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

Chapter 7: Subpopulations and Cultural / Linguistic Competence

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Submitted to:

Chapter 7: Subpopulations and Cultural/Linguistic Competence

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Note about the Use of Gendered Pronouns and Other Sensitive Terms

For the sake of readability, this report follows the example of numerous publications -- for example, by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)[1] and the Missouri Coalition of Domestic and Sexual Violence[2] -- 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. This report also uses feminine pronouns to refer to the provider staff of transitional housing programs that serve survivors. The use of those pronouns in no way suggests that the only victims are women, that the only perpetrators are men, or that the provider workforce is entirely female. 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 the shortcut herein taken is merely used to keep an already long document from becoming less readable.

Although the terms "victim" and "survivor" may both refer to a person who has experienced domestic or sexual violence, the term "survivor" is used more often in this document, to reflect the human potential for resilience. Once a victim/survivor is enrolled in a program, she is described as a "program participant" or just "participant." Participants may also be referred to as "survivors," as the context requires. Notwithstanding the importance of the duration of violence and the age of the victim, we use the terms "domestic violence" and "intimate partner violence" interchangeably, and consider "dating violence" to be subsumed under each.

Although provider comments sometimes refer to the perpetrator of domestic violence as the "abuser" or the "perpetrator," this report refers to that person as the "abusive (ex-)partner," in acknowledgement of their larger role in the survivor's life, as described by Jill Davies in her often-cited *Advocacy Beyond Leaving* (2009).

Finally, although the Office on Violence Against Women 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 geared 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 are framed as pertaining to domestic violence. Consequently, much of the narrative is framed in terms of addressing "domestic violence" or "domestic and sexual violence," rather than naming all the constituencies.

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[1] As stated on page 2 of the NCDVTMH's *A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors* by Warshaw, Sullivan, and Rivera (2013):

"Although many couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of "battering" is a form of gender-based violence characterized by a pattern of behavior, generally committed by men against women, that the perpetrator uses to gain an advantage of power and control over the victim (Bancroft, 2003; M. P. Johnson, 1995; Stark, 2007). Such behavior includes physical violence and the continued threat of such violence but also includes psychological torment designed to instill fear and/or confusion in the victim. The pattern of abuse also often includes sexual and economic abuse, social isolation, and threats against loved ones. For that reason, survivors are referred to as "women" and "she/her" throughout this review, and abusers are referred to as "men" and "he/him." This is meant to reflect that the majority of perpetrators of this form of abuse are men and their victims are women. Further, the bulk of the research on trauma and IPV, including the studies that met the criteria for this review, focus on female victims of abuse. It is not meant to disregard or minimize the experience of women abused by female partners nor men abused by male or female partners."

[2] As stated on page 2, of the Missouri Coalition's *Understanding the Nature and Dynamics of Domestic Violence* (2012)

"The greatest single common denominator about victims of domestic violence is the fact that the overwhelming majority are women. 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. (Durose et al., 2005) And, women experience more chronic and injurious physical assaults by intimate partners than do men. (Tjaden & Thoennes, 2000) That's why feminine pronouns are used in this publication when referring to adult victims and masculine pronouns are used when referring to perpetrators of domestic violence. This should not detract from the understanding that, in some instances, the perpetrator might be female while the victim is male or of the same gender."

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1. Executive Summary[3]

The OVW is committed in its Transitional Housing Assistance Grant program to ensuring that grant-funded housing and services are available to survivors from the full diversity of subpopulations, and are offered in a culturally and linguistically competent manner. Chapter 7 examines the implications of that commitment, that is, the nature of the different subpopulations who need that assistance, and what it means to provide such assistance in a culturally and linguistically competent manner.

The OVW's annual solicitation for TH grant proposals, warns against "procedures or policies that exclude victims from receiving ... assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children." (p.3) Above and beyond requiring compliance with civil rights and non-discrimination requirements, the OVW's annual solicitation for proposals states that,

> *"OVW has determined that serving underserved populations is a priority of the office. Therefore, all applicants must identify the **underserved population(s)** in the community and demonstrate how the proposed project will be responsive to the[ir] needs...."* (p.3)

According to paragraph (a)(39) of 42 U.S. Code §13925, *the term 'underserved populations' means*

> *"populations who face barriers in accessing and using victim services, and includes populations underserved because of geographic location, religion, sexual orientation, gender identity, underserved racial and ethnic populations, populations underserved because of special needs (such as language barriers, disabilities, alienage status, or age), and any other population determined to be underserved by the Attorney General or by the Secretary of Health and Human Services, as appropriate."*

This chapter explores the experience, the challenges, and the approaches of transitional housing (TH) providers in serving survivors of domestic and sexual violence who reflect the full diversity of the United States, and include all of the subpopulations identified by the OVW in these requirements.

The Section 2 narrative largely consists of a description of the Culturally and Linguistically Appropriate Services (CLAS) Standards, which were developed by the Office of Minority Health in the U.S. Department of Health and Human Services, and published at the end of 2000. The CLAS Standards comprehensively define what cultural and linguistic competence might mean for TH programs serving survivors of domestic and sexual violence. The discussion about the CLAS Standards is followed by providers' comments describing their challenges and approaches to offering culturally and linguistically competent services.

The two principal components of Section 3 are (a) extensive annotated listings of resources that may be useful to providers serving African American survivors, Latina/Hispanic survivors, Asian American and Pacific Island survivors, Native American/Alaska Native survivors, and immigrant survivors more generally; and (b) a broad sampling of provider comments about their approaches to serving racially, ethnically, linguistically, and culturally diverse survivors.

The following elements provide context for the resource listings and provider comments that comprise most of this chapter:

- A series of charts comparing the demographics (race and ethnicity) of a national sample of survivors of domestic and sexual violence (as reported in the National Intimate Partner Sexual Violence Survey), with

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[3] The terms **cultural competence** and **cultural/linguistic competence** are used interchangeably in this chapter. Clearly, there are times when cultural competence requires the ability to communicate effectively in a language other than English, and there are other situations, when provider and survivor are both native/fluent English speakers, and different aspects of cultural competence are most important.

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the demographics (race and ethnicity) of participants in OVW TH grant-funded programs and survivors served by FVPSA[4]-funded domestic violence shelters and non-residential service programs; and

- A discussion about the challenge and importance of, on the one hand, building program and staff awareness of, and sensitivity to, the beliefs, customs, and values traditionally associated with the different racial/ethnic/cultural communities that participants may come from, while, on the other hand, avoiding unwarranted assumptions based on demographic stereotypes about those participants.

The Section 3 narrative emphasizes that every survivor is a unique individual with life experiences that have helped shape their perspectives and priorities. Providers can only discover those perspectives and priorities -- and the relevant information about how each participant came to be in the program and what she is hoping to accomplish -- through open communication with that participant, to the extent that she wishes to have such a conversation.

The listed resources reinforce and expand on the importance of balancing awareness of "traditions" with caution about "unwarranted assumptions and generalizations." They make it clear that African Americans, Latinas/Hispanics, Asians and Pacific Islanders, and Native Americans/Alaska Natives are not homogeneous populations. Instead, the identities of community members may be based on a multitude of factors, including, but not limited to,

- their countries, regions, and/or tribes of (family) origin;
- how long they have been in the U.S, if they were not born in this country, and the extent to which they have assimilated into the "mainstream" or maintained traditional ways;
- if they were raised by immigrant parents or parents who were part of a cultural tradition that was outside the mainstream, the extent to which they and their parents attempted to assimilate into the "mainstream" or maintained traditional ways;
- their age, and the age at which they came to the U.S. (and whether/where they attended school), if they are immigrants;
- the extent to which they are currently affiliated with traditional religious or cultural institutions;
- the extent to which they speak English, if English was not their native language or the native language of their parents; and
- their socioeconomic status.

Thus, a survivor's identity and the roles that add meaning to her life[5] may center around a community of origin, a community of affiliation, or both, but shaped and colored by her individual experiences, perspectives, and priorities. Inasmuch as her physical, sexual, psychological, and/or financial victimization were part of an abusive effort to exert power and control by debasing, demeaning, and devaluing her, acknowledgement and affirmation of her chosen identity and roles are an integral part of supporting the survivor in healing and re-asserting her dignity, and in taking back power and control over her own life.

Section 4 focuses on needs and services related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) survivors. In the same way that racial, cultural, and linguistic communities are not homogeneous, the LGBTQ community includes different subpopulations. For example, although there may be commonalities in their struggles, lesbian women, gay men, bisexual men and women, and transgender men and women are likely to have had different experiences with coming out, and with acceptance or rejection by their family of origin, their peers, and the larger community.

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[4] Family Violence Prevention Services Act (FVPSA) grants, administered by the Family Youth Services Bureau in the U.S. Department of Health and Human Services, fund shelters and non-residential services for survivors of domestic and family violence (but not victims of sexual assault committed by persons other than a family member or intimate partner).

[5] See, for example, Melbin, Jordan, and Smyth (2014).

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As described in a special interview that we conducted with providers who have focused on serving LGBTQ people, different survivors have different comfort levels with being open about their gender identity and sexual orientation, and some may not yet have come "out." There are parts of the country where lesbians and gay men can be open about their sexuality, and there are parts of the country where they may feel a need to be more careful about coming out. According to the experts we interviewed, bisexual and transgender individuals are often less-well received, even in communities that have nominally welcomed gay and lesbian men and women. Survivors with other, less mainstream gender identities may have even greater concerns about being open about who they are. In addition to any relationship-related trauma, some of these LGBTQ survivors will have trauma related to their personal struggles to break free of their own or the larger society's expectations about who they are, and to make peace with their realities.

Section 4 includes some national statistics about the prevalence of domestic and sexual violence in the LGBTQ population, but since OVW-funded TH programs do not routinely collect and report on data about gender identity or sexual orientation, there are no cumulative statistics to include in this document. As noted in the narrative, the mention of gender identity and sexual orientation in the non-discrimination provisions of the 2013 VAWA Reauthorization represented the first time a federal funding statute extended such protections to the LGBTQ community, so TH program capacity building with respect to serving LGBTQ survivors is ongoing.

Although our interviews collected some general observations about providers' experience with serving LGBTQ survivors, in hindsight, it would have been helpful if we had more explicitly asked about the extent to which programs had knowingly served LGBTQ survivors, and, whether and how they identified and addressed any special needs related to the survivors gender identity and/or sexual orientation.

> *Recommendation:* Given the importance of gender identity and sexual orientation, we would encourage the OVW to consider working with LGBTQ advocates and providers to assess whether it is appropriate to formally augment data collection for the TH grant program to include information about gender identity and sexual orientation; and if so, how such questions might be asked and how such data might be collected, and what kind of training would be advisable, so that the collection of such information feels welcoming and inclusive, and does not compromise the safety, confidentiality, or privacy of survivors.[6]

Following narrative notes reflecting published wisdom about serving LGBTQ survivors, Section 4 presents some annotated resource listings, the comments we collected from TH providers, and the comments of the specialized LGBTQ providers that we interviewed, who were referred to us by members of our Project Advisory Committee.

Section 5 addresses the challenges and approaches attendant to serving young adults, older adults, male victims, and families with older children. The narrative begins with a listing of online resources addressing youth and young adult homelessness and victimization in relationship and sexual violence, prostitution, and human trafficking, with an emphasis on the experience of LGBTQ youth. The resource listings are followed by a brief summary of what providers told us, which in turn is followed by the actual provider comments.

The second part of Section 5 contains information from the National Clearinghouse on Abuse in Later Life (NCALL), a listing of additional online resources addressing older adult domestic and sexual violence, a brief summary of what providers told us, and the actual provider comments.

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[6] From our review of a 2011 report and 2012 proceedings of an Institute of Medicine-sponsored conference (see Alper & Sanders, 2012), we understand that there is an ongoing national discussion about the collection of data on gender identity and sexual orientation; clearly, the OVW can only proceed in ways that comport with national policy.

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The third and final part of Section 5 includes a brief discussion on serving male victims and families with older male children, some annotated citations from regulations and guidance documents intended to help providers avoid discriminatory program practices, and a small number of provider comments.

Section 6 addresses the challenges and approaches pertaining to serving ex-offenders. Although quite a few of the providers interviewed for this project spoke about TH program participants' challenges in overcoming their history of criminal justice involvement in order to get a job or housing, only one provider specifically discussed how their program was designed to meet the needs of ex-offenders. This section consists exclusively of annotated summaries of some relevant online resources.

Section 7 addresses the challenges and approaches in serving Deaf survivors. In the absence of specific interview data about serving Deaf survivors, the narrative relies on published materials, primarily drawn from resources identified in the National Resource Center on Domestic Violence's "Special Collection" webpage.

Section 8 addresses the challenges and approaches in serving survivors with disabling conditions. The section begins with a review of the literature on the extent and nature of victimization of people with disabling conditions. The narrative continues with a survey of federal laws -- including Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and the Fair Housing Act -- which define providers' obligations to serve survivors with disabilities, and to offer reasonable accommodations and/or reasonable modifications of policies and procedures, to make programs and services accessible. The narrative also includes an annotated listing of relevant online resources that support compliance by mainstream housing and service providers.

Following those resource listings, the narrative describes the documented efforts of OVW-funded collaborative partnerships designed to simultaneously build the capacity of victim services programs to serve survivors with disabilities, and the capacity of disability-focused programs to address the needs of any of their clients who have experienced domestic and sexual victimization.

The Section 8 narrative continues with a focus on two specific disabling conditions associated with domestic violence -- traumatic brain injury and strangulation -- providing annotated listings of relevant resources about the impacts of such victimization and how programs can best work with survivors.

Drawing heavily from Hopper, Bassuk, & Olivet (2010), the narrative explains how trauma survivors, including survivors with PTSD or complex trauma[7], may evidence a range of physical, cognitive, emotional, and behavioral responses to that trauma, which may be misdiagnosed by clinicians, and misunderstood by service providers, in the absence of an awareness of trauma and its impacts. With a trauma-informed lens, behaviors that could have been mistakenly labeled as "uncooperative" or "difficult" or "lazy" or stemming from a "lack of motivation" may instead be understood as manifestations of traumatic brain injury, or as coping strategies or as resulting from the physical, psychological, emotional, and sexual abuse that survivors endured and fled.

Program participants who are in a hypervigilant state may be especially vulnerable to re-traumatization by "triggers" within the service environment that remind them of their traumatic experiences. Such triggers may include meeting new people, being asked personal questions, being informed about program expectations or deadlines, fearing punishment for not meeting such expectations or deadlines, feeling "overloaded" with information, being in a chaotic environment, hearing raised voices or witnessing conflict involving other program participants or staff, participating in a medical exam, etc. When faced with such triggers, survivors suffering from trauma may respond in ways that appear unreasonable, confusing, or frustrating to providers.

One of the most difficult and frequent challenges that providers mentioned is serving survivors with mental health and/or substance abuse issues. The narrative on serving such survivors begins with information from online resources explaining how and why domestic and/or sexual violence, poverty, mental illness, and substance abuse co-occur and are mutually reinforcing and exacerbating, and the importance of interventions

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[7] See Courtois (2010) for a very readable explanation.

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that simultaneously take into account all these factors. The narrative continues with a review of online materials providing guidance to program staff serving survivors with these co-occurring complications.

Although TH program staff are not funded to provide clinical services, understanding some of the clinical considerations and approaches can be helpful to supporting and potentially exploring treatment options with survivors with mental health care needs or substance dependencies. The Section 8 narrative concludes with a brief discussion about the importance of cultural competence in providing treatment services to survivors wrestling with these co-occurring conditions.

Section 8 concludes with two sets of provider comments -- the first addressing providers' experiences in working with participants with disabling conditions more generally, and the second addressing providers' experiences in working with survivors with behavioral health-related conditions (i.e., mental illness, substance abuse, traumatic brain injury, etc.)

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2. Introduction and Overview of Cultural and Linguistic Competence

(a) <u>Introduction</u>

The annual OVW solicitation for transitional housing (TH) grant proposals makes it clear that funded programs are expected to open their doors to the full diversity of survivors of domestic and sexual violence. The solicitation warns applicants against proposing programs that employ

> *"procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children."* (p.3)

Above and beyond requiring compliance with civil rights and non-discrimination requirements, the OVW's annual solicitation for proposals states that, "OVW has determined that serving underserved populations[8] is a priority of the office. Therefore, all applicants must identify the underserved population(s) in the community and demonstrate how the proposed project will be responsive to the[ir] needs...." (p.3)

As discussed in greater detail in other chapters, survivors face a range of challenges as they work to find their path forward in the aftermath of fleeing domestic and/or sexual violence: healing from the trauma; achieving a level of safety that allows them to focus their attention on other matters; developing income from public benefits, if needed, or from employment, if possible; finding safe, decent sustainable housing; rebuilding the relationship with their children and leveraging resources to support their healthy development; etc.

Each person's challenges, their response to the domestic and/or sexual violence they have experienced, the options they perceive and the resources they believe to be available to them, and their path forward are shaped, in part, by who they are and where they come from (e.g., age, race, ethnicity, gender identity, etc.); the circumstances in which they've lived (e.g., trapped by poverty and/or discrimination versus part of the middle class; part of a segregated linguistic and/or cultural community versus part of the "mainstream"); and who their community of support was and will be (e.g., an LGBTQ community of choice, other homeless women on the street, an extended Native American family, an online community of survivors, etc.).

As discussed in Chapter 10 ("Challenges and Approaches to Obtaining Housing and Financial Stability"), chronic poverty increases the risk and adverse impact of domestic violence, and domestic violence, in turn, increases the risk and adverse impact of poverty. While poverty may not be the most important determinant of the presence or outcome of domestic and sexual violence, dependence on others for financial support leaves a person vulnerable to abuse, and lack of financial resources can profoundly limit a victim's options for addressing or escaping that abuse. Perpetuating the victim's reliance on the abuser and limiting her access to people and resources to whom she can turn for help are common strategies used by perpetrators to control their victims. Or, as Goodman et al. (2009) succinctly described it, "IPV and poverty co-occur at a high rate, magnify each other's [negative] effects, and, in each other's presence, constrain coping options." (p.2)[9]

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[8] According to paragraph (a)(39) of 42 U.S. Code §13925, the term 'underserved populations' means populations that

> *"face barriers in accessing and using victim services, and includes populations underserved because of geographic location, religion, sexual orientation, gender identity, underserved racial and ethnic populations, populations under- served because of special needs (such as language barriers, disabilities, alienage status, or age), and any other population determined to be underserved by the Attorney General or by the Secretary of Health and Human Services...."*

[9] For example, according to the National Intimate Partner Sexual Violence Survey (NISVS) of 2010, the 12-month prevalence of IPV impacting women from households with annual incomes of between $25,000 and $50,000 was twice as high (5.9%) as the prevalence among women from higher income households (2.8-3.0%). The prevalence among women from households with annual income under $25,000 was over three times as high (9.7%).

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Like everyone else, survivors are unique individuals **and** products of their environment: each survivor's needs and priorities, perspective on what has happened and why, and the path she has taken to get where she is have been shaped by the community/culture in which she grew up, and by her experiences and interpretation of those experiences. Cultural and linguistic competence means: (a) having an adequate understanding of the sociodemographic context[10] in which a survivor from a "similar" background might have experienced the abuse and made the decision to leave the abusive situation, and the context in which future life choices will be made; **and** (b) being prepared to communicate effectively and appropriately (and with adequate fluency in the appropriate language) to hear the survivor's **individual** perspective on her circumstances (or what she is comfortable disclosing); **and** (c) being prepared to respond with an appropriate offer of assistance, appropriately framed, and if the survivor agrees, to appropriately deliver that assistance.[11]

Cultural competence also requires an understanding of the historical context of a survivor's communities of identification. Thus, Brown-Rice (2013) states that cultural competence with respect to Native American survivors would require an understanding of the **historical trauma** resulting from centuries of oppression, exploitation, efforts at cultural eradication, and forced removal; how generational traumas have contributed to current high levels of domestic and sexual violence and other health and mental health problems in Native communities; and how cultural identification is an integral part of resilience. Similarly, DeGruy (2005) asserts that cultural competence with respect to African Americans requires an understanding of the historical trauma caused by centuries of slavery followed by institutionalized race-based economic and social oppression and discrimination, "predicated on the belief that African Americans were inherently/genetically inferior to whites," and resulting in what DeGruy calls "**Post Traumatic Slave Syndrome**." [12]

Cultural/linguistic competence informs provider understanding of "the complexities of survivors' lives and the barriers survivors overcome when deciding to seek help." (Rana, 2012) Cultural/linguistic competence

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[10] A person might identify with her racial community, her tribe or ethnic community, her linguistic community, her religious community, her country of origin, as a willing or reluctant immigrant or refugee or asylee, as a member of a community defined by sexual orientation or gender identity, as a member of a social caste or class, as a member of the Deaf community or as a person with a disability, as a military veteran, as a member of a profession, and/or based on any other community with which she is affiliated. The communities with which a survivor identifies or affiliates don't necessarily define the totality of her priorities, sensibilities, and expectations -- but understanding the potential implications of that identification/affiliation (and the ability to keep an open mind that is alert to individual differences), provides an important foundational context for building a trusting/helping relationship with that survivor.

[11] Cultural and linguistic competence is not only about increasing staff understanding and sensibilities, and opening the agency's doors wider; it is **also** about building credibility with the targeted clientele, and the capacity to communicate effectively and deliver assistance in a culturally and linguistically appropriate way. Consider, for example, the potential obstacles to serving the target clientele in each of the following fictitious scenarios: (1) A program that does multilingual outreach, but has only English-speaking staff (who have attended training in cultural competence, and who have general knowledge of the cultural context and circumstances of the clients who might need help, but who can't converse with those clients when they respond to the outreach. (2) A program that does multilingual outreach and has multilingual / multicultural intake staff (who can effectively converse with the clientele, but only English-speaking service providers. (3) A program that hopes to serve a largely working class African American community, but is staffed by white, middle-class, college-educated professionals who grew up elsewhere and who commute to work from white suburbs. (4) A program that hopes to serve LGBTQ survivors, but has no connections to local LGBTQ community organizations, no LGBTQ staff or board members, and no history of public support for LGBTQ rights or anti-discrimination protections.

[12] DeGruy (n.d.) describes how Post Traumatic Slave Syndrome is manifested by (a) "insufficient development of primary esteem, along with feelings of hopelessness, depression and a general self-destructive outlook; (b) a marked propensity for anger and violence, [including] extreme feelings of suspicion [about the] perceived negative motivations of others, violence against self, property and others, including the members of one's own group, i.e. friends, relatives, or acquaintances; [and] (c) internalized racism: learned helplessness, literacy deprivation, distorted self-concept, antipathy or aversion for [the] members of one's own identified cultural/ethnic group, [their] mores and customs, [and their] physical characteristics...."

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facilitates the connection -- the spoken or unspoken "I get it" -- that allows meaningful dialogue to continue and helps the provider design and offer responsive assistance and support.

Cultural competence is not only about understanding barriers, but also about understanding the strengths, approaches, and community resources that diverse survivors can leverage to support their healing and way forward -- whether that be church, traditional healing ceremonies, support groups, recovery groups, etc.

As described by Melbin, Smyth, & Marcus (2014), the approach to achieving safety that characterized some of the programs early in the battered women's movement -- and that still shapes the thinking of some programs, staff, or funders -- involved separation from families and communities, *"forcing survivors to fragment their lives and prioritize [safety from domestic and sexual violence] over everything else ... [and] undermining community resources such as critical informal networks."* (p.7)

> *"Requiring survivors to claim a primary 'victim' or 'survivor' identify in order to receive support forces them to dissect their lives into unrelated parts . . . . Treat[ing] survivors as 'broken people' whose only experience is victimization ... [fails to recognize their] important social connections and community resources. The reality is that every survivor is a whole person with a variety of experiences, assets, challenges, and informal support networks . . . . Seemingly intractable issues such as intergenerational poverty[13], systematic oppression, and inadequate access to basic resources ... [are] often treated as results, not causes, of vulnerability to violence. Understanding race, for example, through the lens of domestic violence is fundamentally different than understanding a survivor's experience of domestic violence through the lens of individual and institutional racism . . . .*

> *Safety is compromised by community violence, societal oppressions and disinvestment, and even by systems themselves. Safety is rarely all about leaving an abusive partner, or even all about addressing the DSV [domestic and sexual violence]. Physical safety and separation and/or prosecution of the perpetrator*

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[13] See Chapter 10 ("Challenges and Approaches to Obtaining Housing and Financial Stability)" for a discussion about the deep connections between domestic/sexual violence and chronic poverty (and the societal factors that lead to and perpetuate such poverty); and how "IPV and poverty co-occur at a high rate, magnify each other's [negative] effects, and, in each other's presence, constrain coping options." (Goodman et al., 2009, p.2)

The disproportionate impact of poverty on communities of color highlighted by Goodman et al. (2009) is clearly evidenced in the U.S. Census Bureau's September 2014 report on Income and Poverty in the United States: 2013 (DeNavas-Walt & Proctor, 2014), which documents that:

- Black (12.2%) and Hispanic (9.4%) people are much more likely to be living in deep poverty (incomes under 50% of the federal poverty level), as compared to white, non-Hispanic persons (4.3%) (Table 5, p.17)
- Black (27.2%) and Hispanic (23.5%) people are much more likely to be living in poverty (incomes under the federal poverty level), as compared to white, non-Hispanic persons (9.6%) (Table 3, p.13)
- Black (42.5%) and Hispanic (41.6%) female-headed households are much more likely to be living in poverty than white female-headed households (22.9%) (Table B-1, pp. 45-49)
- The median income of Black ($34,598) and Hispanic ($40,963) households are substantially lower than the median income of white, non-Hispanic households ($58,270) (Table 1, p.6)
- By contrast, median income for Asian households ($67,065) is higher than that of white, non-Hispanic households ($58,270) (Table 1, p.6) and the poverty rate for Asian persons (10.5%) is close to that of white, non-Hispanic households (9.6%), and less than half the poverty rate of Black (27.2%) and Hispanic (23.5%) persons. (Table 3, p.13)

Although DeNavas-Walt & Proctor (2014) do not include information about American Indians/Alaska Natives, that information does appear in Krogstad (2014), a 6/13/2014 post by the Pew Research Center, citing 2012 American Community Survey data (when poverty rates for everyone might have been a bit higher due to the Recession):

- In 2012, Native Americans had a 26% poverty rate, as compared to African Americans (28%), Asian Americans (13%), Hispanic Americans (25%), and White Americans (11%). Among persons that identified as American Indian or Alaska Native as their only race (vs. one of two or more racial backgrounds), the poverty rate was 29.1% in 2012.

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rarely equate with or lead directly to health, wellbeing and happiness. Indeed, leaving and separation often create new, additional problems." (pp. 9-13)

For a variety of reasons, then, leaving is not always the safest or best alternative for a victim of violence.[14] To the extent that survivor-centered advocacy means supporting a participant in preparing to return to her home community -- where she might be in contact with, or even resume her relationship with the person who abused her -- understanding the ways that the survivor derives strength and meaning from her community, as well as the ways that she remains at risk in the community, is a critical aspect of cultural competence.

(b) The CLAS Standards for Cultural and Linguistic Competence

The Office of Minority Health of the U.S. Department of Health and Human Services developed ***National Standards for Culturally and Linguistically Appropriate Services in Health Care*** (OMH, 2001), also known as the CLAS Standards, which were published in the December 22, 2000 edition of the Federal Register as "recommended national standards for adoption or adaptation by stakeholder organizations and agencies." The preamble in the online version describes the purpose and context in which these guidelines were developed, suggests their broad applicability, and clarifies their relationship to existing federal requirements:

> *"The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans."* (OMH, 2001) (p.3)

Although the standards reference racial, ethnic, and linguistic subpopulations, they are equally applicable to other subpopulations -- persons with disabilities, with diverse gender identities or sexual orientations, or from particular faith communities, etc. -- that have experienced discrimination, oppression, marginalization and/*or* other barriers to accessing appropriate services ... but which, at the same time, have traditions, resources, and communities of support that can be leveraged to create or enhance safety and wellbeing.

Likewise, although the CLAS standards are "primarily directed at health care organizations," they have broad applicability, including for programs addressing the needs of survivors of domestic and sexual violence.

In the same way that delivering trauma-informed care involves every facet of a provider organization's interaction with clients/consumers, and not just the direct services provided by a case manager or clinician, so, "culturally and linguistically appropriate services should be integrated throughout an organization." [15]

The 14 CLAS standards[16] address culturally competent care (Standards 1-3), language access services (Standards 4-7, which correspond to mandates for federally funded entities under Title VI of the Civil Rights Act of 1964), and "organizational supports for cultural competence" (Standards 8-14). In the excerpts that follow, the term "[providers]" replaces references to "health care organizations," to highlight the broader applicability of the standards to providers serving survivors of domestic and sexual violence:

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[14] See, also, Davies, 2009 on ***Advocacy Beyond Leaving***; the research on "tradeoffs" by Thomas, Goodman & Putnins (2015); and the research on lethality by Websdale & Dedolph (2000).

[15] The statement in the preamble from which this sentence is excerpted continues by advising that culturally and linguistically appropriate care should be "undertaken in partnership with the communities being served." This theme is addressed in Standard #12.

[16] Standard 14 encourages provider organizations to regularly make available to the public information about their progress in implementing the CLAS standards. For survivor safety and confidentiality reasons, the approaches of health care organizations and victim service providers may diverge around this standard.

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1. *"Standard 1. [Providers] should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural [beliefs] and practices and preferred language.*

   . . . . Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer. Understandable care involves communicating in the preferred language of patients/consumers and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status. Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy.

   Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural [beliefs] and practices in the context of negotiating [services]; using community workers as a check on the effectiveness of communication and care; encouraging patients/consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve [an] advocate ... or ombudsperson with special expertise in cross-cultural issues."

2. *"Standard 2. [Provider] organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.*

   The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services . . . . Staff refers not only to personnel employed by the [provider] organization but also its subcontracted and affiliated personnel. . . .

   Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. It focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff.... The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should use proactive strategies, such as incentives, mentoring programs, and partnerships with local schools and employment programs, to build diverse workforce capacity. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers."

3. *"Standard 3. [Provider] organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.*

   Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/ consumers representing different countries of origin, acculturation levels, and social and economic standing. . . . Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include . . . . Elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services; . . . . Impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and outcomes...."

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Note: "Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (LEP) individuals...."

The annual OVW solicitation of TH grant proposals incorporates the requirement in the section on "[Disability-Related] Accommodations and Language Access," stating that "Recipients of OVW funds must comply with applicable federal civil rights laws, which ... includes taking reasonable steps to ensure that persons with limited English proficiency (LEP) have meaningful access to funded programs or activities." (p.15)

An FAQ publication by Casa de Esperanza (2014) provides information about meeting those requirements.[17]

4. *"Standard 4. [Provider] organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."*

5. *"Standard 5. [Provider] organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.*

   LEP individuals should be informed—in a language they can understand—that they have the right to free language services and that such services are readily available."

6. *"Standard 6. [Provider] organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*

   Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services—they must assess and ensure the training and competency of individuals who deliver such services. . . . .

   In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. A patient/consumer may choose to

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[17] Ensuring Access to Service for Survivors with Limited English Proficiency (LEP), a 2014 FAQ publication by Casa de Esperanza (developed with OVW grant funding) provides answers to questions about provider obligations to ensure language access for persons with Limited English Proficiency under Title VI of the Civil Rights Act and Executive Order 13166. The memo notes that, "Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. Subrecipients are also covered, when federal funds are passed on from one recipient to another. Recipients of federal funds range from state and local agencies, to nonprofits and other organizations. Title VI covers a recipient's entire program or activity. This means all parts of a recipient's operations are covered. This is true even if only one part of the recipient receives the federal assistance." The FAQ cites a speech by Acting Assistant U.S. Attorney General Loretta King explaining that:

- "Even in places with English-only statutes or ordinances, covered recipients 'continue to be subject to Federal nondiscrimination requirements,' including those that support LEP individuals." (p.7)
- "As time goes on, the bar of reasonableness is being raised. The need to show progress in providing all LEP persons with meaningful access increases over time. . . . Even in tough economic times, assertions of lack of resources will not provide carte blanche for failure to provide language access. Language access is essential and is not to be treated as a "frill" when determining what to cut in a budget…" (p.8)

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use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. The health care organization's staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers."

7. *"Standard 7. [Provider] organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area."*

8. *"Standard 8. [Provider] organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services."*

9. *"Standard 9. [Provider] organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations."*

10. *"Standard 10. [Provider] organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language[18] are collected in health records, integrated into the organization's management information systems, and periodically updated.*

    The purposes of collecting information on race, ethnicity, and language are to: (a) Adequately identify population groups within a service area; (b) ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns; (c) prioritize allocation of organizational resources; (d) improve service planning to enhance access and coordination of care; and (e) assure that [program] services are provided equitably."

11. *"Standard 11. [Provider] organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area."*

In the same way that health care providers need to be aware of and prepared to address demographic, cultural, and epidemiological factors that may compromise the health of community members or impair their access to health care services, victim services providers operating TH programs must be aware of the diversity of factors that may compromise the ability of a survivor to access assistance in (a) escaping an abusive and dangerous domestic situation and (b) participating in services that can help them be safer, if and when they eventually choose to return to the relationship they fled, and/or to achieve stability and wellbeing, if they choose to permanently move on from that relationship.

As discussed in Chapter 2 ("Survivor Access and Participant Selection"), different TH providers offer different pathways into their programs: some providers exclusively draw their participants from the survivors in their agency-operated shelter or being served by their agency's outreach or non-residential service programs; some accept referrals from other shelters and outreach programs; some accept referrals from regional hotlines; and some are open to considering referrals and self-referrals from

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[18] The data collection form currently used by OVW TH grantees for the Semiannual Report does not collect information about the language spoken by participants, although it does track the number of persons who identify as "Hispanic or Latino" (whose primary language may or may not be Spanish), and does track the number of persons identified as having "limited English proficiency." A program wishing to assess/report on its success in reaching out to and serving survivors from other ethnic or linguistic communities in its service area would have to separately track that data. *When the OVW updates this report, perhaps it could add a narrative question about efforts and success in reaching such populations*.

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anywhere they might come. In responding to Standard 11, a provider might explore whether their approach to access/selection is suitably inclusive of diverse segments of the survivor population, or whether some survivors might not have adequate access, due to cultural or linguistic barriers.

In assessing whether their TH program services are adequate to address the needs of culturally and linguistically diverse survivors in their service area, they would want to consider their agency/program staff demographics and language capacity; the content, framing, and language of program materials as well as the content, framing, and language of materials utilized by partnering providers to serve program participants; and the specific needs that persons from particular segments of the survivor community might bring to the program, and what it would take to meet those needs.

12. *"Standard 12. [Provider] organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.*

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. As described below, this standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the [provider] organization.

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. . .

[Provider] organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served."

13. *"Standard 13. [Provider] organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers."* (pp. 7-19)

(c) An OVW Grant-Funded Resource for "Creating Accessible, Culturally Relevant Domestic Violence- and Trauma-Informed Agencies"

A free, downloadable self-reflection tool, developed under the *Accessing Safety and Recovery Initiative* (ASRI), with OVW grant funding, is intended to help provider agencies enhance their ability to offer "*accessible, culturally relevant, domestic violence- and trauma-informed (ACDVTI)* advocacy and services to survivors of domestic violence who are experiencing the mental health effects of trauma and/or psychiatric disability." The creators of the tool note that it was developed with "an understanding that agencies have different strengths and challenges, and that creating ACDVTI agencies is a constant learning process with no single end-point." (p.1) The tool provides a framework for looking at how a provider's mission, policies, procedures, and infrastructure, including physical and sensory environment, contribute to its ability to deliver ACDVTI services; how its intake and assessment process, its program and services, and the ways in which it collaborates with community partners support that ability, and could be improved; how staff are trained and supported in providing ACDVTI services, and how that training and support could be improved; and whether and how the provider uses feedback from participants to inform changes and improvement.

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(d) Provider Comments on Cultural Competence

Note: Providers typically described cultural competency as a high priority, and something that staff are trained on when they start and periodically thereafter. Many of their comments discussed how programs demonstrate cultural competence to participants and prospective participants, for example: (a) by employing staff from the same demographic or who speak the same language as participants[19]; (b) by engaging volunteers from those subpopulations; (c) by illustrating program materials with pictures of people from diverse segments of the community; (d) by furnishing program materials in languages spoken by the various subpopulations served; (e) by decorating program spaces with art and artifacts from the diversity of cultures served; (f) by serving food that is representative of the different cultures in the community; (g) by organizing celebrations and gatherings that highlight participants' cultural heritage; and (h) by supporting and facilitating participation by program clients in the ceremonies and/or customs that matter to them (e.g., prayer, church attendance, fasting, appropriate attire, smudge, dietary restrictions, etc.).

Several providers shared that once they became more visibly cultural competent, they started to see a more diverse clientele come through their programs. They noted that given the diversity of the communities and regions their programs serve, and given the relatively small size of many of their programs, it is not possible to support a staff that reflects all the subpopulations who might seek services; therefore, it is important that staff be trained and have experience and enjoy working with a diverse group of people. Providers noted that one goal of such training, and something that comes with experience living and working in a diverse environment, is an awareness of one's personal biases, and hopefully a willingness to acknowledge and address them. Another goal is what one provider called cultural humility -- "knowing that you don't know everything" and recognizing that your own perspective is not the only way of seeing or doing things.

Language came up often in the discussions about cultural competence -- not just in terms of having bilingual staff or volunteers, but what it means to have services provided by a native speaker. Several providers noted that when a survivor is in crisis, being forced to speak English (when it is not their first language) can be very stressful, and can limit the survivor's ability to adequately communicate their feelings, the details of their experience, etc. Being able to communicate with a bilingual/bicultural advocate / case manager who "gets it" can make a big difference. Having to speak through an interpreter can compromise the quality of the communication, can raise questions about the accuracy of translation, and if the interpreter comes from the same community as the survivor, can raise concerns about confidentiality and potential compromises in survivor safety.

