE CANNOT WAIT UNTIL THE NEXT PUBLIC HEALTH CRISIS TO BEGIN BUILDING BETTER PRACTICES.

When the agencies and organizations responsible for addressing these priorities work together, they are able to build greater awareness of how these disparate facets of our lived experiences intersect and how best to foster holistic, integrated approaches for streamlining care and services for those who most need our support. Achieving this requires statewide planning, funding, policies, and resource allocation to help create a wider, more inclusive inter-organizational network of partners, service providers, and other stakeholders across sectors and regions of the state, and it must include grassroots, community-based, and culturally specific programs that often serve historically marginalized populations. This network should focus on building knowledge, skills, and cultural competencies, and it must include an emphasis on emergency preparedness to deploy concerted, pre-designed strategies during times of community crisis.

3 INCREASE IN STATE APPROPRIATIONS FOR SEXUAL VIOLENCE SERVICES

Survivors of sexual violence seeking support in the aftermath of the COVID-19 crisis will likely experience the profound effects the pandemic has had on service provision. We have witnessed both an incremental increase in total clients served over the last two years over pre-pandemic service rates and a concomitant increase in waitlists across just over half of programs in 2022 alone (Note: not counting the four agencies that did not report). With community partners also identifying staffing challenges as a primary concern, we recognize that this is a rampant issue in our field, particularly post-COVID-19. County program data demonstrate an unmet need in our communities—especially regarding new clients—due to these staffing shortages, which, in turn, are likely the result of increased vicarious trauma and burnout, combined with traditional low pay at a time when the cost of living has soared. Culturally specific programs echoed these concerns, which for them are compounded by the fact that they overwhelmingly serve individuals most impacted. We anticipate a continued exodus of highly qualified, passionate professionals from this and related fields if agencies cannot provide thriving wages and robust benefits to employees.

Ironically, this crisis is underscored by unspent funds, a problem that some programs continue to have as they struggle to attract the right candidates due to limited salary budgets for positions. We recognize that helping fields are often chronically undervalued and underpaid, and state budgets continue to reflect this problem, which is common among teachers, childcare workers, health aides, social workers, and more. This combined with current inflation rates has made it untenable for some providers to remain in these fields, leaving programs to make do with decreased staff and/or to try to refill low-paying positions, which often causes other delays due to onboarding and training. At a time when we are witnessing an increase in demand for services, we run the risk of having waitlists grow and

even greater turnover, as existing staff scramble to meet community needs with limited resources. Furthermore, forecasted reductions in federal funding and the cessation of COVID-specific funding are important considerations, as programs stand to lose vital funding at a time when costs and demand are growing. Thus, the only answer is an increase in funding to county-based, culturally specific, and other community organizations serving sexual violence survivors, prioritizing those working with marginalized and minoritized communities most impacted. Also, it is important to note that a reduction in restrictions on funding is needed, giving survivors more autonomy to use funds at their discretion, as, ultimately, they are the experts in determining their own needs.

CONCLUSION

NJ is not unique in bearing the legacies of colonization, oppression, and racism. Nor is the state unique in how these legacies continue to manifest, and the COVID-19 pandemic was no exception. Systems of care continue to be structured to present barriers to access for individuals and communities that do not conform to the established “norm” – namely white, English-speaking, native-born, able, heterosexual, and cis-gender. Members of the community who lack privileged identities find access to healthcare, criminal-legal, and victim-service systems difficult and sometimes even impossible to navigate. For those who do access services, the ability of these systems to meet their needs is often limited, and many may even experience additional harm within them, which can be triggering and retraumatizing.

