Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot

The following is the narrative for the webinar presentation: ***Overview Webinar #4 (Chapters 11 and 12)***

Slide #1.

(No narration. This is the title slide.)

Slide #2.

Welcome to the webinar series describing the report entitled, "Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot."

This report and related products were developed by the American Institutes for Research, supported by a grant from the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

This project would not have been possible without the valuable contributions of the dedicated provider staff who took the time to candidly share their experience and insights to inform the text, nor would it have been possible without all of the research, advocacy, and creative energy of all of the practitioners whose publications and online resources we learned from and cited.

Special thanks also go to the following people and organizations for their help:

- The Office on Violence Against Women for their funding support, and our project officer, Sharon Elliott, in particular, for her ongoing encouragement and support as this project evolved;
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- Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative) for their very helpful reviews and comments on initial drafts of the report chapters.

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The project webpage at www.air.org/THforSurvivors contains links to the 12 chapters of the Report. Each chapter of the report contains background information and reference material on the topics covered, and extensive collections of provider comments from our interviews. Each chapter includes an executive summary; lists of questions that the interviews raised for us, and that we invite interested readers to consider; a reference list; and an appendix describing the project methodology and approach.

The project webpage also contains links to:

- A brief webinar describing the project methodology and approach, and four Overview webinars describing the content of the various chapters of the report;
- Four brief podcast interviews highlighting the approaches of a few of the providers we interviewed; and
- "Broadsides" highlighting a couple of the topic areas this report addresses.

Slide #4.

The project report is divided into 12 chapters. The first overview webinar describes chapters 1-4.

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The second overview webinar describes chapters 5-8.

Slide #6.

The third overview webinar describes chapters 9 and 10, and the fourth and final overview webinar describes chapters 11 and 12. This is Overview Webinar #4, describing chapters 11 and 12.

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Before starting to explore the individual chapters of the report, we should state the obvious: that many of the topics are interrelated. For example, how a funder measures success may, for better or worse, impact how the providers that depend on that funding shape their participant selection process, the kind of housing their programs support, their programs' policies on participant lengths of stay and the types of assistance staff are asked to provide. Source of funding may well impact all of those aspects of programs, and more. The type of program housing may impact policies on length of stay, participant selection, the definition of success, and staffing decisions. Participant selection policies may impact program decisions about the type of housing to support, length of stay policies, and staffing priorities.

That is, policies, procedures, and decisions affecting one aspect of providing transitional housing for survivors may impact and be impacted by policies, procedures, and decisions affecting other aspects.

One more thing before getting started with the individual chapters. Our report has followed the example of numerous publications -- for example, by the National Center on Domestic Violence, Trauma & Mental Health and the Missouri Coalition of Domestic and Sexual Violence -- and uses feminine pronouns to refer to adult victims/survivors of domestic and sexual violence, and masculine pronouns to refer to the perpetrators of that violence.

Citing data compiled by the Bureau of Justice Statistics, the Missouri Coalition, in the 2012 edition of *Understanding the Nature and Dynamics of Domestic Violence, explains that decision as follows:*

> *"According to the most comprehensive national study by the U.S. Department of Justice on family violence, the majority of domestic violence victims are women. Females are 84 percent of spouse abuse victims and 86 percent of victims at the hands of a boyfriend or girlfriend. The study also found that men are responsible for the vast majority of these attacks—about 75 percent. And, women experience more chronic and injurious physical assaults by intimate partners than do men."*

This use of pronouns is not meant to suggest that the only victims are women, or that men are the only perpetrators. Indeed, the victims and perpetrators of domestic and sexual violence can be male or female or transgender, as can the staff that support their recovery, and our shortcut is only used to keep a long document from becoming a little wordier and less readable.

Lastly, although the OVW funds transitional housing programs to address the needs of not only domestic violence survivors, but also survivors of sexual assault, stalking, and/or dating violence, the preponderance of program services are targeted to DV survivors, the large majority of TH program clients are survivors of domestic violence, and much of the literature and most of the provider quotes address domestic violence. Consequently, most of the narrative is framed in terms of addressing "domestic violence" or "domestic and sexual violence," rather than naming all the OVW constituencies.

Just a reminder for viewers interested in the project methodology and approach, that from the project webpage, you can download a brief webinar on the "Project Methodology and Approach." Alternatively, you can read about the project methodology and approach in an appendix at the end of each report chapter.

Slide #8. NEW

Chapter 11 focuses on the experience of trauma by adult survivors and their children; the impacts of that trauma; and how programs support participants in recovering from and addressing that trauma.

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The narrative begins with a discussion about trauma, starting with this definition by SAMHSA.

"***Individual trauma*** results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has ***lasting adverse effects*** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2014a, p.7)

The adverse effects of trauma may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. Examples of adverse effects include inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and adverse impacts to the trauma survivor's ongoing health and well-being. (SAMHSA, 2014)

Sometimes, a trauma survivor may not recognize the connection between the traumatic events and the effects those experiences have had on them. Instead, they may feel bad about or blame themselves for their depression or exhaustion or their anger or unexpected emotions.

Helping people who are suffering from the effects of trauma make the connection between their experience of trauma and troubling behaviors or feelings can be helpful in supporting recovery.

Although physical and sexual violence are typically the manifestations of abuse that police and courts use in deciding whether there has been an actionable offense, those acts of physical and sexual violence, as terrible as they may be, are often only the ***visible*** components of the violence. The accompanying emotional and psychological violence, backed up by the ***threat*** of further physical and sexual violence, allow an abusive partner to exert the kind of domination that Stark (2012) calls "***coercive control***" that demeans and debases the victim, and deprives her of her autonomy -- and that kind of violence may be as much or more of the cause of trauma than the actual physical abuse.

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In discussing trauma and how programs address it, it is important to distinguish between trauma-specific services, which tend to be clinical interventions, and being trauma-informed, which describes the understanding and approach that governs everything that providers do. As explained by SAMHSA,

"The term ***'trauma-specific services'*** refers to evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

A ***trauma-informed [approach]*** is a strengths-based service delivery approach 'that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment' (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services." (SAMHSA, 2014, p.xix)

Slide #11.

The impact of extended or repeated doses of trauma is cumulative, typically results in more serious and chronic trauma-related symptoms than does a single traumatic event, and over an extended period of time, can wear down the victim's resilience and ability to adapt. The effects can be exacerbated when the person is re-traumatized before they've had time to heal from prior traumatic experiences.

Individuals in chronically stressful, traumatizing environments -- like physically, psychologically, emotionally, and sexually violent relationships -- are particularly susceptible to ***chronic traumatic stress***, substance use, and mental health issues. When the victim is someone who was scarred by an early childhood or adolescent experience of physical or sexual violence, the impact is even more devastating.

Courtois (2010) describes how such traumatic experiences "... threaten the individual's emotional mental health and physical well-being due to the degree of personal invalidation, disregard, deprivation, active antipathy, and coercion involved.

Many of these experiences are chronic ... and they can progress in severity over time as perpetrators become increasingly compulsive or emboldened / entitled in their demands ... and the victims increasingly debilitated, despondent, or in a state of adaptation, accommodation, and dissociation.

Because such adversities occur in the context of relationships and are perpetrated by other human beings, they involve interpersonal betrayal and create difficulties with personal identity and relationships with others...."

Framed in that way, it becomes clear why a survivor might feel lost, might have a hard time trusting authority figures, and might have difficulties with interpersonal relationships in the aftermath of victimization.

As discussed in the chapter 10, living in persistent poverty and suffering chronic deprivation, is also a risk factor for trauma. The narrative in this chapter explores the what it means to live in ***traumatic nexus of poverty, homelessness, and domestic and sexual violence***, as have many of the homeless women in mainstream shelters and transitional housing (TH) programs (or in unsheltered situations), as well as the women and adolescent girls and boys who have become trapped in the sex trade and human trafficking.

These are forms of individual trauma. As SAMHSA describes, the experience of trauma can be widespread enough to affect a whole culture, and result in what is known as ***historical or generational trauma***:

> *"Such events [can] also have effects intense enough to influence generations ... beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma. . . .*
>
> *[The] literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes."* SAMHSA (2014, p. 40)

Slide #12.

As documented in the landmark ACES or Adverse Childhood Experiences study in a 1998 paper, exposure to domestic violence -- even if the child is not directly abused -- can be a significant source of trauma, which, in combination with other traumas or "***adverse childhood experiences***" -- abuse, deprivation, etc. -- ***can have serious consequences on the child's development and future wellbeing***. The so-called ***ACES study*** found

- impacts on individual development
- impacts on learning patterns, behaviors, beliefs, cognitions, identity, self-worth, relations with others
- increase risk of addictions, eating and sexual disorders, future victimization, aggressive behavior, dissociation, metabolic and immunologic disorders

The study also found that the ***impact of adverse childhood experiences can be mitigated by treatment***, and ***the earlier the treatment, the better***.

Importantly, the study found that ***a strong, positive parent child relationship can be most important mitigating factor***.

Warshaw (2011) cites numerous studies indicating that "***women who are physically or sexually abused as children or who witness their mothers being abused appear to be at greater risk for victimization in adolescence and adulthood by both intimate and non-intimate perpetrators***," and that "women who experience adolescent IPV are more likely to experience IPV as adults," including one study that found that "women who experienced childhood physical or sexual abuse were almost 6 times more likely to experience adult physical or sexual victimization."

Indeed, in Jasinski et al.'s (2005) study of homeless women in Florida, 92% of the homeless women in their study who had experienced childhood physical or sexual violence were also victimized as adults.