Some of the comments address providers' challenges in achieving their desired level of cultural competency. Hiring a diverse staff can take longer and require more effort than simply filling a position with a competent individual, especially if the usual approach to soliciting job applicants typically generates a pool of candidates which is less diverse than the clientele. Small programs with one- or two-persons staffs and providers who struggle to meet their diversity-related hiring goals/aspirations spoke about finding other ways to show their commitment to cultural competency and to being welcoming and

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[19] **Not all providers agreed about the importance of hiring staff from the diverse demographics** in the community, especially if they saw their choice as being between hiring a more qualified and experienced staff from the white mainstream vs. a less qualified or less experienced person from a targeted demographic. Similarly, **a number of providers felt that language line capacity was sufficient and/or the best their agency/program could do**, given the number of staff positions and their budget. CLAS Standard 12 suggests that members from the targeted community should be consulted in such decision making, as well as in the overall planning of program services to ensure cultural and linguistic competency. Quite possibly, such consultation with and involvement of community stakeholders would also build more community credibility and support, thereby making the program "feel" more welcoming to community members who could benefit from its survivor services.

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responsive programs. One strategy discussed was partnering with local cultural organizations that can provide "warm referrals" to the DV/SA program and can offer complementary services, including reliable interpretation.

Interestingly, providers' comments about their challenges and approaches in serving racially, ethnically, and/or linguistically diverse populations largely focused on immigrant and limited English-speaking populations, rather than on populations defined by race or other attributes.[20]

Providers spoke about the challenges of serving undocumented immigrants, including fear of deportation; inability to legally work until they get a U-Visa, T-Visa, or VAWA-Self Petition[21]; the lengthy process they have to go through to get that visa; their inability to pay for housing until they can earn an income; the challenges they face even with a visa, if they speak only limited English; the pressures they feel to return to their community, and their concerns about isolation from that community; and the challenges they face in successfully integrating into the mainstream, given all the obstacles to earning an adequate income.

Providers serving survivors from small, tight-knit communities -- Native American reservations, islands, distinct religious or ethnic communities -- described how the challenges of transitioning to new permanent housing that separates them from their abusive partner may be complicated by ties between their family and the family of their abusive partner, pressures to keep the family together, and the lack of affordable housing options. They described the difficult choice that such survivors may face, in having to choose between starting fresh in a new community where they have no supports, or returning to their home community and continuing to face all the old pressures and dangers -- In other words, these survivors must wrestle with the difficult "tradeoffs" cited by Thomas, Goodman & Putnins (2015), Davies, 2009, *and* Melbin, Smyth, & Marcus (2014)*.*

Note: Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) I think it's important to hire staff with similar demographics and cultural backgrounds to clients. But the way a person holds themselves and reacts to people can also be very telling. If you can't hire staff from the same demographic as your clients, people can feel comfortable with someone who is culturally aware and empathetic and recognizes the differences. I've had young women on staff who look like their clients, and speak their language, but because of how they acted or held themselves, clients felt that "she acts like she's better than us." And I've had people who look completely different and participants say, "She's one of us."

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[20] Perhaps, given that African Americans constitute 28% of the participants in OVW-funded TH programs (according to the OVW semi-annual reports), providers don't perceive that they do, or need to do, anything special to be more welcoming and effective in serving survivors from that subpopulation. Then again, in the absence of consumer feedback (which the OVW determined was beyond the scope of this project), it is impossible to ascertain the success of provider efforts at being welcoming and culturally competent. As stated in the previous subsection describing CLAS standards #9 and #10, *data collection for assessing program performance must link performance and outcome metrics, including client satisfaction, to demographic data, in order to assess whether a program is working well for all subpopulations.*

[21] As described on the webpage of the Immigration Center for Women and Children, the Victims of Trafficking and Violence Protection Act (VTVPA) of 2000 created two categories of non-immigrant visas, *U Visa for victims of certain crimes* (including, but not limited to rape, sexual assault, and domestic violence) and *T Visas for victims of trafficking* (which brought them to the US), which provide temporary status to individuals who are or have been victims of a severe form of trafficking or who have suffered substantial physical or mental abuse as victims of criminal activity. With a U Visa, a law enforcement official must certify that the victim was, is, or is likely to be helpful in the investigation or prosecution of the criminal activity. With a T Visa, such documented cooperation is helpful, but not required, especially if a victim is under 18 years of age. As described on the webpage of the US Citizenship and Immigration Service, the spouse, children, and parents of a US citizen or legal permanent resident (green card-holder) can apply for a *VAWA Self Petition* if they have been abused by that US citizen or legal permanent resident. All three of these types of visas allow the victim to apply for a work permit, and all three offer a path to permanent resident status.

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(#02) I think that staff that are truly culturally competent understand that they don't understand everything about a person's culture. So they don't make assumptions. For example if we have someone from the Ukraine, I would expect that one of my case managers would read about the Ukraine and its language and customs, before she even meets with the client. And we would have an interpreter available to speak the survivor's language. In shelter it means we would accommodate her food requirements, if they're different than what typically is served: if we have someone who's Jewish and who needs Kosher food, we would have Kosher food. We want to make sure that the signage in our shelter and posters on the wall don't just reflect white straight women. So we might have a picture of two women together or posters of women of color.

And that works. 14 years ago, we weren't serving immigrants, because we were not competent, we didn't offer language capacity. We didn't have bilingual staff. We didn't offer women from the Middle East the type of food they like to eat. We didn't have any of those resources in place, and because we didn't have those resources, we weren't seeing any immigrant women in our shelter. Why would they come? When we started to change, that's when we started to see an influx of immigrant women coming to our shelter.

(#03) Our transitional housing coordinator is from Mexico, so she's bilingual, bicultural. Cultural competence means that participants can talk to staff or volunteers that look like them, who have an awareness and understanding of some of the barriers that are unique to being an immigrant or having a certain religious view or family expectations. Cultural competence is access to people who speak their language, and to materials that have pictures of people who look like them. Everything we do is in English and Spanish, and if we can't do it in both languages, we don't do it. Cultural competence is having staff and board members that look like, reflect the cultures we serve.

We have a diversity team that's made up of former clients, board and staff members. We partner with the [Beyond Diversity Resource Center](#) through OVW. Our diversity team is charged with implementing all our diversity objectives – provide training three times a year around culture competence and diversity. They review every form we use. They walk our building and make sure the pictures and signage meet our benchmarks for cultural competency. They provide feedback for each program on how we can improve.

(#04) The training in dealing with different cultural backgrounds is probably equally or more important than having staff come from the same demographic or cultural background as the anticipated clientele. Our staff used to better match our client demographics than it does now, due to some turnover; however, we have had even more success with the clients we are serving, maintaining relationships, improving our contacts because our current staff have more experience and more training dealing with different cultures and backgrounds, races, ethnicities, and religions. I think it's important to screen your hires for their experience and their attitudes and beliefs about people from different backgrounds.

(#05) Cultural competence starts with being conscious of your own personal biases and addressing them. It's meeting the client where they are, understanding what relationships look like in their culture, and being sensitive to their needs. We're encouraged to attend cultural competency trainings. I've learned, for example, about looking at the client and not the translator. We've tried to make our materials as inclusive as possible. We've worked with our technical assistance provider at NNEDV to create materials that ask the questions we need in a way that's appropriate across the board. For example, asking "what gender do you identify with?"

(#06) Access to Continuum of Care services here used to be first come, first serve, or agency driven, where each agency would have a shelter, and then would get people into their housing program from their shelter. Now we want to create a system where people are ranked based on need, vulnerability, and racial equity.

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Now we have to screen people, assess situations, and then decide what service is best for them, making sure we're proactive in ensuring that underserved communities have equal access.

It's always a challenge working with underserved communities. We have mainstream programs and culturally specific programs. There's tension among those programs, less resources for culturally specific programs, but they have more support from larger umbrella organizations. Mainstream organizations struggle to be more inclusive, to serve communities of color well, even just having people of color on their staff. Their leaders and boards are typically homogenously white. There's a lot of tension around that.

Where there are bilingual case managers, their workloads and caseloads and expectations are higher because in addition to their job with the program, they're "on" when they're in their community. They're expected to represent the agency in the community, translate and interpret, be part of different committees.

(#07) Hiring staff from the same demographic or cultural background as clientele is important, if possible. One way we try to be culturally competent is that where our young mothers are used to living with family, we make allowance for mother or sister to join them in their (scattered site) housing.

(#08) Although we'd like to have staff from the same demographic and culture as clients, it doesn't always work that way. Qualification is the number one thing. It helps if they come from a similar demographic and culture. But most important is that they're qualified and versatile and have the skills and ability to comfortably communicate with people from all walks of life.

(#09) We do our very best to make sure that we are educating our staff to be sensitive and inclusive. We try to diversify our staff in terms of competency, particularly within the transitional housing program because so much advocacy is necessary. Two of the 3.5 people on that team are fluent in Spanish. Three of the women are people of color, so our staff reflects very closely the clients that we are serving. Of course, we don't expect that everyone is going to be competent in all cultures; that's not realistic. I think even appreciating that is part of cultural competency: you have to learn not to make assumptions. For example, if two people are Hispanic, you can't assume one person's experience is the same as the other person's. We try very hard to foster awareness and celebrate the diversity that's present in our population. To appreciate that everyone comes from a different perspective, which may be structured around culture, around religion, around poverty -- around a whole lot of things. It's important to know that there are both common threads and differences.

(#10) Aside from English, Spanish is the most commonly spoken language. So we've committed to making sure that we always have one full-time Spanish-speaking staff member. We actually pay our Spanish-speaking staff a higher wage. We really value that. And if somebody has a different role in the organization and they speak a different language, that's a huge plus for us. We have an African-American support group, which is voluntary, but very-well attended. And our Spanish-speaking case manager goes to a community center for Latina women and facilitates a weekly support group there.

We try to take an individual approach with everybody -- individualizing our support, so participants can keep as much as possible of who they are while they are in our program. We make sure to address racism and homophobia from day one when people enter our programs. There are other cultural issues like serving deaf and hard of hearing women, and so making sure that we have the right equipment; and that we have staff or resources or can access people who can assist us. Culture is such a broad word when you think about it.

(#11) We do everything in Spanish, and so we have Latina advocates in shelter, in our transitional program, in our court program, and in our partnership program within the police department. We have support groups in

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Spanish. The child advocate and the case manager are both bilingual-bicultural. Every facet of what we do we have at least one bilingual/bicultural staff person. We have such a large Latino population here -- clients can access someone in their own language because when you're in crisis, you're second language isn't always helpful. You want to speak in your own language and feel comfortable, not through a translator.

(#12) We're always looking at the underlying cultural factors. For example, within the Hispanic community, it's culturally normative for older children to care for younger children. We try to be sensitive to that, while also helping families realize that some things that are culturally accepted could be seen as problematic and reportable in the mainstream culture.

(#13) There's so much that comes into play - the vocabulary of their language, the terms they use, how they describe their surroundings, what safety means for them. Cultural competence is basically having the ability to understand where a person might be coming from, including their perception of what abuse is.

For instance, the other day I was speaking with my transitional case manager, who is African American. She was helping someone move from one place to another place and she said to the woman "Is this neighborhood suitable for you? There have been shootings and there's a lot of crime." And the client said "it's not unsafe for me. I come from the Bronx and a lot of stuff happens in the Bronx. This is not scary at all." The neighborhood where she is may not be the safest, but it was safe enough for her. My case manager said to me "I think she's right, because I also live in New York City and I know how things are there, and this is nothing compared to that." Cultural competency is key to understanding where a person might be coming from, their concept of good and bad, their perception of what abuse means -- and their ideas about safety.

(#14) Cultural competency is understanding and respect of the different cultures: their holidays, traditions, foods. Our staff is really good about being aware of the different needs of the different cultures. It's also one of the focuses of our children's program. Each month they pick a different culture and do a meal and a brief history of the culture. All the women are invited. Our state DV coalition has training modules on cultural competence, which are part of the initial orientation and training for staff, and refreshed throughout the year.

(#15) Competently serving people means matching the services we have with the culture of the population we're trying to serve. So in our case, offering services in Spanish whenever possible, because we serve monolingual Spanish speakers. It's trying to reduce the need for translators by having Spanish-speaking service providers on staff. It's recognizing the cultural differences between mainstream organizations and culturally specific organizations, in terms of what is offered on site, food, child care, time and location of meeting, how friendly it feels to someone when they're attempting to walk through the door, making sure that they aren't having to do all the explaining, and that staff are prepared to receive them.

(#16) We have a very diverse population, and several staff members with language capacity. We use Language Line often. Cultural competence means understanding people's backgrounds, meeting people where they're at, being aware of who they are and not expecting them to teach us about them -- although certainly that will happen. But the burden is on our staff to be aware and informed about different people and what their needs are and how their needs may be different from ours, different from the next person's.

(#17) Cultural competence is being able to understand and respect participants' cultures, and being able to provide services that are respectful of those cultures, and to understand how cultural issues might pose barriers or contribute to resistance. We had a family who had certain religious beliefs, and they would not participate in some of our events. You have to respect that and not pressure them.

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We have a number of Hispanic staff members and we have a number of Asian staff members; it's vital to have staff and/or volunteers that speak the same language as the participants, and this city has a very large Hispanic population and an increasing Asian population. I would say that being able to speak the language of your participants is the most important thing, ahead of coming from the same demographic.

(#18) We provide culturally specific services in whatever language a person chooses, verbally and in the written materials that we have available. We make sure that our staff are connected with bicultural, bilingual supervision programs, so that they're getting support to provide the best services possible to address the needs of the folks in their communities. It's really important that they get the supervision support from those communities, because each community has some specific challenges and wonderful things about them.

(#19) (Not a current OVW grantee) Our transitional housing funding pays for two part time case managers, or as we call them, resident support coordinators. It used to be there was one full time position but we found it better to split that full time position into two part time positions, so that we could accommodate clients with different language needs, as well as clients with different schedules (e.g., working a late night shift).

It's huge to have in house staff and volunteers with similar backgrounds, cultures, ages, races to the clientele. Inevitably, we take on a client who speaks a language that we don't have, and then we struggle to find a volunteer, or to find somebody who knows somebody. But we've been pretty blessed to have enough staff, former staff, and volunteers so that we're 8-10 languages deep. It might be a game changer because when somebody actually feels the trust, that's when they're able to make some progress. Our clients are diverse. If our staff were majority white, participants from other racial and ethnic backgrounds just wouldn't feel that anyone was reflecting their histories or their culture or their background. There would be less trust.

On the other hand, sometimes people pay less attention to people from their own background. They just dismiss them, and say, "Oh I'm going to listen to the white person that's in charge," or they look at me as an African American woman like, "you're in charge?" And when I say I am, their response is "well who's over you?" So people bring their own biases.

Over the years, we've seen that women often like to talk to other women, but sometimes women like to talk to men. And when we began serving men, we recognized that some of those men would prefer to talk with men. So the fact that we have male staff in the evening, and the children's advocate is male is helpful. We have a male client who was abused by a woman, and we thought that the abuse was by a male roommate and we didn't know he was abused by a woman until he felt comfortable and talked to the only male staff on site ... because there is a stigma in admitting that you were abused by a woman. So having people like you on staff -- not just with respect to race, but also gender, or other factors -- can sometimes be very helpful.

I'm part of a national "white allies" group, and one of the concepts we've discussed on our conference calls is how there is a continuum from cultural awareness to cultural competency to cultural humility to culturally specific. Before you're culturally competent you have to be culturally aware. You have to be aware of what people bring with them from their culture: the challenges, the boundaries and fears that need to be respectfully understood, the things that they expect. It's an ongoing learning process.

We have a lot of clients who are immigrants. And we've got a lot of staff who have been immigrants. And when you have that experience, it helps you understand other people's experiences differently. Nobody is ever completely culturally competent. Do we make mistakes? Absolutely. We try to be aware of and learn from those mistakes. When we have cultural supervision, clinical supervision, or case review, we not only draw on the clients' experiences but our own.

I'll give you an example. Suppose a woman was going through the divorce process with her the abuser, and that abuser asked for a paternity test for her child. In an American relationship, a paternity test is a big insult to a partner because it questions their fidelity. In an Afghani relationship, the woman would be in a life and

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death situation because of honor killings; even her own family might want to kill her to protect their honor if the husband had reason to question her loyalty to him during the marriage.

(#20) One of the biggest things to come out of our focus group with African-Americans who had used our services was that they felt they didn't see enough African-American staff members. And that communicated a lot to them about how our agency feels about the community. The African-American population is shrinking in our city, so we've had to undertake a very dedicated effort to recruit and hire staff to fill that gap.

(#21) We need to be conscious of some of the different values that Native Americans have and how those values might conflict with our rules and expectations. Their sense of tribe, of community, and of connection to one another are really important. Our participants are used to having everybody in their house. By contrast, our transitional program has pretty strict rules initially about who can be in the apartments: we limit access by adult males during the first few months that people are in their program apartments. We specify community areas where they can gather, and we encourage people to visit with family, but not in their apartments.

(#22) Our staff is 98% from different cultural backgrounds. We speak many languages, it's sort of like you're stepping into the United Nations. When we have, say, a legal expert that doesn't speak a particular language, we have the staff and advocates that speak that language there translating, so the resident doesn't miss anything. Our staff are all native speakers and we speak most every language that would ever come to us. At one time we had 70 languages among our full and part time staff; and with our volunteer support groups, we have plenty of people that they can relate to in their native language. You see that, you hear that, you feel that, and you see people that are getting along with each other from different backgrounds, different cultures, different ways of dressing, and different languages. And right away, people find the people they can identify with. Over the years, we have developed support groups from a diversity of different backgrounds. We have Slavic Voices with over 150 people from different Slavic backgrounds. We have our African-American network which was also funded by OVW, led by some real pioneers, and it's highly respected in our area. We have a program called Asian Women. Hermanas is the first Latina domestic violence support group, the largest in the nation, actually, and one of the first that developed. These are all formerly battered women's groups that have joined together with people from the different cultures. All the members of these groups are volunteer advocates and/or staff. Our staff is over 90% former residents that have been with us over the years. The support of our graduates is a huge assistance to the residents. And when you hear people sharing their personal experiences, it opens you to being accepting and understanding of other cultures.

We have a very diverse staff, with different specializations in serving seniors or teens, or people that have been trafficked, or persons from different backgrounds. In both our emergency shelter and our transitional houses, our approach of mixing people with different issues and providing specialized staffing for the individualized programs has worked well. We didn't have the luxury of thinking of different places for different people, and I'm so glad we didn't, because with our staff training and staff diversity, we've been able to have people with different issues under the same roof. It's been like a melting pot.

It's not that everybody always loves each other, but for the most part, it works very well. Staff have to learn how to help people get along. You need staff that will be a positive force, that have experience working with different cultures, and that are excited by it. Can people who have been victimized in different ways be in the same support groups and be supports to each other? Yes. All of the different support communities -- Latino, Islamic, Asian, Slavic, African-American -- provide support around different types of issues with the people that have been through our programs. They've had different backgrounds; some trafficking, some have been victims of domestic violence and sexual assault. The common denominator is language, culture, and having been helped by a place they share in common. There are so many different backgrounds and different issues

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to address within each of those cultural groups, but people that had been victims turn their lives around and become strong, independent, and very supportive of the new people that come into our residences.

(#23) I don't look at people's cultures as a basis of who they are. They're a person just like I'm a person. If I need help with interpretation I reach out to the local agencies that provide it. As far as cultural competency, I don't see people's cultures; I see them as a person. They're individuals that need help regardless of their race, creed, or color. I keep telling everybody we're all the same inside. We all put our pants on the same way. Cultural issues have never been a barrier to helping somebody through our housing program.[22]

(#24) (Not a current OVW grantee) It is much better to have somebody on staff who speaks the language than to use a translator. First of all, having somebody on staff that speaks your language helps establish a sense of trust, and makes it possible to have a much deeper, more intimate, and more ongoing conversation. You get so much more quickly to the heart of what you're trying to communicate. When you use a language line, you communicate the bare essentials, hopefully, whereas if you have staff that speak the language, they can develop a real relationship.

So, to the best of our ability we try to hire a diverse staff with multiple languages represented. I'd be lying if I said we had all 25 languages that participants speak represented on our staff. We probably have eight languages and staff from different backgrounds. And depending on where the conflicts are in the world, it can shift. A few years ago, we had a lot of people from the Darfur region of Sudan; today, with all that's going on in Syria and Iraq, there's probably going to be a huge influx of people from there. We have people from the Eastern Congo; we've had people from Somalia. We're always playing a bit of catch-up, but we do our best.

We totally enjoy the diverse populations and I think it's fun for them to meet each other, too. It's kind of a big melting pot, and there are lots of trainings available to our staff on cultural competency and on best practices in working with special populations. We encourage our staff to do as much continuing education as possible.

(#25) Of our 15 staff members, four are bilingual Spanish speakers. One of those bilingual staff spends about 80%-85% of their time at the shelter but then also transitions with non-English-speaking clients when they enter the transitional program. This is a communications-heavy program, so having bilingual staff is huge, because it helps our clients feel more confident that they are truly being heard. We reduce the risk of miscommunication and residents feeling isolated.

(#26) We probably have 18 or so languages spoken among the staff on our campus. We pull those folks in as needed. We have made it a priority to hire bilingual, bicultural staff, because we want our clients to see themselves reflected. But it is a constant challenge.

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[22] As discussed later on in this chapter, Rios (2007) adapts a model originally developed by Cross (1989), defining a continuum of cultural competence, ranging from "cultural destructiveness" (making people fit the standard cultural pattern and excluding those who don't) to "cultural blindness" (not seeing or believing there are significant cultural differences) to "cultural awareness" (being aware that our identities are shaped by the culture we function in) to "cultural competency" (accepting and tailoring efforts to address cultural differences) to "cultural proficiency" (integrating cultural diversity into the fabric of our work, and taking proactive steps to address any biases and barriers).

Although this provider's comment suggests that they are at the "cultural blindness" point on the continuum, they may nonetheless be successfully addressing the needs of survivors from the diversity of cultural and linguistic backgrounds in their service area. The best indicator, one way or the other, would be implementing the recommendations of CLAS Standard 12, calling for consultation with and involvement of stakeholders from the community to obtain their feedback.

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(#27) We have bilingual counselors and bilingual advocates on staff. Nobody should walk through the door or call where there is not at least someone who can speak Spanish. We just started a collaboration with the Vietnamese community and soon will be hiring a person, but through our partnership with them, they have made translation services available to us, in the meantime. We have a community-based program that is on the streets helping people in the sex trades, and we have agreements with them, so that if someone needs services, and they are typically not going to feel comfortable coming into a structured program like this, there are advocates that we can link them with, that can facilitate a soft transfer, so they feel comfortable and safe coming in for services, and they know they will be respected.

(#28) When we serve Hispanic survivors, we have to be a lot more hands-on. The advocate might end up interpreting for her with a property manager and doing a lot more accompaniment, whereas folks who don't have that language barrier may be able to manage those questions and interviews on their own, or with some coaching or guidance, and might not need or want us there. Our advocates who work with non-English-speaking participants have developed connections to landlords who are more amenable to leasing to participants who don't have papers. That kind of word-of-mouth, insider information can help immigrant participants access resources they might otherwise not learn about. A bicultural advocate is ideal, but you need someone who speaks the language, who's willing and able to learn about and network in the community and who can accompany participants and use the available information to help them build bridges.

Questions to Consider

1. If a program is too small to have a staff that reflects the diversity of the population served, what are the relative pros and cons of achieving targeted levels of diversity by contracting with consultants from the under-represented segments of the population and/or partnering with local organizations that target assistance to those segments of the populations?

2. How can supervision contribute to cultural competency? What kind of attributes, skills, experience does such a supervisor need to have to make it work?

3. To the extent that participants in transitional housing are drawn from the pool of survivors served by shelters, how is access to transitional housing impacted by the cultural and linguistic competence of shelters, the ability of shelters to serve persons with disabilities, and the openness of shelters to serving survivors with non-traditional gender identities and sexual orientations?

4. If some segments of the community are not comfortable accessing congregate shelter services, and referrals from shelter are the primary mechanism for enrolling survivors into the TH program, what should the TH program do to make itself more accessible to segments of the survivor population who are not accessing shelter, but who need a safe place and help navigating the path forward?

5. If a small TH program can't afford to hire culturally and linguistic diverse personnel and develop culturally and linguistically appropriate materials, and if that program is unable to arrange to contract with an MOU partner to engage such personnel and create such materials to support a broadening of its capacity to serve diverse survivors in the community, should it refrain from outreach that would raise expectations in those diverse segments of the community? If not, what is a better strategy?

6. One provider observed that, "I don't look at people's cultures as a basis of who they are. They're a person just like I'm a person. If I need help with interpretation I reach out to the local agencies that provide it. As far as cultural competency, I don't see people's cultures; I see them as a person. They're individuals that need help regardless of their race, creed, or color. I keep telling everybody we're all the same inside. We all put our pants on the same way."

- How might being "color blind" to cultural and linguistic differences require diverse participants to conform to mainstream norms and values?

- In what other ways might color blindness impact the ability of a program to serve the diversity of survivors in the community?

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3. Serving Racially / Ethnically / Culturally / Linguistically Diverse Populations

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Important Note about Serving Undocumented Survivors

An [August 5, 2016 letter](#), jointly released by the U.S. Department of Justice, U.S. Department of Health and Human Services, and U.S. Department of Housing and Urban Development (HUD) provided clarification to OVW-, HUD-, and FVPSA-funded providers that mainstream emergency and domestic violence shelters, *OVW- and HUD-funded TH programs, and HUD-funded Rapid Rehousing programs, may all provide emergency housing assistance to undocumented immigrants.* An [August 11, 2016 news release on the HUD website](#), summarized the message, as follows:

"Today, the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Justice (DOJ) issued a joint letter reminding recipients of federal funds how the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 applies to their programs.

Through PRWORA, Congress restricted immigrant access to certain federal public benefits but also recognized exceptions to protect life or safety. Congress authorized the Attorney General to identify programs, services, and assistance that meet specific criteria for which immigrants remained eligible regardless of immigration status.

The purpose of this letter is to remind housing and service providers that they must not turn away immigrants experiencing homelessness or victims of domestic violence or human trafficking, on the basis of their immigration status, from certain housing and services necessary for life or safety – such as street outreach, emergency shelter, and short-term housing assistance including transitional housing and rapid re-housing funded through the Emergency Solutions Grants (ESG) and Continuum of Care (CoC) Programs.

The letter from the Attorney General and the Secretaries of HHS and HUD, dated August 5, 2016, is not a new policy. It reiterates existing laws and policies and applies those policies to programs that were not in effect when the original Attorney General Order was signed in 2001."

(a) <u>Overview: Demographic Data</u>

The following statistics on the national prevalence by race and ethnicity of domestic and sexual abuse, participation in FVPSA programs, and participation in OVW-funded TH programs are offered for perspective:

(i) Lifetime Prevalence of *Intimate Partner Violence* against a Woman

Source: National Intimate Partner and Sexual Violence Survey of 2011 ([Breiding et al., 2014](#)): Table 7 (p. 12)

	American Indian or Alaska Native	Asian/Pacific Islander	Black	Hispanic	Multi-Racial	White
Rape	*	*	8.8%%	6.2%	11.4%	9.6%
Other Sexual Violence	*	*	17.4%	9.9%	26.8%	17.1%
Rape or Other Sexual Violence	42.4%	*	31.8%	24.2%	43.1%	28.0%
Physical Violence	51.7%	15.3%	41.2%	29.7%	51.3%	30.5%
Stalking	*	*	9.5%	6.8%	13.3%	9.9%
Psychological Aggression	63.8%	29.8%	53.8%	43.9%	61.1%	47.2%

Note #1. Hispanic persons are only counted in the Hispanic column; persons counted in other columns are non-Hispanic

Note #2. Fields with no value (signified by *) lacked sufficient data to be statistically significant

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(ii) Lifetime Prevalence of Rape, Physical Violence, or Stalking by an Intimate Partner against a Woman

Source: National Intimate Partner and Sexual Violence Survey of 2010 (Breiding, Chen, & Black, 2014): Table 3.1 (p. 28)

	American Indian or Alaska Native	Asian/Pacific Islander	Black	Hispanic	Multi-Racial	White
Rape, Physical Violence, or Stalking	46.0%	19.6%	43.7%	37.1%	53.8%	34.6%

Note #1. Hispanic persons are only counted in the Hispanic column; persons counted in other columns are non-Hispanic

Note #2. This is a ***distinct data source (different survey year)*** from the other two NISVS charts listed here, so the numbers are not necessarily consistent with the numbers in the other two tables.

(iii) Lifetime Prevalence of Sexual Violence Victimization of a Woman (see Note #3)

Source: National Intimate Partner and Sexual Violence Survey of 2011 (Breiding et al., 2014): Table 2 (p. 6)

	American Indian or Alaska Native	Asian/Pacific Islander	Black	Hispanic	Multi-Racial	White
Rape	27.5%	*	21.2%	13.6%	32.3%	20.5%
Other Sexual Violence	55.0%	31.9%	38.2%	35.6%	64.1%	46.9%

Note #1. Hispanic persons are only counted in the Hispanic column; persons counted in other columns are non-Hispanic

Note #2. Fields with no value (signified by *) lacked sufficient data to be statistically significant

Note #3. These data on "sexual violence victimization" counted in this table includes rape, sexual coercion, unwanted sexual contact, etc. by any perpetrator, not limited to intimate partners

(iv) Demographics of Persons Served in FVPSA-Funded Shelters and Non-Residential Service Programs

Source: FVPSA Data Sheet on Domestic Violence Services Provided by State and Tribal Grantees (FYSB, 2015)

In 2014, FVPSA-funded local domestic violence shelter and non-residential programs, including Tribal programs, served about 1.27 million victims of domestic violence and their children. About 92.4% of adult participants with documented gender information were female and 7.6% percent were male. 22.6% of participants were children under age 18. Of all the adults and children served:

	American Indian or Alaska Native	Asian/Pacific Islander	Black	Hispanic	White	Unknown or Other
Absolute Percentages	3%	2%	18%	14%	45%	18%
Percentages of Persons with Known Race/Ethnicity	3.7%	2.4%	22.0%	17.1%	54.9%	

(v) Demographics of Survivors (Household Heads) Served by OVW-Funded Transitional Housing Programs

Source: Semi-Annual Reports on the OVW Transitional Housing Program (from the VAWA MEI website)

Survivor Race/Ethnicity	7/1/12-12/31/12	1/1/13-6/30/13	7/1/13-12/31/13	1/1/14-6/30/14	7/1/14-12/31/14
American Indian / Alaska Native	242 (7%)	185 (5%)	181 (5%)	213 (6%)	186 (6%)
Asian	141 (4%)	148 (4%)	165 (5%)	166 (5%)	116 (4%)
Black / African American	797 (23%)	854 (24%)	953 (28%)	945 (28%)	933 (28%)
Hispanic / Latino	548 (16%)	601 (17%)	616 (18%)	626 (18%)	556 (17%)
Native Hawaiian /Other Pacific Is.	58 (2%)	81 (2%)	73 (2%)	58 (2%)	47 (1%)
White	1,749 (51%)	1,846 (52%)	1,545 (45%)	1,495 (44%)	1,558 (47%)

Note #1. Percentages add up to more than 100% because participants are allowed to specify more than one race.

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(vi) Thoughts about the Meaning of these Statistics

The national prevalence statistics are sobering. With anywhere from 1-in-4 to 2-in-5 women experiencing rape or sexual violence, the message is clear: as a society we have a lot of work to do.

The meaning of the statistics about the demographics of persons served by FVPSA and OVW programs is less clear. Do the statistics indicate that any of those segments of the population are over- or under-represented in the program clienteles?

In order to compare within-demographic prevalence rates to program utilization rates, one would have to factor into the calculation the different percentages of whites, Blacks, Hispanics and other demographics in the overall US population. But victimization is only one determinant of program utilization; other are probably economic status, attachment to community, and the presence of children; integrating those factors into the equation would greatly complicate any effort to make a meaningful comparison.

The CLAS standards call for providers to be aware of how their program clientele does or does not reflect the demographics of the community or region they serve, and to assess and address the reasons for any apparent gaps in the program's ability to serve the diverse segments of that community or region. This seems like a practical approach to recommend to each OVW-funded provider, in the effort to ensure that OVW-funded programs are culturally and linguistically available, welcoming, and responsive to all kinds of survivors who need and want the kind of help they offer.

(b) Overview: Cultural Awareness and Sensitivity without Stereotyping

Like everyone else, survivors are **both** products of their environment **and** unique individuals: each survivor's needs and priorities, her perspective on what has happened and why, and the path she has taken to get where she is have been shaped by the community/culture in which she grew up, by all of her life experiences, and by her own individual interpretation of those experiences.

On the one hand, culturally competent providers will want to be aware of beliefs, practices, customs, and values traditionally associated with the different communities that participants may identify with or come from -- which may be based on race, ethnicity, language, religion, country of origin, immigration status, sexual orientation, gender identity, disability status, employment status, military experience, social class, place of residence, or other attributes. On the other hand, providers must be prepared to meet the survivor where she is -- seeking to understand **her** individual needs and desires, **her** perspective on what has happened and why, and the path **she** has taken to get there.

Cultural competence can help a provider understand -- and communicate their sensitivity to -- the community context in which a survivor's needs, desires, perspectives, and life path might have evolved; but that background understanding, and any resulting assumptions, will not necessarily coincide with the reality of every participant from that community or subpopulation. Those realities will only become known to the provider through open communication with a participant, if that participant so desires.

Thus, for example, although "Domestic Violence in Communities of Color," a resource developed by the Woman of Color Network and National Resource Center on Domestic Violence (NRCDV) enumerates "some commonalities among women of color," not every woman of color will share all the attributes in that list:

  (i)   A strong personal identification based on familial structure/ hierarchy, patriarchal elements, and cultural identity (e.g., role as wife, mother, and homemaker)
 (ii)   Religious beliefs that reinforce the woman's victimization and legitimizes the abuser's behavior
(iii)   Fear of isolation and alienation
(iv)   A strong loyalty to both immediate and extended family, as well as loyalty to race and culture
 (v)   Guarded trust and reluctance to discuss "private matters"

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(vi)   Fear of rejection from family, friends, congregation, and community

(vii)   Individual needs often defer to family unity and strength

(viii)   Distrust of law enforcement (fear of subjecting themselves and loved ones to a criminal and civil justice system they see as sexist, and/or racially and culturally biased)

(ix)   Skepticism and distrust that shelter and intervention services are culturally or linguistically competent

(x)   For immigrant and undocumented women, a fear or threat of deportation or separation from children

Nor does cultural competence mean that staff have to personally agree with or support all of the customs, beliefs, values, and traditions associated with a particular racial, ethnic, or religious community. In fact, some of the survivors seeking help from victim services organizations may be personally opposed to, or part of organized efforts to change, some of those traditional attitudes and practices which they believe are oppressive to women, or certain ethnic or religious minorities, or LGBTQ individuals.

That is, while a culturally competent provider would want to be aware of and demonstrate sensitivity to possibly relevant beliefs, concerns, and values, they would also want to engage in open, supportive dialogue, to either verify or dispel any assumptions, to make sure they have not imputed "typical" attributes which do not reflect the specific realities of the particular survivor they are serving, and to gain a true understanding of that survivor's needs, wishes, and perceived constraints.

(c) **Resources Pertaining to Serving Immigrants and Diverse Populations, In General**

Information in Diverse Languages: The HotPeachPages website contains links to domestic violence-related fact sheets and other information in **113 languages**.

> *Note #1*: Rather than presuming to offer definitive information about the racial and ethnic subpopulations that TH programs may serve, the following sections sample a mix of online resources which providers can look to for perspectives about: (a) how domestic and sexual violence manifests and is understood in some of the different racial, ethnic, linguistic, and cultural communities; (b) the variation within those various racial, ethnic, and cultural communities -- which are sometimes incorrectly seen as homogeneous[23] -- and how that variation means that efforts to be culturally competent with respect to one segment of the community might not be resonant with another segment of that community; (c) some of the challenges that survivors from those communities encounter in addressing or fleeing domestic and sexual violence; and (d) some of the resources and approaches that providers might find helpful in supporting survivors from those communities.
>
> *Note #2*: Although the resources described in this section and the sections which follow -- pertaining to African American, Latina/Hispanic, Asian American, and Native American/Alaska Native survivors -- do not specifically address service provision in the context of transitional housing, the insights they offer into the challenges and approaches in serving survivors from these diverse communities will hopefully be useful to the reader.

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[23] For example, Hispanics/Latinas in the U.S. include people with Mexican roots (64.1%), Puerto Rican roots (9.5%), Cuban roots (3.7%), Salvadoran roots (3.7%), Dominican roots (3.3%), Guatemalan roots (2.4%), Colombian roots (2%), Honduran roots (1.5%), etc. Within each of their countries of origin, there are different ethnic communities, races, and social classes, and Hispanics/Latinas in the U.S. include people from those subgroups. Within each subgroup, there may be newcomers to the U.S., longtime residents, and second and third generation Hispanics/Latinas. *Source*: Pew Research Center (2013): Hispanic website for Chart of U.S Hispanic Origin Groups, by Population, 2013 (click on Panel #2)

Likewise, Asians and Pacific Islanders in the U.S. include people from numerous and distinct countries, cultures, and generations, including those with Chinese roots (22%), Filipino roots (18.8%), Indian roots (17.5%), Vietnamese roots (9.5%), Korean roots (9.4%), Japanese roots (7.2%), Pakistani roots (2.3%), Cambodian roots (1.5%). These populations are divided into diverse racial/ethnic/linguistic subpopulations, as well as generational populations. Source: Pew Social and Demographic Trends website: Chart of U.S. Asian Populations by Origin (from 2010 American Community Survey)

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(i) Women of Color Network. (2006) Domestic Violence and Communities of Color. National Resource Center on Domestic Violence. Harrisburg PA

Describes common factors, beliefs, concerns, and values among women from different communities of color, and provides brief statistical examples and background *cultural and contextual information* about domestic violence experienced by African American women, Asian and Pacific Islander women, Hispanic/Latina women, and Native American/Alaska Native women. (See narrative at the beginning of this section of the report.)