To be clear, this is beyond a simple quality improvement issue. Rather, these systems reflect the painful realities of longstanding societal inequities. Racism, homophobia, trans-discrimination, xenophobia, and ableism (to name a few) continue to be insidious influences on policy and practice across sectors. Any attempt to address and remedy the disparities exacerbated by the COVID-19 public health crisis must begin with an acknowledgment of these persistent forms of oppression and must follow with clear action to uproot and dismantle these harmful systems and norms. The pandemic revealed to many how dangerous and lethal a failure to do so can be. However, the danger and the harm existed long before this particular crisis and will, unfortunately, continue to fester unchecked if such changes as proposed in this report are not made.

BIBLIOGRAPHY

2015: *The Report of the U.S. Transgender Survey*. (2015). National Center for Transgender Equality ; National Center for Transgender Equality . https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Bogan, E., Adams-Bass, V. N., Francis, L. A., Gaylord-Harden, N. K., Seaton, E. K., Scott, J. C., & Williams, J. L. (2022). “Wearing a Mask Won't Protect Us from Our History”: The Impact of COVID-19 on Black Children and Families. *Social Policy Report*, 35(2), 1–33. https://doi.org/10.1002/sop2.23

de Cordova, P. B., Johansen, M. L., Grafova, I. B., Crincoli, S., Prado, J., & Pogorzelska-Maziarz, M. (2022). Burnout and intent to leave during COVID-19: A cross-sectional study of New Jersey hospital nurses. *Journal of nursing management*, 30(6), 1913–1921. https://doi.org/10.1111/jonm.13647

DePrince, A. P., Wright, N., Gagnon, K. L., Srinivas, T., & Labus, J. (2020). Social Reactions and Women's Decisions to Report Sexual Assault to Law Enforcement. *Violence against women*, 26(5), 399–416. https://doi.org/10.1177/1077801219838345

Elliott, S. A., Bardwell, E. S., Kamke, K., Mullin, T. M., & Goodman, K. L. (2023). Survivors' Concerns During the COVID-19 Pandemic: Qualitative Insights from the National Sexual Assault Online Hotline. *Journal of interpersonal violence*, 38(1-2), NP84–NP107. https://doi.org/10.1177/08862605221080936

Fast Facts: Preventing Sexual Violence |Violence Prevention|Injury Center|CDC. (n.d.). Centers for Disease Control and Prevention. Retrieved May 15, 2023, from https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html

Homelessness and Housing Instability Among LGBTQ Youth. (2022). The Trevor Project ; The Trevor Project. https://www.thetrevorproject.org/wp-content/uploads/2022/02/Trevor-Project-Homelessness-Report.pdf

Kendi, I. X. (2019). *How To Be An Antiracist*. Vintage.

Klein, A. (2008). *Sexual Violence in Disasters: A Planning Guide for Prevention and Response | Office of Justice Programs*. NSVRC; Louisiana Foundation Against Sexual Assault (LaFASA) & National Sexual Violence Resource Center (NSVRC). https://www.nsvrc.org/publications/nsvrc-publications/sexual-violence-disasters-planning-guide-prevention-and-response

Rieger, A., Blackburn, A. M., Bystrynski, J. B., Garthe, R. C., & Allen, N. E. (2022). The impact of the COVID-19 pandemic on gender-based violence in the United States: Framework and policy recommendations. *Psychological trauma : theory, research, practice and policy*, 14(3), 471–479. https://doi.org/10.1037/tra0001056

Sampsel, K., Heimerl, M., Sobiesiak, A., Fell, D. B., Talarico, R., Denize, K. M., & Muldoon, K. A. (2021). *COVID-19 pandemic and violence: rising risks and decreasing urgent care-seeking for sexual assault and domestic violence survivors* | BMC Medicine | Full Text. BioMed Central; BCM Medicine . https://doi.org/10.1186/s12916-020-01897-z

Sapire, R., Ostrowski, J., Maier, M., Samari, G., Bencomo, C., & McGovern, T. (2022). COVID-19 and gender-based violence service provision in the United States. PloS one, 17(2), e0263970. https://doi.org/10.1371/journal.pone.0263970

Social Determinants of Health - Healthy People 2030 | health.gov. (n.d.). Home of the Office of Disease Prevention and Health Promotion - Health.Gov; U.S. Department of Health and Human Services. Retrieved May 11, 2023, from https://health.gov/healthypeople/priority-areas/social-determinants health#:~:text=Social%20determinants%20of%20health%20(SDOH,of%2Dlife%20outcomes%20and%20risks.