As explained by Courtois (2010), this correlation between childhood sexual violence and adult domestic violence, can be understood in the context of ***complex trauma***:

> *"Rather than creating conditions of protection and security within the relationship, abuse by primary attachment figures instead becomes the cause of great distress and creates conditions of gross insecurity and instability for the child including misgivings about the trustworthiness of others. . . .*
>
> *Rather than having a secure and relatively carefree childhood, abused children are worried and hypervigilant. The psychological energy that would normally go to learning and development instead goes to coping and survival."*

Courtois goes on to describe how child abuse constitutes what she calls a "significant betrayal" of the parenting relationships, one which the child is afraid or forbidden to disclose. That same kind of betrayal occurs when the child witnesses one parent abusing the other, but has no way of disclosing or processing what has transpired.

Although, as noted in the ACES study, a positive parent/child relationship can be the most important mitigating factor in protecting the child from the worst impacts of the trauma, that connection may not happen, for example if

- the abusive partner forbids the victim to offer the kind of comfort and support the child seeks; or
- the victim thinks that the child is innocently unaware of what is going on; or
- the victim is simply not prepared to discuss the abusive relationship with the child.

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The experience of trauma affects behavior, and behavior affects the way we think about a person.

As described in a brief by SAMHSA's National GAINS Center (2006), entitled "After the Crisis: Trauma and Re-traumatization," people who have experienced trauma behave in ways that have led mental health clinicians to mis-diagnose them as having mental illnesses, because of behaviors in common with those diagnoses.

> *"The impact of experiencing traumatic events includes responses such as isolation, hypervigilance, substance abuse, dissociation, self-injury, eating disorders, depression, anxiety, hearing voices, risky sexual behavior, and other psychological reactions that begin as coping mechanisms and end up as compounding problems. Too often, coping responses to experiencing trauma are pathologized and designated by mental health diagnoses--including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, panic disorders, personality disorders, obsessive compulsive disorders, psychotic disorders, and eating disorders—without a full understanding of their interrelation with trauma. Immediate, intermediate, and long-term support, including peer support, for trauma survivors that fosters connection is essential to the healing process."*

In their 2011 publication, ***A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations***, Wisconsin's Violence Against Women with Disabilities and Deaf Women

Project, a partnership involving Disability Rights Wisconsin, the Wisconsin Coalition Against Domestic Violence, and the Wisconsin Coalition Against Sexual Assault, observes that "without awareness, these effects of trauma might be [interpreted] as 'challenging behavior[s]' to be managed or modified by others. . . . [Instead,] all of our interactions with and responses to victims/survivors should begin with the recognition that there is a strong likelihood that what we are seeing, hearing or experiencing is an aspect of or response to trauma." (p.13)

The authors of the Wisconsin guide provide a few examples

- A survivor of domestic or sexual violence who always feels unsafe and on continuous alert, that is, hypervigilant, always on guard, always needing to know who is in the building, might become agitated and restless if she does not know who to expect. The authors observe that "without a trauma-informed awareness, others might characterize her as high-strung, needy, noncompliant, inappropriate, difficult or exhausting to be around rather than coping."
- Another survivor might seems distant, not attentive to the environment and other people, disconnected even from herself, apparently unmotivated and distracted. She might or might not be listening to what you say; she might be looking through you and not at you. The authors observe that, "without a trauma-informed awareness, she might be characterized as detached, [and] unmotivated, rather than coping."
- A third survivor "might express a level of emotion that seems unwarranted or extreme considering her current situation. She might cry when asked to provide an emergency contact name. She might yell at another program participant who asks about her children. She might pace the hallway outside of your office, not requesting anything in particular. Or, she might be the well-known woman who calls the crisis line at least four times each and every Tuesday evening. Without a trauma-informed awareness, she might be characterized as overreacting, trying to get attention ... rather than coping."

Hopper, Bassuk, and Olivet's 2010 publication, Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, identified some of the symptoms, triggers, and coping mechanisms that may make it more challenging to serve a trauma survivor.

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When staffing resources feel too limited to deal with less cooperative clients, when funders' expectations for program performance and participant outcomes seem inconsistent with the needs and circumstances of program candidates or participants, there can be a temptation to pass over those candidates who seem like they will be difficult to serve, or to more sharply limit the duration or magnitude of assistance offered to participants who fail to adequately engage in activities that providers believe are important to their eventual successful completion of the program.

Without the aforementioned trauma-informed lens, their apparent lack of motivation, lack of adequate follow-through, lack of interest in "working the program," or resistance to offers of assistance might be interpreted as attitudinal problems -- laziness, oppositional behavior, etc. -- rather than as trauma-related coping mechanisms.

As discussed in chapter 7 on serving survivors with disabling conditions, some of these same behaviors might also be the result of a traumatic brain injury, as might difficulty focusing, inability to plan ahead, forgetfulness, irritability, anxiety, impatience, intolerance, etc.

Slide #15.

Sanctioning survivors for behaviors associated with trauma, trauma-related disorders (e.g., PTSD, complex trauma), or traumatic brain injury (TBI) could be at odds with:

- The VAWA voluntary services requirement;

- OVW's warnings against "procedures or policies that exclude victims ... based on their actual or perceived ... mental health condition...."
- OVW's warnings against "requiring survivors to meet restrictive conditions in order to receive services...."
- Federal anti-discrimination laws, which specifically prohibit policies and procedures which have a disparate impact -- intended or not -- on persons with disabilities
- Fair Housing laws (if the provider owns or leases program housing).

Slide #16.

42% of the 122 transitional housing providers interviewed for this project reported receiving HUD funding. Some of those providers operate separate programs with their HUD and OVW grants. Other providers operated jointly-funded programs, often using their HUD funding to pay for a disproportionate share of the housing costs, and their OVW funds to pay a disproportionate share of cost for staffing and MOU services.

Given the high percentage of providers that rely on HUD funding, and given the pressure to meet program performance targets that providers operating jointly OVW- and HUD-funded programs might feel -- from the Continuum of Care administering their HUD CoC grant, or the state, county, or jurisdiction administering their HUD ESG grant -- we recommend training and guidance, informed by both OVW and HUD policy leaders, that can help staff for such jointly funded projects find the right balance between a focus on the participant outcomes that HUD tracks and the more trauma-informed, survivor-defined, voluntary services approach that OVW grantees must employ. For example,

- Under what circumstances, if any, is it appropriate to base participant selection on candidates' apparent or demonstrated motivation or readiness to pursue housing and income objectives?
- Under what circumstances, if any, is it appropriate to limit the amount or duration of financial assistance beyond the six-month OVW minimum, for participants who are not "working the program," and not on a trajectory to obtain housing or achieve the income they will need to sustain their housing?

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For completeness, the narrative identifies and provides links to information about a range of different trauma-specific interventions. Although few programs engage in specific trauma-specific interventions, it may be helpful for staff to know a little about the various interventions that are used.

One thing that is clear from the literature is that there is no one-size-fits-all intervention that works for all trauma survivors. Different modalities work for different people, and interventions often need to be modified for compatibility with different racial, ethnic, and cultural subpopulations, and implemented with the needs, circumstances, and life experience of the survivor in mind.

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As discussed at greater length in Chapter 4 ("Taking a Survivor-Centered/Empowerment Approach") rules reduction and voluntary services and an empowerment approach are inter-related elements of a trauma-informed approach. Getting rid of coercive rules -- that spell out allowed behaviors, that require participation in services which survivors may not be interested in or ready for, and that sanction non-compliance -- is essential to implementation of a voluntary services approach.

In turn, a voluntary services approach -- in which participants determine the goals they want to work on, the activities they want to engage in, and the type of assistance and information they would like staff to provide -- is integral to implementing an empowerment-based program.

A voluntary services approach seeks to avoid the re-traumatization that coercive requirements and behavioral sanctions can trigger, and to replace even-well-intended requirements with a victim-centered approach, that

supports the survivor in exercising the autonomy and decision-making power over her own life that she was deprived of by her abusive (ex-)partner.

Hopper, Bassuk, & Olivet (2010) describe being "trauma-informed" as taking a systemic approach to services that is "grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment." (p.133)

Understanding the impacts of trauma is integral to being trauma-informed: awareness of the possible symptoms, triggers, and coping mechanisms that may occur with trauma helps staff avoid making negative judgments -- or at least, helps staff step back from any reflexive negative judgments -- about survivors whose challenging behaviors may well stem from their experience of trauma. And avoiding negative judgments is an integral part of creating the emotional and psychological safety that survivors need, and that a trauma-informed program must be able to support.

Thus, the saying, "Trauma-informed care shifts the philosophical approach from 'What's wrong with you?' to 'What happened to you?' "

Slide #19.

Guarino, et al.'s (2009) Trauma Informed Organizational Toolkit, which provides step-by-step guidance for programs and organizations seeking to become more trauma-informed, defines eight core principles of trauma-informed care, which are elaborated upon in the narrative.

Although all of those principles are important, one in particular -- that healing happens in relationships -- underlines the importance of the role of the advocate/case manager in the success of any program:

In her SAMHSA-funded compilation of evidence-based trauma-informed interventions for adults, children, and families, Jennings (2007) cites Judith Herman, one of the pioneers in understanding trauma, who describes the importance of a helping relationship grounded in trust and respect. Although the quote refers to abused children, it is equally applicable to adult survivors:

> "All trauma-specific service models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections. The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992)." (p.22)

Slide #20.

The final portion of the Chapter 11 narrative on trauma-informed care contains an annotated listing of online resources that can support programs and organizations in becoming more trauma-informed, including resources compiled by the NRCDV in a Special Collection on its VAWNet website; information on ***Promising Practices and Model Programs*** developed and compiled by the NCDVTMH from interviews with victim service providers and providers serving refugees and survivors of torture; information about Dr. Sandra Bloom's Sanctuary Model; information compiled and published by SAMHSA as part of its comprehensive Treatment Improvement series; and resources for ***measuring the extent to which the work they do and the way they do that work is trauma-informed***. Although the importance of a trauma-informed approach extends to the full gamut of health and human services, most of the resources described in this section focus on how organizations serving survivors of domestic and sexual violence can assess and/or enhance the extent to which their services are trauma informed.