(ii) Menjívar, C. & Salcido, O. (2002) Immigrant Women and Domestic Violence: Common Experiences in Different Countries. Gender and Society 16(6):898-920

Rana, S. (2012) Addressing Domestic Violence in Immigrant Communities: Critical Issues for Culturally Competent Services. NRCDV

Discussions of research-documented *barriers* facing immigrant survivors (e.g., race-, class-, and gender-based oppression; lack of viable alternatives; fear of deportation of self or spouse or loss of child custody; the complex process and years required before citizenship can be granted to the immigrant spouse of a citizen[24]; lack of knowledge about the process for obtaining legal status; lack of access to free legal representation; lack of access to employment; fear of poverty; financial abuse preventing access to or personal control over earned income; linguistic isolation; intentional isolation of the victim from family/friends by the abusive spouse; social or religious stigma associated with leaving a marriage, particularly an arranged marriage or a marriage for which the husband has paid a dowry or other price for the bride; extended family and/or community complicity in abuse; concern about children's wellbeing if denied access to the abusive spouse; fear/mistrust of the police, based on experiences in the US or in their native country[25]; etc.) and research-informed *recommendations* (e.g., culturally and linguistically appropriate assistance accessing relevant services for survivors who leave their abusive situation and survivors who choose to remain in that relationship; access to English literacy and employment-related skills training; access to support groups for survivors from similar cultural backgrounds; interagency collaboration to enhance local providers' ability to address immigrant survivors' needs in areas that victim services providers cannot effectively serve).

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[24] See U.S. Citizenship and Immigration Services (2013); see also the private webpages of AllLaw.com and Nolo.com. Note that the citizen husband must play an active role in completing the paperwork for an immigrant wife who wants to become a citizen. The VAWA Self-Petition, discussed elsewhere, created an alternative process eliminating this source of power and control by an abusive spouse, allowing the application to proceed without the citizen husband's participation.

[25] For example, Latta & Goodman (2005) quote a Haitian community leader interviewed in their qualitative study on "Interplay of Cultural Context and Service Provision in Intimate Partner Violence: The Case of Haitian Immigrant Women:

"I grew up in my neighborhood and I saw husbands beating up their wives, literally out in the daylight. This is something common. It's as natural as going to sleep, eating, dressing up. Sometimes people will interfere and say, 'Enough is enough.' But many times, it's normal for a husband or a boyfriend to beat their girlfriend or their wives. So it's widespread, and it continues to be so even in this country."

Latta & Goodman (2005) observe that

"One of the reasons this violence went unchecked ... was that the police in Haiti were unwilling to respond to domestic violence situations. For example, one [Haitian community] provider stated, 'There is no way to deal with it in Haiti because you cannot call the police and say, 'My husband is beating me up.' They will laugh at you. If you see a guy beating up his wife on the street, there is nothing you can do. Actually people will clap—she deserved the beating. There is no such thing as calling the police to get a restraining order. That order doesn't even exist in Haiti—to have a restraining order against your husband—they would laugh at you. Like a woman would not want to have sex with her husband? The guy would laugh, 'It's my wife. I can have sex with her whenever I want.' "

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(iii) Whitaker, D.J. & Reese, L., Editors. (2007) Preventing Intimate Partner Violence and Sexual Violence in Racial/Ethnic Minority Communities: CDC's Demonstration Projects. U.S. Centers for Disease Control and Prevention. Atlanta, GA.

Explores "approaches, challenges, and solutions faced in developing, implementing, and evaluating culturally competent [domestic- and sexual violence-related] intervention for racial/ethnic minority populations. The papers in this volume are primarily descriptive reports that focus on *implementation challenges and lessons learned* . . . . Of the 10 projects, seven focused on African American or Latino populations, and overall, six unique racial/ethnic groups (including various Southeast Asian, Native American, and Hawaiian communities) were targeted as part of this effort. About the same number of projects focused on primary prevention and secondary/ tertiary prevention. " (pp. 10-11)

(iv) National Immigrant Law Center (2014) Federal Guidance on Public Charge: When Is it Safe to Use Public Benefits? An extensive Q&A document. The following are brief excerpts which may be relevant:

> *" **'Public charge'** is a term used in immigration law [that] describes persons who cannot support themselves and who depend on benefits that provide cash — such as TANF or SSI – for their income. Depending on your immigration status, the Department of Homeland Security or U.S. State Department consular officers abroad can refuse to let you enter the U.S., reenter the U.S., or become a lawful permanent resident if they think you will not be able to support yourself without these benefits in the future. Public charge is not an issue for immigrants who are applying to become a U.S. citizen. Public charge is not an issue for refugees, persons granted asylum, or persons certified as trafficking victims. When you seek to enter the U.S. or apply for a green card, the government may ask you questions to see if you are likely to become a public charge in the future . . . . When you are applying for your green card, it is important to give the government information that shows you will not need benefits to support yourself. For example, if you are elderly, but have family in the U.S. with enough money to support you, or if you have a special skill that will get you a good job in the U.S., you should give this information to the government."*

> *"Use of Medicaid, the Children's Health Insurance Program (CHIP), or other health programs by you or your family members [including subsidies via ACA Health Exchanges] will NOT affect the public charge decision unless you use Medicaid or other government funds to pay for long-term care (nursing home or other institutionalized care). Use of [SNAP] (Food Stamps), WIC (the supplemental food program for women, infants, and children), public housing, or other noncash programs by you or your family members will NOT affect the public charge decision. Use of cash welfare by your children or other family members will NOT affect the public charge decision unless these benefits are your family's only income. Your own use of cash welfare, such as Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), or General Assistance, MIGHT affect the public charge decision, depending on your situation. This is because the U.S. Department of Homeland Security (DHS) or U.S. State Department can count your use of these benefits in deciding whether you are likely to become a 'public charge.' "*

(v) Wasem, R.E. (2014) Noncitizen Eligibility for Federal Public Assistance: Policy Overview and Trends. Congressional Research Service Washington, D.C.

A detailed review of the effect of immigration status on non-citizens' eligibility for and utilization of mainstream benefits SNAP, TANF, SSI, and Medicaid.

(vi) *Immigration Status-Related Resources*:

- The American Immigration Council VAWA webpage contains information about U-Visas, T-Visas, VAWA Self-Petitions, Battered Spouse and Child Waivers, and VAWA Cancellation of Removal -- whom they can help and how they work. A downloadable version is available.

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- The U.S. Citizenship and Immigration Services website hosts a 2011 slide presentation explaining: (a) the process and requirements for obtaining a **U-Visa, T-Visa, and VAWA Visa**[26], and (b) the process and requirements for immigrant victims of child abuse to apply for **Special Immigrant Juvenile status**. The presentation includes active links to the forms needed to apply. More detailed information is available on the U-Visa page, the T-Visa page, and the VAWA Self-Petition/Battered Spouse, Children, and Parents webpage. For links to a diversity of other federal resources for immigrant survivors, see the Victims of Human Trafficking & Other Crimes webpage.

- WomensLaw.org, a project of NNEDV, maintains webpages providing information on U-Visas, T-Visas, VAWA Self-Petitions, Battered Spouse or Child Waivers, and VAWA Cancellation of Removal. As described on the WomensLaw.org VAWA Laws for Abuse Victims webpage,

  - A survivor may be eligible to "**VAWA Self-Petition**" for lawful permanent residence if: (a) she or her child is abused by her spouse, who is a US citizen or a legal permanent resident; or (b) she is abused by her parent or step-parent, who is a US citizen or a legal permanent resident; or (c) she is abused by her adult son or daughter, who is a US citizen

  - A survivor may apply for a "**Battered Spouse or Child Waiver**" if she has "conditional legal permanent residence" status as the spouse of a US citizen or legal permanent resident who has abused her (and, under certain circumstances, if s/he has "conditional legal permanent residence" status as the child of a US citizen or legal permanent resident who has abused him/her).

  - A survivor who is in 'removal/deportation proceedings' before an immigration judge may apply for a "**VAWA Cancellation of Removal**," if she has been abused by a spouse or parent who is a US citizen or legal permanent resident, or if she has a child who has been abused by the spouse or parent.

(vii) **Employment and Self-Employment**: Nearly every provider that mentioned serving undocumented survivors noted that helping them with employment was a daunting challenge. Providers described the long and sometimes difficult process for securing a T Visa, U Visa, or VAWA Visa. In the meantime, as one provider explained, staff cannot legally or ethically tell a participant to find work that pays them under the table; even though that is their only option for salaried/hourly work until a Visa is approved.

The one legal option for immigrant survivors without green cards or the permission to work that comes with a T-Visa, U-Visa, or VAWA Visa is **starting their own small business**. Although these immigrants cannot be legally employed by others, they can legally start their own business (or a business jointly owned by all the workers). See, for example, Mastman (2008) "Undocumented Entrepreneurs: Are Business Owners "Employees" Under the Immigration Laws?" in the New York University Journal of Legislation and Public Policy and Geraldino (2014), Undocumented Entrepreneurs: No Social Security Number, Owning a Business posted online at Al Jazeera America.

(viii) Enos, V.P. (2003, rev. 2010). Battered Mothers Involved with Child Protective Services: Learning from Immigrant, Refugee, and Indigenous Women's Experiences. Asian & Pacific Islander Institute on Domestic Violence.

The findings from focus group discussions with immigrant women in Massachusetts and Native and immigrant women in Hawaii about their experience of domestic violence; their children's experience of abuse; the impact of abuse on their ability to parent and their perceived powerlessness to stop the violence; their limited access to or experience with domestic violence services; the impact of cultural

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[26] As stated in Module #1 ("Understanding Financial Abuse") of the Allstate Foundation/NNEDV Moving Ahead Through Financial Management curriculum, "The Violence Against Women Act self-petition is extremely complicated and time consuming. Do not attempt to file these papers on your own. Ask an advocate and immigration attorney to support you through this process." (p.17)

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and community attitudes about violence; the impact of poverty; the role of alcohol and drugs in violence; the need to support child protective services workers and domestic violence advocates in more broadly understanding the interrelatedness of domestic violence and child abuse, the interrelatedness of their respective roles on behalf of the adult and child victims of violence, and the consequences of their different possible responses to that violence.

(d) Resources Pertaining to African American Survivors

(i) Gillum, Tameka L. (2009) The Intersection of Spirituality, Religion, and Intimate Partner Violence in the African American Community. St. Paul, MD: University of Minnesota Institute on Domestic Violence in the African American Community (IDVAAC).

Explores the ***impact of racial stereotypes; the legacy of slavery, Jim Crow, institutionalized racism and oppression, and poverty; economic disparities*** between African American women and men; ***the role of external and internalized racism***; exposure to violence and perceived/stereotypical social norms regarding violence; ***different perceptions about domestic violence depending upon the severity of abuse***; the ***role of African American women as protectors*** of their male partners (from the criminal justice system); and concerns about formal intervention and the ***implications for child custody***.

Discusses the ***centrality of faith and spirituality***; prayer as a coping strategy; spirituality and religious involvement as a protective factor against depression and PTSD, and a source of strength to "cope with, heal from, break free from, and/or remain free from abusive relationship[27];" and the possible adverse role of "conservative religious teachings that dictate that men should be the leaders and decision makers in relationships."

"Explores the ***role of the Black church in addressing intimate partner violence***; ... because of its standing and influence, the Black Church has an exceptional opportunity to play an active role in addressing intimate partner violence in the African American community.... concludes with a set of recommendations for domestic violence and sexual assault service providers on how they can incorporate spiritual elements into their programs.... offers suggestions for clergy on how they can facilitate healing for victims of intimate partner violence and address perpetrators." (p.1)

Contains an extensive bibliography.

(ii) Bent-Goodley, T. B. (2004). Perceptions of Domestic Violence: A Dialogue with African American Women. Health & Social Work, 29(4), 307-316.

A literature review and qualitative research (three focus groups with African American women in NYC) on African American's perceptions of domestic violence. Although the literature review is over 10 years old, some of the themes from that review may still be applicable: inaccessibility of services, lack of cultural competence among service providers, racial loyalty, and gender entrapment. Three of those themes are specific to race/cultural considerations, though not necessarily specific to TH providers:

- ***Lack of Cultural Competence:*** "Negative stereotypes or myths are often at the heart of a service provider's lack of cultural competence (Allard, 1991). One stereotype is that of the strong African American woman, who can sustain anything, has no fear, and can easily protect herself (Hill-Collins, 1991, updated 2000). Shelters have denied housing to African American women for not sounding fearful enough or sounding too strong (Allard, 1991; Barbee, 1992; Kupenda, 1998; West, 1999). 'In many minds a picture has been painted of Black women as hardened, tough, back-

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[27] See also Watlington, C.G. & Murphy, C.M. (2006) for a discussion of the distinctions between spirituality, religious involvement, the social support that comes from being part of a church community, and how each of these factors might or might not impact depression and PTSD.

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talking, strong, permissive, and undeserving of protection, women for whom blows might not be considered cruelty' ([Kupenda, 1998, p. 8](#)). Shelter workers have been found to make assumptions about the mental health needs and safety of the survivor based on this superficial stereotype. Lack of cultural competence results in differential treatment and oppressive practice measures. For African American women, this intentional or nonintentional ignorance serves as a barrier to receiving domestic violence services." (pp. 308-309)

- ***Racial Loyalty:*** **"**Racial loyalty can be defined as when a person withstand[s] abuse and make[s] a conscious self-sacrifice for what she perceives as the greater good of the community, but to her own physical, psychological, and spiritual detriment.' ([Bent-Goodley, 2012, slide #8](#)) When the perception that racism is a more serious issue than sexism develops, African American women deny an equally important part of their identity ([Crenshaw, 1994](#); [Richie, 1996](#)). As these women deny their unique experiences as women to protect their partners, they put themselves at a greater risk of physical harm and do not allow their partners to be held accountable for their behavior . . . . Putting the needs of others first has been documented as one of the perceived roles of African American women ([Hill-Collins, 1991](#)). Many African American women hesitate to report domestic violence for fear of the discrimination and injustice that African American men often experience in the criminal justice system ([White, 1994](#)). Being acutely aware of police brutality and other forms of injustice, the woman forgoes her needs for fear of the criminal justice system. This increases her chances of physical injury and mental anguish. She is almost expected to sustain the abuse to protect the family, maintain the relationship, and spare the larger community of embarrassment, all the while denying her mental health needs and physical safety." (p.309)

- ***Gender Entrapment:*** "[Richie (1996)](#) defined gender entrapment as 'the socially constructed process whereby African American women who are vulnerable to male violence in their intimate relationship are penalized for behaviors they engage in even when behaviors are logical extensions of their racialized identities, their culturally expected gender roles, and the violence in their intimate relationships' (p. 4) Gender entrapment is learned and reinforced through societal expectations and intimate relationships. The theory provides a basis for understanding how African American women who experience domestic violence are further victimized by social structures. Specifically, gender entrapment theory illustrates the connection between African Americans, domestic violence, and the criminal justice system . . . . African American women are incarcerated at a higher rate than white women for domestic violence ([Plass, 1993](#)). In addition, African American men and women are more likely to be arrested for domestic violence than white Americans ([Beck & Mumola, 1999](#); [Fagan, 1996](#); Peterson-Lewis, Turner, & Adams, 1988). Peterson-Lewis et al. (1988) found that African Americans distrust the criminal justice system and do not feel that they are treated equally. These perceptions of the criminal justice system are not without merit. Mandatory arrests have been found to be more often applied to African Americans in comparison with white Americans ([Mills, 1998](#); [Sherman et al, 1992](#))." (p.309)

The three focus groups with 14 African American women from NYC surfaced the following themes:

- There is a ***distinction between a beating*** (escalated violence) ***and abuse*** (e.g., pushing, shoving, slapping, and verbal abuse). Domestic violence and abuse are seen as two different phenomena.

- "***What goes on in my relationship is my business***."

- There is a lack of awareness about local DV programs, a lack of transportation to access DV programs that are known, and a lack of openings in those programs.

- There is concern about ***how to address domestic violence in the African American community without demeaning African Americans***.

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- There are concerns that disclosing domestic violence could result in ***child welfare workers taking custody of the children***.

(iii)   Vann, A. (2003). [Developing Culturally-Relevant Responses to Domestic Abuse: Asha Family Services, Inc.](#) National Resource Center on Domestic Violence

Describes the services and approach of [Asha Family Services](#), a "domestic and sexual violence prevention organization specializing in African American culturally specific services, located in Milwaukee, WI" (and an OVW TH grantee in 2009), and frames the context in which the services are provided and how they are kept culturally relevant and appropriate for the population targeted.

- "The history of pervasive racism and discrimination against African Americans has resulted in a ***general fear of mistreatment and an overall mistrust of systems***, including criminal justice, welfare, social services, political, etc. . . . Domestic abuse agencies historically have been run by White women and are often viewed as connected to the systemic oppression responsible for allowing disparity and discrimination against African Americans and other groups of color. If an agency has not instituted policies and practices to mitigate the effects of this, or engaged staff in training to become culturally competent, then they are perceived as ***perpetuating the class differences where White-controlled agencies provide services to the Black 'have-nots'***.'

  Both African American women and men are taught to be leery of governmental and social service systems. Police and other elements of the criminal justice system traditionally have not been friends to African Americans. When a Black woman calls the police and participates in the ***prosecution of her batterer, it is frequently seen as being disloyal*** and deliberately placing a partner in a system that holds a dim view of both of them. Many, if not the majority of African Americans, see continuing discrimination and racism occurring today. Courts, jails and prisons throughout the country are filled with higher percentages of African Americans even though they make up a far smaller portion of the population. The current practice of racial profiling is a good example of systemic racism. . . . While African Americans make up 16 percent of all drivers nationally, they constitute 74 percent of the drivers stopped by police. The mistrust many African Americans feel continues to be fed by revelations like these." (p.6)

- Asha's origin is within the community it serves; however, when an agency is not, the entire organization must take steps to become culturally competent. Educate staff and Board to the history and culture of the target group, including the various subgroups and cultures that are part of the larger group. Work from top of the agency down in assuring a balanced number of individuals are on board who both reflect the target population and have decision-making power. ... ***All African Americans cannot be lumped into one group***. Simply being African American does not guarantee that an individual can work effectively with or represent other African Americans. Ethnicity alone does not make for a good advocate or competent counselor.... Individuals need training and education and this is true for all communities of people." (p.22)

- [Vann (2003)](#) cites a number of barriers to effectively serving African American victims/survivors of domestic and sexual violence, including:

  - ***"Failure to Recognize Life Context*** - [Mainstream] program approaches frequently fail to encompass the larger context in which African American women experience violence. ***Violence may be [only] one issue on a list of many that African American women are coping with at any given time. Some do not even rank it as the most important***; generational cycles of abuse in families and communities have served to normalize some of these behaviors. The failure to understand the context of African American intimate partner violence ... result in not being able to provide the connectedness necessary for healing. Dr. Carl Bell, a psychiatrist specializing in culturally-specific treatment methodology for African Americans, asserts that to develop a genuine relationship with the victim of partner abuse, a healer must be both

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welcoming and thoroughly familiar with the context in which the victim and perpetrator exist. [Bell & Mattis, 2000]"

➢ "***Lack of Comprehensive Services*** - When there is not recognition of the many competing life issues that may be present in a woman's life, providers do not address or make additional options available to women for dealing with them. ... Rarely does domestic abuse present as the only issue in the lives of women that come to us. Failing to meet other needs, particularly health-related concerns, including reproductive health and mental health issues such as depression and anxiety, will impact the effectiveness of services." (p. 7)

➢ "***Victim-Based Focus*** - ... A majority of domestic abuse programs are based on traditional [white mainstream] feminist philosophy and beliefs. This is not the basis of many African Americans' belief systems. For many African American women, it is ***problematic to accept "victim-focused" services that exclude her partner and children***. The practice is to put "him" in jail, adding to what some perceive as ***further destruction of Black families and his becoming immersed in the criminal justice system, further limiting his options***. Asha's experience with African American women dictates the need to include "him" in separate services that are not necessarily punitive but informational and educational – there has to be something more than just punishment. . . . Dr. Oliver J. Williams, Executive Director of the National Institute on Domestic Violence in the African American Community, states, ***'You cannot talk about "his" issues to the exclusion of "hers."*** Deal with it in a dichotomy – a blended approach. Recognize issues associated with Black men and Black women. Both are important.' "

➢ "***Religious Exclusion***" - A common thread that also runs through many [mainstream] programs is to exclude any religious overtones or references. Many people believe mainstream religion has responded dismally to domestic violence. While that sentiment has also been expressed within the African American community, many African Americans have been raised to value and sustain a deep sense of connection to their God – a connection that goes beyond any one practice or philosophy. So as not to be seen as a religious fanatic or crazy, an African American woman may not share or practice her religious customs or faith tradition – practices which give comfort and strength to many." (p.8)

• Among the approaches employed by Asha Family Services that Vann (2003) encourages are:

➢ "***Woman-Defined Advocacy*** - Service providers must allow the client to identify the priorities in her life. For domestic abuse victims, the priority may not be the violence. ***This community has learned to live with varying levels of violence and, depending on the particular environment, has learned to normalize it. Issues she may prioritize instead could be safer or better housing, concerns with her children, employment, substance abuse, her partner needing help, pending legal matters, incarceration, etc.*** Providers may have to deal simultaneously with multiple issues that are occurring in her life, not just one issue. In essence – hear what women are saying and respond to it."

➢ "***Respectful Interactions*** - African American women ... sensing a lack of respect will stop any effective connection immediately. Be mindful of voice tones and never raise your voice to a client or discuss any part of a person's situation with other people around or within earshot. ***Never demonize or dehumanize a woman's partner, relatives or others***. Remember that this society has a very low opinion of the partners of African American women and they are painfully aware of this impression. Focus on her. Let her know "Your safety is a concern"; "You don't deserve that"; "You are valuable"; "You have a right to feel safe in your home"; "It is not okay to be abused"; and "Let me share what is available, how it works and you can let me know what you want to do." Dr. Peter Bell and Dr. Francis Brisbane, founders of the Institute on Black Chemical Addiction and writers of culturally-specific methods for treating African

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Americans, suggest that when working with African American female victims, ***do not display pity and do not lean heavily on sympathy. Many African Americans view pity and sympathy from the dominant society as patronizing*** and will become passive and not participate. Others will see it as an opportunity to manipulate the process to get what they want." (p. 24)

➤ ***"Effectively Responding to Cultural Dynamics" -*** " An increase in the use and abuse of substances may well have become a way for an abused woman to cope with what is not going well in her life (although many began abusing substances long before they met the individual who is currently abusing them). If counselors and other staff are not familiar with cultural dynamics, the ability to deal effectively with this group of women can be easily compromised. For example, participants may say 'Black folks (men/women) do that this way' or 'It's a Black thing' or 'Black folks don't do that,' etc. These are the kinds of excuses that someone not familiar with particular cultural conventions may accept as being true. This allows participants to avoid treatment and fall back on excuses to justify not participating. Dr. Bell asserts that the way to address this behavior is by first becoming familiar with and understanding the cultural issues that surround clients. Counselors who understand and are familiar with the context of their clients' lives will be better able to make objective assessments and determine the extent to which they are real or being used as excuses." (p.25)

➤ ***"Differing Help-Seeking Behaviors*** - Recognize that African American women may exhibit different help-seeking behaviors. Systems can and do re-victimize Black women often because of their responses to violence. Many African American women do not display stereotypical behaviors. Fear, loss of control and feeling trapped will often result in anger and withdrawal in many women. These responses, when not viewed as valid reactions to a chaotic and traumatic environment, perpetuate the angry, aggressive or violent stereotypes that traditionally have been played out through multiple levels of the media. . . . Many women diagnosed with PTSD report feelings of intense psychological distress, difficulty falling or staying asleep, irritability or outbursts of anger, hyper-vigilance or exaggerated startle response. . . . Be very conscious of an individual's 'space' – the immediate area surrounding the person. Many are not trusting or 'touchy feely' kind of people and do not want their 'space' invaded unless invited." (pp. 25-26)

(iv) Sanders-Thompson, V. & Bazile, A. (2000). [African American Attitudes Toward Domestic Violence and DV Assistance](#). National Violence Against Women Prevention Research Centre.

Conducted 27 mixed-gender focus groups with 134 African American females and 66 males that surfaced a variety of themes, including the following themes specific to community culture:

• Cultural values and beliefs that inhibit disclosure: pride, denial of violence and vulnerability; "as African Americans ***we take care of ourselves***," inability to deal with a situation is a matter of shame; "***African American women are responsible for keeping family together***;" African Americans "don't tell their business;" turn to prayer for help.

• Community attitudes that inhibit disclosure and intervention: "***pushing and shoving are not serious***;" ***distrust of institutions*** (police, legal system involvement, agencies); ***loyalty issues***, family pressure ("How can you have him arrested? How could you leave him?"); "I did nothing wrong. Why should I leave?"; "Rely on family, friends, and church for resources and referrals"

• Cultural Sensitivity ("[staff communicate that they] ***understand that violence is not more acceptable in the African American community***; [diverse staff] are perceived as comfortable communicating with AA women in a ***respectful, non-paternalistic manner***;" "AA women respond to shelter rules within the context of a history of a controlling oppressive relationship and an oppressive society."

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(v) Many of these same themes are raised in other articles, for example, in Feminista Jones' article, Why Black Women Struggle More With Domestic Violence in the 9/10/2014 edition of Time Magazine.

(vi) Creswell, L. (2016). Review of Literature of Women with Co-occurring Disorders through the Feminist and Black Feminist Perspective.

Creswell notes that, "the National Survey of Black Americans reported *most African Americans did not seek mental health services as a response to emotional distress* (Neighbours et al., 2007; Schnittker, Freese, & Powell, 2000)." She cites Collins' (2002)[28] indication of women's reports that "they frequently use drugs to numb the pain that is a direct result of trauma, self-hatred, anger and neglect," and notes that, "these traumas also include sexual and physical abuse from interpersonal relationships." She cites Brady & Ashley's (2005) observation that, "*self-medicating the effects of trauma is common* and interrupts the ability to sort out the experiences of the trauma and symptoms of post-traumatic stress disorder (PTSD)," and Covington's (2007) description of "the relationship between substance abuse and trauma as a means of sustaining a connection to a non-healthy relationship. The use of the substance tends to offer a *numbing effect to a violent relationship*."

Given the aforementioned tendency not to seek mental health services, and given Clark et al.'s (2008) finding that "women who have been abused display difficulty trusting others," she concludes that "it is *essential for a strong therapeutic alliance to be developed as part of the recovery*." Essential to such an alliance is "knowledge of the pervasiveness of interpersonal abuse in the lives of women with co-occurring disorders;" a "holistic assessment [and] individualized understanding of their needs" Frueh et al. (2005); and "approaching addiction, trauma and mental illness from [a] black feminist perspective [that shifts away] from looking for internal deficits and moves towards looking for various environmental and cultural interconnections Collins (2002), [so as to create] services that acknowledge and understand the lived experience of the woman in a patriarchal society Covington (2008)."

(vii) Institute on Domestic Violence in the African American Community (IDVAAC) at the University of Minnesota. Safe Return Initiative

The Safe Return Initiative (SRI) was created by OVW (originally as a partnership between the IDVAAC and the Vera Institute of Justice, but now led by IDVAAC with a focus on domestic violence prevention and intervention efforts. Seeks "to confront the myriad challenges facing African-Americans as previously incarcerated men reunite with their families. SRI provides technical assistance and support to grantees of the Serious and Violent Offender Reentry Initiative, a federal effort that addresses reentry strategies for populations of serious, high-risk offenders. SRI's technical assistance entails community education, training, and on-site assistance to criminal justice professionals and community- and faith-based organizations. Efforts are focused on helping these grantees *confront the obstacles that prevent the successful reunification of newly released [male] prisoners and families in their communities, while decreasing the vulnerability of such families to domestic violence*."

The Safe Return Initiative webpage contains links to print and DVD resources developed by the project:

- Hairston, Creasie F. & Oliver, W. (2006) Domestic Violence and Prisoner Reentry: Experiences of African American Women and Men. New York: Vera Institute of Justice

- Bobbitt, M., Campbell, R. & Tate, G.L. (2006) Safe Return: Working Toward Preventing Domestic Violence When Men Return from Prison. New York: Vera Institute of Justice

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[28] Collins, L. H. (2002). Alcohol and drug addiction in women: Phenomenology and prevention. In M. Ballou & L. S. Brown (Eds.), Rethinking mental health and disorder: Feminist perspectives. New York: Guilford Press.

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- [Domestic Violence and Culturally Diverse Communities in Detroit](#) - a film exploring how domestic violence is being addressed in the Arab American, Latin American, African American, and Asian American communities in Detroit.

- [Safe Return: Building Bridges](#) - DVD "highlights issues related to prisoner reentry and domestic violence and offers examples of collaborations among domestic violence, criminal justice/parole community supervision, and community based programs in addressing domestic violence in the context of reentry."

(e) <u>Resources Pertaining to Latina / Hispanic American Survivors</u>

(i) Rios, E.A. (2007) [On the Road to Social Transformation: Utilizing Cultural and Community Strengths to End Domestic Violence](#). National Latino Alliance for the Elimination of Domestic Violence. New York.

A comprehensive picture of demographics and socioeconomics of US Hispanic/Latino households; cultural considerations and strategies for achieving cultural competence and cultural proficiency.

- **On Cultural Competence**: To the extent that programs addressing domestic and sexual violence are perceived as ethnocentric, that is, framed from the perspective of the European American cultural lens,

  *Latinas/os "seeking help may 'shut down' or disengage [if they perceive that] their cultural perspective is not understood and/or [is] devalued. **Latinas/os are likely to emphasize values associated with kinship, collectivism and interdependence while European Americans are more likely to value independence, individualism and personal achievement** . . . . For many Latinas, community based programs that provide counseling services including services for children and batterers may be preferred to shelters because of their family-centric, cultural orientation. Some Latino researchers and advocates argue that one of the fundamental problems faced by the Latino community is that domestic violence services are structured from an Anglo American, individualist cultural framework which is fundamentally different from the collectivist cultural framework shared by many Latinas/os. Dr. Fernando Mederos observes:*

  > *'Many of the helping systems and legal remedies offered to battered women frame the solution or the achievement of safety in terms of protecting or establishing an autonomous self; **establishing safety for a woman and her children is framed in terms of separating her from the offender and from her community. Protective/restraining orders emphasize removing the offender. Shelters offer women refuge from the offender, but separate them from their communities. This is more culturally appropriate in European American society where the ideal of individuality or the autonomous self has great resonance**. In the European American cultural tradition, people want their children to "be their own persons," "to strike out on their own" and to make their own way in life; [whereas Latinas/os] emphasize wanting their children to be dutiful sons and daughters, to bring honor and prestige to their lineage and to primarily strive to find harmony within their community.'* [from a personal communication between E. A. Rios and Fernando Mederos, Massachusetts Department of Social Services, DV Unit].*" (pp.18-19)

- ***Diversity within the Latino Culture***: "It is important to clarify ... that while many Latinas/os share a common language and certain basic cultural beliefs and values, their experiences and worldview can differ substantially. Influential factors may include immigration status, level of acculturation or assimilation, class, race and gender identity, age, education, religion and sexual orientation, among others. As such, an appreciation for the diversity existing within and across cultures is an essential prerequisite for domestic violence service providers and advocates." (p.21)

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- *Key Cultural Values*:

  - *Familismo*: family, broadly defined -- including persons not related by blood or marriage, who have *become* family, like comadres, compadres, and hijos de crianza (children taken in to be cared for) -- as the primary source of support and identify: "**In the Anglo culture, the function of the family is to serve the development of the individuals who comprise it, whereas in the traditional Latino family, the individuals serve the development of the family**. Family members are expected to actively work towards family unity and preservation. Members' accomplishments are viewed primarily as a reflection on the strength and caliber of the family, more so than the individual. Conversely, individual failures or transgressions can bring shame upon the family name." (p.21)

  - *Gender Roles*: "*Gender roles vary and continue to change rapidly, especially as more Latinas enter the workforce, achieve higher educational status and become economically and socially independent*. Within more traditional families, the father or eldest male is considered the protector, provider and authority or primary decision maker. In accordance with the ideal of family unity and preservation, **Latinas in traditional households are often groomed since childhood to become good wives and mothers, often placing the needs of the family over their own. For many Latinas, identity and self-esteem have been intertwined with the ability to fulfill the ideal of being a good daughter, wife and mother. As such, domestic violence and family disruption often engenders in Latinas a sense of failure and emptiness**. . . . Male gender roles or concepts of masculinity within Latino culture have often been intertwined with the notion of machismo. One definition of machismo is a strong or exaggerated sense of masculinity stressing attributes such as physical strength, courage, virility, domination of women, and aggressiveness. However, Latino academics and service providers working in batterers' intervention programs note that the true meaning of being a macho was historically that of protector and provider for the family and community; someone who is responsible, hard-working, honorable — a man of his word." (pp. 22-23)

  - *Personalismo*: value and trust in people, and not institutions

  - *Role of the Catholic Church:* "Dr. Julia Perilla, a researcher and domestic violence survivor herself, points out [in Perilla , 1999, pp. 123-124] that the church has played a central role in silencing Latinas' concerns about domestic violence:

    *'The emphasis placed on the family and the indissolubility of marriage, at whatever cost, is found in Catholic, as well as fundamentalist churches, the denominations to which most Latinas/os belong. **Although it is slowly changing, the salient message that Latinas receive from many members of the clergy and religious representatives is that domestic violence is at best a miscommunication between the couple and at worse the fault of the woman who must amend her ways to safeguard the family**. Using the Virgin Mary or biblical passages to support their assertions, church representatives often silence the voice of women who have taken the difficult first step to tell the truth regarding their relationships. For many Latinas who still subscribe to traditional beliefs and values regarding the church, the message they receive often has lasting and dangerous consequences.'*" (p.24)

- The design of programs and interventions should be informed by an understanding of oppressions related to socioeconomic status and class, race and ethnicity (nativism and anti-immigrant rhetoric and actions), isolation and persecution of LGBTQ members of the Latina/o community, etc. Rios

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(2007, p.35) adapts the work of Cross (1989)[29] in framing a "Cultural Proficiency Continuum," and provides strategies and recommendations for moving along the continuum:

➢ from "*cultural destructiveness / cultural deficit perspectives*" ("excluding those who don't fit," "pressuring assimilation")

➢ to "*cultural blindness*" ("one size fits all")

➢ to "*cultural awareness*" ("being aware that we live and function within a culture of our own and that our identity is shaped by it," "outreach to communities of color")

➢ to "*cultural competency*" ("understanding and accepting different cultural values, attitudes, and behaviors," "development of culturally and linguistically appropriate educational materials")

➢ to "*cultural proficiency*" ("having the capacity to communicate and interact effectively with culturally diverse people, integrating elements of their culture—vocabulary, values, attitudes, rules and norms;" "understanding that culturally biased helping systems may have an oppressive impact; taking proactive steps to change biases and remove barriers;" "[implementing] customized, culturally responsive services and organizational practices.")

(ii) Lake, C., Snell, A., & Lethbridge-Cejku, F. (2015) No Más Study National Latin@ Network , Casa de Esperanza, Lake Research Partners

Gender-segregated focus groups with recent immigrant Latino men and women and U.S.-born Latino women and men; telephone surveys of 800 Hispanic men and women nationwide, with oversamples of 100 recent immigrants and 100 Hispanic men and women under 30; online survey of 1,307 Hispanic and non-Hispanic Americans. Data collected to assess awareness and attitudes about domestic violence and sexual assault; findings included:

• Perceptions that domestic violence is a bigger problem than sexual assault, and that such violence is a bigger problem in the overall American population than in the Hispanic/Latino community.

• Latino women and men "tend to attribute domestic violence and sexual assault to drugs and alcohol... lack of good parenting and education in the home, lack of education, and economic problems." "Lack of respect for the opposite sex is overall seen as more of a cause than traditional male gender roles [by both men and women]."

(iii) Casa de Esperanza & Mujeres Latinas en Acción. (2012). Latina Portrait: The Reauthorization of VAWA and Latinas St. Paul, MN

Discusses the Latina experience of domestic violence and barriers to accessing assistance, including research indicating that (a) *immigrant Latinas are often "unaware that domestic violence is a crime in the United States and that there are resources that exist to help them;"* (b) Latinas, especially immigrant Latinas with lower levels of acculturation, "are only half as likely to report abuse to authorities as survivors from other ethnic/racial groups;" (c) *as the person responsible for the wellbeing and cohesiveness of the family, Latinas are reluctant to seek outside help*; and (d) abusers are often able to use immigration status -- specifically, *fear that calling the police for help could result*

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[29] Towards a Culturally Competent System of Care. Volume 1. CAASP Technical Assistance Center. Georgetown University Child Development Center. Washington, DC.

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in deportation[30] *or loss of custody of their children* -- as a tool of power and control, even though "many undocumented immigrant victims may qualify for immigration status pursuant to VAWA."

When Latinas do seek assistance, *limited English literacy can be a barrier, as can fear of involvement with the criminal justice system, even among Latinas with official immigration status*, As a result, "Latinas are more likely to seek support from family members, female friends or neighbors, than from service provides...." (pp. 11-12)

(iv) Rizzo, C.F. & Macy, R.J. (2011) [Help Seeking and Barriers of Hispanic Partner Violence Survivors: A Systematic Review of the Literature](). Aggression and Violent Behavior 16 (2011) 250–264

A review of 27 qualitative and quantitative studies examining the reasons that Latina victims/survivors of domestic violence do or don't seek assistance, and from whom.[31]

(f) Resources Pertaining to Asian American/Pacific Island Survivors

The [website of the Asian Pacific Institute on Gender-Based Violence]() (API-GBV) contains links to extensive resources. The [resources webpage]() (right-hand side) provides a comprehensive directory of resources by topic and resource type (e.g., research/data, fact sheet, webinar). Some of the many resources include:

- Warrier, S. (2002) [Culture: What It Is, Who Owns It, Claims It, Changes It](). APIGBV

   "Often in our conversations, assumptions are made, for example, that as Chinese Americans and as South Asians we have much in common. Well, we do and we do not because there *are numerous inter-ethnic diversities that make us different*. Sometimes we do not recognize our diversities or we do not talk about them and how they can lead to contests within cultures. There are no clear-cut boundaries. Most boundaries are permeable and as Uma Narayan states[32] there is no such thing as a 'packaged picture of culture.'