Stone, M., Koss, M. P., & Yuan, N. P. (2006, March). *The Psychological Consequences of Sexual Trauma*. VAWnet.Org; VAWnet: The National Online Resource Center on Violence Against Women National Resource Center on Domestic Violence (NRCDV). https://vawnet.org/material/psychological-consequences-sexual-trauma

Truman, J. L., & Morgan, R. E. (2022). *Violent Victimization by Sexual Orientation and Gender Identity*, 2017–2020 | *Bureau of Justice Statistics*. Bureau of Justice Statistics; Bureau of Justice Statistics. https://bjs.ojp.gov/library/publications/violent-victimization-sexual-orientation-and-gender-identity-2017-2020

Violence Prevention at CDC |Violence Prevention|Injury Center|CDC. (2022, January 18). Centers for Disease Control and Prevention; Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/about/index.html#:~:text=The%20Division%20of%20Violence%20Prevention%20(DVP)%20is%20one%20of%20three,healthy%2C%20and%20free%20from%20violence.

Walker, T. (2020, May 1). *A Second, Silent Pandemic: Sexual Violence in the Time of COVID-19*. Center for Primary Care: Harvard Medical School; Harvard Medical School Primary Care Review. https://info.primarycare.hms.harvard.edu/review/sexual-violence-and-covid#:~:text=Evidence%20shows%20that%20rates%20of,Katrina%20and%20the%20recovery%20period.

OTHER RESOURCES

BLACK WOMEN & COVID-19

Black Women's Experiences of Stress During COVID-19

Resilient but not Recovered: Black Women in the Covid-19 Pandemic

Sex Disparities in COVID-19 Deaths Hide High Toll on Black Women

Black Women, Medical Racism, and COVID-19

Improving Health Outcomes for Black Women and Girls with Disabilities

DISABILITY & COVID-19

NJ COVID-19 Disability Action Committee Impact Report

Impact of the COVID-19 Pandemic on People with Disabilities

The NJ Council on Developmental Disabilities

Coronavirus Guide for People with I-DD

Sexual Violence and the Disability Community

Bringing the Pandemic Home: The Shifting Realities of Intimate Violence for Disabled People in the Time of COVID-19

COVID-19, Gender, and Disability Checklist

NDRN Launches: "Know Your Right to Be Safe at Home"

COVID-19 and Employment Trends for People with Disabilities

Has COVID-19 Impacted Disability Employment?

Resources for Survivors During COVID-19

GENERAL

Healthy Equity Tracker

Raising Awareness of Hate Crimes and Hate Incidents During the COVID-19 Pandemic

Rebuilding New Jersey after COVID-19: Advancing a Healthy, Resilient, Sustainable and Fair Garden State

Sexual Assault Kits (SAKs) and the Backlog of Untested Sexual Assault Evidence: In Brief

The Impact of COVID-19 Intensifies the Shadow Pandemic of Domestic Violence in NJ

HIV & COVID-19

A reproductive justice response to HIV/AIDS and COVID-19

Coronavirus LockSowns Seen Increasing HIV Risk to Women and Girls

COVID-19–Related Stressors, Sex Behaviors, and HIV Status Neutral Care Among Black Men Who Have Sex with Men and Transgender Women in Chicago, USA

The Burden of COVID-19 in People Living with HIV: A Syndemic Perspective

HOSPITALS & COVID-19

Sexual Violence Preparedness and Response

The Impact of the COVID-19 Pandemic on Healthcare Service Access for the Victims of Sexual Assault

LGBTQIA+ & COVID-19

COVID-19 Pandemic Increased the Frequency of Intimate Partner Violence

Implications of the COVID-19 Pandemic on LGBTQ Communities

Sexual and Gender Minorities Assigned Male at Birth Have Higher Odds of Partner Violence

OUTSIDE U.S.