With respect to assessment...

Sullivan & Goodman's (2015) ***Guide for Using the Trauma-Informed Practice (TIP) Scales*** describes the use of an assessment instrument, which is available for download in English or Spanish from the Domestic Violence Evidence Project website. The instrument uses ***survivor responses*** to questions pertaining to six categories or subscales to assess whether a DV-focused program is trauma-informed:

- ***Agency*** subscale scores reflect the extent to which survivors feel that the program and its staff respect their agency and autonomy by protecting their privacy and offering opportunities for choice and control as to what they work on and the pace at which they share information
- ***Information*** subscale scores reflect the extent to which survivors feel that staff offer information that increases their understanding of trauma and coping skills.
- ***Connection*** subscale scores reflect the extent to which survivors perceive that their program creates opportunities for giving and receiving support with peers, and being connected in supportive relationships.
- ***Strengths*** subscale scores reflect the extent to which survivors feel that staff recognize and value the unique strengths they bring from their family, culture, relationships, and life experiences.
- ***Inclusivity*** subscale scores reflect the extent to which survivors feel that staff understand and are responsive to various aspects of their identity, including culture, religion, sexual orientation, socioeconomic status, immigration status, and disability status.
- ***Parenting*** subscale scores reflect the degree to which survivors feel the program helps them understand how exposure to domestic violence may have affected their children and their relationships with their children, and helps them strengthen those relationships through support and education.

The Praxis Safety and Accountability Audit focuses on "how work routines and ways of doing business strengthen or impede safety for victims." Through a series of ***interviews with and observations of staff***, the Praxis process looks at how various operational factors add to or undermine participant safety, and either address survivor needs or leave an unfilled gap between the support they get and what they actually need. Factors considered by the Praxis Safety and Accountability Audit include:

- Program or funder "rules and regulations" or applicable laws;
- Agency practices (e.g., case management procedures, forms, documentation practices, intake or screening processes);
- Agency resources (e.g., caseload, technology, staffing levels, availability of support services and other resources);
- "Concepts and theories" (e.g., philosophical framework, assumptions, and language used to describe participants, their circumstances and actions, and the system's responses);
- "Linkages" to previous, subsequent and parallel interveners;
- The "mission" of the overall process, "purpose" of the specific stages of the process, and "functions" of workers at those various stages;
- The "accountability" (of the abusive (ex-) partner for the abuse, of the system to the survivor, and of interveners to each other); and
- The "education and training" of the staff involved.

Slide #21.

The ***Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed (ACDVTI) Agencies Self-Reflection Tool*** was the product of a collaboration between the Illinois-based Accessing Safety and Recovery Initiative (ASRI) and the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH).

The ACDVTI Self-Reflection instrument takes a different approach than the Trauma Informed Practice Scales (which develops a numeric score based on the inputs of program participants), and the Praxis Audit (which is

conducted by Praxis staff, who review agency policies and protocols and interview staff). The ACDVTI Self-Reflection instrument builds on the feedback of agency staff, who reflect on and answer questions about:

- The organization's commitment to being accessible, culturally relevant, and DV- and trauma-informed;
- The extent to which the agency's physical and sensory environment are welcoming, accessible, inclusive, non-stigmatizing, non-re-traumatizing, and physically safe for people receiving services and for staff;
- The extent to which questions about current and past traumatic experiences and ongoing physical and emotional safety are incorporated in intakes and assessments in a sensitive and culturally relevant way;
- The extent to which program services affirm and are inclusive of survivors' many identities (e.g., identities related to age, disability, language, sexual orientation, gender, culture, ethnicity, religion, and immigration);
- Whether and how staff members are supported through participation in regular training, supervision, and consultation on working with survivors experiencing trauma, substance abuse, and mental health issues; and
- Whether the agency has mechanisms for obtaining regular input and feedback from program participants, and whether those mechanisms specifically address accessibility, culture, trauma, and domestic violence.

The reflection process could be facilitated by external consultants or by designated agency staff.

Slide #22.

Guarino et al.'s (2009) trauma-informed organizational self-assessment -- which can be ***downloaded and used at no cost*** -- is part of a larger Trauma Informed Organizational Toolkit, which offers health and human service providers a roadmap for becoming more trauma informed. The self-assessment consists of a series of questions answered by ***staff*** on the nature of services offered by their agency, program, or service location, and the associated policies and procedures. Rather than yielding a numerical score, the self-assessment engages staff in reviewing what they do and how they do it, in assessing whether they have instituted trauma-informed policies and procedures and whether their service environment incorporates trauma-informed principles, and identifying opportunities for improvement. Aspects assessed include:

- Staff training and support/supervision to enhance awareness and understanding of trauma and skills to provide trauma-informed care, and support to address vicarious trauma;
- The physical and emotional safety of the service environment;
- The manner in which participant needs are assessed, the tone of the questions, and how and whether participants are empowered to define their own goals and chart the path to achieve those goals;
- The extent to which current/former participants are engaged to advise and implement program services; and
- The ability and willingness of the organization to adapt policies and procedures to reflect clients' changing needs and circumstances.

Two other resources for assessing the extent to which health and human service (or other) programs or their parent organizations are trauma-informed are

- The A.I.R. Trauma-Informed Organizational Capacity Scale (TIC Scale), described as the first psychometrically validated instrument to measure the extent to which an organization and its component parts provide care and services that are trauma-informed.
- Community Connections , led by Dr. Maxine Harris, a thought leader on trauma and trauma-informed care, provides training and consultation to support implementation of the "Creating Cultures of Trauma-Informed Care (CCTIC)" model which "draws substantially" on Harris and Fallot's (2001) seminal book, ***Using Trauma Theory to Design Service Systems,*** to create a step-by-step approach for provider systems and individual agencies to become trauma-informed.

An extensive set of provider comments about how their programs take a trauma-informed approach follows the description of these assessment resources.

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The remainder of chapter 11 focus on children and parenting-related challenges, approaches, and resources.

Slide #24.

Research tells us that the adverse effects on children of exposure to domestic violence vary by age and stage of development; they vary with the duration and intensity of the violence to which the child is exposed; and they also vary based on the child's exposure to other sources of violence, stress, and trauma. Resiliency and mitigation of those adverse impacts varies with the child's access to supportive persons, and especially, their receipt of support from the non-abusive parent or other primary caregiver.

Young, pre-school-age children exposed to domestic violence may struggle with elevated levels of fear and anxiety, difficulty separating from caregivers, regression to an earlier developmental stage (e.g., losing speech or toileting skills), sleep and eating disturbances, and/or frequent illnesses. They may have trouble regulating emotions, and difficulty developing social connections, which can adversely impact relationships with peers and adults. And they are at increased risk of developing mental health problems, memory and attention problems, learning disabilities, language impairments, or other neurocognitive problems.

Elementary school-age children may experience nightmares, difficulties concentrating and learning at school, physical complaints, behavioral issues such as aggression towards adults or peers, and attempts to process what happened by reenacting the traumatic event in their play.

Adolescents exposed to domestic violence in childhood are at higher risk for victimization by peers and for internalizing behaviors such as withdrawal, anxiety, and depression, as well as externalizing behaviors including aggression and delinquency. Adolescents exposed to domestic violence are more likely to have post-traumatic stress disorder and major depression.

Teenagers may engage in more risk-taking behaviors such as alcohol or drug use, risky sexual behaviors, fights, or self-harm as ways to manage feelings related to the trauma.

Children and youth exposed to domestic violence may experience particularly intense worry about their safety or the safety of a parent or caregiver and become distressed by reminders of the violence, such as loud voices, arguing, or aggressive behaviors. They may believe the abuse was their fault, may have conflicting feelings about parents and their parents' ability to care for them, and may fear talking to others about what they have experienced, which can lead to increased isolation and negative coping.

Exposure to chronic, interpersonal trauma from an early age can alter how a child's brain develops, focusing on survival at the expense of higher level skills related to learning, memory, self-regulation, and coping. The child may manifest increased medical and mental health problems; learning difficulties; difficulty planning and anticipating; problems with boundaries; difficulties with peers; self-destructive or self-injurious behaviors; oppositional behavior; difficulty managing rules and limits; learning difficulties and poor academic performance; and low self-esteem, shame, and guilt.

As traumatic experiences accumulate, the physiological and psychological impact becomes more significant and challenges to daily functioning become more profound, putting youth at greater risk for adverse developmental, emotional, functional, and academic outcomes. School-age children who have had longer-term exposure to domestic violence suffer from higher rates of PTSD, depression, and anxiety and are at greater risk for becoming perpetrators of violence as adults.

Studies such as the aforementioned ACES study have shown that without intervention, early exposure to adverse experiences can have profound effects into adulthood, and that as the number and extent of those adverse childhood experiences increases, so does the risk for problems in adulthood, including high-risk behaviors like smoking, drug abuse, and unprotected sex; mental illness; chronic physical illnesses such as heart disease, obesity, autoimmune disorders, and cancer; and even risk of early death.

This awareness of the potential for enduring impacts over the lifespan is a powerful argument for efforts to prevent and address childhood trauma, rather than waiting until problems or symptoms pose even greater challenges for the child as she/he ages.

Slide #25.

Though children experience intense responses immediately following a violent event, this does not mean that they necessarily become “traumatized” by the experience. Children and adolescents are remarkably resilient, and the majority of youth who experience a traumatic event, especially a one-time event, are able to bounce back to their previous level of functioning.