   Most of us have been asked to present what domestic violence looks like in a particular Asian community. We get up and give a nice list of what it looks like. We give people lists of what they can do if they have encountered a Chinese woman, or a Korean woman, or a Cambodian woman.... That is not to say that these lists do not have some value. . . . *These totalizing notions of culture are in fact idealized pictures of our traditions; and as we know, traditions have both nurturing as well as oppressive elements. It is important to shift our understanding away from totalizing culture to illustrating its diversity, contradictions, contrasts, ambiguities, and the interconnections between various internal systems that structure power."* (p.2)

- Kim, M. (2002, rev. 2010) [Innovative Strategies to Address Domestic Violence in the API Communities: Examining Themes, Models, and Interventions](). API-GBV. San Francisco, CA.

   Examines (a) how *domestic violence in the context of different Asian cultures and households may involve more actors than just the husband and wife* (e.g., in-laws, ex-wife, extended family living arrangements, dowry/bride price, etc.); (b) how for many women, "leaving" the relationship

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[30] More likely, reporting abuse would result in the deportation of the abusive partner, which could lead to other culturally undesirable outcomes, including permanent separation of the children from their father, permanent loss of a partner to whom the survivor is emotionally attached and, at least in part, financially dependent.

[31] Interestingly, the study looked at the decision about utilization entirely based on attributes and circumstances of the victim/survivor. Given the insights of [Rios (2007)]() and other research emphasizing the importance of cultural competence in determining whether community resources are utilized, it would have been helpful to assess whether the resources in question were on the "ethnocentric" or "culturally destructive" or "culturally blind" end of the continuum that [Rios (2007, p.35)]() adapted from [Cross (1989)](), or whether they were structured and delivered in a way that was consistent with the needs, values, and constraints of the Latinas whose help-seeking behavior was being studied.

[32] See [Narayan (2000)]() or [Narayan (1998)]()

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is not a relevant strategy, how mainstream programs minimize the impact of leaving the community, but for immigrant women, "*leaving the relationship often means leaving the community, which is a source of identity, familiarity, and resources*;" (c) how involving the criminal justice system, which increasingly puts the abusive partner at *risk of deportation, is not what Asian women want for their husbands and the fathers of their children*, but they have little voice in the outcome, once they initially involve the system; (d) how becoming "independent" is not necessarily what Asian women want for themselves; (e) how compartmentalizing services -- DV services versus legal services versus housing services versus employment services -- and putting artificial time limits on assistance undermines their accessibility as a community resource; (f) how standard notions of non-disclosure by staff about their own lives and experience of violence may pose *barriers to self-disclosure by participants who seek a more equal/mutual relationship*; (g) how the desire to support community-building may conflict with mainstream notions prohibiting gift-exchanges and socialization between survivors and volunteers outside of services.

- Dabby (2007) Curriculum on Domestic Violence Against Asian & Pacific Islander Women - Explores the many ways that power and control manifest in the context of API relationships (e.g., multiple batterers, including parents and siblings of the abusive husband; surveillance; forced labor; honor or dowry-related killings; isolation; dishonoring; forced marriage; marital rape; forced pregnancies; forced abortions; separating children from their mother; serial immigrant marriages, failure to update a spouse's immigration status; threatened deportation; etc.) See also the API-GBV webpage Types of Gender-Based Violence with links to subtopic pages with extensive resources.

- Islamic Marriage Contracts: A Resource Guide for Legal Professionals, Advocates, Imams & Communities (2012) - Reviews the principles of Islamic and US Family Law, explains the Islamic Marriage Contract, offers suggestions for drafting such contracts, and discusses divorce.

- Shattered Lives: Homicides, Domestic Violence, and Asian Families, a study dissecting 160 domestic violence-related murders in the API community over the period 2000-2005 in 23 states.

- Training and background materials on sexual violence and victimization in childhood homes, as adults, as victims of trafficking or prostitution, as immigrants and refugees, as domestic workers, in conflict zones, etc. How sexual victimization can be addressed, and why it is important for advocates who have relationships with survivors to address it.

- Fact Sheets on domestic and gender-based violence in specific ethnic Asian communities, including Chinese, Filipino, Hmong, Korean, Muslim, Pacific Islander, Vietnamese, and various South Asian (Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka) cultures, with links to translated resources.

- A webpage on culturally-specific advocacy, with links to diverse resources.

- A webpage on abusive international marriages, and resources developed by Hmong advocates to address the problem

- A webpage of webinars about trafficking: an overview of trafficking, a look at "the culture of family controlled trafficking," and a discussion on survivor-centered, trauma-informed support for victims

- A webpage on Language Access, Interpretation, and Translation, with links to numerous resources, including a comprehensive Guide for Advocates and Attorneys on Interpretation Services for DV Victims; a step-by-step technical assistance brief on Considerations and Recommendations for developing and implementing a Language Access Plan; and briefs on addressing problems with interpreters and considerations in using interpreters with victims with limited English proficiency.

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(g) Resources Pertaining to Native American and Alaska Native Survivors

(i) Context/Prevalence

According to Krogstad (2014), "Some 5.2 million people (1.7% of the total U.S. population) identify as Native American or Alaska Native, with 44% identifying as at least one other race, according to 2010 Census Bureau data, the most recent data available . . . . Of those who identify as Native American or Alaska Native as their only race, one-in-three (33%) live on reservations or tribal lands. Among all American Indians and Alaska Natives, about one-in-five (22%) live on reservations or tribal lands."

Delivering domestic violence- and sexual assault-related transitional housing and services to Native American victims/survivors not only *requires an understanding of the distinct customs and traditions of the 566 federally recognized American Indian and Alaska Native tribes and villages*[33]*; it also requires an understanding of the historical legacy*: (a) the "*many instances of violence, maltreatment, and neglect inflicted on Native Peoples[34] by citizens of the United States*," as described by President Obama, as he signed the Native American Apology Resolution into law in December 2009[35]; (b) the high levels of sexual violence that Native Americans continue to face, and the *documented sense of futility and resignation in obtaining help or justice that has resulted from inadequate enforcement*[36,37,38,39,40]; and (c) the lack of trust in federal and state governments, in light of that dismal history.

The 2007 report by Amnesty International called attention to alarming rates of sexual violence in Indian Country -- a Bureau of Justice-documented rate of rape and sexual assault that was 2½ times the rate for other American women[41], and which Amnesty's research suggested was even higher in rural regions -- and the *widespread perception among victims that reporting the violence was futile, in terms of getting help or protection, and instead, was likely to result in humiliation and further violence*. The report stated that,

> *"Sexual violence against Indigenous women today is informed and conditioned by this legacy of widespread and egregious human rights abuses. It has been compounded by the **federal government's steady erosion of tribal government authority and its chronic under-resourcing of those law enforcement agencies and service providers which should protect Indigenous women from sexual violence**. It is against this backdrop that American Indian and Alaska Native women continue to experience high levels of sexual violence, a **systemic failure to punish those responsible** and official indifference to their rights to dignity, security and justice . . . . [As, a result,] the great*

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[33] See U.S. Department of Interior, Bureau of Indian Affairs FAQ

[34] Futures Without Violence's (2010) The Facts on Violence against American Indian/Alaskan Native Women (p.3) cites Bigfoot & Schmidt's (2010) in noting that, "It is likely that the higher rates of exposure to traumatic events, coupled with the overarching cultural, historical, and intergenerational traumas, make this population more vulnerable to PTSD."

[35] See also Chapter 1 ("The Context") (pp. 4-13) in the Minnesota American Indian Women's Resource Center (2009) Shattered Hearts: The Commercial Sexual Exploitation of American Indian Women and Girls in Minnesota

[36] See Perry, S.W. (2004) American Indians and Crime – A BJS Statistical Profile 1992-2002. Bureau of Justice Statistics, US Department of Justice, Office of Justice Programs, Washington, D.C.

[37] See Futures Without Violence's (2010) The Facts on Violence against American Indian/Alaskan Native Women.

[38] See, for example, the "Victim Assistance" page of the Bureau of Indian Affairs website.

[39] Amnesty International USA. (2007) Maze of Injustice: The Failure to Protect Indigenous Women from Sexual Violence in the USA. New York, NY.

[40] Dobie, K. (2011) Tiny Little Laws: A Plague of Sexual Violence in Indian Country. Harper's Magazine 332(2/2011):54–64. New York, NY.

[41] See Perry, S.W. (2004) American Indians and Crime – A BJS Statistical Profile 1992-2002. Bureau of Justice Statistics, US Department of Justice, Office of Justice Programs, Washington, D.C.

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majority of stories remain untold. **Violence against women is characteristically underreported. Barriers to reporting include fear of breaches in confidentiality, fear of retaliation and a lack of confidence that reports will be taken seriously** *and result in perpetrators being brought to justice."* (pp. 1-3)

"Intimate partners who commit sexual violence often do so with impunity, in part because of a lack of recognition -- by women themselves, by responding authorities and by society in general -- that such violence constitutes a crime. Many women do not report domestic violence. The response of the police and courts to those that do is often grossly inadequate." (p.6)

"In order to achieve justice, survivors of sexual violence frequently have to navigate a maze of tribal, state and federal law. The US federal government has created a complex interrelation between these three jurisdictions that undermines equality before the law and often allows perpetrators to evade justice. In some cases this has created areas of effective lawlessness which encourages violence. Action by US Congress is required to eliminate the possibility that complex jurisdictional rules and legislation in practice may deny survivors of sexual violence access to justice." (p.8)

"Overall, Amnesty International's findings indicate that many American Indian and Alaska Native victims of sexual violence find access to legal redress, adequate medical attention and reparations difficult, if not impossible. **Impunity for perpetrators and indifference towards survivors contribute to a climate where sexual violence is seen as normal and inescapable rather than criminal, and where women do not seek justice because they know they will be met with inaction**." (p.9)

The research for the Amnesty Internal report pre-dated the 2005 reauthorization of the Violence Against Women Act (VAWA), which added a new Title IX to the Act with provisions intended to study and improve safety and justice for Native American and Alaska Native women. Among its other provisions, Title IX mandated that 10% of funds be allocated for direct services for victims of sexual violence, including OVW funding for transitional housing programs. Although the FVPSA and VAWA/OVW grant programs now incorporate such earmarks, the VOCA program has yet to be amended to designate funds for use in compensating Native American victims of crime.[42]

Although the disparity in rates of sexual violence between American Indians and other racial and ethnic groups has decreased, as described in charts included earlier in this section, the 2011 National Intimate Partner and Sexual Violence Survey shows that Native American women still face disproportionately high rates of rape, other sexual violence, physical violence, psychological aggression, and stalking.

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[42] As described on a [webpage of the National Indigenous Women's Resource Center](#) describing a March 2016 webinar co-presented with a representative from the U.S. Department of Justice,

"American Indians and Alaska Natives experience the highest crime victimization rates in the country. **Complex jurisdictional issues, along with the cultural diversity of tribes and the basic reality of geography, pose significant challenges for tribal crime victims.** *Tribal governments, like other governments, are responsible for meeting the needs of victims in their communities. Unfortunately, [they] often have few or no resources ... to provide services to victims."*

"Congress created the Crime Victims Fund in 1984 based on the idea that money that the government collects from criminals should be used to help those victimized by crime . . . . In FY 2015, the CVF distribution was $2.3 billion and in FY 2016 the distribution was $2.6 billion"

"Unlike state and territorial governments, who receive an annual formula distribution from the Crime Victim Fund, Indian tribes [and Alaska Native villages] are only able to access these funds via pass-through grants from the states or by competing for very limited resources administered by the Department of Justice. **According to DOJ, from 2010– 2014, state governments passed through 0.5% of available funds to programs serving tribal victims—less than $2.5 million annually nationwide. In 2013—the year with the highest number of state subgrants to date—more than 60% of states with Indian tribes made no subgrants to tribal programs**."

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(ii) Jurisdictional Issues

The "maze of tribal, state and federal law" that the Amnesty International report cited continues to exist, and providers we interviewed cited the importance of understanding the complex interplay of federal, state, and tribal jurisdictions pertaining to law enforcement and public safety, adjudication of criminal justice, and punishment of offenders. Thus, Roadmap for Making Native America Safer, the November 2013 report by the federally chartered Indian Law and Order Commission, concluded that

> *"**Criminal jurisdiction in Indian country is an indefensible morass of complex, conflicting, and illogical commands, layered in over decades via congressional policies and court decisions and without the consent of Tribal nations. Ultimately, the imposition of non-Indian criminal justice institutions in Indian country extracts a terrible price: limited law enforcement; delayed prosecutions, too few prosecutions, and other prosecution inefficiencies; trials in distant courthouses; justice system and players unfamiliar with or hostile to Indians and Tribes; and the exploitation of system failures by criminals, more criminal activity, and further endangerment of everyone living in and near Tribal communities.** When Congress and the Administration ask why the crime rate is so high in Indian country, they need look no further than the archaic system in place, in which Federal and State authority displaces Tribal authority and often makes Tribal law enforcement meaningless."* (Executive Summary p. ix)[43]

> *"Problems with safety in Tribal communities are severe across the United States -- but they are systemically worst in Alaska.[44] **Most Alaska Native communities lack regular access to police, courts, and related services. Alaska Natives are disproportionately affected by crime, and these effects are felt most strongly in Native communities. High rates of suicide, alcohol abuse, crimes attributed to alcohol, and alcohol abuse-related mortality plague these communities**. In Alaska's criminal justice system, State government authority is privileged over all other possibilities: the State has asserted exclusive criminal jurisdiction over all lands once controlled by Tribes, and it exercises this jurisdiction through the provision of law enforcement and judicial services from a set of regional centers, under the direction and control of the relevant State commissioners. This approach has led to a dramatic under-provision of criminal justice services in rural and Native regions of the State."* (Executive Summary p. xii)

A 2013 VAWA reauthorization gave tribal courts the authority, starting in March 2015, to prosecute domestic violence cases when defendants are non-Native and assuring that civil orders of protection

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[43] A February 2013 National Congress of American Indians (NCAI) Policy Insights Brief highlighting data from Bachman et al. (2008)'s report to the U.S. Department of Justice, entitled "Violence Against American Indian and Alaska Native Women and the Criminal Justice Response: What is Known," noted that (a) "The death rate of Native women on some reservations is ten times the national average;" (b) "34 percent of American Indian and Alaska Native women will be raped in their lifetimes, compared to 19 percent of African American women, 18 percent of White women, and seven percent of Asian and Pacific Islander women;" and (c) "Among Native women victims of rape or sexual assault, an average of 67 percent describe the offender as non-Native."

Futures Without Violence (2010) observed that this "rate of inter-racial violence [is] five times the rate of inter-racial violence involving other racial groups," pointing, in part, to the "jurisdictional complexities and limitations in Indian Country," resulting from federal legislation and Supreme Court decisions (Oliphant v. Suquamish Indian Tribe and Duro v. Reina) that until corrective 2014 legislation, deprived Native American law enforcement and courts of the authority to prosecute non-Native perpetrators for crimes committed on Native land (Taylor, 2015). As described in Harper, Entrekin, & Hart (2006), "This inability of tribes to adequately deal with violence against their female citizens, coupled with the reluctance of [federal and state] government agents who do have the power to prosecute the perpetrators of violence against Indian women, has created a clear message to abusers that such behavior will go unpunished." (p.8)

[44] See also Horwitz (2014), In Remote Villages, Little Protection for Alaska Natives

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against abusers be recognized in every U.S. state, including on tribal lands. Follow-up amendments in 2014 extended these provisions to Alaska Native Courts (Taylor, 2015).[45]

Other recommendations of the commission have yet to be acted upon.

Harper, Entrekin, & Hart (2006) traces *centuries of murder, exploitation, and persecution of Native Americans, followed by 70+ years of forced assimilation via mandatory children's attendance at Boarding Schools*. Accompanying these policies were laws -- The Major Crimes Act of 1885, PL 280 (giving certain states criminal and civil jurisdiction over Indian Country), and the 1968 Indian Civil Rights Act -- and a 1978 Supreme Court decision (Oliphant v. Suquamish Indian Tribe) that *left tribal nations "powerless to criminally punish non-Indians who ... commit domestic or sexual violence against Native women" on tribal land.* In turn, "the federal government rarely prosecut[ed] domestic violence and sexual assault cases arising in Indian Country. Similarly, state governments with jurisdiction pursuant to Public Law 280 rarely prosecut[ed] these crimes by non-Indians." (p.10, citing Goldberg & Champagne, 1996).

As noted, earlier, it is hoped that amendments to VAWA 2013 finally restoring tribal authority to prosecute such crimes, will eliminate the impunity with which women are victimized. However, as described by the aforementioned Indian Law and Order Commission, there are still issues of serious under-funding of tribal law enforcement and courts, which will need to be resolved before tribes are truly in a position to protect the safety of women.

Harper, Entrekin, & Hart (2006) note that *one of the important contributions of VAWA and its 2000 and 2005 reauthorizations was establishing that any valid civil or criminal order of protection issued by a state or tribal court "shall be accorded full faith and credit" by court in other states or tribes, and "enforced as if it were the order of the enforcing State or tribe*." (p.13) However, as of the 2006 date of publication of their Guide, there were *multiple barriers to the effectiveness of this statute*, including the relatively poor access of Native women to legal resources; limited access to tribal courts with pro se forms to assist unrepresented women; inconsistency among tribal and state jurisdictions in honoring tribal orders of protection; lack of a national tribal registry for protection orders; inconsistent availability of adequate infrastructure to enable tribal protections orders to be entered into the federal registry for protection orders; some tribes' outdated rape or sexual assault laws that require proof of violence or force (instead of lack of consent), and that still exempt a married man from being prosecuted for raping his wife; and lack of tribal resources for enforcement, prosecution, adjudication, and incarceration of perpetrators. The authors also note that "The small size of a tribal community may also pose problems," to the extent that gossip about the victim, breaches of confidentiality, the status of the alleged perpetrator's family within the tribe, or the interrelatedness of the alleged perpetrator with prominent members of the tribe, the judge, law enforcement personnel, etc. can compromise the pursuit of justice and endanger the survivor.

(iii) Sexual Exploitation and Trafficking: A Minnesota Example

Historical Context: The Minnesota American Indian Women's Resource Center's *Shattered Hearts: The Commercial Sexual Exploitation of American Indian Women and Girls in Minnesota*, hereafter (MIWRC, 2009), traces the violence and persecution and suppression of cultural norms of Native Americans, and the exploitation of Native American women, during colonization, western expansion, the Boarding School era, the establishment and relocation of Native Americans to reservations, the broken promises behind relocation of Native Americans to cities, federal dissolution of legal

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[45] The website of the VAWA Sovereignty Initiative of the National Indigenous Women's Resource Center and Pipestem Law provides current information about the status of their efforts in "defense of the constitutionality and functionality of all Violence Against Women Act ('VAWA') tribal provisions."

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agreements and erosion of tribal authority, involuntary sterilization, and the Indian Adoption Project -- all adding to *generations of historical trauma and contributing to current levels of social dysfunction including disproportionate rates of domestic/sexual violence*. (pp. 4-13)

Deer's (2010) *Relocation Revisited: Sex Trafficking of Native Women in the United States* chronicles how Native women were enslaved, raped, and sexually exploited from the earliest days of the European occupation of North America, up until and including the sexual abuse of children in the Boarding Schools, and how that *pattern of oppression set the stage for the present-day overrepresentation of Native women among the victims of sex trafficking*:

> *"Trafficking in the United States long predates the current legal regime in power; the tactics used by sex traffickers today were used against Native peoples from the first moment of contact. These tactics were pioneered by the Spanish and Portuguese, the French and the English, the Dutch and the Russians. All of these invaders colonized the "New World" and its occupants. Colonial legal systems historically protected (and rewarded) the exploiters of Native women and girls and therefore encouraged the institutionalization of sexual subjugation of Native women and girls. This dynamic continues today, albeit in a different guise."* (pp. 628-629)

Current Situation: MIWRC, 2009 explores the widespread and disproportionate involvement of Native women and girls in prostitution and trafficking (by boyfriends, individual pimps, gangs, and families); the early age (14-15) of girls' entry in to that world; the precursors to such involvement -- incest, rape and other sexual assault; physical and sexual abuse at home[46,47], leaving a foster home or running away from parental home and becoming homeless[48], early involvement in the "booster economy" (the sale of illegal goods), survival sex (food, shelter, transportation, etc. for sex), stripping, nude dancing, escort services; the "recruitment" process; and gang raping as "initiation." (pp. 36-53) "Advocates reported that Native girls' frequent exposure to violence, abuse, and commercial sexual exploitation in their homes their peer groups, and communities, tends to normalize these behaviors... [and] often lead[s]

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[46] "Studies in the U.S. have found that 60-73 percent of youth in prostitution and 55-90 percent of adult women in prostitution were sexually abused at home . . . . Physical abuse at home has also been identified as a major risk factor for youth entry into the sex trade. The 2007 rate of American Indian child maltreatment reports in Minnesota was more than six times their proportion in the population, and American Indians also had the highest rates of recurring maltreatment at six- and twelve-month follow-up." (MIWRC, 2009, p.60) "In the 2006 Wilder Research study of homelessness in Minnesota, 40 to 50 percent of Native girls and women disclosed physical or sexual maltreatment or parental neglect as a child. Native girls and younger women frequently cited not feeling safe from violence in the home or abuse by someone in the household as the reason for their current homelessness." (p.64) In that same 2006 Wilder Research study, "almost half of the homeless non-reservation Native women ages 18 to 21 reported having been in an abusive relationship, and the same proportion reported staying in one because they had no other housing." (p.67) Also in that Wilder study, "over half (56%) of the Native girls age 21 and younger described their parents" drug and alcohol use as the partial or main reason they were currently homeless." (p.74)

[47] Farley et al.'s (2011), *Garden of Truth: The Prostitution and Trafficking of Native Women in Minnesota* is a devastating report on prostitution and trafficking of Native women in Minnesota, informed by detailed interviews with 105 Native women involved in prostitution. Their research indicated similarly high levels of childhood victimization: 79% of the women they interviewed had been sexually assaulted as a child, by an average of four perpetrators. (p.3)

[48] "In the 2006 Wilder Research statewide study of homelessness, non-reservation American Indians represented 28 percent of the unaccompanied homeless youth ages 17 or younger in outstate Minnesota and 12 percent in the Twin Cities area, though they are only two percent of Minnesota's youth population. Sixty percent of non-reservation homeless Native girls 17 and younger reported having left home to be on their own by the age of 13. Over the years that the homelessness survey has been conducted (every three years since 1994), there has been a significant increase in the proportion of American Indians among unaccompanied homeless youth, from 10 percent in 1994 to 20 percent in 2006." (MIWRC, 2009, p.59) In that same Wilder study, "56% of the Native girls age 21 and younger described their parents' drug and alcohol use as the partial or main reason they were currently homeless." (p.74)

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them to view threats to their safety and sexual exploitation as 'no big deal' . . . . Other advocates described some prostituted Native women and girls that viewed freelancing, prostitution without a pimp ... and/or working with other women in a collective group as a way to empower themselves [and] have some control over their lives." (pp. 67-69)

The authors state that "most American Indian women and girls in the sex trade have not completed high school, so they rarely have marketable job skills or a formal employment history. Though 90-95 percent want to get out of the sex trade, most do not feel they have any other realistic options for earning enough money to survive." (p.91).

(MIWRC, 2009) reviews some of the other barriers, including distrust of law enforcement; distrust of advocates; community unwillingness to discuss sexual exploitation and trafficking, particularly when they know the families involved; inadequate and/or inappropriate support from the mental health system (e.g., misdiagnosing as bipolar disorder or schizophrenia what is actually a symptom of chronic or complex trauma and the dissociation that allowed the women to survive the repeated trauma; the absence of a culturally relevant model and training for serving Native women and girls who have been prostituted; and, in general, insufficient services). (Based on Canadian studies of commercial sexual exploitation, the authors estimate that girls and women make up 75-80% of the victims, and that boys, Two-Sprit, and transsexual individuals make up the remaining 20-25% of victims. (p.113))

The authors observe that "These victims have known nothing but exploitation most of their lives, so are very reluctant to trust any program or organization that applies limits or makes demands; the most useful and effective services have the fewest requirements, and focus on 'meeting victims where they are.' " (p.116) They recommend that services be staffed by culturally competent persons, have few requirements, and be funded over a sufficiently long timeframe, so that survivors have enough time to make a final decision to separate themselves from the sex trade, and enough time to build the skills and stability they need to avoid returning to prostitution.

Rather than requiring a diagnosed mental illness to qualify for housing, the authors call for people attempting to exit the sex trade to have equal priority as persons with mental health diagnoses. They call for opportunities and support (e.g., mentoring, child care, flexible hours) for finishing high school; tailored employment services; the provision of "culturally based healing that holistically addresses chemical dependency, mental illness, and sexual trauma;" and "healing centers where victims and families can re-integrate into cultural healing and build pride in cultural identity." (p.118)

Note: *The disproportionate involvement of Native American girls and women in the sex trade is not limited to Minnesota, and was raised by several providers serving Native American communities*:

- A May 24, 2015 report in *Indian Country Today* notes that: "In Hennepin County, Minnesota, roughly 25 percent of the women arrested for prostitution identified as American Indian while American Indians comprise only 2.2 percent of the total population. In Anchorage, Alaska, 33 percent of the women arrested for prostitution were Alaska Native, but Alaska Natives make up only 7.9 percent of the population. Canadian studies show similar results. In Winnipeg, 50 percent of adult sex workers were defined as Aboriginal, while Aboriginal peoples comprise only 10 percent of the population; and 52 percent of the women involved in the commercial sex trade in Vancouver were identified as First Nations, while First Nations people comprise only 7 percent of the general population." (Sweet, 2015).

- A March 9, 2016 report in *Indian Country Today* states that "[the] South Dakota Assistant U.S. Attorney noted that more than 50 percent of the sex trafficking cases prosecuted over the past five years by the South Dakota State's Attorney's office involved Native victims, an astonishing number." (Pember, 2016)

- Additional examples of the problem are reported in Alaska, North Dakota, and South Dakota.

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(iv) *Overview of Providers' Comments on Providing Transitional Housing to Native American Survivors*

OVW-funded programs serving Native Americans and Alaska Natives are set up differently in different parts of Indian Country. Some programs are based on a reservation and operated by the tribe. Some are housed outside the reservation and operated by an association of tribal members, but not by the tribe itself. And some are operated by a non-profit agency that serves a broad range of survivors, including but not specifically limited to tribal members. Although their tribes may have different structures, geographies, histories, and resources, providers described similar challenges and strategies.

First and foremost, providers described the *importance of Native survivors being served by Native staff who understand the traditions and customs that are important to the survivors, and that can provide grounding and relieve some of the trauma*. Nearly all providers talked about *pressure on the survivor from the community to return to the situation she fled, in order to keep the family intact, especially if the survivor fled with her children.* Several providers noted that because there are often multiple connections between the extended families of the survivor and her abusive partner, that pressure can come from both the abusive partner's family and the survivor's family.

In some cases, several providers told us, DV survivors had previously been sexually assaulted, often by a member of the extended household, often under circumstances involving substance abuse -- so that these *survivors' decisions to flee the domestic violence may, in part, have been a decision to protect their children from the kind of sexual violence and trauma that they experienced as younger women*.

Like many other survivors with limited employability and few resources to draw from, Native American survivors face difficult odds finding housing they can afford. On the one hand, they may be reluctant to relocate to other housing on the same reservation where they were victimized -- even if that housing is the only subsidized tribal housing for which they are eligible. They may instead want to relocate to another reservation, where they can at least live among people who understand, support, and practice some of their customs and traditions, but they may not be able to find housing they can afford there.

Although urban areas may offer more affordable housing, survivors may lose access to the free health care that they and their children are entitled to as Native Americans, if they don't live on a reservation. (There are a few urban areas where there are Indian Health clinics.) If they don't live on a reservation, they may also not be able to send their children to Indian schools, unless they board their children on a reservation, which would isolate them from their children, as well as extended family and community.

These providers told us that *culturally competent Native staff are the best people to help survivors navigate these kinds of difficult tradeoffs and choices*. Some of the providers also cited the importance of workshops that help survivors put the violence they experienced into historical context -- helping them understand that the sexual and domestic violence that they may have experienced is not a Native tradition, but an outcome of oppression and cultural violence that has been perpetrated over many generations against Native peoples; of the poverty and substance abuse that filled the vacuum created by extremely high unemployment; and of the loss of traditional roles for young tribal members.[49]

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[49] Artichoker & Mousseau (2006) explain how *violence against Native women is not traditional, and how it is a consequence of displacement of Native egalitarian traditions by the hierarchical power structure of non-Native society*, in which, "someone is always above someone else and the person above has the power. . . . White people are above people of color, heterosexual people are above homosexual people, adults are above children, the healthy are above the sick, the rich are above the poor, etc. In the family, the one usually seen as above or the boss, is the man/husband. Many have come to believe that this triangle or hierarchy is the natural order: 'someone's got to wear the pants in the family.' Hierarchy only exists through violence and power. . . . Our ancestors lived in a Circle. In the Circle ... everyone has equal power and importance. We may be at different places in the Circle, but no one is above anyone or anything else. . . . To end violence, we must return the Circle and share power in our relationships...." (p.28)

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While they are in shelter, safe housing, or transitional housing, protecting survivor confidentiality is a significant challenge, as it would be in any close-knit community where people know each other well, and many families are interrelated. One provider spoke about how denying the request of a family elder for information about the survivor is a violation of one of the most important cultural norms in Native society, namely honoring and obeying elders -- but something they train their staff to do.

Finally, as mentioned earlier, providers suggested that experienced ***Native advocates are the best people to help survivors navigate the jurisdictional maze to obtain an order of protection or to prosecute the perpetrator of the violence, if that is the course of action they wish to pursue***.

As logistically challenging as serving Native American survivors in the Lower 48 states can be, it can be even more difficult serving Alaska Natives. A few paragraphs of the aforementioned Indian Law and Order Commission's November 2013 "Roadmap" report sheds light on some of the challenges:

> *"Forty percent of the federally recognized tribes in the United States are in Alaska, and Alaska Natives represent one-fifth of the total State population. Yet these simple statements cannot capture the vastness or the Nativeness of Alaska. The State covers 586,412 square miles, an area greater than Texas, California, and Montana combined. Many of the 229 recognized tribes in Alaska are villages located off the road system, often resembling villages in developing countries. Frequently, Native villages are accessible only by plane, or during the winter when rivers are frozen, by snow-machine. Food, gasoline, and other necessities are expensive and often in short supply. Subsistence hunting, fishing, and gathering are a part of everyday life. Villages are politically independent from one another, and have institutions that support that local autonomy -- village councils and village corporations. Unsurprisingly, these conditions pose significant challenges to the effective provision of public safety for Alaska Natives.*

> *Problems with safety in Tribal communities are severe across the United States—but they are systemically worst in Alaska. Most Alaska Native communities lack regular access to police, courts, and related services. Alaska Natives are disproportionately affected by crime, and these effects are felt most strongly in Native communities. High rates of suicide, alcohol abuse, crimes attributed to alcohol, and alcohol abuse-related mortality plague these communities.*

> *In Alaska's criminal justice system[50], State government authority is privileged over all other possibilities: the State has asserted exclusive criminal jurisdiction over all lands once controlled by Tribes, and it exercises this jurisdiction through the provision of law enforcement and judicial services from a set of regional centers, under the direction and control of the relevant State commissioners. This approach has led to a dramatic under-provision of criminal justice services in rural and Native regions of the State." (p. xii-xiii)*

One of the interviewed providers described the tremendous dislocation attendant to fleeing abuse and seeking services: ***when a woman from one of these Native Alaskan villages has to escape an abusive relationship, she needs to be flown out to one of the network of providers; she could end up hundreds of miles from her community. Having lived all her life in a tiny subsistence village with no roads, no traffic, and no plumbing, her program residence could be in a modern building on a street with more people than live in her entire village.***

(h) Provider Comments on Serving Racially-Ethnically-Linguistically-Culturally Diverse Survivors

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

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[50] Until the 2014 amendments to the 2013 VAWA Reauthorization Act, restoring authority to tribal police and courts.

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(#01) There have been a lot of educational campaigns around the country that really made it easier for DV survivors to come forward and talk about their experience and to identify themselves as survivors. It is much harder, I think, for immigrants to come forward because that kind of normalization -- how it's not their fault, looking at DV as a public health and public safety issue -- has not happened in the immigrant community. There haven't been consistent campaigns like that in immigrant communities, and if there was one during a given period of time, there are newer immigrants who may not have been reached by that earlier campaign. And members of small non-English-speaking ethnic groups with more limited community infrastructure – few or no established community based organizations or ethnic media -- are even harder to reach. So there are still misconceptions and there's still a stigma.

There are two different deportation-related fears among immigrant victims. Abusers often threaten to have them deported, so they'll never see their children again, because of their immigration status. That's a big issue that hotline callers always want to talk about. The other fear is about deportation of the abusers. Everyone who's in a DV situation wants the abuse to stop. Not everyone wants the father of their child and often the sole provider to go to jail and possibly be deported. And deportation for the Asian and Pacific Islander (API) community means being sent very far away, so the likelihood of coming back is minimal.

We could have a shelter full of people from the same API ethnic group, but their individual life experiences are going to make them very different from each other -- even if they're all DV survivors. So we try to work with them as individual families and get to know them and figure out what they're interested in with respect to employment or job training or where they are hoping to live. We try to not only provide a space for healing, but also to make sure they know they have options, including options they maybe didn't think they had.

Our transitional units are clustered in two buildings, in which two families share each 2BR apartment. If a family that's staying with us has a challenge with another participant, we encourage them to talk directly to that person about the issue. In a lot of API cultures, it's not a cultural practice to do that. API communities can be kind of indirect sometimes with their communication. If they're not ready to address that person, we ask them what will help. Will talking about it more with staff help? Do you need other strategies to prevent it from happening again? And we tell them that if the problem continues, we can explore that again. We have conversations with families about how to understand people of different shapes and sizes and how to create a community together. And if you really just don't get along with someone, how you can still stay cordial?

One thing we do really well at our agency is provide a lot of training and open discussion about our own culture. We talk very openly about what we see as common cultural practices in our own homes and with our families and how that might either influence us at work or play out in conversations with the survivors. For example, if you're a young staff and you work with an older survivor, how would that relationship be for you?

We see culture as more than ethnicity. We also look at age and socioeconomic status. And we engage the participant, and ask them to tell us what about their culture they want us to know so we can best serve them.

Language is huge. It's not just being able to communicate, but there's so much cultural context to the words. You may think you're talking about the same thing, but you may not be, because of the cultural orientation of the word. That's why 90 plus percent of our staff are bilingual and bicultural, and cover 14 or 15 API languages and dialects. And we also have a language bank of over 100 volunteers, 80% of whom are bilingual/bicultural. Aside from having interpretation available at meetings, we also try to make sure that all our notes to families and written information is translated. So we also have a lot of volunteers who not only speak the other API languages but also can read and write them, which allows us to have other ways to communicate to families.

(#02) If a survivor is undocumented or in the process of applying for a U-Visa, they have added challenges in getting housing, because a Social Security card, a birth certificate, and documentation of income are often required for permanent housing; and if they are working off the books, they have no verification of income.

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(#03) We're in the Bible Belt, and their religious beliefs can keep them in abusive situations. Victims coming forward is also a major challenge in our Native American community. Domestic violence and stalking are taboo subjects. There is fear of leaving home and reluctance to reach out for services.

(#04) I think the most challenging population is undocumented women because they're under the radar. They can't get legal employment, they can't get housing without IDs. We work very closely with Legal Aid and if there's any chance that an undocumented woman can qualify for a VAWA self-petition or a U visa, we go with that approach. Unfortunately, a lot of women we serve will never be able to be legally documented, unless the federal government fixes the immigration issue. We can't say, "You need to find a job where you get paid under the table," but that's what ends up happening with a lot of women. It's very frustrating.

(#05) About 40% of our clients are Latino. Their real challenge is residency. If they're eligible, we'll work with them on the Visa process; that's a long term process, but we have legal advocates who work closely with attorneys and can facilitate that.

If you're undocumented, concerns about how you will support your kids without your abuser -- particularly if he is documented -- are a huge barrier. Often Latino clients go from one abusive partner to the next because they're worried about, what if they get caught? If the children are citizens, then there's more leeway. Fear of deportation is also a huge barrier. Access to mainstream benefits becomes a barrier, because safety nets aren't designed for people who are undocumented, even if their children are citizens. There's a lot of economic exploitation because they have to work under the table. They can have their earnings stolen, or not be fairly compensated, or have the rules for their compensation change. We have a lot of clients that do migrant farm work, and there's a lot of sexual exploitation.

And no one will rent to someone without papers in our community. If someone won't rent to you and you can't get a job, those are huge barriers.

(#06) There are special challenges with the immigrant population. If we don't speak the language or if there are cultural issues we don't understand, we utilize some of the cultural organizations around us. We have a lot of immigrants from Africa; we have a great center here that we utilize, whether we need to learn something about the culture or need an interpreter.

(#07) Our area has a small migrant farm population, some of whom end up staying. If an undocumented woman marries a citizen and there is domestic violence, then when she flees, she doesn't have resources. We can work around it if she doesn't speak English very well, but lack of documents is a huge barrier to housing.

We don't typically get much cooperation from law enforcement to get the documentation they need to apply for a U Visa. That's been a real struggle, which is why our OVW grant specifically focuses on immigrants and refugees -- because we know they need a longer time in transitional housing, and a higher level of services.

We house them in transitional apartments which are all rented in our agency's name because they can't get units in their own names; if they need extra time because they're in the process of getting a U Visa, they sometimes move into our agency-owned units for a little while. It's just really hard to connect them to resources. I think that some of the more recent activity of ICE, particularly in our community, has scared people. They endure the violence -- both sexual assault and domestic violence -- because they're afraid to come forward and risk deportation. They're fearful of engaging with any kind of government-connected agency, and we get government funding. We would never report them, but they don't know that.

We have an ongoing relationship with a Hispanic organization that provides services to the migrant population, and we make referrals back and forth with them. They are perceived as safer to approach by

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undocumented folks who might never come to us directly. If they come to that Hispanic organization, staff there can make a warm referral to us with assurances, and they can explain what we do and what we won't do. So we let that more trusted provider be the front door for our service.

(#08) If immigrants have come over legally, there usually are restrictions on their visas that say they won't access the public welfare system for X years. If their partner was the person with documentation, we have to advocate to allow her to get services for her and her kids, because "she didn't choose to be in this situation," while we help her through the U-Visa or T-Visa process. We try to put participants in touch with informal networks that are supportive but won't push them back toward their abusers.