Impact of COVID-19 on the Overall Health and Well-being, and Participation of the Transgender Community in India

Record Breaking Demand for Rape Crisis Services

COVID-19 Global Gender Response Tracker

World Health Organization: Corona Disease (COVID-19) Pandemic

The Covid-19 Pandemic: Three Years In | Human Rights Watch

COVID-19 Map - Johns Hopkins Coronavirus Resource Center

SCHOOL-AGED CHILDREN & COVID-19

Changes in Adolescents' Psychosocial Functioning and Well-Being as a Consequence of Long-Term COVID-19 Restrictions

Experiences With COVID-19 Stressors and Parents' Use of Neglectful, Harsh, and Positive Parenting Practices in the Northeastern United States

Supporting Adolescents and Young Adults Exposed to or Experiencing Violence During the COVID-19 Pandemic

COMMUNITY-CARE AND SELF-CARE PRACTICES

As discussed above, the trauma experienced by sexual violence survivors is often complex, and the professionals that support these individuals are highly trained to address it. However, this field carries the burden of vicarious trauma and secondary traumatic stress that can impact practitioners. When vicarious trauma leads to burnout and attrition, the continuity and quality of care available to survivors are undermined. Furthermore, as disparities in workload, compensation, etc. predominantly affect People of Color and/or with additional marginalized identities, the impact on survivors with marginalized identities is also disproportional. We know that the COVID-19 pandemic has only increased stress factors/levels among service providers, creating an even greater urgency for finding ways to address this problem.

While we fully recognize the need for comprehensive, cross-sector actions, such as those proposed herein, we must also come to terms with the demands of the current situation, reconciling ourselves to a two-pronged approach: one that builds towards broader, systemic changes, and another that seeks to alleviate the more immediate crisis to better support those working with survivors at this critical time. Below are resources, recommendations, and strategies for promoting self- and community-care and enhancing work culture. While not the long-term solutions we must continue to strive towards daily, we hope these practices foster more supportive, wellness-centered approaches in the field. We suggest adopting as many of these and/or similar practices as you are able to accommodate. While bandwidth and cost are important factors to consider when incorporating some, there are several that are quite practical in nature, ensuring options for organizations of all sizes and capacity levels. Also, these tools and activities align with the core values needed to upend the oppressive systems and harmful norms that have only been further exposed and exacerbated by the pandemic. Thus, incorporating them in concert with continued advocacy for the much more substantive changes outlined in the “Action Items” section of this report will provide both survivors and the providers who serve them the support they deserve, as we make strides towards creating a safer, more equitable NJ.

GENERAL RESEARCH

African Philosophy: UBUNTU: "I AM BECAUSE WE ARE. WE ARE BECAUSE I AM."

A Space for Us*

Beyond Self-Care: Understanding Community Care and Why it is Important

BIPOC Death and Grief Talk (Instagram Page)*

Community Care is Key to Collective Well-Being

Coping With Loss Workbook*

Grieving While Black*

Philly Death Doula Collective*

Self-Care Isn't Enough. We Need Community Care to Thrive

Stronger Together: When Self-Care Becomes Community Care

The SOAR Collective

What is Community Care?

Why Community Care is the Perfect Companion to Your Self-Care Practice

**Thanks to the SOAR Collective for these recommended resources.*

NONPROFIT-SPECIFIC:

5 Ways to Incorporate Community Care in the Workplace

7 Tips for How to Practice Community Care

A Better Way to Do Good: The Case for Comprehensive Community Care

Evolving a Culture of Care

Minnesota Community Care – Note: a great example of what nonprofits could do to implement more community-care practices.