How children respond to the experience of witnessing a domestic violence event is influenced by the nature, intensity, duration, and apparent outcome of the violence; the child’s age, gender, personality, level of awareness, cultural background, and role within the family; the nature and duration of the child's prior exposure to other violence or sources of trauma, the child's level of internal resources and coping skills, and her/his relationships with siblings, parents, and other persons who can provide meaningful, reliable support.

A secure attachment to a non-violent parent or other significant caregiver is consistently cited in the literature as an important protective factor in mitigating the impact of trauma. If the caregiving parent is prevented by the abusive partner from offering her support to the child, or if her capacity to provide support is depleted as a result of chronic victimization, the child's vulnerability to trauma and its concomitants dramatically increases. Thus, for example, high rates of parental PTSD are associated with higher rates of child PTSD.

By affording survivors a safe, nurturing environment in which they can begin to heal, and by providing the kind of support that helps restore their mental and emotional health and reserves, a TH program can help rebuilds the survivor's capacity to offer the support her child desperately needs.

As will be discussed, however, it may be beneficial to also explore other interventions that can help address the damage done to the child's wellbeing, even if symptoms of that damage are not yet raising red flags. The increased awareness of trauma's potentially multifaceted and enduring impacts over the lifespan argues for best efforts to prevent and proactively address childhood trauma, rather than waiting until manifestations of those impacts threaten the child's ability to lead a healthy, successful life.

Slide #26.

Sadly, one of the ways that perpetrators of abuse punish their victims is by attempting to undermine their relationships with their children, including preventing them from soothing a child that is in crisis.

Another traumatizing way in which abusive partners work to undermine their victims' relationships with the children is via ***court challenges to their custody rights***. The narrative describes the grounds for two of the most common challenges -- claims of "***failure to protect***" and "***parental alienation***" -- and how legal and judicial advocates work to address the problem. Two leaders in the efforts to address these challenges are

- DVLEAP, the Domestic Violence Legal Empowerment and Appeals Project, which provides policy advocacy, advocate training, and litigation support in custody cases involving domestic violence or child abuse. The DVLEAP webpage provides links to training materials and relevant legal research.
- The National Child Custody Project, an initiative of the Battered Women's Justice Project, which provides training and technical assistance to courts and advocates working to resolve child custody disputes in ways that take into account the domestic violence and its impact on and implications for the abused parent and the child. The National Child Custody Project webpage provides free access to over two dozen webinars and other resources.

Given that different courts handle custody cases involving domestic violence differently, the narrative cautions that DV victims involved in custody cases should consult with their lawyer as to whether the mention of any violence they have experienced would be helpful or harmful to their case.

Slide #27.

The narrative continues with extensive annotated listings of online resources, developed by leading organizations and practitioners, providing general guidance and information about programmatic or clinical approaches for addressing trauma in children and families. Some of the resources discuss approaches for working with children; other resources explore strategies that allow programs to take a balanced approach to advocacy with children and mothers, as individuals and together as families.

As noted in Lyon, Perilla, & Menard's (2016) ***Building Promising Futures***, "Separate responses to mothers' and children's safety and well-being often place them at odds with one another. In contrast, an integrated approach to intervening with the family as a whole results in better outcomes for children, their mothers, and the whole family. These comprehensive solutions more accurately reflect the lived realities of families affected by the violence."

Following the listing of these resources, the narrative offers a summary of providers' comments about their approaches to addressing the needs of children. It is important to note that given the OVW's directive that *"applicants may not use grant funds to provide direct services to children ... except where such services are an ancillary part of providing services to the child's parent ... such as providing child care services while the [adult] victim receives services"* (p.10) -- ***only TH providers with other sources of funding or the ability to leverage services from otherwise-funded in-house staff (or from community-based providers) can provide or leverage direct services for children***.

Quite a few providers interviewed for this project did not have such resources. Some providers have child-focused staff connected to their shelter, who are able to continue to make their services available when families move on to the transitional program, and that continuity can be very helpful. Other programs, including many that operate scattered site TH programs, indicated that once a family leaves the shelter, program staff rarely see the children, especially when the logistics of travel are challenging.

In our interviews with providers with the potential to offer or leverage services for children, there were two nearly universally shared perspectives: (a) that parents are the gatekeepers in terms of services for their children; and whether or not staff believe that a child needs or could benefit from services, the parent is the final decision-maker; and (b) that parents typically want what's best for their children, and are often willing to accept services for their children before they accept services for themselves.

The majority of providers indicated that their programs do not conduct formal child assessments or use specific tools to assess for the impact of trauma on children and youth. These programs rely on staff observation or concerns raised by parents to identify children who may have more significant needs. Some staff explained that children of families that came from their agency's shelter (or another shelter) would have already been assessed by child-focused staff at that shelter, and could continue to participate in any specialized services that they were already enrolled in, as long as logistics allowed.

Many providers stated that the only child-focused services they were able to offer was child care or children's activities while parents are in meetings, and that they rely on the school system for specialized supports. Nearly every program cited their good relationship with school personnel, either the McKinney Liaison or other staff. Some providers noted that local preschool or Head Start programs can assess for and address special needs, if requested. A few providers mentioned referring infants/toddlers for Early Intervention.

Pretty much every provider indicated that their TH program offers "DV 101" to adult participants, to enhance understanding of domestic violence and its impacts. In some interviews, staff specifically mentioned providing information about children's developmental stages, and how "normal" development might be impacted by exposure to trauma. With that information, they told us, parents could draw their own informed conclusions about whether their child needs services. A few staff noted that parents who feel overwhelmed by their other challenges may not be emotionally ready to accept the reality that their child has developmental needs that could be related to the violence they fled.

Some providers reported that parents in their programs often believe that their children were not impacted by, or were largely unaware of, the violence that took place between the program participant and her abusive

partner. A couple of providers with in-house children's services asserted that children often demonstrate greater awareness of that violence (e.g., via conversations, play, or artwork) than their parents expected.

Several providers with in-house clinical capacity or children's services indicated that they take steps to nurture a trusting relationship between the parent and their children's services provider, to facilitate any necessary discussions about behaviors that may indicate a problem that would benefit from specialized attention. One provider mentioned their effort to "normalize" the idea that children have been effected by trauma, just as their parents have, so that parents will not feel guilty or ashamed if their child has a trauma-related condition.

Several staff mentioned that some parents are reluctant to refer children for off-site mental health services, out of concern that the child will be labeled with a diagnosis that creates a long term stigma; a few providers with in-house clinical staff noted that because those in-house positions are grant-funded, they don't have to bill insurance or Medicaid for services, and therefore do not need to specify a diagnosis. Travel logistics, waitlists, and/or insurance requirements can also be a barrier to follow-through for some children's services.

A few staff in programs operated by agencies that offer more substantial on-site child services, including therapeutic daycare or clinical services described their ability to do in-house assessments and developmental screening and to offer interventions like art therapy, play therapy, Cognitive Behavioral Therapy (CBT) for children and youth, Trauma-Focused Cognitive Behavioral Therapy, or specialized interventions such as the Families of Tradition program for Native children, and Darkness to Light, addressing child sexual abuse.

Slide #28.

Given all that is known about the potential adverse impacts of early childhood exposure to violence and trauma, and about the benefit of addressing that trauma as soon as possible, it seems unduly risky to wait -- as a number of program staff told us they do -- until a child enters kindergarten, so that the local school department can assess for developmental delays or other effects of that exposure to violence. In fact, not all school departments have the resources to identify and appropriately respond to such needs; and if staff there believe that a child in a TH program will only be in their district for a few months, assessing and developing an IEP (Individualized Education Program) for that child may not be their highest priority.

The narrative recommends that the OVW consider sponsoring, in cooperation with its partners at the Family and Youth Services Bureau of the US Department of Health and Human Services, staff training on strategies for appropriately engaging parents of pre-school-age children in discussions about the potential impacts of untreated trauma and about the options and potential benefits and drawbacks to child assessments through the local Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, or through the local Early Intervention, Early Head Start, or Head Start programs, depending on the child's age and access to such programs. With income eligibility for Medicaid/CHIP coverage ranging (depending on the State) from 140% to over 300% of the federal poverty limit (FPL), many, if not most of the children of TH program participants are likely to be eligible.

Few of the providers we interviewed described any staff involvement in the process of developing an IEP for a school-aged child. More often, providers told us that they leave that to the parent to work out with the school. A number of providers told us about parents that are apprehensive about stigmatizing their children by requesting special education services. Given how advocating for their child could be extremely intimidating for a parent in a TH program (as it is for many mainstream parents), and given that parents who are unfamiliar with special education may not have enough data to make an informed choice about whether or not to pursue an IEP for their child, it may be helpful for the OVW to sponsor provider staff training about IEPs: why they may be helpful, how they are developed and monitored, how to minimize any stigma, and how to discuss the topic with parents. It may also be helpful to assure staff that supporting a parent in navigating the process of advocating with the school on behalf of their child is not a violation of the OVW's limitations on providing services for children.

Following that recommendation, the Chapter offers an extensive set of provider comments about their approach to serving children.

The chapter concludes with a brief narrative on visitation services, citing the guiding principles of the ***OVW's Safe Havens: Supervised Visitation and Safe Exchange Grant Program***, and the work of the National Council of Juvenile and Family Court Judges' in developing a Model Code on Domestic and Family Violence, which includes a section on "conditions on visitation in cases involving domestic and family violence." That brief narrative is followed by a handful of provider comments describing their approach to supporting visitation.

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Chapter 12, the final chapter of this snapshot report, focuses on the opportunities and challenges attendant to funding and collaboration, the two essential strategies for building the capacity of programs to serve survivors with diverse needs.