Women from the mainstream understand protective orders much better than immigrants; with an immigrant, you have to explain that "there's no deportation involved," and that "Child Protective Services is not going to give the children over to him just because he's the head of the household."

(#09) The Vietnamese and Korean communities are very tight-knit, so one challenge we face if we have to use an interpreter is confidentiality, e.g., an interpreter seeing and acknowledging a client in the community. We try not to have these conversations by phone because we don't know where an interpreter is from. Another challenge is if the interpreter is not interpreting verbatim. Most of our participants speak some basic English and tell us if the interpreter isn't interpreting correctly. Most of the time, if that happens, we notify the interpreter service and ask for a different interpreter. Most of our clients prefer female interpreters.

(#10) We hired someone who is not bilingual, so it has been challenging to serve limited English-proficiency clients. They require our creativity and funding to bring interpreters and translators. If we don't have bilingual staff down the road, we might not be able to serve limited English-proficiency applicants.

(#11) I think 99% of the clients are foreign-born immigrants who came to the US, but generally don't have papers, so we have to work on linking them to the lawyer program to get a U-Visa or VAWA Visa. But because it takes a year or more to get the visa, it's hard to find a stable job for them while they are in our program.

(#12) Some of immigrant clients have lived in isolation under their abuser for a very long time. The abuser didn't allow them to do anything, so it's a challenge for them to live on their own and do things for the very first time without somebody telling them what to do or how to do it. They don't speak English; they may not even be literate in their own native language. We serve participants who have to start with the basics. So we reach out to our community partners who have served people from that language group before, and find out what they did or who they connected them to, and then we take it from there. For example, we have a large Egyptian community here that we have reached out to for help working with Egyptian families.

Before we reach out to any organization on behalf of a client, the client must sign a confidentiality agreement. We once asked a Somali family we were serving if we could reach out to people in her community, and she said, "No," because that would help her abuser find her. So we had to find an alternate way to work with her.

(#13) We've had a huge influx of South Asian people. They've been particularly challenging in that they want us to find them housing, but they're very private and don't want to engage in case management. Women come to us who have been in extremely abusive situations, and then they get pressure from their family and they leave, and that's hard for staff to watch. We went to a helpful conference run by South Asian folks. It comes down to meeting people where they are. If they're not ready, we need to be okay with that.

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(#14) We always have access to telephone interpreters, but it's just not the same. I can have a phone conversation with someone, but so much of communication is non-verbal, and they can't see my face or body language. And sometimes interpreters don't quite say what you're saying. We work hard to make sure that we have bilingual/bicultural staff to provide services to participants. It goes so far with building trust and building relationships. I think we do a pretty good job, but we also partner with other community agencies because we can't possibly represent the full diversity of people.

(#15) One of the most important steps is budgeting money for interpreter services because if we don't provide language access, we're not going to be able to provide a good quality of services to someone who doesn't speak English. We're fortunate in our city to have access to a lot of different interpreting services. But it's sometimes hard to find an appropriate local interpreter for some languages, and that has led to the less desirable, but sometimes necessary, telephone interpreting.

(#16) There's a Native American reservation smack in the middle of our service area, and we work very closely with their domestic violence victim services program, which also has funding for housing assistance for tribal members. We help them structure their rental assistance program. It's pretty much the same as our transitional housing. So sometimes if we get women in the safe shelters, if they're a tribal member, we can then refer them to the outreach program operated by the tribe for housing, for advocacy, or for counseling. If they're a tribal member, or a member of another tribe that's living here, even if they're not a tribal member, they can be affiliated with their housing program. And if a tribal member isn't comfortable accessing assistance through the tribal program, they can come to us. So hopefully nobody's slipping through the cracks.

(#17) We served a Hindu woman from Nepal who doesn't speak English. She's learning, but I've learned a lot from her. I asked her about who in the community she trusts and who has been her helper. And she introduced me to those people. If she wants, she can invite those people to our sessions to help with communication. She always has access to the language line, as well.

(#18) (Not a current OVW grantee) I think the major difference in serving women from the reservation is the cultural piece. I don't think our services are really that different from anybody else's emergency shelter, court advocacy, or transitional housing. The difference is that cultural piece, the trusting piece, and my understanding of how things work, because I am Native, because I've been there. I went to the boarding school right down the road. I'm from here, and people know me, they know my family, and there's a certain amount of trust and understanding of what a person goes through living on a reservation, the family dynamics, and how a lot of families are related.

When I have to emergently shelter a victim, I use the local hotel, which is the tribal casino. We try very hard to accommodate victims and their children, and fortunately have a very good collaborative relationship with the casino. The perpetrator's family may be working there; they might even be working security, or surveillance. Tribal or family politics can become a big factor when everybody lives and works in a small, remote area.

The number one reason why I wrote the application for the transitional housing grant was because of our lack of housing and because I saw how many of my clients were having to go back to the abuser. Because they didn't have a job, they were never allowed to work, or they had no place else to go. They might be from another Reservation or another tribe, so they would be dependent on the abuser's tribal affiliation for access to housing here. There was no housing available or no place for the victim and her children to go.

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(#19) (Not a current OVW grantee) One of the biggest challenges is trying to establish legal status for a client. Sometimes they come in, and they're not aware of their options. Sometimes they made decisions that can no longer be taken back, and they're not able to take advantage of those options. For example, if there was a domestic violence incident, and the victim withdrew the charges, she can no longer have a U-Visa or have her work permit through VAWA because she dropped the charges. Maybe she was afraid, or given the wrong information. But at that point, there's very little we can do for them.

(#20) (Not a current OVW grantee) A lot of our participants were immigrants who came here to work in the factories; they married local men who were U.S. citizens. Many of them got abused, but many of them did well – just like anywhere else. Many of them still don't speak English very well or at all. And they don't have the family support system that an indigenous woman might have. And if they're immigrants, they don't have permanent status; only humanitarian parole to stay on the island because they have U.S. citizen children. So we help with VAWA petitions, self-petitions for transitional housing clients. We do T visas, and U visas, we do it all for immigrants, depending on what they need. We have staff who can speak most of their languages. Right now, we don't have staff who speak Chinese, so we've had to work with translators. But, the economic opportunities here are very bleak; most of the women we serve don't have much education and skills, they'll be waitresses or cooks or store clerks. If they can get themselves going, they can maybe go back to school.

(#21) If a survivor comes from a tightknit immigrant community and doesn't speak English, it seems like they face the choice of moving into the mainstream and being isolated or moving back into their community and being back in the circle of their abusive partner. We have assisted a victim in relocating out-of-state, and we have transported, through our rural advocates, victims from one side of the state to the other.

If someone doesn't speak English, we can go to Lutheran Social Services, and see if they can get into the English classes. It could be that their partner didn't allow them to go to English classes - which happens frequently, because it is such an effective way to isolate someone. Or maybe, their partner allowed them to go, but only with that partner. Or maybe they're working at the same job. Our programs advocate to help them obtain a different class time, a different shift, a different job. A lot of time, there's huge pressure on non-English-speaking survivors to go back, rather than to find independent housing. If we get them into Transitional Housing, they may still feel isolated from their community, because that's the community that speaks their language. And trying to find the employment they need to maintain their housing is very difficult — especially if they're undocumented.

(#22) Sometimes a survivor will leave the reservation to go to housing or shelter somewhere else. We've heard, for years, comments that "I can't go to the tribal shelter, because my spouse's cousin works there." We're very aware of some of the politics that goes on in tribal areas that can jeopardize a victim's safety. Sometimes it's a better alternative to leave the reservation, the tribal area, for at least a while, to find emergency housing. But ultimately, of course, they want to return because that's where their family is, and that's where they're enrolled. It's a very difficult choice. And depending on who their relatives and family members are, and how connected they are to the perpetrator's family, it could be very dangerous for them to stay or return to the reservation.

(#23) Leaving the reservation to come to our shelter or transitional housing can be very difficult, especially for women with children. When they leave the reservation, they also leave behind the children's aunties and grandmother, who have typically helped with caregiving since the children's births. So they are leaving their entire support system and coming to a place where they may not know anyone. It might be the first time they've ever left the reservation. We wanted to make sure we were doing everything we could to provide a

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supportive environment for these women, and we convened focus groups with some of our Native American participants and asked them for feedback about what we could do.

Over time, we've hired Native American staff, incorporated Native American arts on the walls, Native American foods in the kitchen, and the traditional practice of smudging to cleanse the body and the soul. Over time, we've also developed a unique partnership with a local tribal college. We provide DV-related training for college staff and security personnel and do classroom presentations about domestic violence for their nursing and criminal justice programs. In turn, they provide dormitory housing for Native American women who are completing stays in our shelter or transitional housing and who are enrolled in their programs, and who might not otherwise be able to find suitable housing while they attend classes.

We've been very fortunate with this partnership to be able to offer our Native American participants the opportunity to register for classes -- and access to campus housing -- not only at the beginning of the school year, but also mid-term. And when women become students at the college and have their housing on campus, they also have access to child care. There's also an affiliated elementary school where children of matriculating students can attend classes. If the women are still actively participating in our shelter or transitional housing, the college furnishes bus transportation to and from the campus.

(#24) We work with families coming out of the FLDS community.[51] The FLDS women that we've served, who've come from polygamous situations, have often been isolated and are determined and strong and, like so many others, seem to be motivated when they recognize the harm or risk to their children, especially teenage daughters. Although they may not have the job skills, they are really hard workers and most of them have been very successful in making that transition.

One of the major issues we face is that the children are fearful that mom's going straight to hell and they're going with her. They're just terrified by being in a different environment, and they miss all the things they had at home. It's a huge shift for these kids.

When they leave the FLDS community, they're basically shunned. They're cut off from everything and everyone they know. Family, friends, and neighbors have absolutely nothing to do with them. Anyone who engages in any contact with them is also ostracized. So they become very isolated and part of the challenge is assisting them to develop support systems.

(#25) When we interview Native American women that are interested in participating in the transitional program, there are some big questions that we ask, trying to find out who they have in the community to help support them when they leave their relationship on the reservation, because we understand that they're often getting called to go back to the reservation, and it's hard to maintain housing here when, for example, you're gone for a week out of every month.

We look for applicants that have more support here in the community, and who are more likely to stay and not leave on a consistent basis; we've had participants that leave to be with family on the reservation so often that they are not able to maintain their jobs, or maintain good grades in school. If somebody tells us that, "yes, it's going to be a huge struggle," and they don't know if they can do it, then we may not choose to put them into the program, based on past experience. We've learned to try to not set somebody up to fail.[52]

(#26) We have a large Hispanic population. I think the language barrier and distrust of the legal system make things very difficult for these clients. Ensuring adequate time to build a relationship, making sure that we have

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[51] Fundamentalist Latter Day Saints

[52] The scenario described by this provider frames one of the "Questions to Consider" at the end of this set of comments.

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someone on staff who speaks Spanish, and working with other community partners who serve the Hispanic population have all been helpful.

(#27) (Not a current OVW grantee) Right now, all our case managers are bilingual. Two of them are bilingual Spanish and one is bilingual Vietnamese. We also have a language access program. For example, when we've served Haitian women or Korean women and needed interpretation, we just reached out to our language access program coordinator. We also have smartphones and computers with hotspots, so we're able to translate for home visits. We've come a long way, even since I've been here in six years with being able to serve anyone in any language.

Everything just takes longer when it comes to serving non-English-speaking participants, because they need a lot more support -- including assistance navigating their interactions with other service providers, government agencies, employment, and housing. There's a waitlist to get into ESL classes pretty much everywhere. That's why we need staff who are able to communicate in their language and be their interpreter, support person, and advocate with all the different resources that we're connecting the women to.

We've become adept at researching and connecting with cultural agencies within the community that can offer guidance in working with these clients and discussing difficult subjects, and to whom we can make referrals. There aren't local agencies that serve all the populations we serve, and we may have to avoid referring clients from some of the smaller cultural communities, because a referral may compromise their confidentiality and safety, if they or their abusers are known by agency staff or volunteers. In those cases, the case managers are comfortable just asking the women about cultural do's and don'ts. And we just Google things or reach out to state agencies for information about DV-certified advocates that speak a particular language. And then we reach out to that advocate, for guidance and resources.

(#28) (Not a current OVW grantee) Last year, we served a refugee family who had no English, and spoke a very unusual dialect. It was very hard to get an interpreter in that language, and it wasn't a written language. It takes a long time to prepare a family like that for life on their own. The advocates helped mom enroll in our local ESL classes. They took her on the bus and explained how it worked. She really tried very hard to learn the language and was very anxious to work. Our legal advocate helped her process her refugee card and get a work permit. We helped her get a job as a housekeeper in a hotel and put the kids in the local school. That woman was just so motivated and life was so much better here than her situation back home, so she just had an amazingly positive attitude.

We have some other East African immigrants who came to us with no English who were extremely traumatized from the abuse they had suffered in their homes here; they had PTSD and their children were acting out and very badly impacted by the violence. The local health system provides counseling and support services for recovery from trauma and violence, but for Medicaid clients, it's often interns and trainees providing the services -- in English, so they need an interpreter. Services in their respective languages are nonexistent. I just think it would be so weird to do trauma counseling through an interpreter. I understand why they say no. But I think they say no a lot of the time because the concept of mental health counseling isn't familiar to them. And if it is familiar, there's a real stigma, even moreso than in the general public. So, none of our East African clients use the services.

We have some Spanish speakers and a Vietnamese speaker in the program but it's very hard to attract staff with the language skills, given the wages we pay -- or the wages for DV advocates generally. Instead, we work with the culturally-specific agencies that work with refugee and immigrant survivors, if the family wants us to. Sometimes they don't want to deal with anyone that they feel is identified with their community.

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(#29) (Not a current OVW grantee) Oftentimes, perpetrators aren't apprehended, so people can't go back to the villages they came from. That's pretty common, especially when you have small villages that have no law enforcement. In the 42 small villages of our service area, there are only 13 village public safety officers. The safety mechanism for victims of abuse is for us to get them a plane ticket here. That's especially true if the victim is seen as "the problem," because "she drinks too much," or "she won't take her meds," or "she's the one always nagging," and the village is unwilling to hold the offender accountable. If the offender is a member of the power family in the village -- the dominant family that runs the tribal courts -- it's that much more difficult to find any kind of relief in their community.

Then, too, Alaskan Native women tend to not get protective orders; they tend to not want the abuser jailed. When you're a woman in the village living a subsistence lifestyle and he goes to jail, who chops the wood? If the village is mad at you because he went to jail and they don't help you chop your wood, it can really be a life or death thing. The systems that work in our urban communities don't necessarily work where they live; we have to figure out what could possibly work in our rural communities to make sure that people aren't further hurt by accountability systems that aren't a good fit.

(#30) Many of our clients identify as LDS.[53] We've seen expansion in the last 10 to 15 years in support from the LDS church in educating their constituents against domestic violence. However, we have an interesting culture here of focusing on the family, probably largely informed by the LDS church, that lends itself to taking care of things in-house. You don't air your dirty laundry in the front yard, so I think that's a cultural barrier. But we haven't seen LDS folks have a hard time leaving an abusive partner once they're ready to do so.

(#31) There's a very strong cultural norm against separating -- that once you're married, you're married. We see that a lot with our Hispanic clients, and that's certainly a factor in the Vietnamese community.

(#32) Part of our service area includes a Native American reservation, and our housing advocate lives there. She is a key link to connecting us with people who may not know about our services or about the options available here. We're always conscious about trying to make ourselves available. People in our field talk a lot about creating culturally responsive services. At the end of the day, we just want people to define for us what they need, and explore whether we can meet those needs. I feel like we have opened ourselves to a lot of people that might not have come here, just because they wouldn't have known that it's safe and open.

(#33) We have a growing population from Santa Domingo and Spanish speaking islands. Transitional housing helped us with some of our challenge in serving these survivors because there was no other place for them to move to from shelter, since they couldn't move into subsidized housing, lacking the necessary immigration paperwork. We let a client stay in the shelter for over a year and a half with her five children because there was no place for her to go. Transitional housing created some opportunities for us to serve that population.

Our community is very diverse. We have a big city-type of population as far as what the mix looks like, but many fewer people. We serve anybody that walks in our door, but we're not big enough to have specific programs, say, for gay and lesbians, or for disabled persons, or for the elderly. It's a very diverse-but-small community, which sometimes makes providing culturally appropriate programs very challenging.

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[53] Latter Day Saints (Mormons)

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(#34) We are a close-knit community so we know who their perpetrators are. We know if there's stalking involved. The safety factor is very good because it's a small program and a small community. Geographically it's huge, but population-wise small. Everybody knows everybody else, so we're able to provide that extra security. Our local law enforcement is real close. And we work real well with our tribal law enforcement, and the BIA law enforcement, and the city law enforcement, and the county law enforcement. We have to work real close with both the tribal court and the state court, because of the jurisdiction issues. It's very important to understand the jurisdictions, and we do.

The issue of jurisdiction on Native American reservations is very challenging: you have to know where the crime took place so that you know whose jurisdiction -- tribal, state, or federal law enforcement -- the crime fell under and which court will address the situation. Will it be the tribal court? The state court? Or depending on the severity of the situation will it go into federal court? The jurisdiction issue is huge. And even though there's supposed to be good faith in terms of the protection orders, a lot of times the state doesn't want to acknowledge a protection order or a restraining order that was issued by the tribal court. And that's heinous as far as I'm concerned. At the end of the day, victim and her children are the ones who suffer from all of this.

We're on state land so we have county and local/city law enforcement. However a lot of times, the incident happened on tribal land, so we have to go back onto tribal land to take the victim to court. We want to make sure the security will be there; that the law enforcement officer isn't a brother or a cousin or a buddy of the perpetrator. These are challenges we confront on a daily basis just trying to do what we're supposed to do.

When it comes to supporting the survivor, there are cultural and language differences that we understand. There are traditional ceremonies and customs that our clients often choose to participate in. We can facilitate getting their family to a ceremony. Our staff understands if we have to pick somebody up after a sweat or after devotions at 1AM or 2AM when it's over. We can provide that support and we understand why it's important -- because it's something you do, especially in a time of chaos in your family, to become grounded and to receive the spiritual and emotional support you need to move forward.

Sometimes survivors will go off to the urban area to get away for safety reasons, but they come back – or they request to go to another reservation because those customs and traditions are not respected in the mainstream, and it's difficult for somebody who's in trauma and really needs that kind of support.

I'll give you an example of one of our challenges. Being an elder is very esteemed in our society; when an elder says, "jump," you ask, "how high?" Often, an elderly female, like the mother or the grandmother of the perpetrator, will call the shelter and want information, and we have to say, "I'm sorry but we can't give that information out" -- as much as saying "No" goes against our cultural values. Confidentiality is a very big issue. Understanding that you're not being disrespectful to the elder, but you're probably saving the person in shelter from the abuser, and also protecting the abuser from doing something stupid and harmful that could put him in prison. When we explain it to our staff like that, they're able to deal with that cultural pressure that can be put on them by an elder. Because we often recognize the voice on the other end of the phone. And we have to be very careful who we talk to, where we go in public, because people are seen all the time.

There may also be a lot of pressure for a survivor to return, coming from her family or from members of the perpetrator's family. One of the great things about the advocates - they're there to listen when a woman is facing those challenges. And sometimes a woman will request to leave the area to get away from the pressure to go back, and we help facilitate that as much as we can. It's very difficult because there's often pressure not only from his family but also from hers, because the kids are involved, and they're not realizing, "is that really the best situation for the children and the woman?" It takes a lot of community education and, for lack of a better word, counseling, so that the woman can make a decision that will benefit her and her children.

Sometimes we can help with a transition to a different reservation so she isn't losing access to the cultural aspects, but is at least removed from the situation. If she goes to another reservation, she can also keep her family's access to health care, through the Indian Health Service, which she might lose if she goes to an urban area. When she gets on Title 19 (the Urban Indian Health Program) she has to wait until all of those papers are

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complete and the service kicks in, so that both her and the children can have healthcare. But that's only for families that have a low enough income; in the meantime, she has to find a job so she can pay for housing, and she's got a whole lot of challenges to address. All of a sudden she has to pay for insurance because she's off reservation, and Indian Health Service does not extend unless there's an urban Indian clinic, which there isn't always in an urban area.

Then, there are issues with the educational system. Is she going to leave her children, put them in boarding school so the father has access to them or is she going to take them with her, get them into a school on that other reservation? There's just a lot of things to be worked out when she leaves the area -- health coverage, whether to take the children with her and get them into a school on that other reservation, etc.

What about housing? How long can she stay in the shelter on that reservation -- some of them have limits. Do they have transitional housing, and is there an opening? There probably is not an opening for her to get tribal housing on another reservation, because some tribes only provide housing for their own members. And that's a huge issue because there's such a lack of housing. So we work with them so they understand that they have a choice but that it's not going to happen overnight, and that they're going to have to work at it. If they stay in our shelter, they may have to stay longer than 30 days until they can get their own place and begin their transitional housing. We've had women stay in shelter for six months. It's very flexible, and it has to be because we're not going to kick somebody out the door.

Finding housing is a real challenge in rural areas. There's no getting around it. We've got families doubled and tripled up moving into a facility. There might be 15 people living in a three or four bedroom home. You can imagine how difficult that is. If that's all your family, your companion, and your children, that's one thing; but when they're separate families living in that kind of a situation, then there are a lot of challenges.

(#35) We're on the reservation boundary, one block outside of the reservation, which is kind of nice because it's a safe middle ground. Not all of our people have always lived on this reservation; some members of the tribe live in the surrounding area. Although we focus on people from this community, we serve Native Americans in general. So we have people fleeing from other reservations who come here for services because they're not feeling safe within their own tribal community. And they know they can qualify for healthcare services because they are Native American. They come to get established here. Others have lived in the surrounding area, but still access tribal resources. And in some cases, they might want to change that and access county resources because the abuser is a tribal employee or they just want their information out of the tribal system. Every person is different. And when we're serving one person, often we're serving the entire family -- it's a package deal, whether that means safety planning to protect against violence by a member of the family or bringing the family in as a support. Every decision that person makes is going to affect a larger group of people in a different way than it would with a Caucasian family.

I think the biggest difference in working with Native Americans is understanding the overwhelming amount of oppression and historical trauma and intergenerational trauma that their people have gone through -- so that we're not just serving that one person who comes through the door and their family; we have to look generationally at what has occurred and where the barriers are coming from. One of our main programs is focused on healing from intergenerational historical trauma, grief, and loss. So that people understand who they are, and can reconnect with their culture.

For example, we look at the genocide in the boarding school era going back seven generations -- how people were taken from their community and how they were punished for using their language or for sharing stories of history and culture. Or how their hair was cut, how their clothing was changed, and all that. The cultural cleansing that occurred, as people in boarding schools were taught nontraditional ways of running a household. And if they were not compliant, there was so much violence - rape, beating, near-death experiences. There were situations where children were set upon other children.

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So we look at how inter-tribal racism has emerged through that. How traditions and cultural practices were lost - not their values, but their practices. How they lost a lot of the teachings about peaceful communication, ways of teaching their own children. We look at how the introduction of drugs and alcohol impacted Native Americans, and how given their body composition and metabolism, it was much more toxic to them. And how violence, particularly sexual and domestic violence, has become more prevalent over the generations.

So many people say, "I've asked my grandma to tell me about my culture, about my community, and they refuse." So they get angry about that, but once they understand that they were punished for doing that in the past, that there were serious consequences for passing on traditional tribal teachings, they start to understand their own family history and why people did things the way they did, which can release a lot of that anger and hate and resentment and everything that goes with that.

Sometimes, a woman who reports the abuse, accesses the legal system, and flees with her children, has to pay a price in the community. There can be a lot of shaming and blaming that goes with that. If someone is starting to move forward in their life, they might hear, "You're too good for us. Why are you doing this?" They get shamed and blamed or shunned almost. So they end up in this very isolated situation where they haven't yet established other informal supports that are positive, people with the same kind of experiences or who are further along the path of leaving an abusive relationship.

So as people are moving forward on their journey of healing and wellness, helping them connect with informal supports from other areas is one of the most important things a program can do. A person can have systematic support, to help with financial issues and some skill-building; but it's also very important to have another person at three o'clock in the morning who is available to talk and validate the woman's feelings, or someone who can give them a ride when it's after hours. So I always encourage people to join groups that do things that they like. If they've wanted to learn how to bead, I encourage them to join a beading group as part of their safety and networking and informal supports because it's a different group of people, with a different set of skills and different past experiences that's separate from their family, so they're not so isolated.

(#36) A lot of our communities have a high minority population but it's more of the African American population; very few people are seeking services that don't speak English. Now I'm not going to say they're not out there because I know that they are, but currently it's predominantly Caucasians and African Americans who are accessing services. We have a high poverty rate in our communities, and a very high generational poverty rate. Literally the grandmother was in poverty, possibly domestic violence, then the mother was, and now the grandchild, and so we have served sometimes generations of the same family.

Questions to Consider

1. Apart from, or in addition to, employing African American staff, what does cultural competence mean when it comes to serving African American survivors? How can a small program with one white case manager / advocate demonstrate that it is welcoming and supportive to African American survivors?

2. How might class differences between a college-educated professional staff and a working class clientele pose a challenge to building a trusting relationship, and what could staff do to help overcome that challenge?

3. What can providers do to help survivors create alternate social connections when they leave the community where they were abused and where their family, extended family, and/or cultural community remains?

4. Staff from a number of transitional housing programs serving survivors from tightly knit ethnic or cultural communities described the pressures those survivors feel to return to the situation they fled, particularly if they are parents and have fled with their children. One such provider talked about "not setting survivors up to fail" and, therefore, not enrolling survivors who expect to feel pressure from their extended family, to regularly return to their community for perhaps week-long visits with extended family.

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- Is a decision not to enroll such a survivor consistent with the OVW's warning (in its annual solicitation for TH grant proposals) against "requiring survivors to meet restrictive conditions in order to receive services?" How, if at all, is such a basis for denying assistance different from requiring applicants to commit to permanently ending their relationship with the abusive partner?

- What approach might a TH provider take to serve a survivor who, on the one hand, wants an end to the violence and victimization, but on the other hand, feels a strong imperative to hold her family together and remain connected to her possibly unsympathetic extended family and community, in which her abusive partner continues to live?

- What should a TH program do if the survivor does not want to see her abusive partner punished by deportation or incarceration, because it would deprive the children of a connection to their father and/or signify the survivor's failure or lack of loyalty as a wife?

5. One of the goals that the "Roadmap" report by the Indian Commission on Law and Order described in conjunction with restoring tribal sovereignty, was restoration of traditional models of restorative justice, instead of punishment and incarceration. Survivors from some other racial, ethnic, and cultural groups may also prefer a pathway to reconciliation and reduction of violence instead of permanent separation and punishment of the abusive partner.

- How might such a model work in the context of transitional housing, given the prohibition on using grant funds to pay for housing in which the survivor lives with her abusive partner, and given the prohibition against mediation or negotiation between the abuser and the victim?

4. Serving LGBTQ Survivors

(a) Overview

Although providers and advocates and the mainstream media often speak of the LGBTQ[54] community in aggregate, it is as heterogeneous as the "immigrant community" and the "mainstream community." Lesbian, gay, bisexual, transgender, and genderqueer people come from diverse socioeconomic strata and diverse racial and ethnic backgrounds. In some parts of the country and in some segments of society and in some families, they are accepted for their gender identity and/or sexual orientation; elsewhere, they may be subject to legal exclusion, social ostracism, being disowned by parents, and/or hate crimes.

Even in the more "progressive" communities, where lesbian and gay people may generally feel more comfortable about "coming out," there may not be acceptance for bisexual, transgender, or genderqueer individuals, and gays and lesbians may find that "political support" for their right to be out doesn't mean social and family acceptance in their personal lives.

The two primary funders of transitional housing for survivors of domestic and sexual violence -- OVW and HUD -- have made it clear that programs may not discriminate against or exclude LGBTQ survivors:

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[54] On its "LGBTQ Victims" webpage, WomensLaw explains that

"LGBTQ is an abbreviation for lesbian, gay, bisexual, transgender or transsexual and queer or questioning. 'Lesbian,' 'gay,' and 'bisexual' are terms used to identify people who experience sexual attraction to partners of the same gender, sometimes along with attraction to partners of the opposite gender. These terms describe sexual orientations or sexual identities. The 'Q', which stands for 'queer' or 'questioning' was once considered a derogatory term, but now is more commonly used in the community in a positive way to include the wide diversity of people whose sexual orientation and/or gender identities are other than the majority. Transgender and transsexual people have gender identities that in some way do not fit into the sex they were assigned at birth. For example, a transman could be a person who was born with female body parts and now identifies as male. Trans people may also identify as lesbian, gay, bisexual, or may identify as heterosexual."

WomensLaw directs the reader to the Transgender and Gender Nonconforming Support webpage of the Lesbian, Gay, Bisexual, & Transgender Community Center's Gender Identity Project, for more information about the trans community.

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- The OVW's 2015 solicitation and 2016 solicitation for TH grant proposals cite the 2013 VAWA Reauthorization Act non-discrimination provisions, which apply to all OVW grants, "prohibit[ing] OVW grantees from excluding, denying benefits to, or discriminating against any person on the basis of actual or perceived ... gender identity [or] sexual orientation ... in any program or activity funded in whole or in part by OVW." Additionally, the OVW included underserved populations based on gender identity and sexual orientation among its "priority areas," and indicated that any "procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived ... sexual orientation [or] gender identity" would be considered "activities that compromise victim safety and recovery," and as such, would adversely impact the scoring of their application or eliminate them from consideration for funding.

- On February 3, 2012, HUD issued a "Final Rule on Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity," effective March 6, 2012, stating that its programs -- including the Continuum of Care program, which funds transitional housing and rapid rehousing projects, and its Emergency Solutions Grant program, which funds states, counties, jurisdictions that, in turn, fund rapid rehousing projects -- "are open to all eligible individuals and families regardless of sexual orientation, gender identity, or marital status."

Non-discrimination is a baseline requirement; being welcoming and affirming, and providing appropriate services to LGBTQ survivors who may well have experienced poly-victimization requires a higher level of awareness, commitment to trauma-informed services, and cultural competence.

(b) Prevalence and Description of Domestic and Sexual Violence Against LGBTQ Persons

(i) Information about the Prevalence and Perpetrators of Domestic and Sexual Violence

Source: NISVS 2010 Findings on Victimization by Sexual Orientation (Walters, Chen, & Breiding, 2013)

NISVS (2010) Findings by Sexual Orientation	Women			Men		
	Lesbian	Bisexual	Heterosexual	Gay	Bisexual	Heterosexual
Lifetime prevalence of rape (by any perpetrator)	13.1%	46.1%	17.4%	*	*	0.7%
Gender of perpetrator	*	M: 98.3%	M: 99.1%	*	*	*
Number of perpetrators	*	one: 62.3%	one: 72.3%	*	*	*
Lifetime prevalence of other sexual violence (by any perpetrator)	46.4%	74.9%	43.3%	20.2%	47.4%	20.8%
Gender of perpetrator M=male only; F=female; B=both M & F perpetrators	M: 85.2% F: * B: *	M: 87.5% F: * B: *	M: 94.7% F: * B: *	M: 78.6% F: * B: *	M: 65.8% F: * B: *	M: 28.6% F: 54.8% B: 16.6%
Number of perpetrators	one: * two: * 3+: 38.6%	one: 32.3% two: 31.3% 3+: 36.4%	one: 47.0% two: 23.1% 3+: 30.0%	one: 42.3% two: * 3+: 33.0%	*	one: 49.7% two: * 3+: 27.0%
Lifetime prevalence of rape, physical violence, or stalking by an intimate partner	43.8%	61.1%	35.0%	26.0%	37.3%	29.0%
Gender of perpetrator M=male only; F=female; B=both M & F perpetrators	F: 67.4%	M: 89.5%	M: 98.7%	M: 90.7%	F: 78.5%	F: 99.5%
Lifetime prevalence of severe physical violence by an intimate partner (e.g., beaten, hit with a fist or something hard, or slammed against something)	29.4%	49.3%	23.6%	16.4%	*	13.9%

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NISVS (2010) Findings by Sexual Orientation	Women			Men		
	Lesbian	Bisexual	Heterosexual	Gay	Bisexual	Heterosexual
Lifetime prevalence of psychological aggression (or coercive control) by an intimate partner	63.0%	76.2%	47.5%	59.6%	53.0%	49.3%

Note #1. An asterisk (*) signifies insufficient data for statistically reliable estimates.

The 2010 National Intimate Partner and Sexual Violence Survey of victimization by sexual orientation marked the first time that the NISVS collected data about sexual orientation. As noted in the WomensLaw "LGBTQ Victims" webpage, the actual rate of such violence is "difficult to determine because of the high number of unreported cases." [55] The NISVS 2010 Survey did not collect data pertaining to gender identity, so there is no information about transgender persons. However, according to research cited by the National Coalition of Anti Violence Programs, "studies [have estimated] lifetime experiences of IPV among transgender people ranging from 31.1% to 50%." (NCAVP, 2015, p.34)

(ii) National Coalition of Anti-Violence Programs[56] Annual Survey (2014) of Member Organizations

The National Coalition of Anti-Violence Programs conducts its own annual survey of member organizations (NCAVP, 2015, pp. 19-25) to better understand the demographics of the victims and perpetrators of domestic and sexual violence against LGBTQ persons. The NCAVP survey cannot calculate prevalence rates, and is not necessarily representative of the entire LGBTQ subpopulation, since the only persons counted are victims of violence who have sought assistance from its member organizations, and persons counted in public records (e.g., homicide victims); however it provides more in-depth information about survivors and perpetrators than is captured in the NISVS report:

Victims/Survivors:

- *Gender Identify*[57]: Male (29%), Female (24%), Cisgender (40%), Transgender (7%)
- *Sexual Orientation*: Gay (49%), Lesbian (20%), Heterosexual[58] (12%), Bisexual (12%), Queer/Questioning (5%), Other (2%)
- *Race and Ethnicity*: White (49%), Latina (25%), African American (14%), Asian/Pacific Islander (3%), Multi-Racial (3%), Native American (3%), Other (3%)
- *Age*: 15-18 (1%), 19-24 (11%), 25-29 (21%), 30-39 (32%), 40-449 (19%), 50-59 (13%), 60+ (2%)
- *Immigration Status*: Citizens (87%), Permanent Residents (3%), Undocumented (6%), Other (3%)
- *HIV Status*: HIV-positive (26%), HIV-negative (74%)
- *Disability Status*: No Disability (70%), With Disability (30%): Physical Disability (17%), Mental Disability (11%)

Abusive Partner and Survivor Relationship:

- *Relationship to Victim*: Lover/Partner (53%), Ex (34%), Other (inclusive list) (12%)

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[55] Based on a review of a number of studies, The Network La Red / Quinn (2010) has estimated that

"Partner abuse in LGBTQ [Lesbian, Gay, Bisexual, Transgender and Queer] communities is a serious public health and community issue, occurring in approximately 25-33 percent of relationships where one or more partner identifies as lesbian, gay, bisexual and/or transgender. This rate is comparable to the rate of domestic violence perpetrated against heterosexual cisgender[55] women. LGBTQ people have been killed and seriously injured by their partners, have lost housing, children, and pets, and have suffered emotional, sexual, financial, cultural and identity abuse at the hands of abusive partners." (p.7)

[56] The NCAVP, is a coalition of over 50 state, national, and Canadian organizations that "monitor, respond to, and work to end hate violence, domestic violence, and other crimes affecting LGBT *[sic]* communities."

[57] Some of the people identified as male or female are cisgender, some as transgender, and some as genderqueer.

[58] A transgender person might identify as gay, lesbian, heterosexual, bisexual, etc.

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- *Gender Identity*: Male (37%), Female (15%), Cisgender (47%), Transgender (1%)
- *Sexual Orientation*: Gay (39%), Lesbian (19%), Heterosexual (34%), Bisexual (4%), Queer/Questioning (2%), Other (1%)
- *Race and Ethnicity*: White (42%), Latin@ (21%), African American (28%), Asian/Pacific Islander (4%), Other (7%)
- *Age*: 15-18 (1%), 19-24 (18%), 25-29 (21%), 30-39 (27%), 40-449 (21%), 50-59 (11%), 60+ (2%)

(c) Progress in Addressing Domestic and Sexual Violence Against LGBTQ Persons[59]

According to a joint policy report by the National Center for Victims of Crime and the National Coalition of Anti-Violence Programs (NCVC/NCAVP, 2010),

> *"In 2009, LGBTQ victims of crime still did not have consistent access to culturally competent services to prevent and address the violence against them. Too often, mainstream victim assistance agencies cannot meet the needs of LGBTQ crime victims in culturally sensitive ways, while LGBTQ-specific anti-violence programs either lack the resources to do so or do not exist. Without access to culturally competent advocacy, intervention, and other critical services, LGBTQ victims will continue to suffer disproportionately from violence and the after-effects of victimization."* (p.2)

In the years since that study, the situation has evolved, in part, as a result of the historic 2013 reauthorization of the Violence Against Women Act, which "for the first time in a federal funding statute ... explicitly bar[red] discrimination based on actual or perceived gender identity or sexual orientation" by OVW grantees.[60]

There have been trainings to enhance providers' cultural competency in serving LGBTQ survivors, and, as evidenced by the comments of a number of staff interviewed for this project, some number of TH programs are indeed serving, or say they are prepared to serve, members of that subpopulation. However, in the absence of statistical data about the actual numbers of LGBTQ survivors served by OVW- (or HUD-) funded programs, it is impossible to know the extent of such progress in broadening access to housing and services.