Rest Is Resistance by The Nap Ministry

OTHER RECOMMENDATIONS AND STRATEGIES:

FOUR-DAY-WORK WEEK

Studies have found that four-day work weeks improve productivity, morale, and team culture. Companies and organizations that have adopted the model are typically reporting a great deal of success. Many European countries, such as Spain, Ireland, and the United Kingdom have already adopted the four-day-work week and have seen advantages. As continued reporting on the outcomes of this model becomes available, we recommend evaluating how this and other work-week/work-day reduction practices can be incorporated to allow more time for staff to care for themselves and their loved ones.

SUMMER FRIDAYS

Summer Fridays are an opportunity to take Fridays as a half-day or a full day off during the summer months of June, July, and August. This allows staff members the liberty to catch up on their personal lives (I.e., chores, family, mental breaks, etc.), which, in turn, can help reduce distractions and stress in the workplace. Careful planning is required to ensure coverage of all essential responsibilities and to create an equitable model whereby all staff are able to avail themselves of this benefit.

MEETING-FREE BLOCKS

For positions that require attendance at many meetings, creating non-meeting-time blocks in the work calendar can help increase focus and reduce stress. Plus, carving these periods into your team's calendar can help ensure that you have time available for everyone on staff to participate in designated self- and community-care activities, such as the items shared here in this list.

BOOK CLUBS

This is an opportunity to build team culture and collaboration via the sharing of knowledge. Learning together is a good way to improve educational practices within the workplace and can help reinforce an organization's mission and principles through the selection of relevant content while developing shared values and interests.

MEDITATION MONDAYS

Create opportunities where staff get to choose 15-30 minutes of their work time on Mondays (or any day of the week) to meditate, recenter, or just relax (i.e., take a walk). Small mental breaks throughout the day have been proven to increase productivity and mental health. Our brains are not meant to be hyper-focused for long periods of time, which can lead to mental fatigue. Incorporating practices that encourage staff to regroup, even if it's only once a week, can promote self-care to help reduce burnout. Similarly, creating opportunities to practice group and individual mindfulness exercises can help. Working in this movement is taxing on the mind and body, and these proven strategies will help decrease anxiety while fostering a culture of support.

STAFF CHECK-INS

It is important that executive directors and other leaders view their staff as people before employees. Building an authentic relationship with staff and caring about their interests and well-being will boost morale and strengthen team culture. This can include such practices as giving staff kudos to recognize even small achievements that contribute to the overall success of the team. While check-ins take time, they help reduce burnout, turnover, and conflicts that can be both costly and time-consuming for an organization. Creating consistent schedules for these regular meetings can help make them sustainable.

QUARTERLY OR BI-ANNUAL STAFF FIELD DAYS

Field days are a nostalgic and enjoyable activity for staff to connect with each other while being outdoors or in a different setting. Many studies have shown the increased health benefits of playing outside in community with one another. Additionally, field days offer the opportunity to boost morale in the workplace and strengthen team culture.

QUARTERLY STAFF APPRECIATION DAYS

While there is one official Staff Appreciation Day in the calendar year, we know that our colleagues in the field deserve more than just a day of recognition. Staff Appreciation Days are days dedicated to celebrating staff in the form of potlucks, games, art, fun activities, and casual mingling. Taking a slight break from work demands can help restore and refresh staff.

VICARIOUS-TRAUMA TRAINING/SUPPORT

This type of training has proven to be beneficial for sexual violence service providers and those in other helping fields, as the demands of these types of roles are mentally and emotionally taxing. This training can support staff in developing strategies for coping with and healing from vicarious trauma, plus reaching a deeper understanding of trauma's impact on the mind and body will also support our work with clients.