Slide #30.

Few, if any, transitional housing programs have enough funding to meet all the needs of the survivors leaving shelter, let alone the survivors who may not have gotten into shelter, or who timed out of shelter and who resorted to couch surfing to buy more time away from the violence or to figure out next steps.

Few, if any TH programs have as many housing units as they could fill with survivors who need interim housing or housing assistance, if the program had the staffing to support additional units.

Given that different housing options work best for different survivors, it would be ideal for programs to be able to offer a mix of options -- transition in place for those who are ready to sign a lease; agency-leased transitional housing for those who want to live in the community, but don't have the income or tenancy credentials to get a lease, or who don't feel safe or ready to put their name on a lease; and congregate or clustered housing for survivors who want the increased access to services or peer support, or the increased security that those modalities can offer.

Given the breadth and depth of survivors' needs, it would be ideal if, in addition to their advocate or case manager, each program had the luxury of dedicated staff who could help with housing, employment, legal issues, children's needs, counseling needs, community integration, and transportation, as well as, perhaps, access to a clinician who understood domestic and sexual violence and trauma, and who could support staff when they needed help in situations with clinical implications, when they felt personally overwhelmed, or when they started to show signs of secondary traumatic stress or vicarious trauma.

In the real world, few agencies have that kind of in-house capacity. Programs that are part of full-service domestic violence/sexual assault agencies are often able to leverage ***some*** of these resources from other program operated by their agency. Programs in richly resourced urban areas may be fortunate to be able to leverage ***some*** of these services from partnering providers in the community -- although such providers may or may not be trauma- or DV-informed. Even when those resources exist, need often outstrips the availability of services, making waitlists prohibitive.

One way or other, programs face hard realities about what they can and cannot do, even as they try to expand their resources and build new provider relationships that can add gap-filling capacity.

Besides their OVW TH program grant, the largest source of funding for transitional housing for the providers we interviewed was HUD. 42% of the 122 TH providers we interviewed received one or more HUD TH or rapid rehousing grants. Many of those HUD grants are larger than the average OVW grant of between $100,000 and $117,000/year; however, HUD funding is awarded one year at a time, and, therefore, provides less program stability than OVW grants, which are awarded for three-year periods.

Other sources of government funding mentioned by interviewed providers were other OVW or DOJ grants and, in at least one case, TANF block grant funds. Nearly every provider also cited non-governmental funds -- from foundations, donors, fundraising events, and/or income from thrift stores or other social enterprises.

Given the outsized role that HUD funding plays in sustaining transitional housing and transition-in-place programs for survivors, most of the following discussion on funding opportunities and challenges centers on the HUD Continuum of Care and Emergency Solutions Grant programs.

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As discussed in Chapter 2 ("Survivor Access and Participant Selection"), with the adoption in December 2011 of a revised definition of homelessness, HUD established categorical eligibility for all the OVW TH program constituencies. Category 4 of the homeless definition now includes:

> (4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

(Note that the VAWA Reauthorization eliminated the word "fleeing" from the OVW eligibility criteria, so that the test if whether the survivor is homeless due to domestic or sexual violence, and not "is she fleeing?")

A HUD-funded TH or RRH program may be subject to additional eligibility requirements, above and beyond meeting the Category 4 definition of homelessness. In particular, the ESG Interim Rule specifies that ESG-funded RRH programs may only enroll individuals and families that are "literally homeless" -- that is, living in a shelter or motel unit in-lieu-of-shelter or on the street, in their car, or in some other place not meant for habitation. And, as discussed earlier, HUD's regulations instruct CoCs administering Continuum of Care grants and states/counties/jurisdictions administering ESG grants to develop and implement "written standards," which may further limit eligibility, define priorities for assistance, or reduce the amount, duration, and/or scope of assistance below the levels established in HUD regulations.

As discussed in Chapter 6 ("Length of Stay"), HUD's priority is to serve and end the homelessness of as many homeless households as possible, which means that for any given client, the shorter the stay needed to enable that individual or family to transition to permanent housing, the better. The emphasis on shorter stays applies to both transitional housing and rapid rehousing grants. Although HUD regulations for CoC-grant-funded transitional housing and for both ESG- and CoC-grant-funded Rapid Rehousing allow stays of up to two years (as is the case with OVW grant-funded programs), HUD and its proxies (the CoCs, states, counties, and jurisdictions administering HUD grants and developing the written standards) typically look for stays of between 6-12 months, as per the guidance in HUD's Rapid Rehousing Brief.

The difference between the OVW and HUD approaches is epitomized by an ESG regulation that allows RRH assistance to extend beyond one year only for clients whose income at the 12-month mark is at or below 30% of the Area Median Income, which is a pretty low threshold. That regulation exists to ensure that resources are targeted to homeless persons with the greatest need. If the program were intended to provide longer-term support while participants build their income and develop a safety cushion, so that they were less likely to be financially dependent on potentially abusive partners, the regulations wouldn't end assistance for households simply because their income had increased above the 30% of AMI threshold.

HUD's emphasis on providing just enough assistance to facilitate a transition to permanent housing, articulated in its Rapid Rehousing Brief, is different from the OVW's emphasis on victim-centered, holistic support. In the voluntary services framework that governs the OVW TH program, the focus of the services and the pace of programming are largely determined by the survivor, rather than the program. Although the enabling statute for the OVW program, 42 US Code §13975 specifically calls for services that help the survivor locate and secure permanent housing, secure employment, and integrate into a community, it is the survivor that determines the goals they will pursue. After weighing their tradeoffs, a survivor may ultimately decide to resume living with their abusive partner, may decide to move in temporarily with family or friends, or may

pursue some other path. By contrast, as noted earlier, the clear focus of HUD-funded projects is transitioning to housing, and secondarily, achieving the income to sustain that transition. Everything else is peripheral.

This different focus creates challenges for jointly OVW- and HUD-funded projects, which face potentially conflicting pressures around length-of-stay, and which may have trouble meeting HUD-defined performance standards, which are all about participant outcomes with respect to housing and income or employment.

In keeping with its focus on permanent housing, HUD requires that RRH participants be named on their leases. To be assisted in CoC-funded RRH programs, a participant must be able to get a full-year lease in their name. Some survivors are not emotionally ready for the responsibility that comes with being named on the lease, or they fear for their safety. Survivors with poor credit or histories of evictions -- often caused by their abusive partner -- may not be able to find suitable housing with a landlord who is willing to put their name on a lease, let alone a full-year lease, particularly when the rental assistance isn't guaranteed to last the full year.

HUD's focus on the details of the housing outcome -- the lease terms, the apartment's compliance with HUD "Housing Quality Standards" (which are typically more demanding than local housing department standards), and compliance with HUD Fair Market Rent and/or Reasonable Rent standards -- differs from the OVW TH program's focus on safety and providing a supportive environment.

One paradigm isn't better than the other; rather, the two program models were just designed with different target populations and program outcomes in mind, and combining the two models makes it challenging for providers to take advantage of the greater flexibility available under the OVW grant program.

The HUD requirement to participate in a coordinated access/coordinated assessment system is likewise intended to ensure that programs focus on housing homeless persons who fit into HUD's highest priority categories: chronically homeless individuals and families and veterans with disabling conditions who need long-term supported housing. ***There is, of course, nothing intrinsically wrong with those priorities; they do what they were designed do -- prioritize persons with severe behavioral health-related needs who are likely to be heavy utilizers of emergency rooms, psych ERs, detox facilities, ambulances, and public safety resources. They were not intended to prioritize survivors of domestic violence and sexual violence, even if those survivors are threatened by further abuse or violence, and therefore they don't.***

The ESG Interim Rule exempts VAWA-covered grant recipients from participating in the local mainstream coordinated entry system, and the CoC Interim Rule allows VAWA-covered grant recipients to opt out of the mainstream coordinated entry system, as long as they participate in an alternate system operated by victim services providers, if one exists. In regions where no parallel system exists, participation in the CoC's system could mean less access to HUD-funded transitional housing or Rapid Rehousing programs for survivors in DV shelters (or other interim living situations) whose needs don't match the criteria for high priority referrals.

Slide #32.

At the same time as there have been pressures on HUD-funded TH programs to shorten the duration of assistance and boost performance -- that is, to increase the percentage of participants who transition to permanent housing and who increase their incomes or employment level -- there has been overall pressure on Continuums of Care to move away from the use of transitional housing, in favor of the RRH model.

There have been a number of messages from senior HUD staff about the higher cost and lower success rates of transitional housing as compared to rapid rehousing, and HUD's interpretation of data from the Family Options study (comparing the cost and impact of permanent housing subsidies, transitional housing, rapid rehousing, and shelter) has only reinforced its position about the preferability of the RRH model.

While advocates point to the most definitive result of the Family Options study -- that permanent housing subsidies are the most effective intervention for stabilizing a homeless family's housing situation -- there will likely continue to be debate about the relative merits of transitional housing vs. RRH, and about what the appropriate duration of assistance and mix of services should be in a "standard" RRH intervention. However, HUD has clearly decide that Rapid Rehousing, and not TH, is where its resources should be invested.

Although HUD officials have said that serving survivors of domestic and sexual violence ***is*** an appropriate role for traditional TH programs, the fact is that a number of those programs have lost their HUD funding (as part of a system-wide reduction by over 50% in the number of HUD-funded TH beds in the past 2-3 years). Some of that loss came as a result of Continuums of Care deciding to de-prioritize TH programs, in hopes of scoring higher on their HUD applications; some of that loss came because funding from Congress was inadequate to renew all projects while adding higher priority new RRH projects, so HUD made the decision not to renew many TH programs, which applicant CoCs had been encouraged to assign a more vulnerable Tier 2 priority. Indeed, some of the providers we interviewed subsequently lost HUD TH grant funding in the 2015 or 2016 Continuum of Care competitions.