NCAVP (2015) asserts that "IPV within LGBTQ communities has not been integrated into the mainstream narrative on IPV, and only limited culturally specific services exist." (p.13) The study authors report, however, that higher percentages of surveyed LGBTQ survivors sought shelter and/or orders of protection in 2014, and suggest that,

> *"Because of the increased awareness of VAWA services and the protections for LGBTQ people, LGBTQ survivors may have felt more empowered to seek orders of protection and traditional domestic violence services like shelter, which were historically not accessible for LGBTQ survivors, particularly transgender survivors and male survivors . . . . [However,] it should be noted that roughly three quarters of [surveyed] survivors did not seek orders of protection in 2014, and the overwhelming majority (85%) of [surveyed] survivors did not seek shelter. Many resources are invested into these traditional remedies, and while they can be life-saving and critical for some survivors, they are not the main choices [surveyed LGBTQ] survivors [made] to address IPV."* (p.41)

As is true with many subpopulations, even if a provider feels open and ready to serve survivors from a particular segment of the community, if members of that demographic don't know about a program, or do not perceive that it is safe and welcoming, they won't necessarily seek it out when they need help. To the

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[59] In some interviews, staff were specifically asked about their experience in serving LGBTQ survivors. If they indicated that they had had "no problems," staff did not probe further to find out whether that meant they hadn't had the occasion to serve LGBTQ survivors, or that such survivors had been served successfully. In other interviews, staff were asked more generally about their experience in serving survivors from diverse segments of the population. If staff didn't specifically mention LGBTQ survivors in response to that more general question, interviewers did not necessarily follow-up to specifically ask whether and how they serve persons with "non-traditional" gender identities or sexual orientations.

[60] See the April 9, 2014 OVW blogpost announcing new guidance to grantees.

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extent that lesbian, gay, bisexual, transgender, and genderqueer survivors have different needs, face different barriers, and pose potentially different logistical challenges to programs, different segments of the LGBTQ population might feel more or less welcome, and be perceived by staff as a good or not-so-good fit with the program.

Finally, given that a significant percentage of TH programs don't broadly advertise program vacancies, and instead fill their open slots with survivors referred from DV shelters (as discussed in Chapter 2 ("Survivor Access and Participant Selection"), access to such TH programs would depend on whether an LGBTQ survivor felt comfortable seeking refuge in such a (typically) congregate shelter. If they were apprehensive about being in a shared living arrangement with other survivors who might be uncomfortable with or judgmental about their gender identity or sexual orientation, an LGBTQ survivor might not see shelter as a viable alternative, and therefore would not have meaningful access to next-step transitional housing.[61]

NCVC/NCAVP (2010) collected survey responses from 648 legal system-based and community-based victim assistance agencies, including domestic violence providers, sexual assault providers, prosecutorial staff, law enforcement, and agencies serving child victims. Although the provider community is overall far ahead of the country in accepting and embracing diversity, and although LGBTQ access to victim services is undoubtedly better now than it was when their survey was conducted, it is fair to assume that progress is not yet complete, and that the authors' observations about the need for training and technical support in creating welcoming and affirming program options are still relevant:

> *"Agencies expressed both a strong need and a willingness to receive culturally-specific training and technical assistance..., acknowledged the importance of LGBTQ-specific victim assistance, and demonstrated a desire to better serve LGBTQ victims. Most respondents reported that their agencies:*
>
> - *Lack outreach to LGBT victims;*
> - *Lack staff LGBT cultural competence training;*
> - *Did not implement LGBT-specific victim services policies and practices;*
> - *Did not collaborate with LGBT-specific service providers; and*
> - *Were under-resourced to correct these barriers to LGBT-specific services."* (pp. 9-10)

> *While a strong majority of those surveyed reported a belief that it was important to serve LGBT victims, many agencies [had] not implement[ed] policies and procedures specifically for working with LGBT victims, including LGBT-friendly signs and materials, and gender-neutral intake forms. Most [providers] face challenges in providing culturally competent services to LGBT survivors.... Obstacles range from general underlying staff homophobia to a perception that there is no need for specialized services for LGBT people [e.g., 'We treat everyone the same.']. Victim service providers report they are overworked, under-funded, understaffed, and have limited options for offering a broad range of services in ways that are culturally specific. Thus, many providers have adopted a "one size fits all" approach to service provision...."* (pp. 9-10)

To the extent that LGBTQ survivors are not comfortable accessing victim services, they remain at risk of prolonged trauma and/or further violence. As NCVC/NCAVP (2010) noted,

> *"... the harm caused by anti-LGBTQ bias [and public manifestations of that bias] poses additional barriers for victims of intimate partner violence [by contributing to] hesita[ncy] to disclose partner violence for fear that the abuse will be considered evidence that the victim's sexual orientation and/or gender identity is unhealthy. Seeking support from family members is especially difficult if the family disapproves of the relationship, although studies reveal that even LGBTQ friends and community members are largely*

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[61] At present none of the main funders of emergency shelter or transitional housing for survivors of domestic and sexual violence -- FVPSA, OVW, or HUD -- ask grantees to collect data on the gender identity or sexual orientation of persons served in their programs, so there is no good data about utilization by those constituencies.

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unprepared to support victims of intimate partner violence. Additionally, criminal justice personnel and victim assistance providers often underestimate the physical danger involved in same-sex relationship abuse, or fail to recognize that a physically smaller partner may be the perpetrator. Victims may not be believed, or their concerns minimized, by service providers as well. Mainstream victim services and civil and criminal justice agencies may contribute to the appearance of bias by the lack of inclusive language or images used in outreach materials or even their program name. For example, a name that may seem innocuous, such as 'The Women's Safeplace,' may prevent men, transgender persons, or even lesbian or bisexual women, from seeking services."

There is a dearth of culturally competent victim services for LGBTQ victims of crime. Furthermore, many victim-serving agencies are not well trained to work with LGBTQ victims and survivors of crime. Perhaps the most significant barrier to services for LGBTQ victims is the existence of bias attitudes: homophobia, biphobia, transphobia, and predominant heterosexism. The history and prevalence of such attitudes means that LGBTQ victims may fear encountering bias, even if the service provider or justice agency has made efforts to increase their cultural competency.[62] Without training, providers often fail to consider and address the relevance of anti-LGBTQ bias in the victim's experience. An LGBTQ crime victim may experience bias repeatedly, from being targeted because they are LGBTQ to problems reporting the crime to lack of inclusive victim services. Failure to understand the significance of the victim's sexual identity and/or gender expression therefore presents a great barrier to LGBTQ victims of crime seeking services. While accessible support services can play an important role in preventing victimization and helping victims live free from victimization, many LGBT victims and survivors do not feel that supportive services are readily accessible. In fact, studies have shown that only one in five survivors of same gender sexual assault and intimate partner violence received victim services." (pp. 5-6)

An important part of dispelling those apprehensions is effective outreach materials specifically designed to address the concerns of LGBTQ survivors, and to convey a sense of welcome and affirmation. Indeed, the lack of such outreach materials was identified as "the top challenge reported by service providers."

"Culturally specific outreach signals to LGBT victims that the available services will address their real-life needs and communicates that LGBT survivors' feelings, experiences, and concerns about the victimization are valid, and that someone else understands this. Victim assistance providers expressed a desire to increase their outreach to the LGBT community, let them know of the services available, and increase general awareness of the impact of LGBT victimization." (pp. 10-11)

Although organizations like the National Coalition of Anti Violence Projects (NCAVP) have, since the 2009 survey, developed and delivered cultural competency trainings on serving LGBTQ survivors, it seems safe to assume that additional trainings reaching staff who have not yet been trained, and refreshing the knowledge and awareness of already-trained staff, would be beneficial:

"Such training would help them become attuned to the concerns of LGBT victims, including victims' fear of encountering a homophobic or heterosexist response by the criminal and civil justice systems or victim service providers, fear of being "outed" if they were not fully public with their sexual orientation and/or gender identity, and the fear that they may be seen as betraying their community if the perpetrator is also LGBT. Training would also help victim service providers learn to recognize their own internal biases or actions that imply the existence of a bias." (p.11)

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[62] The report cites a U.S. Department of Justice policy memo that, "Homosexual victims may decide not to report hate crimes to police because of fears of reprisals or a belief that they will be forced 'out of the closet.' Such an 'outing' may cause repercussions to their career and relationships with family and friends. Some victims have little confidence that authorities will bring the perpetrators to justice." (pp. 7-8)

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When the NCVC/NCAVP survey was conducted in 2009, the authors encountered provider staff that failed to distinguish between "equal treatment" and treating all participants as if their experiences have been the same, and so they have the same needs, regardless of their distinct sexual orientations and gender identities:

"Many victim service providers responded ... that they strive to serve all victims equally or that they do not discriminate. While these are appropriate values in victim services, the statements indicate the perception that all victims' needs are the same, sexual orientation and gender identity do not matter, and, therefore, there is no need for cultural competency training or LGBT-specific services. Without additional training, victim assistance providers risk believing that they are delivering "equal" services to LGBT victims while delivering fewer or less than adequate services.

Training in cultural competency would help victim service professionals achieve their goal of being accessible and sensitive to all victims and support more effective identification of crimes, classification of crimes, safety planning, lethality assessment, and options counseling." (pp. 11-12)

Among its other recommendations (e.g., promoting broader public awareness through outreach and education about the extent and impact of victimization of LGBTQ persons), the report called for:

- [Recommendation #1.] Build collaboration among LGBTQ anti-violence programs and mainstream victim assistance providers to increase the availability of culturally competent services for LGBTQ victims of crime by providing LGBTQ-specific training for criminal and civil justice system personnel and victim assistance providers.

- [Recommendation #4.] Increase state and federal funding for collaboration, training, outreach, services, research, and data collection on the victimization of LGBTQ people

The report also cited the need for better data on both hate crimes and domestic violence against LGBTQ persons:

"A factor that contributes to the underreporting of intimate partner violence against LGBT people is police failure to identify incidents as crime victimization. Studies suggest that police often fail to recognize that the incident has occurred in the context of an intimate partnership, or, because of a misconception among law enforcement that a determination of domestic violence is based primarily on the sex of the victim, many simply assign the label of "mutual abuse" and arrest both parties in incidents of violence in an LGBT relationship.

... It is imperative to learn more about the need for LGBTQ victim services, including the number of those who seek assistance, the number served, and the number referred or turned away. This data is crucial for developing support for services and advocacy, and for indicating how services may need to be adapted.

We can only speculate how many LGBTQ victims of intimate partner violence are using victim assistance services because there are numerous challenges to obtaining this data, such as victim assistance providers not wanting victims to feel pressured to disclose sexual orientation and/or gender identity.

Other issues in data collection reflect general mores concerning socially encouraged privacy around matters of sexuality, assumptions of heterosexuality and gender identity, lack of understanding regarding diversity among LGBTQ people, and the need for data collection skills development. Misconceptions and assumptions about a victim's sexual orientation and/or gender identity, especially as they correlate to age

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or any additional identity-based marker, increase the risk that LGBTQ victims will fail to be identified and fail to receive culturally relevant services and advocacy." (pp.8-9)[63]

(d) LGBTQ Resources

(i) National Coalition of Anti-Violence Programs (NCAVP). (2015) Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2014

In addition to the data and recommendations cited earlier in this section, this report provides detailed local information from the 14 member organizations that participated in the survey, information about LGBTQ DV-related homicides, recommendations based on the findings, and contact information for all 50+ members in 26 states and the District of Columbia, and two Canadian provinces. Additional resources are available from the NCAVP on its Reports webpage.

(ii) The NCAVP Training and Technical Assistance Center on LGBTQ Cultural Competency "provides free ongoing technical assistance and support to current and potential Office on Violence Against Women (OVW) grantees nationwide through a toll-free warmline number, list serve, Deaf-accessible instant messaging AIM, and resource bank of LGBTQ anti-violence materials." Topics covered include language and terminology, creating an LGBTQ-inclusive organization, developing LGBTQ-inclusive policies and procedures, building relationships with LGBTQ communities and more." Contact the Center via email (info@ncavp.org); phone (1-855- 287-5428 weekdays 10 a.m. to 6 p.m. EST); or Deaf/Hard of hearing accessible instant messaging AIM: AVPlgbt.

The Center's webpage contains extensive links to resource materials for providers, community stakeholders, and LGBTQ survivors addressing, for example, organizational LGBTQ capacity building; serving LGBTQ survivors in a mainstream program; LGBTQ-Inclusive Model Policies; screening and assessment for relationship dynamics; guidance for working with trans partners; a glossary of terms; and materials for LGBTQ persons who may be in an abusive relationship.

(iii) WomensLaw LGBTQ Webpage

FAQ addressing a broad range of topics, including the definition and prevalence of domestic violence in the LGBTQ community; forms of abuse unique to LGBTQ victims, and, in particular, transgender victims; tactics used by transgender abusers to gain power and control over their partners; tactics abusers use to gain power and control over HIV+ victims, and tactics HIV+ abusers use to gain power and control over victims; unique obstacles faced by LGBTQ survivors, and in particular, transgender survivors, when they reach out for help; where on the WomenLaw website to find state-by-state information about getting a restraining order against a same-sex partner, finding a lawyer, and locating state and local programs that can offer non-legal assistance.

(iv) Forge. (2013) Safety Planning with Transgender Clients FAQ

FAQ exploring reasons transgender and gender-non-conforming individuals may be less likely to recognize and address abuse; components of safety planning; how safety planning for transgender and gender-non-conforming individuals might be different from safety planning for other survivors.

(v) The Network La Red / Quinn, M. (2010) Open Minds, Open Doors: Transforming Domestic Violence Programs to Include LGBTQ Survivors

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[63] As this report is being finalized, the author is unaware of any proposed changes to the aforementioned data collection systems (FVPSA, semi-annual reporting for OVW-funded providers, or HUD's HMIS data standard) that would facilitate the collection and reporting of data about services furnished to LGBTQ victims/survivors.

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Comprehensive resource addressing: choice of language in describing relevant terms (e.g., different terms to describe gender; ways in which transition between one gender and another may occur; gender-inclusive pronouns; etc.); the importance of understanding that domestic violence is not just something that occurs between a man and a woman; the consequences, including homelessness, of an approach to addressing domestic violence which is not culturally competent and not adequately inclusive; the importance of a survivor being able to find support outside their usual circle of friends and family (who may also have some loyalty to the abusive partner); the vulnerability of survivors who don't feel able to be "out" in public; homophobia, biphobia, transphobia, and heterosexism: how they manifest and the need for program staff to be able to address them, whether they comes from other survivors or elsewhere; myths about abuse; similarities and differences of abuse in heterosexual relationships versus LGBTQ relationships: sample tactics of emotional, physical, sexual, economic, and cultural/identity abuse; screening (i.e., figuring out who the abuser is, and who the survivor is); barriers to services; consent is the difference between S/M and abuse; consent is the difference between polyamory and cheating; building organizational commitment to serve LGBTQ survivors; organizational self-assessment; an LGBTQ Domestic and Sexual Violence Access and Competency Survey (developed by and use with permission form the California Partnership to End Domestic Violence); types of staff training to consider; collaborating with LGBTQ organizations (being careful to protect survivor confidentiality); personnel policies (making sure that LGBTQ staff and board members feel safe in the organization, addressing inappropriate behavior by staff, handling staff transitions from one gender to another, etc.); creating a welcoming environment (policies, language, physical space, ensuring safety); direct services practices (safety planning, gender-inclusive language and mirroring, interrupting and addressing homo/bi/transphobia and heterosexism, civil and criminal legal advocacy: restraining orders/custody/divorce/immigration, sheltering issues; outreach and media; reflection and feedback; case studies of LGBTQ inclusive programs.

(vi) National Center for Transgender Equality / National Gay and Lesbian Task Force. (Grant, Mottet, & Tanis, 2011) Injustice at Every Turn: A Report of the National Transgender Discrimination Survey

Report describing how transgender and gender non-conforming people face injustice and discrimination in childhood homes, in school systems, in harsh and exclusionary workplaces, at the grocery store, the hotel front desk, in doctors' offices and emergency rooms, before judges and at the hands of landlords, police officers, health care workers and other service providers.

(vii) National Resource Center on Domestic Violence. Special Collection on Sexual Violence in Lesbian, Gay, Bisexual, Transgender, Intersex, or Queer (LGBTIQ) Communities

Webpage featuring links to resources providing context about being LGBTIQ; about same-sex violence, sexual assault against transgender persons, and other sexual violence in LGBTIQ communities; about sexual assault as a hate crime; about sexual violence in prisons; and about improving services for LGBTIQ individuals.

See also the NRCDV's (2007) LGBT Communities and Domestic Violence: Information and Resources, a series of briefs addressing the appropriate use of language and vocabulary in conversation with and about LGBTQ persons; how sexism and homophobia impact the development of LGBTQ youth and how they contribute to domestic violence, dynamics of domestic violence; intervention and prevention services; statistics; a general fact sheet; a bibliography; a website resource list; and a video resource list.

(viii) The Northwest Network's Information Clearinghouse webpage

A webpage with links to hundreds of resources pertaining to LGBTQ relationships and abuse, including Self-determination is the MEANS, Safety & Empowerment are the ENDS (Burk, 2003, updated 2009)

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(ix)   Office for Victims of Crime / Office of Justice Programs (U.S. Department of Justice). (2014) Responding to Transgender Victims of Sexual Assault

Resource guide including materials on why cultural competency matters; Transgender 101: the basics of what it means to be transgender; sexual assault and how it occurs in the transgender community, and how it impacts the victim; and throughout the guide, tips on a variety of issues for a broad spectrum of providers (e.g., health, law enforcement, therapists, etc.) who serve transgender victims of sexual assault: language, body image, internalized transphobia and shame, sexuality, relationships, mistrust of professionals, about the perpetrator, disclosure and confidentiality, insurance and financial matters, documenting the assault, segregated services, crime victim compensation.

(x)   National Gay and Lesbian Task Force / National Coalition for the Homeless (2003) Transitioning Our Shelters: Making Homeless Shelters Safe for Transgender People (Mottet & Ohle, 2003)

A resource guide for congregate residential programs (not just shelters) providing a framework for understanding the gamut of gender identities and sexual orientations of people who may seek assistance, and addressing challenging questions about how to convey respect and create a safe space, how to address other residents' concerns, preempting bathroom and shower-related issues.

(xi)   National Sexual Violence Resource Center (NSVRC)/Pennsylvania Coalition Against Rape (PCAR). (2012) Annotated Bibliography: Sexual Violence & Individuals Who Identify as LGBTQ

(xii)   California Partnership to End Domestic Violence / Community United Against Violence / Los Angeles Gay and Lesbian Center (2007, 2010) Improving Domestic Violence Program Access for Lesbian, Gay, Bisexual, Transgender and Questioning Domestic Violence Victims/Survivors: Trainer's Guide

See also the California Partnership's Resource Search Engine

(xiii)   NY State Office for the Prevention of Domestic Violence. (2010) Domestic Violence in LGBTQ Communities: Trainer's Manual

(xiv)   LGBT Resource Center at the University of Wisconsin in Milwaukee (n.d.) Fact Sheet on Gender Inclusive and Gender Neutral Pronouns.

(e) Provider Comments on Serving LGBTQ Survivors

Note: Different providers have made different levels of progress in developing cultural competency, with respect to serving LGBTQ survivors, since the historic provisions of the 2013 VAWA reauthorization barring discrimination on the basis of gender identity and sexual orientation: One provider described their belief that it was intrusive to ask about sexual orientation. Another provider mentioned work with NNEDV technical assistance staff on appropriate strategies for asking about gender identity or sexual orientation.

When interviewers specifically asked about their' challenges and approaches in serving LGBTQ survivors, a number of providers simply indicated that, "it wasn't a problem." In some cases, that meant that because their program used a scattered site housing model, they didn't have to worry about how LGBTQ survivors and their "more traditional" cisgender heterosexual participants would coexist in a shared living arrangement. In some cases, "not a problem" probably meant that the program had not served any LGBTQ survivors that it was aware of.

(As noted in Chapter 2, to the extent that (typically congregate) DV shelters are the primary referral source for a TH program, that TH program is less likely to see survivors who feel that "the shelter is not for people like me," for example, older adult survivors, male survivors, LGBTQ survivors, survivors from an immigrant population that doesn't typically seek shelter, or that speaks a language that isn't spoken in the shelter, etc.)

In hindsight, it would have probably been more helpful to ask (a) whether the program had knowingly served any lesbian, gay, bisexual, or transgender survivors (i.e., since that information would not have been routinely collected

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using the data collection template for the semi-annual report form); [64] (b) whether/how the topic of the survivor's gender identity and sexual orientation came up in conversation (e.g., did program staff explicitly ask, was it something that the survivor brought up or alluded to, or something that was inferred); (c) what the program did to be welcoming and affirming; (d) whether and how the program ascertained and addressed any special needs; and (e) how services to its LGBTQ participant(s) were different, if at all, from its "usual" services.

We would recommend as an area of further study whether and how programs identify the gender identity and sexual orientation of survivors, and how -- if at all -- their services are adapted to address the specific needs of LGBTQ survivors. We would encourage OVW to consider working with LGBTQ advocates and providers to assess whether augmenting routine data collection for the TH grant program to ask about gender identity and sexual orientation would be appropriate, and if so, how it might be accomplished, without compromising the safety, confidentiality, or privacy of survivors, and whether any additional training would be needed to normalize

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[64] From the "Introduction and Overview" of Alper & Sanders' (2012) proceedings for the October 12, 2012 Institute of Medicine (IOM) workshop on "Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records:"

> *"In 2011, the Institute of Medicine (IOM) released the report, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding," the first comprehensive compilation of what is known about the health of each of these groups at different stages of life. This report also outlined an agenda for the research and data collection necessary to form a fuller understanding of this subject. One of the recommendations in this report was that, provided that privacy concerns could be adequately addressed, information on patients' sexual orientation and gender identity should be collected in electronic health records, just as information on race and ethnicity is routinely collected. Such data are essential because demographics provide the foundation for understanding any population's status and needs. This recommendation recognized that the possible discomfort on the part of health care workers asking questions about sexual orientation and gender identity, a lack of knowledge by providers about how to elicit this information, and some hesitancy on the part of patients to disclose this information may be barriers to the collection of meaningful data on sexual orientation and gender identity.*
>
> *As the next step in exploring this recommendation, an ad hoc committee was assembled to plan and conduct a public workshop on collecting sexual orientation and gender identity data in electronic health records. The workshop, held on October 12, 2012, featured invited presentations and facilitated discussions about current practices around sexual orientation and gender identity data collection, the challenges in collecting these data, and ways in which these challenges can be overcome."* (pp. 1-2)

In remarks at the conclusion of the IOM-sponsored workshop on "Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records," Ignatius Bau, who chaired the planning committee for the workshop, made the following summary observations and recommendations. Pursuant to CLAS Standard 12, we respectfully suggest that these ideas be put before stakeholders from different segments of the LGBTQ community for their feedback and insights:

1. *"LGBT people experience significant health care disparities and the Obama administration and HHS are committed to identifying and addressing those disparities through the use of data.*
2. *To address health care disparities in the LGBT population, it is important to identify and understand the barriers that these Americans face and to determine if nondiscrimination policies meant to eliminate those barriers are truly protecting LGBT individuals when they seek health care in real-world settings.*
3. *'If you are not counted, you do not count.' The health of every individual depends on disclosing sexual orientation and gender identity, so it is important to educate LGBT people about the need for them to self-identify while at the same time creating a safe environment conducive for doing so.*
4. *In addition to technical issues about the questions they need to ask their patients, health care providers have their own fears and biases that will require a significant amount of education to address, both on an individual and institutional level.*
5. *Employee resource groups in an institution can become a powerful and important internal force of change.*
6. *The use of language in questions about sexual orientation or identity and gender identity is becoming more precise and that will improve the quality of the resulting data collected using these questions.*
7. *It is important as a matter of principle that data is always collected through a self-identification process and that there is always an opt-out option available to patients.*
8. *Though the questions or processes for data collection have room for improvement, data collection should start now to better understand the health care issues experienced by LGBT people."* (p.52)

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> *discussions about gender identity and sexual orientation in conjunction with the collection of that data and the routine provision of victim services*.
>
> In an effort to expand the depth of our interview data about the challenges and approaches in serving LGBTQ survivors, we decided to conduct an *extra telephone interview with two non-OVW-funded providers* who focus on serving LGBTQ survivors of intimate partner violence, and who were recommended to us by members of our Project Advisory Team. The comments of those two providers are included at the end of the set of comments by TH program providers; although these providers work in two separate programs, their answers were integrated, to reflect the flow of the conversation.
>
> Following those comments, we have also included an excerpt from a presentation (at a White House Champions of Change awards ceremony) by the (former) director of the NYC-based Gay and Lesbian Anti-Violence Project, because her message speaks to the role that programs like those funded by OVW Transitional Housing Assistance Grants Program can play in serving LGBTQ survivors of intimate partner violence.

Note: Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) We haven't had a male in transitional housing but I'm waiting and excited for that to happen because it means we're growing and learning, and the DV movement is expanding. We've had people with different sexual orientations in the program and so far no issues with that. Not too many issues yet but it's a small program. We'll get more experience as it grows.

(#02) In our community, we're seeing a larger need for services that are inclusive for the LGBT population. We're part of a task force with 3 or 4 other agencies working to develop trainings for each other and other agencies in our community around the specific needs of our LGBT clients; because they not only experience the same challenges as other DV survivors, but also all the stigmas that go with their LGBT status. We want to get our staff and programs to a place where our LGBT clients know that they can call or show up and not be treated with disrespect. We're working on that in our own agency and with other agencies in this task force, so we are all trained appropriately and can train our own agencies, and then offer trainings in the community.

(#03) We're encouraged to attend training. I've participated in cultural competency trainings where you learn different tactics like not looking at the translator but looking at the client when you're speaking. We've tried to make our materials as inclusive as possible. We work with the National Network to End Domestic Violence with our technical assistance provider through our grant to create materials to ask the questions we need in a way that's appropriate across the board. For example, asking "what gender do you identify with?"

(#04) With regard to serving LGBT survivors, there has not been a problem with that particular group. We don't take that into account other than we are very clear with them that we are open and sensitive, but it's not been an issue.[65]

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[65] The previously discussed model that Rios (2007) adapted from Cross (1989), defining a continuum of cultural competence -- ranging from "cultural destructiveness" (making people fit the standard cultural pattern and excluding those who don't) to "cultural blindness" (not seeing or believing there are significant cultural differences) to "cultural awareness" (being aware that our identities are shaped by the culture we function in) to "cultural competency" (accepting and tailoring efforts to address cultural differences) to "cultural proficiency" (integrating cultural diversity into the fabric of our work, and taking proactive steps to address any biases and barriers) -- is probably equally applicable to the matter of how services are offered to LGBTQ survivors, as is CLAS Standard 12, calling for consultation with and involvement of stakeholders from the relevant community to obtain input that could enhance cultural competence.

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(#05) We have not served any LGBTQ participants in our transitional housing. That population has stayed underground mostly in our area.

(#06) Our residential program has not served any LGBT clients. The shelter doesn't take in anyone except women and we haven't had anyone that's applied but actually we're trying to gain more resources in order to help that population better.

(#07) We serve gay and lesbian, transgender individuals. We are not terribly diverse but there is diversity. There've been challenges in serving transgender persons in our congregate shelter; in our transitional program those challenges are minimized, because it is scattered site, and people are in their own units.

(#08) Our clients start at age 18 and I think our oldest is 54, so we cover the gamut. They are all parents – we don't have a grandparent parenting children. We have, in the past, served LGBTQ participants. In our program, we've had Native American, Korean, Russian, and Vietnamese.

(#09) In all of the training that we do, in all of the literature that we produce, we use a trauma informed framework. We've provided a number of in-person training opportunities and webinars to help our programs understand the trauma informed approach. We are also doing some pointed work right now around LGBTQ communities and again that work is being done with the trauma informed framework. By no means are we where we need to be, but we have been invested in that work for a number of years and are continuing to work towards that and help to build programs' capacity.

(#10) We make sure to do trainings on all the different types of populations to make sure that our staff are aware of the differences that may occur in an LGBTQ domestic violence situation, an African American DV situation, or a Latino DV situation. We try to educate our staff on all of those different cultural pieces, so they're aware of how those populations may experience domestic violence and homelessness differently.

(#11) We are very committed to cultural competency and we really try to work with folks and meet them where they're at. As far as LGBTQ, we are doing a lot of training. My goal is that hopefully they'll actually be able to enter our programs, even housing, just as anybody else would. We're still working that out and how that would look. We're not there yet, but we are committed to the process. Certainly now they would just go into our hotel program, which would be the same for a straight male. But we do our best.

(#12) We do what we do well in terms of domestic violence and sexual assault, but we're certainly not doing everything that a person needs support with. So I think creating those collaborations and those partnerships with the people who are the experts in all the other fields, the folks who are experts in the mental health field, the folks who are experts on youth, or LGBTQ communities... those are the partnerships that create the team that's needed to help people rebuild their community again. We can't really help people rebuild community if we're not working in that community model.

(#13) Most of our transitional housing is in a building complex on the same campus with our shelter and resource center, and most of the referrals into that transitional housing come from our shelter. Based on feedback that we received in our consumer surveys and through a staff committee formed to help us better serve the LGBTQ community, we found that both men and members of the trans community were feeling like our shelter and some other core services were not accessible to them. We also discovered that even though

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our actual policies about who is eligible for shelter were open, in practice, a lot of our frontline staff didn't feel comfortable bringing men and trans people into shelter because they weren't already seeing them there. They assumed that, "since I don't see them in shelter, maybe I'm not supposed to bring them there."

We had previously served men with motel vouchers, and over the past decade, had begun serving them directly in our shelter building. And we had always served trans individuals, but in trying to help them safety plan in advance of coming into shelter, it seemed like we were scaring folks away. So our Senior Director of Residential Services sent out a communication that we were not going to have separate, segregated spaces, and we would not use motel vouchers unless that's what somebody asked for, for their own safety. Since that announcement, we've already seen an increase in the diversity of the folks that we're serving in the shelter.

The fact is, participants are not always kind to each other. Our staff are already prepared and experienced at addressing racist or discriminatory comments and conflict. But if, in the interest of protecting one segment of the clientele from those kinds of comments or hostility, we don't provide access to the usual services, that's not keeping them safe. We just have to be prepared to address issues as they come up and be clear with everyone – staff, volunteers, and residents -- that this is a communal living environment, and when you walk in the door, you are agreeing to offer everybody basic respect and dignity, regardless of race, religion, sexual orientation, ... all the categories of non-discrimination. And we let folks know that if they see or experience something that doesn't follow those principles, here's who they can talk to, and what they can do.

In a recent staff training, we had a good conversation about how staff can quickly respond to a participant who makes a discriminatory comment in a group or a public setting, so that we keep that space safe and validating for everyone. We talked about different strategies for responding without breaking the trust of the relationship, when someone receiving one-to-one services expresses their prejudices.

Saying, "I don't want to talk to you anymore because you're a bigot," is not client-centered or trauma informed. We wouldn't let pass someone's statement that they were to blame for the abuse that was perpetrated against them, nor would we label such a statement "ridiculous." Instead, we would find a gentle way to offer a different perspective and/or a little bit of relevant information. Similarly, we would want to find a tactful, supportive way to offer a different perspective and maybe seek some accountability in response to an expression of prejudice or discrimination. It's a tough area, and a work in progress.

(#14) There's always something that you have to learn. We've housed men in our emergency shelters. We've housed trans women. We've housed gay men. We really haven't had too many problems; we just do it and figure it out later.

(#15) (Not a current OVW grantee) We've had a few survivors from same sex relationships, but it's not really an issue for us because we're scattered site. I think that the congregate models struggle a little bit more with that. As with any survivor, you don't want to prejudge or make assumptions about where they're at or where they've been and what they need. There are program rules about not inviting an abusive partner into your transitional unit; our old stereotype, based on heterosexual relationships, is that that partner is male, and that it's okay to invite women over, because they are friends and supports. When we are serving LGBTQ survivors, we can't make those kinds of assumptions. Given that requirement, it becomes important to know a participant's sexual orientation, because we need awareness about who might be a partner and who might be a friend.

(#16) I think our position is a little unique in that we are one of four groups awarded a state grant to work with the LGBTQ community, because we have a very strong support system in our agency. There's often prejudice against the LGBTQ community. You often hear and/or pick up on energy that isn't quite accepting in the beginning. But the thing that makes it different is that each of these groups has a strong support group

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with our advocate graduate groups that are working really closely, and our staff that are working closely with those different groups, so they can deal with their issues and be better able to express themselves. For the most part, we've seen people leave our programs talking about how they've grown; how they had come from a very closed background; how living side by side with people from different parts of the world, different cultures, different backgrounds, different sexual orientations that they had never been exposed to before ... how they not only learned how to get safe and how to have a new life away from violence of whatever type they were experiencing, but they were better able to navigate in this community.

(f) Comments of Specialized LGBTQ Providers

(i) *Comments from Special Interview with Providers Serving LGBTQ Survivors of Domestic/Sexual Violence*

LGBTQ Survivors and Identity: The subpopulations commonly lumped together as LGBTQ are all very different, with specific nuances to the strengths and challenges that members of each of those communities face. In particular, the differences between gender identity and sexual orientation can be enormous.

In some parts of the country, those distinctions may make more of a difference than others. In some areas, people identifying as lesbian or gay would face relatively few barriers, whereas for survivors who are queer or trans or gender-intersex, the barriers may still be enormous, whether they are related to ignorance or fear or the lack of legal protections in housing and employment protections, or the courts' inability to understand what it means to afford trans and genderqueer[66] survivors protection.

And bisexuals may experience biphobia from both queer and straight communities and might have less support and feel less inclined to go to an LGBTQ program. I often get calls, "I'm bisexual, do I still qualify for services?" So along with trans and gender-queer folks, bisexual survivors may face very specific barriers. . I think that race, ethnicity, class, and region also play a huge role in how LGBTQ people are treated.

Being Welcoming and Creating Safety: The first step in helping LGBTQ survivors to heal from their trauma is being welcoming and affirming to them, and there are some easy, concrete steps that programs can take to be welcoming. On an environmental level, they can have affirming posters and signs, maybe safe-zone stickers that visually show that LGBTQ people are welcomed; those can also be on brochures and websites. Also making sure that organizational personnel policies and program rules address discrimination around gender identity, gender presentation, and sexual identity; and making sure there are anti-harassment policies, and that staff address breaches in these policies consistently and immediately.

Another important step is making sure forms are inclusive, so participants can identify their gender identity and sexual orientation, and can include their preferred name and pronouns. The LGBT Resource Center at the University of Wisconsin in Milwaukee has produced a fact sheet about pronouns that may be helpful. Some of our colleagues at a local rape crisis center now put their preferred pronouns on their email signatures, which surfaces the issue, and invites the reader to share their own gender identity.

A lot of this looks like what our community did with shelters – the work that The Network La Red did in Open Minds Open Doors and the work that the National Gay and Lesbian Task Force and the National Coalition for the Homeless did in Transitioning Our Shelters: Making Homeless Shelters Safe for Transgender People. The guidance in those publications was for shelters, but it is equally applicable to transitional living programs.

Part of being welcoming is giving a participant the opportunity to say who they are. Staff might wonder, "Isn't it enough for us as providers to know that someone was a victim of abuse and trauma? Do we need to ask about their gender identity and sexual orientation?" I think it's so very important that we ask the question. If

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[66] *A person may be described as genderqueer if their gender identity is not exclusively masculine or feminine. They may identify as being non-gendered or bi-gendered (with both masculine and feminine identities) or tri-gendered (masculine, feminine, and non-gendered) or gender-fluid (moving between gender identities) or other-gendered.*

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we don't ask, it's like "don't ask, don't tell" -- it could send a message that maybe it's not okay to be out in this program. And that can make people feel like our program is not a safe place for them to be.

I would encourage staff to make a habit of both modeling the gender pronouns they prefer, and asking survivors about the pronouns they would prefer that staff use in referring to them. In LGBTQ spaces, we often do that at the beginning of meetings, "Hi, I'm Chris; my preferred gender pronouns are she, her, and hers." In short, ask. And recognize that we will all make mistakes. Apologize and move on. The aforementioned LGBT Resource Center fact sheet on pronouns has some helpful hints about how to have those discussions.

It's hugely important to the effectiveness of groups or trauma support or advocacy support in the program. How can they talk about abuse, if they can't talk about the person who was abusing them? How can they talk about the details of their experience, if they can't name the gender of that person? We know that for men abused by men, there's a whole piece about masculinity. And for women abused by women, there's so much in our society that women aren't violent, women aren't abusive, so this really didn't happen to you. You can't unpack those things if you can't talk about it.

The act of asking is so important; whether we get the answer is less important. It is important to know, but we always want to create space for people who choose not to disclose. If someone chooses not to tell us, or to wordsmith their story in a way that's not explicit, we need to make room for that. While we need to create space for that conversation, there will be some survivors who won't be able to have it with us. We might have conversations about the person who abused them, but their need to remain hidden is another kind of abuse they have suffered at the hands of the larger community, and for now, the best we can do is create safety.

We don't want to pry information out of people, but asking is important. And how you ask is important. We normalize it. We ask about sexuality and gender orientation in the same way that we ask about every other piece of demographic information --routinely and matter-of-factly. And at the beginning of the conversation, before we ask a single question, we say "You don't have to answer any questions you don't' want to answer."

And if a survivor is not comfortable with their sexuality or gender identity, we need to meet them where they're at. We need to use the language that they use about themselves. If they've talked about behaviors that might be considered bisexual, but they're not comfortable identifying as bisexual, and instead refer to themselves as straight, then we should use that same label, and if that's "straight," then that's what we use. It's about supporting them around their identity and being open to how they want to identify themselves.

It's important not to push any individual person or their boundaries. The nature of abuse is that someone hasn't respected your boundaries. And I think our proactive responsibility is to create affirming environments, which might help them feel more accepting of themselves. That may be posters and materials and brochures and intake questions, and all the ways we do that.

It's also about the environment that we create; so in our support group meetings, if someone says something racist, we'll confront that – we'll do it gently but we won't let it go unremarked upon. And the same should be true of homo-, bi-, and transphobia. We should not be tolerating those kinds of comments or attitudes any more than we'd tolerate someone's racism or xenophobia.

Where staff are in safe situations, we can model for participants that, "I'm part of the LGBTQ community and happy to be who I am in the world." And my colleagues can say, "We're really happy to have her on our team." Personally, when I've been able to be out with survivors, I feel like it's been very appreciated. It could be by just having a rainbow sticker on my water bottle; and I've found that people would come out to me all the time because they'd see that -- and I don't think they would have told me otherwise. I think it's fantastic if a staff person feels comfortable being out – it can be so helpful to survivors who identify in similar ways. But while staff should be allowed to be out, they should never be forced to be out.