APPENDIX:

NEW JERSEY COALITION AGAINST SEXUAL ASSAULT AND NEW JERSEY COALITION TO END DOMESTIC VIOLENCE STAFF EXPERIENCE STUDY COVID-19 DATA

The New Jersey Coalition Against Sexual Assault (NJCASA) and the New Jersey Coalition to End Domestic Violence (NJCEDV) contracted Mathematica, data collection and analysis specialists, to collect survey data from employees of all member programs across both coalitions that provide sexual and/or domestic violence services to survivors throughout New Jersey (NJ). The Staff Experience Study data collection activities consisted of a combination of a multi-page survey, focus groups, and in-depth interviews.

Data collection efforts lasted for about eight weeks from March 29 to May 19, 2023. The survey gathered information about staff employment characteristics and tenure, compensation and benefits, job satisfaction, workplace climate, quality of the services provided to clients, professional development and support, and the impact of the COVID-19 pandemic. Specific to the latter, of the 330 respondents who answered the survey, 218 were working for their current organization during the COVID-19 pandemic. Below are the findings of the study as they pertain to COVID-19's impact. The full report will be released this summer (2023)

Sixty-six percent of respondents strongly agreed or agreed that their workloads were overwhelming at times during the pandemic. Most respondents strongly agreed or agreed their organizational leadership clearly communicated its policies. They also mostly reported that the health and safety policies that their organizations implemented during the pandemic were adequate (81%). In addition, 72% of respondents said they strongly agreed or agreed that they were supported by their supervisors during the pandemic. However, not surprisingly, almost half of respondents (47%) strongly agreed or agreed their organization had challenges providing high-quality services to survivors during the pandemic.

When asked whether it was difficult to provide high-quality services in a remote environment, 44% strongly disagreed or disagreed with this statement, implying that they felt it was not difficult to provide high-quality services in a remote environment, and 33% of respondents strongly agreed or agreed that it was difficult to do so. This likely indicates that many providers were generally able to offer robust services once resources were in place to support virtual practices, while others continued to experience challenges.

In general, many respondents (72%) strongly agreed or agreed that they have confidence in their organizations' ability to adapt to challenging external situations. When asked about the most important supports that their organizations provided during the pandemic, respondents stated these as the top three (Table 2):

- Support for remote work (e.g., VPN access, equipment for working at home like headsets, ITS support) (57%)
- Provision of clear health and safety guidelines (17%)
- Additional PTO (9%)

However, 8% of respondents said they did not receive any of the supports listed in the question and did not specify another type of support they were offered. This indicates that a smaller proportion of respondents did not feel like they had any of the listed supports. Other important supports respondents chose less frequently were having working groups to troubleshoot challenges related to providing services and receiving resources for managing staff well-being.

It is also significant to note that some respondents did share varying levels of dissatisfaction with the handling of the crisis by programs. For instance, some participants said they wanted to be able to work from home to protect themselves and their families but were told that they needed to go in while management stayed at home. Others noted

TABLE 2. MOST IMPORTANT TYPE OF SUPPORT THAT ORGANIZATION PROVIDED DURING THE COVID-19 PANDEMIC

TYPE OF SUPPORT	% %AGE
Provided support for remote work (e.g. VPN access, equipment for working at home like headset, ITS support)	57.0%
Offered clear health and safety guidelines	16.8%
Provided additional paid time off (PTO)	9.5%
None of the above	7.9%
Some other support	4.2%
Had working groups to troubleshoot challenges related to providing services	2.3%
Provided resources for managing staff well-being	2.3%
Sample Size	**214**

Source: NJCASA and NJCEDV Staff Experiences Survey (Question F4)

having to come back to the office before they felt ready and that organizational messaging was often either inconsistent or unclear. Overall, this demonstrates inconsistencies in how this crisis was handled across programs, with some offering more support than others.