Following the narrative outlining these and other funding-related challenges and opportunities, the report presents extensive **provider comments** on the topic.

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Providers either build capacity by expanding their staffing and ability to deliver services in-house, or by building partnerships with other community agencies and professionals that can offer gap-filling services that the target clientele need. The first half of Chapter 12 addressed sources of funding which allow a provider to build that internal capacity, but that may also come with strings attached. The second half of Chapter 12 looks at the opportunities and challenges associated with the different kinds of partnerships that victim services providers enter into, in order to better serve their clients.

Much of the narrative is devoted to the collaboration between victim services providers and the mainstream homeless services provider community and the Continuums of Care they are part of.

The opportunities and obstacles to such collaborations was an intended focus of DeCandia, Beach, & Clervil's (2013) study ***Closing the Gap***. The Chapter 12 narrative looks at why the level of collaboration identified by the providers we interviewed appears to be much greater than was described in the ***Closing the Gap*** study, and assesses the potential for greater collaboration.

In addition to exploring the benefits and challenges to participating in a Continuum of Care, the narrative and some of the provider quotes describe the benefits -- no drawbacks were mentioned -- to being part of a state coalition of domestic violence or sexual assault providers.

Finally, the narrative looks at some especially successful collaborations, some of which were assisted by OVW grants, with staffing support from the Vera Institute, and highlights published information about what it took to create and sustain those collaborations.

The chapter ends with provider comments describing their general approaches to collaborating, and then in separate sections, their collaborations with children's services providers, education providers, employment programs, health services providers, housing providers, legal services organizations, life skills trainers, and mental health and substance abuse treatment providers.

Slide #34.

By requiring applicants for TH grants to enter into a funded MOU with at least one provider, the OVW has made linkages with mainstream providers an integral part of the Transitional Housing program. And by basing over 20% of an applicant's score on its description of the MOU collaboration and how it will benefit survivors, the OVW signals its recognition of the important contribution a funded MOU partnership can make.

Collaborations described by TH providers and discussed in this chapter involve agencies and consultants providing participant housing and/or support with their housing searches; education and training services; employment services; life skills and financial empowerment services; health, dental health, and/or mental health services; substance abuse treatment services; child-related services; and legal services.

Chapter 7 ("Subpopulations and Cultural/Linguistic Competence") includes provider comments describing

examples of collaborative arrangements with agencies serving specific ethnic, cultural, linguistic, and/or disability-related subpopulations that help TH programs reach and more competently serve segments of the community that might ordinarily not know about or trust their organization, or that TH program staff might not have the knowledge, sensibilities, or language skills to appropriately serve.

Partnerships with clinical consultants, financial services providers, health and behavioral health care providers, lawyers and legal services offices, and employment assistance agencies, for example, not only allow TH programs to make available gap-filling services, but to offer participants the opportunity to obtain such services from a different or differently credentialed person or organization that might have more credibility in such specialized areas than generalist TH program staff.

Depending on the information-sharing arrangement that a participant has consented to, obtaining specialized services from MOU providers may afford the participant a level of confidentiality they might not have if they work with in-house staff. For example, they might be able to share concerns with an external provider that they would be reluctant to disclose to their advocate, or to one of their advocate's in-house colleagues.

Slide #35.

Partnerships allow TH providers -- especially smaller agencies -- to facilitate participant access to the kinds of specialists that they can't financially afford to keep on their own payroll. Whereas a case manager/advocate is essential to the day-to-day operation of a TH program, client interactions with therapists or employment specialists, for example, are much more limited, and it may not make sense for a small agency to keep such specialists on its payroll. Similarly, if a small agency wishes to provide clinical supervision and support to staff, it might make more sense to engage that clinician as a consultant, rather than as a salaried staff member, given the very part-time nature of the role. However, without the formality of an MOU or contractual arrangement, these adjunct providers would not necessarily be available when needed.

Funded MOUs, in particular, ensure that providers from other agencies will make regular visits to the TH program or the victim services provider's non-residential program offices, where TH program participants can conveniently access assistance, or will prioritize TH program participants who make appointments to receive services at the offices of the MOU agency. In the absence of a funded agreement, referrals of TH program participants (or self-referrals by motivated participants) might not result in timely services, given typical waiting periods, insurance or payment requirements, or other barriers.

Funded MOUs help leverage the participation by MOU providers in special training or orientation about the victim service provider's approach, or about trauma- and DV-informed care, so that leveraged services will be more sensitive and successful. A number of providers commented on the adverse consequences when a survivor seeks, for example, mental health or substance abuse treatment services from a provider that ***doesn't*** understand the DV context in which the survivor's problems developed or were exacerbated.

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The Violence Against Women Act (VAWA) confidentiality requirements are some of the most important protections offered by the legislation. Parallel protections are also included in the Family Violence Prevention Services Act. These laws ***protect the confidentiality of personally-identifying information or person-specific information*** of any survivor receiving VAWA-covered services (including OVW-funded transitional housing) or FVPSA-covered services (including FVPSA-funded DV shelter). Specifically, the laws

- Ensure that personally identifying information or individual information “collected in connection with services requested, utilized, or denied" will not be entered into a data system that can be accessed by other providers, even if information in that system is routinely encoded, encrypted, hashed, or otherwise protected;“
- Ensure that personally identifying information or person-specific information will not be disclosed “without the informed, written, reasonably time-limited consent of the person ... about whom

information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program..."

- Prohibit service providers from requiring a survivor to consent to the release of their personally identifying information as a condition of eligibility for services; and
- Prohibit any sharing of personally identifying information with any Federal, State, tribal grant program for purposes of compliance with reporting, evaluation, or data collection requirements.

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The laws were written with HUD data collection requirements in mind, and make it impossible for VAWA-(and FVPSA)-covered providers to participate in HMIS, the data collection and reporting system that all HUD-funded homeless services providers are otherwise required to use -- and that an increasing number of other providers serving homeless persons are now also using to enter data.

VAWA-funded providers that receive HUD funding for their programs may be required to collect ***the same kinds*** of data as other HUD-funded programs. However, they must collect and store that data in separate, segregated data collection systems, and may only share ***aggregate*** reports with the Continuum of Care (for CoC grants) or the state/county/jurisdiction (for ESG grants) that administers their grant.

As previously noted, HUD-funded programs are expected to participate in the geographically appropriate Coordinated Entry system. As also previously noted, ESG grant funded victim service provider are allowed to opt out entirely from that requirement. CoC grant-funded victim service providers must either participate in the CoC's coordinated entry system, even if such participation entails entry of data using HMIS – or – they may participate in a parallel coordinated entry system operated by victim service providers, whose data collection is entirely separate from the CoC's coordinated entry system.

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In response to concerns about situations in which survivors seek assistance from mainstream programs that are not covered by FVPSA or VAWA protections, or are required to participate in a standard assessment as part of a CoC's coordinated entry process, HUD issued the following guidance:

> *"All households, regardless of their DV status, have the **right to refuse to disclose their information in HMIS** and may **refuse to allow the CoC to share their information** among providers within the CoC.*
>
> *In fact, all service **providers are prohibited from denying assistance** to program applicants and program participants if they refuse to permit the provider to enter their information in to HMIS or refuse to allow their information to be shared with other providers.*
>
> *However, some information may be required by the project, or by public or private funders to determine eligibility for housing or services, or to assess needed services. In those instances, the information must still be collected by the recipient to determine whether the individual or family is eligible, but it must not be entered into HMIS if the program participant objects...."*

Of course, survivors can only assert their rights if they are informed about them. So, it is incumbent upon all victim services providers to alert survivors who may be seeking assistance from a HUD-funded mainstream program about their right to refuse to allow their information to be entered into the HMIS or to be shared with other providers. Ideally, HUD providers (including persons staffing the coordinated entry system) would be aware of these rights and inform prospective clients about them; at a minimum, though, they must be prepared to honor survivors' requests that identifying or personal data not be entered into the HMIS or shared with other providers.

Slide #39.

FVPSA and VAWA are not the only federal laws affecting disclosure of personal information. There are laws protecting survivors' medical records (HIPAA); addressing the privacy of their primary, secondary, and certain post-secondary school records (FERPA); and addressing the disclosure by schools of information about on-campus cases of rape or sexual assault (Jeanne Clery Disclosure law). The narrative provides some information from, and a link to, a 2011 NNEDV Fact Sheet on federal confidentiality-related laws that summarizes protections under those laws.

Since that fact sheet pre-dates the most recent VAWA Reauthorization in 2013, the narrative also provides a link to an excellent NNEDV FAQ document that addresses current VAWA and FVPSA confidentiality requirements, and how they address HMIS-related matters. The narrative also provides links for updates on HIPAA and FERPA regulatory requirements.

Each state has its own laws governing the privacy and confidentiality of information about domestic and sexual violence, and the narrative provides a link to a U.S. Department of Justice webpage allowing users to search for federal, state, territory, and tribal laws describing those protections.

The narrative also provides links to information about laws pertaining to the privacy of client-level data about substance abuse-, mental health-, and HIV/AIDS-related conditions and treatment, and a link to information about the role of privileged conversations with lawyers, advocates, and certain other providers in the context of an investigation and prosecution of criminal domestic and sexual violence.

Provider comments on privacy and confidentiality-related matters follows that portion of the narrative.

Slide #40.

As noted earlier, the benefits of and obstacles to collaborations between victim services providers and the "mainstream" homeless housing and services system, and strategies for navigating those challenges, were the subject of DeCandia, Beach, & Clervil's (2013) OVW-grant-funded technical assistance project entitled ***Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness: A Toolkit for Transitional Housing Programs***.