LGBTQ-Specific Aspects of Being Trauma-Informed: I often say that "trauma-informed care" is just "human-informed care" and there are some things human beings need and have in common, no matter what. But there is a specificity of oppression that also must be addressed. If you're LGBTQ and a survivor of domestic

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violence, statistically you're more likely than your straight cisgender[67] counterparts to have a history of childhood sexual abuse, to have been subject to hate crimes or police brutality -- so there may be lots of different kinds of trauma in your life. With young LGBTQ people in particular -- across their lifespan, they, and especially the TQ and bisexual folks, are more likely to suffer more and different kinds of violence and trauma at the hands of lots of different people. LGBTQ survivors are far more often subject to poly-victimization and more likely to encounter barriers to help and healing. And they are far more likely to be carrying the weight of historical trauma. At the same time, though, LGBTQ communities carry enormous strengths and have developed effective survival and coping strategies precisely because of those historical traumas.

Even something as simple as the concept of "family of choice" means different things to a straight person versus an LGBTQ person. If you're LGBTQ, "family of choice" is a necessary survival strategy; we create community in strong and profound ways, and very intentionally -- otherwise we are alone and isolated. We don't grow up in queer families. So the trauma and the healing that needs to happen are both the same and different for LGBTQ survivors as compared with cisgender survivors whose abuse happened in a heterosexual relationship.

While aspects of the trauma may be the same, addressing the aspects of that trauma that are specific to their experience as LGBTQ survivors is extremely important. So many survivors have experienced external shaming around their gender identity and sexual orientation, and their abuser may have used this against them, or perhaps their friends and family used it against them, and blamed the abuse on them. A huge part of the work we do is taking that apart and helping survivors realize that the violence and abuse is not about their identify – it's not because they are gay or trans; it's about their partner using violence to assert power and control.

Many of the tactics that abusers use are rooted in the LGBTQ experience. Like, "it's us against the world," or "you're not gay enough" or "you're not trans enough" or "I'm not going to let you be connected to your queer community." So much of unpacking and healing from the abuse is dealing with the specific issues that arose and that are particular to the LGBTQ experience, and that are compounded by the shame that becomes internalized, even though it's coming from external sources of homophobia, biphobia, and transphobia.

LGBTQ-Specific Aspects Empowerment: I get this question a lot from the staff of short-term congregate shelters: "How can we prevent same sex participants from having sex in the shelter?" Personally, I think it's pretty paternalistic to tell people they can't have sex or be in relationships. It doesn't come from an empowerment place. And, as someone who's worked in congregate shelters, I have to say that realistically, these programs have been in denial about what is happening.

When you have a survivor who is in a place of complex trauma, who has experienced poly-victimization, who's a survivor of childhood sexual abuse or rape as an adolescent, and they come to TLP after moving through a DV shelter -- then for all the really complex reasons we know that people cultivate the necessary survival skills in the face of oppression and trauma, just trying to hold on emotionally, they might not have boundaries that we believe are conducive to their safety, or that we think of as "healthy." And even as we recognize being in a place of judgment, their boundaries worry us, and they are in a residence that we're nominally in charge of, and we want to keep them safe. We struggle over what do in those messy circumstances when we're concerned that people can't hold their own boundaries, and yet we want to work the empowerment model, but we're watching people who've been traumatized for so long, and don't know where their boundaries are.

On the one hand, are we replicating the structures of oppression when we tell DV survivors -- whether LGBTQ or cisgender and straight -- that "you can't have sex," even though it's such a fundamental part of most human being's lives? When we try to set up those kinds of rules, we end up policing people, which is the

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[67] *A cisgender person is someone whose gender identity and experiences of their own gender agree with the sex they were assigned at birth; thus someone who was identified as a male at birth and who experiences himself as a male, or someone who was identified as a female at birth and experiences herself as a female. By contrast, a transgender person was identified as a male at birth, but experiences herself as a female, or someone identified as a female at birth, but experiences himself as a male.*

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antithesis of what we're about. Philosophically, I'm in agreement that telling someone, "You can't have a sexual relationship here because you're not ready" is at odds with our effort to support agency and empowerment. The Northwest Network has a great handout on how self-determination has to come first, before safety. But, when I put on my manager hat, I become ambivalent. I agree that from a clinical place, healing is about establishing healthy boundaries, about finding value in your own self, and not only in other people's eyes. And people in pain look for ways to self-soothe, and sex is one way people do that.

The value of empowerment is in people making decisions for themselves. Even if people make decisions that we have questions or concerns about, what I've learned as an advocate is that there is always an internal logic to what people are doing -- at least for the vast majority of people we serve. People make decisions based on real needs and a real calculation of their options in life, and they're usually grounded in their choices. We may judge those choices differently, because we think there are more options than they perceive, whether there are or not.

(ii) *Excerpt of Sharon Stapel Speech for Domestic Violence Awareness Month (October 2011):*

The following is an excerpt of a brief speech by Sharon Stapel, former Executive Director of the New York City-based Gay and Lesbian Anti-Violence Project (AVP), recorded as part of a *Champions of Change* awards ceremony, during which the White House honored leaders in addressing domestic violence.

> "My name is Sharon Stapel; I'm the executive director of the New York City Anti-Violence Project.
>
> And our mission is to work with lesbian, gay, bisexual, transgender, queer and HIV-affected people who experience hate violence, sexual violence or domestic violence through a combination of direct services, community organizing and public advocacy. Our principles ... are safety, support and self-determination, and we work with survivors to create programs that we think are particularly effective in LGBTQ communities, including ... in the Bronx and in Queens work with transgender people of color who are experiencing violence that is unique to both their sexual orientation and their race and ethnicity.
>
> We also work with survivors of violence through our speaker's bureau where we teach survivors the speaking, leadership and activist tools that they need to become anti-violence activists in their own rights. And we also work -- we provide the first and, as far as we know, the only mixed gender and LGBTQ inclusive support group in working with survivors of intimate partner violence which provides folks with the space to explore both the violence and how that impacts their identities specifically.
>
> Sometimes I think the most radical work that we do is actually the simplest, which is to make LGBTQ people visible in this work and in the conversation that we have about domestic violence. LGBTQ people have very few safe places in this country. We face almost daily discrimination [and] bias ... against ourselves and our communities because of who we are and who we love. And in the midst of that, we also experience intimate partner violence at the same rates that every other community experiences it, in 25 to 33% of our relationships.
>
> And while there are unique issues that affect LGBTQ survivors, at the root of all of this, we have the same issues that everyone else has, which [is] the power and control that abusive partners have over those who are being abused in a relationship.[68] And despite our similarities in that way, one of the big differences ... is that we don't find the same treatment or support or welcome environment when we try and seek help to address the violence that's in our relationships.
>
> And we at AVP know it can be complicated to talk about violence outside of the boxes that we've sort of identified as the paradigms that we talk about violence. So we talk about husbands and wives and we talk about girlfriends and boyfriends, and we talk about men and women, but when we do that, we

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[68] See the power and control wheel specific to LGBTQ relationships on the National Domestic Violence Hotline webpage.

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exclude every LGBTQ person who is listening to that conversation or who is in that room or who is a part of that discussion, because that's not the paradigm that we live with.

Part of what the New York City Anti-Violence Project does is create a space for people of be exactly who we are. And part of what I have to say to you today is we know as allies you work with us to end violence. And we work with you to end violence. What we need from you as our allies is to create the space for us to be exactly who we are and to love exactly who we love while we are dealing with this violence."

Questions to Consider

1. What kind of training and support would providers need to be able to routinely ask about participants' gender identity and sexual orientation? Might there be any adverse consequences to adding such questions to the intake process? If so, how might those consequences be addressed?

2. Prevalence statistics from the 2010 National Intimate Partner Sexual Violence Survey[69] indicate that over 43% of lesbian women and 26% of gay men experience rape, physical violence, or stalking by an intimate partner over their lifetime; and that the corresponding statistics for bisexual women (61%) and bisexual men (37%) are even higher. (The NISVS did not collect data about gender identity, and so, does not have IPV statistics for transgender persons.)

-   If a TH provider has not yet received requests for program assistance from LGBTQ survivors, how can they ascertain whether the reason is (a) lack of need within the service area, or (b) perceptions in the LGBTQ community that the TH program and/or the sponsoring agency doesn't serve LGBTQ survivors?

-   If the reason for the lack of demand for services from the LGBTQ community is about community misperceptions about the agency and its programs, what steps might the agency take to change those perceptions, so that LGBTQ survivors feel better about accessing these victim services programs?

-   Given the preferred paths to TH program services (e.g., DV shelter referrals, referrals from other homeless services providers, self-referrals, etc.), what more system-wide changes would be needed in order to improve access by LGBTQ victims of intimate partner violence?

3. What kind of training would be helpful to support providers in operating programs that facilitated integrated programs and services bringing together heterosexual cisgender survivors and LGBTQ survivors?

4. What kinds of different supports might gay versus lesbian versus bisexual versus transgender versus genderqueer survivors need? How might the need for support vary for LGBTQ survivors from various racial and ethnic communities and/or different age cohorts (young versus older adult)?

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5.   Serving Young Adults, Older Adults, Males, and Families with Older Male Children

(a)   Serving Young Adult Survivors

(i)   Sources of Information

Much of the literature about youth and young adult homelessness reveals that relationship violence, and even more often, sexual violence and exploitation, including organized prostitution and sex trafficking, are endemic to youth homelessness. In particular, the population of homeless youth includes a disproportionately high percentage of LGBTQ who report having left home or been kicked out of their home, in some cases with accompanying violence, because of their sexuality or gender identification, and the literature suggests that LBGTQ individuals are some of the most severely victimized young adults.

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[69] See Breiding, M.J., Chen J., & Black, M.C (2014). For a more detailed statistical breakdown of data about IPV experienced by lesbian, gay, and bisexual persons, see Walters, M.L., Chen J., & Breiding, M.J. (2013).

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For more information, the reader is referred to the following resources:

- Ray, N. (2006) Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness. New York: National Gay and Lesbian Task Force Policy Institute & the National Coalition for the Homeless

- Choi, S.K., Wilson, B.D.M., Shelton, J., & Gates, G. (2015). Serving Our Youth 2015: The Needs and Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Experiencing Homelessness. Los Angeles: The Williams Institute with True Colors Fund. For access to their Serving Our Youth 2012 Report and other related materials, visit the True Colors Fund webpage.

- Burwick, A., Oddo, V., Durso, L., Friend, D., & Gates, G. (2014). Identifying and Serving LGBTQ Youth: Case Studies of Runaway and Homeless Youth Program Grantees: Final Report. Princeton NJ. Mathematica Policy Research

- The Hollywood Homeless Youth Partnership. (2007) Addressing Intimate Partner Abuse in Runaway and Homeless Youth: A Practical Guide for Service Providers. Addresses topics including: creating a culture of safety, how and when to ask questions integral to an assessment for IPV; assessing and addressing imminent danger; mandated reporting laws for intimate partner abuse; protective or restraining orders; safety planning; staff and supervisor roles/self-care; housing options and alternatives for homeless youth; youth friendly websites.

- National Resource Center on Domestic Violence. Runaway and Homeless Youth and Relationship Violence Toolkit - research, more research, web-based resources for youth on relationship violence

- Greene, J.M., Sanchez, R., Manlove, J., Terry-Humen, E., Vandivere, S., Wertheimer, R., Williams, S., Zaff, J., and Ringwalt, C.L. (2002) Sexual Abuse among Homeless Adolescents: Prevalence, Correlates, and Sequelae. Washington DC. (for the Administration on Children, Youth and Families)

- Homeless and Runaway Youth Webpage of the Youth.Gov website - links to federal and other programs, publications, and resources related to youth homelessness

- Runaway and Homeless Youth Webpage of the Family and Youth Services Bureau (FYSB) - links to program information and news updates from the FYSB, which funds a range of programs targeting outreach and services to runaway and homeless youth

- National Alliance to End Homelessness: (1) Practice Knowledge Project (a convening of experienced practitioners to discuss successful approaches to addressing youth homelessness) (2) How Can We Prevent Sexual Exploitation of LGBTQ Youth (10/21/2015 Blogpost with link to the *Urban Institute's* September 2015 report, Locked In: Interactions with the Criminal Justice and Child Welfare Systems for LGBTQ Youth, YMSM, and YWSW Who Engage in Survival Sex); (3) Youth Homelessness home page

- National Child Traumatic Stress Network. (2014) Complex Trauma: Facts for Providers Working with Homeless youth and Young Adults

- National Child Traumatic Stress Network. (2014) LGBTQ Youth and Sexual Abuse: Information for Mental Health Professionals - per the website: "a short glossary of relevant terms; a chart delineating the continuums of sex, gender, and sexual orientation; brief summaries of issues concerning LGBTQ youth and their parents related to sexual orientation and sexual abuse; a table of common myths and stereotypes about LGBTQ youth and sexual abuse; recommendations for practitioners and agencies on counseling LGBTQ youth; and guidance in treating LGBTQ youth following sexual abuse"

- National Child Traumatic Stress Network. (2015) Safe Spaces. Safe Places: Creating Welcoming and Inclusive Environments for Traumatized LGBTQ Youth (video) - per the website: "highlights the effect of trauma on LGBTQ youth; how bias impedes optimal care, and practical steps for creating safe and welcoming environments for traumatized LGBTQ youth."

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(ii) What Providers Told Us

In their comments, providers suggested that very young survivors (i.e., age 17+ to 24) typically face the challenges of overcoming their lack of experience running a household, their incomplete education, their lack of mainstream employment experience, and depending upon the circumstance that led up to their experience of violence (e.g., leaving home early to escape a bad situation, being caught up in trafficking or precursors to the sex trade, getting pregnant and moving in with a boyfriend who grew increasingly abusive, etc.), the lack of a viable support network.

For many young people, a certain level of housing instability can seem normal; even young adults in the mainstream tend to move frequently. So, the TH program's focus on achieving housing and financial stability aren't necessary perceived as relevant by young participants.

Provider staff told us they sometimes fall into a parental role, because they find that young participants aren't fully matured, and even if they have children for whom they are responsible, they are still prone to acting impulsively and with the same short-sightedness that characterizes the teenage years.

Young adults who have been involved in sex trafficking, who have been victims of rape and abuse, and/or who have been in foster care or institutional settings where they have been mistreated, or feel that they were mistreated, are less willing to trust program staff or other adults who, in their eyes, may or may not have their interests at heart. For more information about trafficking, see Chapter 8 ("OVW Constituencies: Survivors of Domestic Violence, Sexual Assault, Stalking, Dating Violence, and Trafficking").

(iii) Provider Comments on Serving Young Adults

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) Young adults, ages 18-25, pose some unique challenges for us. First of all, their obtaining supportive services is not always easy, especially if they just turned 18, and have to prove that they are eligible, that they are adults, that they are out on their own. The biggest thing, though, is that they do not seem to have a sense of direction or a sense that they need direction. It is very difficult to get them to participate in support groups and life skills classes, because they are still young enough to just want to be playing loose and free with life. And they may not have had strong support systems in the past, and may not create new ones easily because the only experience they have had in getting support was in school, and they are not going to school anymore.

(#02) We have a lot of very young moms that are victims of domestic violence who are in that 20 to 25 year age range. We have particular challenges with that group. I think that part of the struggle is just about their stage of development; they're still young and they make decisions like teenagers. A lot of their choices are short-sighted, they're impulsive and that's just an artifact of not a fully matured brain. We can't fault them for that, but when it comes to looking forward to permanent housing and looking at consequences for choices with regard to safety, that group poses some unique challenges because it's like working with teenagers – who happen to have two or three kids, so their choices impact their children.

To address that, we train our staff so that they're tuned into where our young adults are developmentally, and so we can make sure we're not setting them up for failure. And built into our supportive housing program, we have counseling that is available to mentor them through that process. The counseling is funded through our counseling center, it's not part of the transitional housing program, but those services are available to them and, if necessary, to their young children, in hopes that we can wrap around and almost become a surrogate parent for them. Often they've gone from home to a domestic violence relationship to us and have never been on their own. They don't know how to be on their own, are still are longing for their adolescence, and still make choices like adolescents. We try and accommodate that in what we do.

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(#03) One of the biggest hurdles for the very young ones is usually lack of education -- even a GED -- because they started with the abuser at 15 or 16 years old, and had children. With survivors who are 10-15 years into an abusive relationship, they've invested so much of their life in it, that emotionally, it seems to take them longer to get to where they feel good about themselves, much less about their situation. The trauma is definitely a lot more noticeable in survivors who've been in very long-term abusive, controlling relationships.

(#04) We don't see a lot of 18-25 year old survivors, but we've had some. The biggest challenge is just the level of maturity that comes with that age; it can be a challenge to help them focus on priorities that they're not inclined to focus on, like finding secure housing and planning ahead; they're more focused on "right now."

(#05) Sometimes very young adults lack the motivation to find employment or achieve any goals. Most of our clients get some type of public assistance, and feel they can live off it. Budgeting is a big struggle for them.

(#06) We work with younger women. We encourage family relationships if they have them – stable and healthy ones, of course. Those are some of the cases that take a little longer. We have one now, and we're just going to keep her longer. She's been trafficked. She's very young, very naïve. So we're just keeping her in our safe house, keeping her closer to our staff, to be able to walk her through what needs to be next for her.

(#07) Developmentally, transition age youth are not necessarily prepared for the responsibilities and challenges of self-sufficient living. And they've got attitude, and I can understand that. A lot of them are rape victims and they're not about to be told what to do by some adult that they don't feel has their best interests at heart or cares about them.

(#08) One of the more challenging populations to serve is the younger population - late teens, early 20s, single parents. They're in that life stage where they're starting out on their own, and everything is a big learning experience. And socially and culturally, there isn't a huge expectation for young adults to have housing stability... it's really common for people that age to move around from place to place, stay with a roommate, stay with family, and potentially even move back in with parents. There's a certain amount of housing instability that is just very acceptable in that age range and peer group. If long-term housing stability isn't important to them, it can be harder to serve them in a transitional housing format, which is all about trying to help folks access stable, long-term permanent housing.

And, of course, the other thing that can come up when you're serving a very young adult population – and this is another generalization – is resistance to rules and authority. We are a program that tries not to have a lot of rules; but we are a drug- and alcohol-free site, and we do ask folks to register their visitors so that we know who's coming and going on the property. And in enforcing those things, it's easy to fall into a parent-child dynamic with younger adults. We try to be more inviting and receptive to open communication.

(#09) I think the needs of 18 to 24-year-olds who have been "in the life" are similar, but not the same as the needs of their somewhat older peers. They're both coming right off the street, they're both in that same vulnerable state. It may depend on their life experience, how old they were when they began their life on the street, how long they've been running in the street. I don't know that the age is as important as where they are developmentally. In our transitional housing, the programing is pretty individualized. We have our Sisters of Survival groups and all the people that come through our housing have to go to that group. But, we break it down according to age, so our younger people sit with the older group for a little while and then get into their own under-24 age group, and our older folks have their own group, and later, they come back together.

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They're all living under the same roof but every participant has their unique needs, and our assistance is all very different according to what their needs are.

(b) Serving Older Adult Survivors

(i) Background Information from the National Clearinghouse on Abuse in Later Life (NCALL)

Funded in part by the OVW's Abuse in Later Life grant program, the National Clearinghouse on Abuse in Later Life (NCALL) maintains a website that provides online access to a wealth of information and links to numerous published and online resources, including, for example, Abuse in Later Life and Elder Abuse, Domestic Violence in Later Life, Safety Planning, Sexual Abuse in Later Life, and Stalking in Later Life. The following background information is from some of the publications that can be downloaded from that webpage:

As defined by the National Clearinghouse on Abuse in Later Life, in its Overview of Abuse in Later Life (hereinafter NCALL (2013)) the phrase "Abuse in Later Life" means, "the willful abuse, neglect, or financial exploitation of an older adult that is perpetrated by someone in an ongoing relationship (e.g., spouse, partner, family member, or caregiver) with the victim. As such, the term ... calls attention to the nexus between domestic violence, sexual assault, and elder abuse[70]. . . . Sexual abuse and stalking by an offender who is known to the victim or a stranger is also included in the definition. . . . Power and control dynamics, similar to those seen in domestic violence and sexual assault cases involving younger victims are often present in abuse in later lifer situations." The motives behind abuse in later life may be access to money, a place to stay, access to prescription medication, sexual gratification, caregiver stress,[71] or simply power and control.

"Abusers typically use various coercive tactics including physical and psychological abuse and isolation. Abusers may intimidate their victims and prevent them from reporting the exploitation or abuse out of fear of retaliation." "In the majority of abuse in later life cases the perpetrator is the victim's family member or intimate partner (Acierno et al., 2010; Lifespan of Greater Rochester et al., 2011). Intimate partner violence may have been present for the entire duration of the relationship or it may emerge later in life as the couple ages. Abuse can occur in heterosexual, lesbian or gay relationships." NCall (2013)

NCALL's Unique Challenges in Abuse in Later Life Cases (hereinafter NCALL (2013-a)) explains that older victims may be reluctant to report or seek help in addressing abuse, because of their relationship with the abuser, their fear of the abuser, their fear of losing their independence and ability to remain in their own home and community without the abuser, their financial dependence on the abuser (i.e., inability to sustain an alternate living situation), or their concern about being without reliable care for any health conditions.

NCALL (2013-a) also explains older adult survivors may face some systemic barriers, which may render help-seeking difficult, frustrating, and unproductive: older adults may face institutional and provider ageism and feel humiliated by staff who treat them as incompetent, or less competent than the abusive party; they may be frustrated by the inaccessibility of services (e.g., due to lack of accommodation for their physical, hearing, or vision impairments, or simply due to the arduousness of the process of seeking help); they may feel that services are geared to younger persons (e.g., focused on parenting, employment, etc.); or accessing help may depend on a level of literacy or computer literacy or access to technology that they do not have.

NCALL's Working with Victims of Abuse in Later Life (hereinafter NCALL (2013-b) asserts that "No matter the age of the victim, service providers should maintain a victim-centered approach when planning services. The advocates' role is to explore options with older victims, to help them identify and remove obstacles, and to

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[70] The term "Elder Abuse" applies to a broad range of abuse, neglect, and exploitation of an older individual in a trusting relationship with the offender (e.g., family member, paid or family caregiver, service provider, etc.). NCALL (2013)

[71] NCALL (2013-a) states that, "caregiver stress, anger management, and substance abuse issues may also be present in cases of abuse in later life. Generally, addressing these issues may alleviate some problems. Although often given as an excuse, caregiver stress is not the primary cause of elder abuse."

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honor and support their decisions, taking into account age-related generational and cultural values. When there are concerns about an older adult's cognitive capacity, a victim-centered approach includes working with health care providers to assess the individual's situation. In some cases, what appears to be limited or diminished cognitive capacity can be a temporary condition that is the result of trauma, inappropriate medications, infection, or lack of sleep, food, or fluids."

As in the case of advocacy with younger survivors, NCALL (2013-b) stresses the importance of safety planning, especially given any physical or cognitive limitations that the victim/survivor may have. The NCALL webpage on Confidentiality and Mandatory Reporting provides links to resources providing guidance for advocates and provider organizations on when and how to report elder abuse, and how to work with a survivor who may be ambiguous about such reporting. As NCALL (2013-b) points out, "many older victims want to maintain a relationship with their abuser. The abuser may be an intimate partner, adult child, other family member, or a caregiver. The victim may want help ending the abuse while still finding a way to have a connection with the abuser. Advocates should consider these views when safety planning." Or, as NCALL (2013-b) suggests, the older victim may be worried about immigration-related consequences, or about disclosing an LGBT relationship or gender identity that they have kept hidden, or they may simply have difficulty making a decision about what to do, due to decreased or impaired cognitive abilities. In the same way that victims/survivors weigh tradeoffs in deciding about leaving, older adults have tradeoffs that they must weight, and their advocates have, on the one hand, reporting requirements, and on the other hand, an obligation to respect the wishes and decisions of the older survivor.

(ii) *Other Resources*

- Brandl, B. (2016) Working with Older Survivors of Abuse: A Framework for Advocates NCALL

    A comprehensive resource guide providing strategies for offering "responsive, victim-defined advocacy;" "elder-informed" services, including safety planning, that are tailored to the needs and circumstances of older survivors; that are welcoming and accessible; that benefit from collaborations with organizations with expertise, experience, and resources in assisting older adults; and that likewise benefit from trainings that promote greater understanding of the needs of older survivors, and that encourage the respectful provision of services that protect the dignity of the older participant.

- National Clearinghouse on Abuse in Later Life Website Resources (a sampling):

    ➢ NCALL Online National Abuse in Later Life Resource Directory (2014 edition) - a searchable data base for older adult survivor services, searchable by state and (using the advanced search) type of service.

    ➢ NCALL Resources and Publications Webpage – providing links to a broad range of print and multimedia resources addressing Abuse in Later Life and Elder Abuse more generally, and domestic violence, sexual abuse, and stalking in particular; dealing with caregiver stress; collaboration and supporting a coordinated community response; confidentiality and mandatory reporting; ; Emergency Shelter and Transitional Housing; working with the faith community; working with health care providers; serving survivors in rural communities; serving survivors from tribal communities; safety planning; serving survivors with disabilities; safe use of technology; and more.

    ➢ NCALL Technology and Abuse in Later Life webpage, leveraging materials developed by Disability Rights Wisconsin, End Domestic Abuse Wisconsin, and the National Network to End Domestic Violence Safety Net Project. The webpage includes extensive links to information about common technologies and how to use them as safely as possible, assistive technology, techniques that older adults can use to "safeguard themselves from those who misuse technology to control, harass, stalk, and/or threaten them."

    ➢ NCALL's Library of Training Webinars, containing 40+ video trainings addressing a diversity of general and specialized topics, including abuse in later life more generally; caregiver abuse, domestic violence, sexual abuse, financial exploitation, and stalking; addressing neglect/self-neglect; the investigative process; safety planning; confidentiality and mandatory reporting; addressing

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mobility issues, communication barriers, dementia, and cognitive impairment; victim-defined, trauma-aware, strength-based approaches; program planning and policies; working with older survivors that have experienced violence and trauma over an extended period of time; etc.

➢ NCALL's collections of resources for law enforcement personnel, prosecutors, and civil attorneys.

➢ NCALL's 13-module Advocates' Toolkit, pairing some of the above-listed training videos with relevant printed materials, and a more general Trainers' Toolkit, including PowerPoints, videos, and exercises

- Ramsey-Klawsnik, H. (2010) Sexual Violence in Later Life: A Technical Assistance Guide for Advocates National Sexual Violence Resource Center

  A comprehensive look at sexual assault of older adults: the victims; the signs and symptoms; the different kinds of perpetrators (e.g., intimate partner, family member, caregiver, acquaintance, stranger); the settings in which the abuse takes place (home, institutional care, etc.); added vulnerability and risks due to aging; the tradeoffs that victims weigh in deciding how to respond; prevention strategies; and adapting services to accommodate the abilities and disabilities of survivors.

- Spangler, D. & Brandl, B. (2007) Abuse in Later Life: Power and Control Dynamics and a Victim-Centered Response. J Am Psychiatric Nurses Assoc. 12(6):322-331

  "This article focuses on three main topics: the dynamics of abuse in later life, a victim-centered response, and collaboration. The dynamics of abuse section covers (a) defining domestic abuse in later life [i.e., victim profile, nature of the relationship between the perpetrator and victim], (b) describing why abuse occurs and debunking common misconceptions [e.g., caregiver stress] about causation, (c) identifying consequences of abuse, and (d) discussing common barriers victims experience that make it difficult for them to live free from abuse. The victim-center response section highlights (a) recognizing indicators [of abuse], (b) screening [interviewing to assess for abuse], (c) offering hope and support, (d) providing information and referrals, (e) planning for safety, and (f) reporting. Given the complexity of these cases, the final section focuses on collaboration between domestic violence, mental health, adult protective services, aging network, and other professionals." (p.323)

(iii) *What Providers Told Us*

Although most of the preceding discussion about abuse in later life emphasize a range of different types of abuse, the survivor situations that providers discussed pertained to domestic violence, typically in longstanding relationships that the victim had finally decided to end.

An older adult DV survivor who decides to leave an abusive situation faces the challenge of undertaking a dramatic, dislocating late-in-life change that may take them away from the home and community they've known for years, and may engender opposition and alienation from their children and family members who don't understand or don't support their decision, or who feel allegiance to the abusive partner.

Starting over again as an older adult can be frightening, particularly if it means new housing in a new community where the older adult has no social network. An older adult who has been out of the workforce for years would likely have a difficult time finding employment, if they needed income above and beyond what they are entitled to through pensions, Social Security, etc.

Providers observed that in order to serve older adults, they need an understanding of a very different set of resources -- Social Security, SSI, Medicare, elderly housing, Area Agencies on Aging, home care, home health care, etc. -- as compared to the systems they would need to understand in order to serve younger people. To the extent that they are serving people who are more likely to have physical or sensory limitations, they need to arrange for housing (and perhaps longer-term services) that address the abilities and any disabilities that the survivor may have.

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(iv) Provider Comments on Serving Older Adults

> **Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.**

(#01) We see elderly participants in the shelter, but we have never seen them ask for transitional housing.

(#02) We've always served elderly participants, but we saw that maybe we weren't serving as many people as we should be, or were somehow missing people. So we work closely with adult protective services now so they can call us directly when there's domestic violence or sexual assault and get us involved if the person would like. We have a later-in-life advocate right now, who's specifically designated to support folks and make sure that we're addressing their unique needs.

(#03) The older adults that we've served have tended to do very well in our transitional housing. Leaving a long-term abusive relationship is a huge step to take as an older person, especially if it essentially means making yourself homeless. Those that we've served tend to be very certain of that decision by the time they've gotten to transitional housing. We try to link them with appropriate support services that can help them in their temporary housing, help them understand their different housing options, and help them get linked with housing that feels safe and quiet, where they will have some support. Senior communities tend to be much quieter than a lot of other apartment buildings, and that tends to appeal to most of the older adults.

(#04) A lot of cross-training had to happen between people who work in geriatrics and the domestic violence case workers, who were used to serving younger people. For 6 to 9 months, there was a lot of communication and training and outreach. We had to re-think things like the words we use on the brochures. People who are 80, when they hear "domestic violence", may think it's just somebody that's been beaten by their husband. They don't understand that it could mean emotional abuse and threats and different things.

When these women were younger and were having children, domestic violence wasn't even a crime. It wasn't something you could prosecute someone for. So for us to say, "We can report this and we can get protection from abuse orders," that's sometimes just foreign to them. They don't necessarily trust it right away.

Older adults are much more reserved, I think, about discussing what's happened to them. There's a lot of shame and it just takes longer time and a deeper understanding of where they're coming from. We figured out early on that although DV shelters say, "we serve any age," in fact, the older women don't think of those shelters as a place they can go, because the focus in those shelters is on younger women and their children. Older adults end up feeling like they need to be grandma – caretakers for the kids.

And although they're fabulous advocates, the staff at these shelters didn't know anything about elder services -- about Social Security, Medicare, elderly housing -- things that older women need. There's a lot to learn about how public benefits and housing programs differ for older people versus younger persons and families.

Our advocates spend a lot of time filling out applications and getting people to the Social Security office and taking care of all those things that have to be done in order for them to live independently after the transitional period is over -- separate from the whole emotional turmoil of moving and leaving their home environment. And, it's always interesting how the adult children respond to issues about domestic violence. Some are very supportive of their mother leaving and want to help her. And other times, there's resistance.

We served a woman who had been married for 43 years to this really abusive man. They had two sons and a daughter. And when she finally got up her nerve to leave, we said, "Don't even let your kids know where you are because you don't know how they'll respond, and we want to keep the location secret and keep everyone safe." So she said, "No, I wouldn't tell them. My sons are really angry with me for leaving." They were upset because her leaving was going to put the burden of taking care of the diabetic father on them, even though

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they knew that he was abusive to her. It was like she had somehow abandoned them. But we don't work with the family. Just like DV agencies don't mediate between the victim and the abuser.

(#05) (Not a current OVW grantee) We see older adults who are leaving long-term relationships, especially in the emergency shelter. And that's one of the hardest things to see to see - somebody that's been abused for so long. And sometimes they don't even know it. They don't even recognize that it's abuse until they're at a breaking point that has them reach out to us on our crisis line maybe, or walk into the shelter. I think it's harder for those clients to leave, because they've been together for so long. It's a huge change in their life.

(#06) Some older people feel that "shelter's not for me. I'm not walking around with two black eyes," or "Save that space for a younger person who has more to live for in life." They have the old stereotypes that "If you're in this place, you're a certain kind of person." I think that's one of the great benefits of the OVW funding for transitional housing - that we can offer a safe, abuse-free home for a person who isn't comfortable with the idea of going into a communal shelter.

A person that we were working with recently, in her 60s, came in as an outreach client. She felt like shelter wasn't for her. She has a lot of mental health issues, a lot of anxiety, and she has a dog, so shelter wasn't a good fit for her. The OVW-funded transitional housing was really a wonderful thing for them. And I came to understand that pets can be a significant part of their life and it would be a great loss to them if they had to part with their animal. This particular client suffered from depression. She would just isolate herself and stay in the house, but because she had the dog, and because the dog has to go out, it got her to go out, so the dog is helping with her mental illness. The scattered site program is a great option for survivors like them.

(#07) The majority of participants fall in the 25 to 40-year range and second-most are the 18 to 24-year-olds. We don't see a lot of older survivors coming and asking for help; I'm not sure why. With our OVW rural funding, we do a lot of community outreach: we have billboards in the rural areas that advertise that we provide services. We have this coordinated community response (CCR) network that we've built with all of our community partners – law enforcement, judges, health care professionals, faith-based professionals – and we offer trainings for them, and we do a lot to get out into the community to make sure that everyone is aware of our services and how to access them -- but we don't see a lot of the older survivors seeking services.

(c) <u>Serving Male Survivors and Survivor Families with Older Male Children</u>

(i) *<u>Overview and Regulatory Framework</u>*

In an effort to discourage enrollment policies which discriminate against male survivors and families with older male children, the [annual OVW solicitation for TH grant proposals](#) warns against "activities that compromise victim safety and recovery," such as "procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children." (p.3)

Historically, providers operating congregate transitional housing programs were often reluctant to serve men and older male dependents of female survivors. None of the interviewed providers expressed concern about serving families with male children under age 18. A number of providers, however, described their program as serving "women and families."

The [Fair Housing Partners of Washington State's Guide to Fair Housing](#) gives advice to shelters that seems equally applicable to congregate transitional housing.

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"Gender is a protected class under fair housing laws, and male domestic violence survivors need housing services similar to female survivors. There may be privacy reasons and compelling programmatic reasons for excluding adult men from domestic violence shelters that serve women, but communities and funders should have a mechanism in place for serving male domestic violence survivors in an alternative fashion (for example, a separate facility for males or providing motel vouchers with counseling services)." (p.26)

Scattered site and clustered units don't have to worry about the problems engendered by a coed facility; however, to the extent that male survivors can be transitionally housed in their own units, there would no longer seem to be a compelling reason to exclude males from being served. It was not clear (and interviewers did not push the question) whether programs that claimed to serve only women and families were prepared to offer an option for serving male survivors.

Emergency shelters, transitional housing projects, and permanent housing projects funded with HUD grants awarded under the Continuum of Care (CoC) and/or Emergency Solutions Grant (ESG) programs are subject to the same kind of prohibition against discriminating against families based on the age/gender of their children as OVW-funded projects. Approximately 42% of the providers interviewed for this project also receive HUD CoC funding for their Transitional Housing projects, or ESG or CoC funding for their Rapid Rehousing (transition-in-place) projects. All these projects are subject to the provisions of Section 404 of the McKinney-Vento Act as amended by the HEARTH Act in January 2009 (see pp. 13-14):

Section 404 Preventing Involuntary Family Separation. *Starting two years after enactment [of the HEARTH Act], any shelter, transitional housing, or permanent housing program that serves families with children would be required to serve families regardless of the children's ages. The only exception is when a transitional housing program is using an evidence based practice that requires targeting families with children of a specific age, and only when the provider commits to ensuring that any family they do not serve has an equivalent and appropriate alternative for the entire family.*

The corresponding HUD regulation, 24 CFR Part 578.93(e), states that, "The age and gender of a child under age 18 must not be used as a basis for denying any family's admission to a project that receives funds under this part." As explained in the preamble to the regulation, "This provision clarifies, especially for projects where the current policy is to deny the admittance of a boy under the age of 18, that denying admittance to a project based on age and gender is no longer permissible."

Again, the Fair Housing Partners of Washington State's Guide to Fair Housing advice to shelters seems equally applicable to congregate transitional housing. (Again, programs utilizing scattered site and clustered units should have no problems complying with the requirement.)

"Housing and shelter providers who house domestic violence survivors and their children, or other women and children, should not refuse to house women with sons under 18. If there are no shared sleeping or bathing areas or shared bathrooms, such policies [i.e., refusing to house women with teenage sons] are probably illegal. Even in environments where there are shared sleeping or bathing areas, providers should consider if there is any way to modify floor plans or usage times to provide privacy. Funding sources may want to consider providing resources to ... increase privacy.

Refusing to house teenaged sons is an especially risky policy in smaller communities where few housing or shelter resources are available. If a family is turned away because they have teenaged sons and they are not provided with alternative lodging and necessary services, that family would be considered a victim of discrimination. Some providers have expressed concerns that teenage boys may have had past arrests or other run-ins with the criminal justice system. A housing or shelter provider could screen teenagers for past arrests, just as they screen adults, as long as the screening criteria is used consistently for both males and females." (pp. 25-26)

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(ii) *Provider Comments on Serving Adult Males and Families with Older Male Children*

> ***Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.***

(#01) We haven't had a male in transitional housing but I'm waiting and excited for that to happen because it means we're growing and learning, and the DV movement is expanding. We're open to it if it comes up.

(#02) We've always taken boys up until the age of 18, both at our shelter and in our transitional housing program. It's never posed a problem, because our housing is all scattered site, not congregate living. They're basically living as a family. We've even had a couple with male children who were over 18 and dependent on their mother because of a developmental disability -- and we had no problem. We keep families together.

(#03) We don't have an age limit on the children staying in emergency shelter or the transitional program. If it's an adult male child, 19 or older, it's difficult to say; it has happened in transition. Sometimes they're by themselves; sometimes they're living with another family in our transitional unit. We would have to take into consideration who else was living there. But if he was a 20-year old young man and he's been her dependent, we would not say no to that.