TABLE 3. HOW CHALLENGING WERE CERTAIN SITUATIONS TO HANDLE DURING THE COVID-19 PANDEMIC

STATEMENTS CHALLENGES FACED DURING THE COVID-19 PANDEMIC	NOT AT ALL CHALLENGING	SLIGHTLY CHALLENGING	MODERATELY CHALLENGING	HIGHLY CHALLENGING	NOT APPLICABLE	SAMPLE SIZE
Handling my work-life balance	19.6%	29.0%	25.2%	25.7%	0.5%	214
Arranging for consistent care for children	9.8%	9.8%	7.0%	9.3%	64.1%	215
Arranging for consistent care for other dependents	9.3%	6.9%	6.0%	4.2%	73.6%	216
Managing my physical health	25.7%	28.0%	24.8%	16.4%	5.1%	214
Managing my mental health	16.7%	29.8%	26.0%	24.7%	2.8%	215
Managing my workload because not enough staff were available	19.5%	23.7%	20.9%	24.7%	11.2%	215

TABLE 3. HOW CHALLENGING WERE CERTAIN SITUATIONS TO HANDLE DURING THE COVID-19 PANDEMIC

STATEMENTS CHALLENGES FACED DURING THE COVID-19 PANDEMIC	NOT AT ALL CHALLENGING	SLIGHTLY CHALLENGING	MODERATELY CHALLENGING	HIGHLY CHALLENGING	NOT APPLICABLE	SAMPLE SIZE
Managing Vicarious Trauma	22.3%	35.8%	19.5%	14.0%	8.4%	215
Separating my work life and home life in a remote working environment	20.2%	25.4%	19.7%	20.7%	14.0%	213
Working overtime (compensated)	19.3%	9.4%	8.5%	4.8%	58.0%	212
Working overtime (uncompensated)	11.8%	14.2%	9.9%	19.3%	44.7%	212
Advocating for my own health concerns in my working environment	36.0%	21.5%	16.8%	11.2%	14.5%	214
Being able to choose the work environment that best suited my needs (e.g. work from home, in person)	39.9%	13.6%	15.0%	14.6%	16.9%	213

Source: NJCASA and NJCEDV Staff Experiences Survey (Question F3)

With regard to the challenges of handling work-life balance and managing workloads during the pandemic, 50% of respondents said that handling their work-life balance was moderately to highly challenging (Table 3). Furthermore, 40% of respondents reported that it was moderately to highly challenging separating their work life and home life in a remote working environment. In addition, 51% of respondents said that managing their mental health was moderately to highly challenging. This underscores a need for programs to better address work-life balance issues among employees, which will help reduce burnout and increase staff satisfaction.

Finally, in the aftermath of COVID-19, participants noted that they experienced a lot of staff leaving due to burnout. As a consequence, there are still many vacancies, and many staff noted that it has been very difficult to find qualified staff. Also, the job market is more competitive, making it even harder to identify and retain staff. Finally, social services received additional support and funding during the pandemic, but now those programs are winding down and often not being replaced, amplifying challenges for hiring new staff with competitive pay and strong benefits. Thus, funding will likely continue to be a critical factor for programs in the coming months and years.

KEY FINDINGS AND TAKEAWAYS:

- Balancing work and personal life posed challenges for many survey respondents. This is likely due to inadequate staff levels, further exacerbated by the transition to working remotely. This finding indicates organizations should consider having more realistic expectations for their staff during stressful events and organizational strategies to encourage self-care and work-life balance.
- About half of the survey respondents reported that managing their mental health was a challenge during the pandemic. This finding indicates that respondents would benefit from increased access to mental health supports during stressful events, like pandemics, and in their aftermath.
- Management-level participants noted concerns about maintaining the same level of services now that COVID-19 funding is decreasing/ending, demonstrating a need for additional funding.
- While many non-management-level participants indicated satisfaction with leadership during the pandemic, others shared that they did not always feel supported. This demonstrates inconsistency in practices across programs that should be addressed by identifying best practices and standardizing these in preparation for future disruptions in services.