Our project's finding differed somewhat from the findings of that earlier report, and the narrative takes a close look at the potential reasons for those differences, and what they say about the state of collaboration between the two systems.

Slide #41.

Citing the research of Baker et al. (2010), the ***Closing the Gap*** authors observed that while the mainstream homelessness system and the DV-focused system "often serve the same population and aim to achieve similar outcomes for families (stability and safety, housing and recovery), they operate philosophically and practically under different principles" (p.5) and that "the DV and homeless service systems are generally not integrated, operate in silos, and are not connected to mainstream services in most communities." (p.2)

What we heard from the TH providers we interviewed was not that black-and-white. Probably the most important reason for that difference in findings is that the two projects studied different segments of the provider community. The respondents in the ***Closing the Gap*** study included a mix of victim services providers (~54%) and mainstream providers (~45%). Victim services providers operating ***transitional housing*** constituted about one-sixth (17.4%) of survey respondents in the ***Closing the Gap*** study. By contrast, 122 of the 124 (98%) interviews used for ***this project*** were with provider staff from current or formerly funded TH programs for survivors of domestic or sexual violence.

For a range of reasons, survivor-focused TH programs appear to be better connected to mainstream homelessness-related (and non-homelessness-related) service providers than DV shelters, notwithstanding the differences in philosophical and practical operating principles cited by DeCandia et al.

For one thing, the DV shelter experience is inherently more insulated from the outside world than the TH

program experience. DV shelters serve as safe zones for survivors who have just left an abusive situation, who are still in crisis, and who are statistically in the greatest danger of serious violence at the hands of the perpetrator they fled. DV shelters are often sited in undisclosed locations, in unidentified buildings, with full security; they are intended to be hard-to-find and hard-to-enter for unauthorized persons. In keeping with that more protective and insulated approach, DV shelters can be expected to be, on average, less interactive with mainstream providers than TH programs.

Source of funding is perhaps one of the most important reasons why survivor-focused TH programs are more connected to mainstream homeless providers than are DV shelters. Fifty-one (42%) of the 122 providers we interviewed who operated one or more specialized TH programs receive HUD Rapid Rehousing (RRH) or Transitional Housing (TH) grants to help pay for their transitional program, which means they are ***part of the mainstream homeless housing/services system***. Many, if not most, of these 51 providers have been receiving HUD grant funding since long before the ***Closing the Gap*** survey, and their HUD funding essentially ***requires*** involvement with the local Continuum of Care as well as with other mainstream providers.

Although some of the nearly 1,600 DV shelters funded under the Family Violence Prevention and Services Act (FVPSA) may also receive HUD Emergency Solutions Grant (ESG) funding to support shelter operations or staffing costs, those small ESG grants are not as strong a link to the mainstream system as the RRH and TH grants utilized by 42% of our sample group of specialized TH providers.

CoC-funded projects go through an annual evaluation process which informs the CoC's decision as to whether and how to prioritize the project for renewal funding in its annual application to HUD. That decision is based on a variety of considerations: (a) the project's performance, as measured by standard HUD metrics and any other metrics established by the CoC; (b) whether the project served as many households as promised in the prior funding application; (c) whether the project leveraged the cash and in-kind contributions promised in the prior funding application; (d) the project's adherence to HUD regulatory requirements for recordkeeping, reporting, and fiscal/billing practices, and whether it complied with the "written standards" developed and adopted by the CoC, as required by HUD (e.g., setting further limits on the amount, duration, and scope of services); (e) the participation of project staff in CoC meetings and activities, like the annual point-in-time count; and (f) whether the CoC believes that HUD will see that project as an "effective" use of its grant funds.

The need to receive favorable consideration from that kind of evaluation process is a strong incentive for ongoing provider engagement with the CoC.

By contrast, ESG-funded shelters, which typically receive much smaller grants, are not subject to that same level of scrutiny. While the process for awarding ESG grants is competitive at the state, county, or local level, the review is typically far less comprehensive, and there are typically much lower expectations with respect to ongoing provider engagement.

In their comments, transitional housing (including transition-in-place) providers receiving HUD funding (and some providers receiving only OVW funding) described a range of involvement in their CoC: some are actively involved in advocating for survivors, shaping the CoC's coordinated assessment / coordinated entry system, and in one case, actually administering that system. Several providers described sharing tips with other CoC providers about housing opportunities and about "bad" landlords to avoid and "good" landlords to work with. Other providers described a more passive role in their CoC (possibly because other staff in their agency are more active). Given that some of their HUD grants dates back to the late 1990s or early 2000s, it is not surprising that the Correia & Melbin (2005) study reported that, "Collaboration with a Continuum of Care group or local homelessness coalition was mentioned most often as a vital relationship by the transitional housing programs surveyed. These partnerships are viewed as crucial for building community support and soliciting HUD funding." (p.13)

In other words, a substantial percentage of OVW-funded TH providers are ***part of the mainstream homeless housing/services system*** and/or are actively engaged in collaborating with system providers. On the one hand, the fact that these TH providers participate in the mainstream homeless system is evidence of cross-system collaboration; on the other hand, the pressures they feel from that system -- to define success and measure performance using standard metrics, to shorten stays, to shift from the traditional TH housing model

to a transition-in-place model that is more compatible with rapid rehousing, as described elsewhere in this chapter -- is a reflection of the conflicting philosophies cited in the ***Closing the Gap*** study.

That is, the relationship between the mainstream homeless system and TH providers targeting survivors of domestic and sexual violence is complex. Although it is unfair to characterize the victim service provider-operated TH programs and mainstream homeless housing/services programs as operating in separate silos, neither is it true that there is broad-based collaboration. Baker et al.'s diagnosis of the barriers to collaboration -- different frameworks based on "differences in history, philosophy, and practices," and the fact that both systems are working with issues that overwhelm their funded capacities -- still rings true.

Comments from the providers we interviewed suggest that the most significant barriers to additional collaboration are (a) inadequate resources ***in both systems*** to fully address the needs of the constituencies the systems are intended to serve; (b) program policies and procedures adopted pursuant to HUD regulatory requirements and guidance that make sense in terms of HUD's goal of maximizing the numbers of households transitioning from homelessness to housing, but that make it harder to ***appropriately*** serve survivors, and that create conflicting pressures to focus on housing- and income-related outcomes, rather than the survivor-defined priorities that a program guided by voluntary services ***should*** focus on; and (c) mainstream providers' inadequate understanding of the profound impacts of chronic exposure to domestic and sexual violence, and too-limited adoption of a trauma-informed approach, which means that mainstream programs are not necessarily well-suited to serving survivors with trauma-related needs and symptoms.

Slide #42.

In discussing the state of collaboration between survivor-focused transitional housing and the mainstream homeless housing/services system, it is helpful to ask what "better" collaboration might look like, in light of some of the concerns expressed by victim services providers, and what it would take to achieve that "better" collaboration. In other words, (a) how could the mainstream homeless housing/services system be a more useful and more available resource to DV/SA-focused TH programs and the survivors they serve? (b) how could DV/SA-focused TH programs be a more useful resource to mainstream homeless housing/service providers and the individuals and families they serve?

For the purposes of exploring possible answers to those questions, the narrative looked at the following elements of the "mainstream" homeless system: (a) outreach programs; (b) shelters for individuals and families; (c) transitional housing; (d) rapid rehousing; (e) permanent supportive housing; and (f) non-residential supportive services programs (e.g., health care for the homeless programs, housing assistance programs, employment assistance programs, and behavioral health programs).

A quick review of these component elements suggests that ***given present-day levels of funding and need, there is not that much additional potential for collaboration with OVW-funded TH programs***.

Specifically, a component-by-component review of the mainstream system suggests that apart from the jointly operated TH / RRH programs that already focus on serving survivors, the other system components –- outreach programs, shelters, TH, RRH, PSH, and Supportive Services Only programs – simply ***don't have the available capacity or specialized programming*** to adequately address the needs of survivors who require additional housing / services beyond what victim service provider-operated TH and RRH programs can offer, or who cannot get into a victim services provider-operated TH / RRH program when they time out of DV shelter, or who need to move on from other interim housing where they are staying after fleeing violence.

Perhaps, if the staff of victim service provider agencies and/or state coalitions had available capacity, they could contract with mainstream agencies to provide staff training or direct services, so as to increase the capacity of those mainstream programs to address the needs of the survivors and other trauma victims that they already serve.

HUD's 2015 FAQ on Coordinated Entry and Victim Service Providers describes a very positive vision for how the two systems could interact, and articulates important protections not just for the clients who use the coordinated entry system, but for any individual or family who is identified as a victim/survivor during their

interaction with a CoC's Coordinated Entry system. It calls for

- Training of the staff implementing the coordinated assessment and entry system by knowledgeable persons with appropriate expertise in the complex nature of domestic violence, on privacy and confidentiality requirements, and on safety planning;
- A coordinated system that is trauma-informed and culturally relevant, and that includes confidential and/or virtual entry points, so that a survivor's safety is not jeopardized by her attempt to seek help; and
- Use of an assessment tool that doesn't re-traumatize the survivor with its questions.

An "FAQ" is a guidance document, not a "Notice" or a "Regulation," so these are HUD's intentions and not requirements. As this report nears completion, CoCs are still in various stages of implementing their coordinated systems, and, as noted elsewhere, some of the providers we interviewed described experiences with their CoC's coordinated entry system that fall short of HUD's stated intentions.

Notwithstanding the gap between HUD's vision and the on-the-ground reality of existing coordinated entry systems, there is an even bigger challenge to collaborating: a coordinated entry system can only make referrals to programs with available capacity, and the system simply doesn't have enough capacity to meet even its highest priority needs. As long as HUD-funded programs lack that capacity -- given current funding levels, system priorities, and regulatory constraints -- even a trauma-informed coordinated entry process will be ***unable*** to find openings in appropriate next-step programs to serve survivors who were unable to resolve their housing and income needs while in "specialized" TH/RRH programs, or unable -- due to lack of capacity in the victim services system -- to access such specialized TH programs when they were timing out of DV shelters or hoping to move on from other interim living situations.

Interestingly, a more trauma-aware coordinated entry system might identify more individuals and families than the mainstream system currently knows about, whose homelessness is linked to domestic and/or sexual violence, and who could benefit from referral to the already-under-resourced "specialized" TH/RRH programs.

All CoC- and ESG-funded programs must participate as members of their geographically relevant Continuum(s) of Care. And just about every OVW- or FVPSA-funded agency is a member of a statewide or tribal domestic violence and/or sexual violence coalition.

CoCs range from the very small -- with little or no paid staff, and with only a handful of HUD-funded programs -- to the very large -- with multiple staff, and grants totaling in the tens of millions of dollars. Some CoCs have the capacity to develop and implement sophisticated systems for coordinating intake and access to services, for assessing client needs, for tracking services and analyzing changing client characteristics and outcomes, for implementing standardized grants management protocols, and for organizing regional trainings and conferences. Other CoCs have all they can do to meet the basic requirements that HUD has established.

Similarly, some domestic violence and sexual assault coalitions have the resources to offer extensive trainings, organize conferences, create and implement innovative grant-funded initiatives, develop model program materials (e.g., templates for agency policies and procedures, multilingual resources for participants, assessment tools, survivor satisfaction surveys, etc.), offer guidance on emerging or neglected issues, maintain sophisticated resource-rich websites, and provide comprehensive technical assistance – while others provide a much more limited array of services for their member providers. Some coalitions have a more hands-on role, coordinating and administering regional or statewide transitional housing grant programs, particularly in rural states, allocating and overseeing the use of OVW funds by local providers that serve small numbers of clients, but don't have the infrastructure to manage an entire grant. Other coalitions contribute cutting edge thinking about addressing domestic and sexual violence and/or are leading advocates for funding, legislation, and policy changes.

This huge variation in the capacity and focus and temperament of different Continuums and DV/SA Coalitions is reflected in the diversity of comments by the providers we interviewed.

Every provider comment about participation in a state coalition was positive. As described in some of those comments, participating in a state coalition affords member programs access to coalition resources, including

trainings, information-sharing, technical assistance, and the opportunity to come together to discuss issues of mutual interest or concern. DV/SA coalitions are able to leverage foundation, corporate, and government funding which they, in turn, make available to member organizations. One provider's comment describes their coalition's ability to leverage AmeriCorps staff for its member programs. Coalitions also mobilize member agencies to advocate for legislation or policy changes which will better protect the interests of victims/survivors. DV/SA coalitions have the staff to keep abreast of new research, resources, and approaches by sister organizations across the country, and disseminate those findings and resources to member agencies.

Participation in a CoC affords providers a different mix of benefits. Not infrequently, a CoC's membership includes only one or two providers focused on the needs of survivors of domestic and sexual violence, so those providers' participation is critical to ensuring that the interests of survivors are represented, and that the constraints on data sharing and the VAWA restrictions on requiring participation in services are followed.

To the extent that CoCs engage employment and housing and health and social service agencies from the community, they create opportunities for member agencies, including victim service providers, to develop referral or service relationships that can benefit program participants. To the extent that CoCs engage members of the business community, faith providers, representatives from local universities and colleges, and other interested members of the lay community, they create opportunities for member providers to cultivate relationships that may result in funding and in-kind donations of valuable services, as well as general goodwill.

Participation in a CoC allows victim service providers to get current information about resources – openings in housing programs; sources of donated furniture and household furnishings; sources of affordable mental health or addictions services; sources of assistance for survivors from ethnic, cultural, or linguistic minorities -- that might benefit their participants. Providers who have good (or bad) experiences with local landlords can share their knowledge, and make informed recommendations about, and introductions to, landlords that a DV provider might want to approach or refer a participant to.

To the extent that CoCs facilitate community dialogues about the causes and solutions to homelessness, they create opportunities for victim services providers to raise awareness about the prevalence of domestic and sexual violence, and how it is not just a problem affecting the clients of a handful of specialized providers, and that there are survivors in many of the Continuum's programs, on the staffs of some of those programs, and perhaps even sitting around the CoC table. Victim services providers can offer trainings and encouragement for staff from mainstream programs that, in the best cases, can strengthen the CoC's overall ability to offer trauma-informed services to homeless families and individuals whose experiences of domestic or sexual violence may continue to impair their forward progress.

The ability of victim services providers to advocate for the interests of survivors is critically important as the CoC develops and periodically reviews and revises its HUD-required "written standards" (defining eligibility constraints and the amount, duration, and scope of assistance); and as it develops and refines its coordinated entry and referral systems for HUD-, VA-, SAMHSA-, and possibly OVW-funded housing and services.

Although, as a few comments suggested, some victim services providers may experience participation in the CoC as a "challenge," their ability to advocate for the interests of survivors and the providers that serve them is truly a "benefit."

Slide #43.

The last section of the Chapter 12 narrative focuses on challenges and strategies for building successful collaborations more generally -- with mainstream homeless services providers, but also with mainstream mental health and substance abuse providers, mainstream employment services providers, mainstream disability services providers, etc.

The Alaska Network on Domestic Violence and Sexual Assault's comprehensive resource guide on "Responding to Multi-Abuse Trauma" (Edmund & Bland, 2011) contains an excellent discussion about the challenges of collaboration and strategies for overcoming them. Two important and interrelated barriers they discuss are lack of trust among different providers and cultural differences (using the term "cultural

differences" to refer to not just ethnic/racial/linguistic community-related differences, but also differences in provider cultures). For example, they observe that

> *"Providers from different disciplines such as victim's advocates, substance abuse counselors, mental health providers and criminal justice personnel often have differing philosophies and theoretical orientations and may not trust each other because of this. For example, drug and alcohol treatment providers may be focused on accountability, while the criminal justice system is often focused on punishment, and victim's advocates are focused on healing and empowerment." (p120)*

They note that additional trust issues may [stem] from cultural differences between providers – for example, between well-intentioned providers whose expertise was acquired through education and professional training and providers with lived experience.

Our interviews with providers indicated broad appreciation of the expertise, perspectives, and services that collaborators can add to a program, tempered by caution borne of mixed experience. Collaborations can fill gaps, but they can also result in fragmentation of care; can engender complications related to confidentiality, information-sharing, and the need for explicit client consent; and can be counterproductive if collaborators' lack adequate understanding of domestic and sexual violence and its impact on survivors and/or lack understanding or are unprepared to provide trauma informed services. Collaborations that engender a referral to an outside provider may add one-too-many logistical barriers to client follow-through in accessing assistance (e.g., making an appointment with an outside provider, figuring out transportation and possibly childcare in order to attend the appointment, and actually keeping the appointment).

Slide #44.

Providers seeking to overcome some of these obstacles have taken various steps to more fully integrate collaborators with their client services team, including having them attend team meetings, having them attend some of the same trainings as in-house staff, and arranging for them to deliver their services onsite, or if that isn't possible, arranging for them to present at participant gatherings, so that clients can get to meet and know them, and hopefully overcome any anxiety about scheduling an "outside" appointment.

Edmund & Bland (2011) cite the wisdom of a local Alaskan provider who explained that,

> *"Insisting that our way of doing things is 'better' than what others are doing, or that our priorities are more important, can create barriers to cooperation: 'It is helpful to understand each of us is coming to the table with different agendas, and none of those agendas is designed to hurt the victim. . . . If we are on a crusade to be the only people in the game to protect victims, then we are going to be in a constant war with all the other disciplines that are trying to do the same thing, only in a different way.' "* (p.121)

Given the critical importance of a trauma-informed approach, they advocate training to promote a universal presumption of trauma, and to ensure that both in-house staff and external collaborators share a common understanding of trauma, it's impact on survivors and the varied and sometimes difficult-to-accommodate coping mechanisms they have developed, and their risks of re-traumatization.

Successful collaboration with external partners depends on a shared understanding and belief that working together benefits the survivors; that there is mutual respect among the collaborating parties; that they hold the best intentions for the survivor; and that we all can learn from one another.

> *"Different issues may require different priorities and different approaches. For example, it's perfectly appropriate that an advocate would be focused on safety for victims of violence while a substance abuse counselor focuses on sobriety for people with substance use disorders, a child welfare caseworker focuses on the best interest of children and a criminal justice professional focuses on community safety. . . . A key to reconciling differing priorities is to take a both/and approach rather than an either/or approach, so that priorities and philosophies are not necessarily seen as being in conflict with each other. For example, an advocate's priority of helping a parent get safe from violence is certainly compatible with a child welfare caseworker's priority of protecting the best interest of the children."* (pp. 124-125)

The narrative concludes with a look at some successful collaborations between victim services providers and community partners from other disciplines, and what it took to achieve success, and provides links to the written materials documenting the process and the outcomes.

Slide #45.

Chapter 12 concludes with several sections of provider comments about their partnerships and collaborations with community-based providers, more generally, and with specific types of providers, including: children's services providers, education providers, employment services providers, health care providers, housing providers, legal services providers, life skills programs, and providers of mental health and substance abuse treatment services.

Slide #46.

Thank you for taking the time to attend this presentation. We encourage you to return to the project website where all of the webinars, the 12 chapters of the report, the podcasts, and the broadsides can be found.