(#04) We haven't had a man in transitional housing, but we actually had a male last week who we thought would be appropriate for transitional housing. So we asked our current clients in the clustered site -- because that's where we have an opening -- if they would be okay with having a male victim living in the building. And they each said that they had no problem with that: that a victim is a victim. It turns out we had some different funding that allowed him to stay in the apartment that he was in, and he preferred that.

(#05) We've housed men in our emergency shelters, we've housed Trans women, we've housed gay men; we really haven't had too many problems. We just do it and figure it out later.

(#06) If a survivor is a male that's transitioned to female, then they would be treated as a female, so they would have access to both DV shelters and they'd have access to transitional and permanent supportive housing. We've had transgender women in our shelters. We don't serve men in our DV shelter because it's a DV shelter but we place male survivors in hotels, and so if the survivor is a female that has transitioned to a man, then they would be served in the hotel, just like a man.

Questions to Consider

1. What are the pros and cons of serving younger adults separately versus as part of a transitional housing programs that serves adults of all ages?

2. What are the pros and cons of serving older adults separately versus as part of a transitional housing programs that serves adults of all ages?

3. What would a transitional housing program for young adult survivors that takes a survivor-centered approach and that adheres to the voluntary services model look like ...

- Given that young adult survivors may not be developmentally ready to commit to working towards a stable "adult" lifestyle -- e.g., with regular employment, motivated by a desire for financial stability, characterized by (primarily) celibate sleeping arrangements, with only limited alcohol use, and without use of illicit drugs; and

- Given that young adult survivors are likely to be further victimized and/or get into trouble with the law -- if they remain homeless and without a "legitimate" means of self-support?

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4. Does transitional housing have a more limited or different role if an older adult survivor can get into elderly housing within a short time frame? What kind of longer term support would an older adult survivor need once they transitioned to elderly housing?

5. To the extent that some older adult victims/survivors might think of DV shelters, especially shelters that serve families with children, as "not for them," and given that DV shelters are often the gateway to transitional housing and transition-in-place housing, what kind of system would offer older survivors a more appropriate pathway to residential stability and safety from further domestic violence?

6. As discussed in the narrative, there are a number of reasons why older adult survivors may not want to publicly acknowledge that they have been abused or assaulted, and may not want to see the abusive family member or caregivers punished, for fear that loss of that caregiving resource could lead to the older adult's loss of independence, and necessitate a move from their longtime home.

- How can an advocate who is a mandated reporter, nonetheless develop a trusting and empowering relationship with an older adult who may be in an abusive relationship, and allow that older adult to make the same kinds of decisions as a survivor in their 20s, 30s, or 40s who is deciding whether to leave/stay with/return to an abusive relationship?

- Is there a way for an advocate to have a candid discussion without precipitating the need to file a report of suspected abuse that takes control and autonomy away from the older adult survivor, and puts it in the hands of the investigating authority? If there is no way to have such a candid discussion without precipitating a filing, does that discourage disclosure by the older adult?

7. To the extent that peer support is an integral part of the transitional housing experience of women in the program, is a scattered site alternative for male or transgender male survivors an adequate and comparable alternative?

- If a program offers support groups and other group activities, would the participation of a male or transgender male survivor inevitably adversely impact the participation of the female survivors, or could skillful facilitation avoid any such impact?

6. Serving Ex-Offender Survivors

(a) Overview: Survey of Resources

Although quite a few providers interviewed for this project spoke about TH program participants' challenges in overcoming their history of criminal justice involvement, in order to get a job or housing, only one provider specifically discussed how their program was tailored to meet the needs of ex-offenders. That provider worked with the OVW to gain approval to arrange for the periodic urinalysis tests that the probation officers required, as a condition for approving placement of the women in the program. Likewise, being able to demonstrate that they had the required amount of "clean time" was prerequisite to some of the women served by the program being able to regain custody of their children. No other provider that we interviewed described any specific steps that they were required or chose to take, to enable their program to effectively serve ex-offenders.

That said, much has been written about (a) how women's prisons are filled with victims of domestic and sexual violence; (b) how the crimes that women were sentenced for may have been linked to coerced activities related to the domestic or sexual violence they experienced; (c) how women in prison that defended themselves against a perpetrator of violence do not belong in prison; (d) how daunting are the challenges facing women exiting prison, especially low-income women, with limited educations, limited employability, and limited (if any) ability to call upon family for support; and (e) how re-entering the community with little or no money to rent an apartment or to cover other basic costs of living leaves a woman vulnerable to the same kind of financial dependence and abuse that she struggled with before she was incarcerated.

The following are some resources available online that may be of interest to providers serving ex-offender survivors, or to the survivors themselves:

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(i)   Covington, S. S. (2002) *A Woman's Journey Home: Challenges for Female Offenders in Prisoners Once Removed: The Impact of Incarceration and Reentry on Children, Families, and Communities. Travis, J. and Waul, M. eds.* Urban Institute

"Among women, the most common pathways to crime are based on survival (of abuse and poverty) and substance abuse. Pollock points out that women offenders have histories of sexual and/or physical abuse that appear to be major roots of subsequent delinquency, addiction, and criminality (Pollock, 1998).

The link between female criminality and drug use is very strong, with the research indicating that women who use drugs are more likely to be involved in crime (Merlo and Pollock, 1995). Approximately 80 percent of women in state prisons have substance abuse problems (CSAT, 1997), and about 50 percent of female offenders in state prisons had been using alcohol, drugs, or both at the time of their offense (Bureau of Justice Statistics, 1999). Nearly one in three women serving time in state prisons report having committed their offenses in order to obtain money to support a drug habit. About half describe themselves as daily users.

Abusive families and battering relationships are ... strong themes in the lives of female offenders (Chesney-Lind, 1997; Owen and Bloom, 1995). Frequently, women have their first encounters with the justice system as juveniles who have run away from home to escape situations involving violence and sexual or physical abuse. Prostitution, property crime, and drug use can then become a way of life. Addiction, abuse, economic vulnerability, and severed social relations often result in homelessness, which is another frequent complication in the lives of women in the criminal justice system (Bloom, 1998b).

Another gender difference found in studies of female offenders is the importance of relationships and the fact that criminal involvement has often come through relationships with family members, significant others, or friends (Chesney-Lind, 1997; Owen and Bloom, 1995; Owen, 1998; Pollock, 1998). Women are often first introduced to drugs by partners, and partners often continue to be their suppliers. Women's attempts to get off drugs and their failure to supply partners with drugs through prostitution often elicit violence from the partners; however, many women remain attached to partners despite neglect and abuse. These issues have significant implications for therapeutic interventions addressing the impact of relationships on women's current and future behavior.

The gender differences inherent in all of these issues -- invisibility, stereotypes, pathways to crime, addiction, abuse, homelessness, and relationships -- need to be addressed at all levels of criminal justice involvement. Such issues have a major impact on female offenders' successful transition to the community, in terms of both programming needs and successful reentry. Unfortunately, these issues have until now been treated separately, at best, even though they are generally linked in the lives of most women in the system. The absence of a holistic perspective on women's lives in a discussion of criminal justice leads to a lack of appropriate policy, planning, and program development." (p.128)

(ii)   The Sentencing Project (2007) Women in the Criminal Justice System Briefing Sheets

Presents statistical data addressing the sociodemographics of women in prison. (a) Women in prison were more likely to report using drugs at the time of their offense than men; the majority would not receive treatment while they were in prison. (b) Women in prison were substantially more likely to have a mental health problem, including a diagnosed mental health problem than male inmates; the majority would not receive treatment in prison. (c) Women were more likely than men to have been convicted of a drug or property offence and substantially less likely to have been convicted of a violence crime; (d) 57% of women incarcerated under state jurisdiction reported that they had experienced either sexual or physical abuse before their admission to prison; (e) Black women were more than three times as likely as white women to be incarcerated and Hispanic women 69% more likely, so that Black children were almost 9 times more likely than white children to have a parent in prison and Hispanic children were 3 times more likely; (f) Nearly half (44%) of women in state prisons had not completed high school, and nearly one-third (30%) were receiving welfare benefits prior to their arrest (most would become ineligible to receive benefits, due to their offense).

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Other sources of statistics from approximately the same time period are:

- the American Civil Liberties Union's Words from Prison - Did You Know...? webpage

- The Domestic Violence Survivors Justice Act (DVSJA) Campaign webpage; the DVSJA Campaign "is part of the Coalition for Women Prisoners' multi-year advocacy campaign to change the criminal justice system's response to DV survivors who act to protect themselves from an abuser's violence. . . . The Coalition for Women Prisoners, coordinated by the Correctional Association of New York's Women in Prison Project,[72] is a state-wide alliance of more than 1,800 people and 100 organizations. Members include people with criminal justice histories, social service providers, community-based organizations, lawyers, teachers, students, faith leaders, and concerned individuals."

(iii) Kubiak, S., Sullivan, C.M., Fries, L., Nnawulezi, N., & Fedock, G. (2011). Best Practice Toolkit for Working with Domestic Violence Survivors with Criminal Histories. Michigan Coalition Against Domestic and Sexual Violence

The Michigan Coalition Against Domestic and Sexual Violence's **Open Doors Project** is a national demonstration project that aims to identify and address the many barriers that incarcerated and formerly incarcerated domestic and sexual assault survivors face in obtaining advocacy and support from domestic violence and sexual assault programs. An important capacity-building goal of the Open Doors Project is to enhance the community collaboration between DV/SA advocates, community service providers, and those working in the criminal justice and corrections systems. The goal of these collaborations is to facilitate a shared objective of keeping women safe and out of jails and prisons.

The Open Doors Best Practices Toolkit addresses the following topics: (a) what DV advocates need to know about the criminal legal system (how it works and the services provided); (b) how domestic and sexual violence (broadly defined) may occur and impact women before, during, and after incarceration; (c) the need and opportunities to advocate for women throughout the criminal legal/incarceration process (pleading, trial, sentencing, incarceration); (d) visitation, facilitating counseling and support groups, safety planning; and planning for reentry; (e) parole and probation; (f) what criminal legal professionals need to know about working with DV survivors (decreasing re-traumatization, screening for trauma history, safety, confidentiality); (g) women's needs after incarceration (housing, employment, child custody, financial assistance, the criminal record, health/mental health/addiction-related services; immigration-related issues; helping women stay safe and free); challenges and strategies for collaboration between domestic violence and criminal legal advocates.

The Open Doors project also created "Advocating for Women with Abusive Partners Who Are Facing Criminal Charges," described as a resource to "assist DV/SA program advocates and executive leadership staffs to critically problem solve through the barriers and hardships which survivors, who are facing criminal charges, experience in the various stages of the [criminal legal] process. The [resource] includes ... advice and suggestions for advocacy at all stages of a survivor's experience with the legal system including ... outstanding warrant ... arrest and pre-trial ... prosecution - trial stage ... sentencing ... appeal, commutation, and clemency ... {and} post-conviction parole and probation.

(iv) National Clearinghouse for the Defense of Battered Women - Reentry Resources

As described on its webpage,

> "The National Clearinghouse for the Defense of Battered Women, a nonprofit organization founded in 1987, is a resource and advocacy center for battered women charged with crimes related to their battering.

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[72] Founded in 1844, the Correctional Association of New York (the CA) is an independent non-profit organization that advocates for a more humane and effective criminal justice system and a more just and equitable society. In 1846, the CA was granted authority by New York State Legislature to inspect prisons and to report its findings and recommendations to the public.

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Through its work, the organization aims to increase justice for — and prevent further victimization of — arrested, convicted, or incarcerated battered women.

The National Clearinghouse works with battered women who have been arrested and are facing trial, as well as those who are serving prison sentences. Most frequently, these cases involve women who have defended themselves against life-threatening violence at the hands of their abuser, and have been charged with assault or homicide. We also assist in cases where women have been coerced into crime by their abuser, are charged with "failing to protect" their children from their abuser's violence, or are charged with "parental kidnapping" after fleeing to protect themselves or their children from their abuser.

National Clearinghouse staff provide customized technical assistance to battered women charged with crimes and to members of their defense teams (defense attorneys, advocates, expert witnesses and others). The National Clearinghouse does not provide direct representation to battered women charged with crimes. Rather, staff provides information and resources to defense teams at any stage of the legal process (pre-trial, when the case is on appeal, and in limited circumstances, during post-conviction proceedings) in an effort to increase the likelihood of a better – and more just – outcome. . . .

In addition to providing individualized technical assistance, National Clearinghouse staff conduct training seminars for members of the criminal justice and advocacy communities, and for the general public, regarding the unique experiences of battered women defendants. Our Resource Library contains a comprehensive collection (over 11,000 entries) of articles, case law, litigation materials, and legislation relevant to battered women who find themselves in conflict with the law."

With the help of grant funding from the Office on Violence Against Women, the National Clearinghouse has compiled resource listings on the following topics [to support] survivors as they reenter their communities after being incarcerated in prison and/or jail:

- General Overview (general resources addressing reentry, narrative overviews, national resources)
- Collateral Consequences (understanding and mitigating the direct and collateral consequences of criminal records)
- Curricula and Groups (curricula and resources for working with incarcerated and reentering women individually and in groups)
- Evidence-Based Practices (evidence-based reentry practices for justice-involved women)
- Employment (employment issues, strategies, resources for reentering people)
- Family Reunification (strategies and resources for family reunification for reentering people)
- Health & Health Insurance (addressing incarcerated and reentering women's health & health insurance needs)
- HIV & AIDS (resources to assist women living with HIV/AIDS with histories of criminal justice)
- Juvenile Justice (supporting reentering youth and/or youth with juvenile justice involvement)
- LGBTQ People (addressing the needs and protecting the safety of arrested, charged, incarcerated, and returning LGBTQ people)
- Mental Health, Substance Abuse & Co-Occurring Disorders (supporting justice-involved victims of battering with mental health, substance abuse, and co-occurring disorders)
- Probation and Parole (supporting victims of battering who are on probation or parole)
- Sexual Abuse & PREA[73] (addressing sexual abuse inside jails and prisons)

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[73] Prison Rape Elimination Act

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7. Serving Deaf Survivors

(a) Introductory Note

As described in the introduction to Deaf Culture in the National Resource Center on Domestic Violence (NRCDV)'s Special Collection on Violence in the Lives of the Deaf or Hard of Hearing,

> *"According to federal definition, people who are part of the group commonly referred to as deaf and hard of hearing have a disability. Thus, they have the right to accommodations under the Americans with Disabilities Act (ADA) as well as the Rehabilitation Act of 1973 and other pertinent laws.*

> *However, within this group there are several sub-groups. Among them are those who consider themselves Deaf, with the capital D signifying a cultural identity. These members of the Deaf community do not typically consider themselves to have a disability; rather they consider themselves to be part of strong culturally cohesive community. While not all people who are deaf or hard of hearing identify with the Deaf culture, a significant portion do. Organizations must integrate knowledge of Deaf culture into their policies, practices, and attitudes in order to provide culturally affirmative services to Deaf survivors.*

> *To understand Deaf culture, it is helpful to consider the definition of culture in general: the values, traditions, norms, customs, arts, history, folklore, institutions, and experiences shared by a group of people who are defined by race, ethnicity, language, nationality, or religion. In the United States, one of the central unifying characteristics of Deaf culture is the use of American Sign Language (ASL). ASL is a language with an established linguistic structure; it is not a different form of English, as many believe (for an illustration of the differences between ASL and English, see the PowerPoint/webinar Violence in the Lives of the Deaf: Unique Challenges). The use of ASL brings together a disparate group of individuals across the country, essentially creating a medium for shared values, norms, traditions, history, and experiences. This strengthens and emphasizes the linguistic minority status of the Deaf community.*

> *There has been a significant movement in the United States to develop direct, culturally specific services for Deaf survivors of sexual and domestic violence. More than a dozen programs are currently operating across the country and many more are in development. However, since most communities do not have ready access to these programs, hearing advocates continue to have a significant role to play in offering culturally appropriate and linguistically accessible advocacy services to Deaf survivors of sexual and domestic violence."*

(b) Survey of Resources

(i) The ***Deaf Survivors of Domestic and Sexual Violence section of the NRCDV's Special Collection*** provides links to resources addressing important aspects of domestic and sexual violence as they might affect a person who is Deaf or Hard of Hearing.

- A webpage listing Organizations for Deaf Survivors of Abuse identifies and provides links to programs in over a dozen states and the District of Columbia, and notes that "the National Domestic Violence Hotline (NDVH) provides lifesaving tools and immediate support to [survivors]. The hotline has partnered with the Abused Deaf Women's Advocacy Services (ADWAS) to ensure Deaf advocates are available to respond through email, instant messenger, and video phone to those callers seeking help:

    IM: DeafHotline
    Email: deafhelp@thehotline.org
    TTY: 1-800-787-3224
    Video Phone: 1-855-812-1001
    Live Chat: www.thehotline.org

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- A 2009 [PowerPoint by Gretchen Waech of the Justice for Deaf Victims National Coalition](#) offers suggestions about communicating with Deaf persons, and explains some of the special challenges that might arise for a Deaf survivor, for example:

  - lack of accessible/culturally competent services, resulting in difficulty communicating with law enforcement, health/mental health care providers, and/or victim service providers who are not trained in American Sign Language, and who cannot provide access to interpreters;

  - issues related to gossip versus confidentiality in the Deaf community, and/or secrecy/protection of perpetrators who are members of the Deaf community;

  - need for specialized safety planning, for example, even if the survivor chooses to relocate geographically, she remains a member of the Deaf community, and vulnerable to the spread of gossip that might compromise her safety; and/or

  - abuse which targets the victim's hands/ability to sign, or technology/ability to electronically communicate.

- A [Q&A accompanying the webinar/PowerPoint](#) provides the following guidance about accessible communication (as well as affirming the right of survivors to have an interpreter[74]):

  - **Q: Are TDD/TTY machines still in common use in the deaf community or has text messaging or IM/chat become more popular?** A: "TTY machines have fallen out of use in the Deaf community in general due to the popularity and availability of videophones (VP). In using a TTY, one runs into the problem of language barriers just as one would in written communication, whereas the VP allows a Deaf person to communicate in his or her own language [i.e., ASL]. However, the technology required for use of a VP is not always available or affordable; thus, some Deaf persons continue to use their TTY. IM, chat, text messaging, and email are used more often than are TTYs, but again, the language barrier exists for those for whom ASL is their first language."

  - **Q: What kind of equipment/assistive technology do you recommend we have in programs in order to facilitate the communication with Deaf survivors and enhance their safety in case of emergencies?** A: "I don't advise programs to consider accessibility to be reachable via equipment purchase; rather, access is best achieved through a deeper change in attitudes and thought process. There are two concrete actions programs can take: spending some time familiarizing staff with the use of relay services (both calling out and receiving calls) and, in the case of shelter [residential] programs, installing and maintaining video phones to enable Deaf residents to have access to communication equal to that offered hearing residents...."

- The [VawNet webpage on Accessibility](#) offers the following guidance:

  "Understanding your responsibility as service providers to Deaf or hard of hearing populations establishes the foundation for making those services accessible. Such responsibilities are delineated in the [Americans with Disabilities Act](#), Section 504 of the Rehabilitation Act, and the Fair Housing Act. However, these requirements describe minimum standards *for accessibility. Creating an environment and a program that is truly welcoming to Deaf individuals requires solutions that exceed these expectations. . . . Understanding that accessibility goes beyond improving the physical characteristics of a building is critical for service providers. [Restrictive] programmatic or attitudinal practices, such as maintaining strict 9-5 access to a video phone while providing 24/7 access to a regular phone, can be devastating for Deaf individuals. Assistive devices such as video phones, computers, and smart phones make communication with the*

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[74] See the VawNet webpage on [Use of Interpreters](#) for information on how providers can make interpreting accessible.

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outside world and with one another possible for Deaf persons. The importance of this type of communication accessibility cannot be overstated.

Additionally, when Deaf survivors are expected to engage in a [program] culture that does not promote accessibility ... the survivor may become further isolated and more likely to leave the [program], for example if there are] punitive or restricting practices [like] refusing to provide interpreters (often excused due to the cost/budget restraints) or expecting the survivor to surrender a cell phone in the name of safety.

In the context of sexual assault programs, the issue of accessibility revolves primarily around the need for a certified and qualified sign language interpreter during individual and group counseling sessions and any other contact between the survivor and agency. Although adding a third party during these sessions is not ideal, it provides the survivor with the option to share her story. Utilizing paper and pen or a computer during these sessions in place of an interpreter is not recommended unless the survivor specifically requests to communicate in this manner."

(ii) *Culture, Language, and Access: Key Considerations for Serving Deaf Survivors of Domestic and Sexual Violence* (cited as Smith & Hope, 2015), a resource developed by the Vera Institute with funding support from the OVW, which provides background information on the Deaf community; available data about the perpetration of domestic and sexual violence against members of the Deaf community; ways in which Deaf persons are uniquely vulnerable to such violence and the barriers to accessing victim services; the gap in accessible and appropriate victim services; the role of Deaf-run, Deaf-staffed victim services providers[75] in partially filling that gap; and challenges, strategies, and recommendations for building successful collaboration between mainstream and Deaf providers to build mutual capacity to address violence against Deaf women.

(iii) *Serving Individuals Who Are Deaf, Hard of Hearing or Deaf-Blind and Do Not Use American Sign Language*, a Tip Sheet developed by the Asian Pacific Institute on Gender-Based Violence, emphasizes the importance of staff training and preparedness for a range of possible communication preferences, the ability to partner with appropriately resourced providers, and testing assumptions about fluency in sign language, English literacy, and/or use of technology.

8. Serving Survivors with Disabilities/Reasonable Modification and Accommodation

(a) Overview: Prevalence and Impact of Domestic/Sexual Violence on Survivors with Disabilities

Note: As discussed in Chapter 11 ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children"), the physical, psychological, and emotional violence perpetrated by an abusive partner or sexual assailant can cause or exacerbate disabling trauma; it can also result in traumatic brain injury (discussed in a subsequent section) or other physical injuries. The more extensive and prolonged the abuse and violence, the more profound the impact. As also cited in Chapter 11, persons who experienced abuse and neglect as children or adolescents are more prone to victimization in their later lives, and the resulting complex trauma can be extremely debilitating. Although much of the discussion that follows describes the vulnerability of persons with physical or sensory disabilities to abusive behavior by their partner/caregiver, all of the federal protections ensuring programmatic accessibility, reasonable accommodation, etc. apply to victims/survivors with a disabling condition that pre-dates the abuse/violence, as well as to victims/survivors whose disabling conditions were caused or exacerbated by that abuse/violence.

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[75] See, especially the website of Abused Deaf Women's Advocacy Services (ADWAS), the Seattle-based organization that pioneered the effort to create Deaf-led resources to address violence against women.

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Findings from a decade's worth of research compiled as part of Powers et al.'s (2009)'s report, ***Interpersonal Violence and Women with Disabilities: A Research Update*** describe the disproportionate and multifaceted impact of domestic and sexual violence on women with disabilities and Deaf women, as a result of "complex intersections of [these] women's experience of impairment, poverty, isolation, reliance on others for support, discrimination, and other factors that may restrict women's violence awareness, safety promoting behavior, and access to resources:"

> *"Recent studies confirm earlier findings that, compared to women without disabilities, women with disabilities are more likely to experience physical and sexual violence (Brownridge, 2006; Martin et al., 2006; Powers et al., 2002; Smith, 2007), increased severity of violence (Brownridge, 2006; Nannini, 2006; Nosek et al., 2001b), multiple forms of violence (Curry et al., 2004; Martin et al., 2006; Nosek et al., 2001a), and longer duration of violence (Nosek et al., 2001b).*

> *For example, Powers et al. (2002) surveyed 200 women with disabilities and found that 67% of the women had lifetime experiences of physical abuse and 53% had experienced lifetime sexual abuse. Brownridge (2006) found that, compared to women without disabilities, women with disabilities had a 40% greater chance of experiencing intimate partner violence in the five years prior to the study. Martin et al. (2006) found that women with disabilities were four times more likely to have experienced sexual assault in the past year than non-disabled women. In a recently completed study of 305 women with diverse disabilities and Deaf women, 68% of participants reported physical, sexual, emotional, and/or disability related violence in the past year (Curry et al., 2009, referred to as Safer and Stronger study).*

> *Research consistently documents the high cost of interpersonal violence for women with disabilities, including its negative impact on women's abilities to work, to live independently, and to maintain their health (Hassouneh-Phillips et al., 2005; Nosek, Hughes, Swedlund, Taylor, & Swank, 2003; Nosek et al., 2006; Powers et al., 2002). In a survey conducted by Powers et al. (2002), of 200 women with mobility disabilities, and mobility and intellectual disabilities, 30% of the women reported that interpersonal violence kept them from maintaining employment, 61% said interpersonal violence stood in the way of independent living, and 64% indicated interpersonal violence kept them from caring for their health.*

> *While early research focused primarily on physical, sexual, and emotional violence against women with disabilities, additional forms of disability-specific violence have now been documented. Examples include destruction of medical equipment and communication devices, withholding, stealing or overdosing of medications, physical neglect, and financial abuse (e.g., Curry, Powers, & Oschwald, 2004; Gilson, Depoy, & Cramer, 2001; McFarlane et al., 2001; Nosek, Foley, Hughes, & Howland, 2001a; Saxton et al., 2001). Recent research continues to support earlier findings that maltreatment by personal assistants and other service providers is a unique problem facing Disabled women (Nannini, 2006; Nosek, Howland, Rintala, Young, & Chanpong, 2001c; Oktay & Tomkins, 2004; Powers et al., 2002; Saxton et al., 2006). This class of perpetrators includes not only spouses and other domestic partners who may dually function as unpaid or paid personal assistants but also parents or other family members, friends, and health care and other service providers. . . . Dependence on a perpetrator for essential personal care and/or specialized services for communication or mobility (such as an interpreter or mobility guide) adds an additional layer of difficulty to seeking safety (Copel, 2006)."*

As described in Hoog (2003)/The Washington State Coalition Against Domestic Violence's "Enough and Yet Not Enough,"

> *"Violence against people with disabilities has been characterized as 'occurring in the context of systemic discrimination against people with disabilities in which there is often an imbalance of power, including both overt and subtle forms of abuse, which may or may not be considered to be criminal acts' (Ticoll, 1994). Persons with disabilities actually experience a much higher rate of abuse and have significantly fewer pathways to safety. Although people with disabilities are susceptible to the same general types of violence*

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as the population at large, the barriers they face expose them to additional ways for perpetrators to target their abuse." (ch.1, p.7)

In intimate partner relationships – and in relationships involving family or paid caregivers -- risk of physical, sexual, psychological, and financial abuse is exacerbated by dependence and isolation related to the victim's mobility or communication barriers, lack of control over personal finances, and fear of the consequence of losing necessary help and support. And as with other domestic and sexual violence, the risk increases with a perpetrator's alcohol or drug abuse.

(b) <u>Obligations to Serve/Provide Reasonable Accommodations to Persons with Disabilities</u>

Although, as described above, disabling conditions may significantly increase a victim's vulnerability to further abuse and violence, federal laws attempt to ensure that the existence of such disabling conditions do not also make it more difficult for a survivor to access and participate in appropriate housing and services, if and when she so desires.

The Civil Rights Compliance section of the Solicitation Companion Guide (which accompanies the annual OVW TH program grant solicitation) enumerates non-grant-specific federal compliance requirements which grantees must meet, including the requirements of *Section 504 of the Rehabilitation Act of 1973, requiring that federally funded housing and services be both physically and programmatically accessible by persons with disabilities*. OVW grantees also have obligations under the Americans with Disabilities Act, and, if they provide housing, under the federal Fair Housing Act.

As explained in the Fair Housing Partners of Washington State's Guide to Fair Housing (2013), the disabilities covered by these "protection[s] include, but [are] not limited to, mental and emotional disabilities, developmental disabilities, cognitive disabilities (stroke, brain injury, etc.), sensory disabilities (blindness, deafness, etc.), long-term systemic conditions (cerebral palsy, diabetes, heart disease, multiple sclerosis, spinal cord injury, arthritis, HIV/AIDS, cancer, etc.), alcoholism, and drug addiction (provided there is no current use of illegal drugs)." (p.26)

HUD's webpage on the key provisions of Section 504 provides a good summary of Section 504 requirements with respect to housing and services, including the requirements to provide "*reasonable accommodations which may be necessary for a person with a disability to use or participate in the program, service or activity; unless the recipient can demonstrate that the accommodation will result in an undue financial and administrative burden or a fundamental alteration in the nature of the program, service or activity*".

A reasonable accommodation is an *adaptation or modification to a policy, program, service, or workplace* which will allow a qualified person with a disability to participate fully in a program, take advantage of a service, or perform a job. Reasonable accommodations may include, but are not limited to, adjustments or modifications to buildings, facilities, dwellings, and may also include provision of auxiliary aids, such as readers, interpreters, and materials in accessible formats."[76]

Both Section 504 and the Americans with Disabilities Act (A.D.A), which addresses the affirmative obligations of entities providing public accommodations (including housing) and providing services using government funds (e.g., transitional housing), treat alcohol- and drug-addicted persons as persons with disabilities, who must be afforded reasonable accommodations. (Although persons with a history of drug addiction are protected, persons actively using illegal drugs are excluded from A.D.A. protections.)

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[76] See also a May 2004 Joint Statement on Reasonable Accommodations under the Fair Housing Act, issued by the U.S. Departments of Justice and Housing and Urban Development.

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As stated in [Fair Housing for People with Disabilities - A guidance manual for emergency shelter and transitional housing providers](#), a resource published in 2007 by the Mental Health Advocacy Services[77],

> "It is best to inform all applicants of the availability of reasonable accommodations to people with disabilities as part of your obligation to abide by fair housing laws. Most federal and state funding sources require programs receiving their funding to comply with all fair housing and civil rights laws and take steps to affirmatively further fair housing. Informing participants of their rights is a form of furthering fair housing. It is a good practice to include a written statement about the right to reasonable accommodation on the application itself, and to verbally inform all applicants of this right as well." (p.22)

Providers may be generally familiar with their obligations under the Americans with Disabilities Act and Fair Housing Act to offer *reasonable modifications* that make their programs more accessible to people with physical and sensory disabilities (e.g., physical adaptations such as ramps for mobility-impaired survivors, Braille signage for visually impaired survivors, sign language interpretation for deaf survivors).

Some of the providers that own or lease program housing[78] may not be quite as familiar with all their obligations as housing providers to make *reasonable accommodations in rules, policies, and procedures* to help make their housing and services accessible to survivors with *psychiatric, emotional, and/or cognitive disabilities* -- including alcoholism[79] and drug addiction, but not including current use of illegal substances[80] -- as long as those accommodations do not pose an undue administrative or financial burden or fundamentally alter the nature of their transitional housing program.

Such accommodations might include creating alternate mechanisms for reminding people with impaired memory function to pay their share of the rent; shortening the duration of meetings with survivors whose PTSD limits their tolerance for such interactions; scheduling time for the extra support that survivors with traumatic brain injury may need, if TBI has impaired their cognition or ability to remember and follow instructions; allowing companion animals in buildings where pets are otherwise prohibited; or providing incremental support to address hoarding, instead of threatening eviction.

Depending on the nature of their circumstances and path to transitional housing, survivors with disabilities might or might not be ready and able to discuss their needs and preferences and might require a range of possible accommodations. The National Coalition Against Domestic Violence 1996 publication, with the Domestic Violence Initiative for Women with Disabilities, "[Open Minds, Open Doors](#)" provide information about a broad range of disabilities and chronic conditions which may constrain mobility, limit strength and stamina, impair cognition or memory, or profoundly impact a person's emotions -- and suggests approaches, resources, and accommodations which might be useful.

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[77] See also the [Fair Housing webpage of the Mental Health Advocacy Services](#) for many other Fair Housing-related tips.

[78] Providers that offer rental assistance, but don't actually provide housing may not be subject to the same Fair Housing requirements as providers that own or lease the housing where program participants live.

[79] As explained in the Corporation for Supportive Housing guide, [Between the Lines (2010 National Edition)](#) (see p.64), alcoholism is considered a disability if it interferes with one or more major life activities and therefore is not a basis by itself for refusing occupancy, even if the applicant has not achieved nor desires sobriety. Both the Fair Housing Act and the Americans with Disabilities Act (ADA) include alcoholism within the definition of handicap. Since alcohol is a legal substance, whether the applicant is currently drinking alcohol is not relevant. Refusing housing to someone because that person is an alcoholic would be unlawful discrimination since alcoholics are treated like all other disabled persons.

[80] As explained in [Fair Housing Partners of Washington State (2013)](#),

> *"Current illegal drug abuse ... is not considered a disability. Therefore, it is legal to deny someone housing on the basis of his current illicit drug use, [whether or not] he is an addict. However, fair housing laws do protect former drug addicts, [if they are part of a protected class (e.g., race, religion, gender, etc.), and/or if they are a disabling condition, whether that disabling condition is related to their former drug use or not], so housing should never be denied to a person because of his history of former addiction."* (p.21)

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With transitional housing providers increasingly relying on privately owned housing, rather than provider-owned housing, addressing mobility-related accessibility needs most often means finding an accessible apartment, rather than building accessible units or modifying a provider-owned unit. When an accessible provider-owned or provider-leased unit becomes available, it isn't necessarily occupied by a person who needs an accessible unit, because the next survivor to be enrolled may not have that kind of disabling condition. If and when a survivor who needs an accessible unit is enrolled in the program, the provider may be able to move participants around to free up an accessible unit. Similarly, a program that leases units from a housing authority or other large affordable housing provider may – if there are no available accessible units – request that the housing authority or property owner switch the units allocated to the program, in order to make an accessible unit available to an incoming participant who needs it.

The following resources address fair housing laws and reasonable accommodation requirements / strategies:

- Fair Housing Partners of Washington State. (2013) A Guide to Fair Housing for Nonprofit Housing and Shelter Providers. (A comprehensive guide, including fair housing basics, screening and admissions, fair housing vis-a-vis programs housing the homeless, including transitional housing; disability, accessibility, reasonable accommodation, confidentiality, group living issues, etc.)

- Fair Housing Partners of Washington State. (2013) Reasonable Accommodations and Modifications for People With Disabilities: Sample Policy & Disability Resource Information (Requesting and denying requests for reasonable accommodation or modification; verifications; alternative accommodations; sample letters, sample policies, etc.)

- Housing Research and Advocacy Center. (n.d.) Obtaining and Maintaining Housing: Fair Housing for People with Mental Health Disabilities (a very readable brochure)

- Corporation for Supportive Housing (2010), Between the Lines (2010 National Edition) (Fair housing, permissibility of targeting specific subpopulations for tenancies, tenant selection, reasonable accommodation and reasonable modification, clean and sober requirements, time-limited leases for transitional housing, etc.)

- Chicago Community Trust / Irene Bowen. (2010) Renewing the Commitment: An ADA Compliance Guide for Nonprofits. Facilities; Communication; Policy Considerations; Integration; Specific Types of Services, Activities, and Programs;

- Bazelon Center for Mental Health Law. (2003) Fair Housing Information Sheet #4: Using Reasonable Accommodations to Prevent Eviction (If a tenant identifies a disability-related behavior or characteristic that is causing him or her to be noncompliant with a lease, and proposes a change in the tenant's behavior or the landlord's policies that would eliminate or reduce the impact of the lease violation, then a reasonable accommodation may protect the tenant against eviction.) See also the Bazelon Center's 2011 edition of What "Fair Housing" Means for People with Disabilities.

- Northeastern University School of Law Legal Skills in Social Context Social Justice Program -- and -- Mental Health Legal Advisors Committee (2006) A Guide to Help Massachusetts Tenants with Mental Health Issues Maintain Their Housing (A guide for lay persons and advocates in supporting tenants whose risk of eviction stems from disability-related behaviors that could be mitigated by a landlord-furnished reasonable accommodation or other steps.)

- Mental Health Advocacy Services (MHAS), Inc. (2007) Fair Housing for People with Disabilities: A Guidance Manual for Emergency Shelter and Transitional Housing Providers (A comprehensive guide covering fair housing laws as they apply to: tenant selection; reasonable accommodation during the application process and during the tenancy; terminating a tenancy/program stay; addressing substance use; etc. See also the MHAS Fair Housing website, which offers dozens of Fair Housing-related tips.

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Exception to the Rule: The underlying spirit and purpose of the reasonable accommodation requirements have much in common with the "survivor-centered approach" that many DV and sexual assault providers embrace: both seek to "meet participants where they are" and to remove barriers to successful program participation -- which, at least in part, is also what rules reduction efforts have been about.

To the extent that transitional housing providers have retained program rules, they most often apply to behaviors that might pose a danger to staff or other program participants, or that are illegal. Fair Housing Laws allow a property owner (or a provider making transitional housing available pursuant to a sublease or an occupancy agreement) to deny housing to someone who is a "***direct threat*** to the health and safety of others." A Joint Statement from HUD and the Department of Justice on Reasonable Accommodations under the Fair Housing Act, dated May 17, 2004, explained that in order to determine the existence of such a direct threat -- in conjunction with a decision to reject a candidate for housing or for the purpose of evicting a participant -- an individualized assessment must consider, (1) the nature, duration, and severity of the risk of injury; (2) the probability that the injury will actually occur; and (3) whether there are any reasonable accommodations that will eliminate the direct threat.[81]

Disparate Impact Doctrine: Even if program policies and procedures are not intended to have a discriminatory impact, they may violate the Fair Housing Act if they have a ***disproportionate adverse impact*** on persons in protected classes, including persons with disabilities. For example, a work requirement may not be intentionally discriminatory, but if it disproportionately prevents survivors with disabilities from participating in a program, and if there are no compelling reasons why that work requirement could not be replaced by policies and procedures that have a less discriminatory effect, it could be deemed a violation of the Fair Housing Act, under the Disparate Impact doctrine, as recently reaffirmed by the U.S. Supreme Court.[82]

See Chapter 2 ("Survivor Access and Participant Selection") for information about disability-related protections pertaining to participant selection and enrollment decisions.

(c) Traumatic Brain Injury (TBI)

(i) NRCDV "Special Collection" on Traumatic Brain Injury and Domestic Violence

Although a significant number of DV survivors may have suffered a traumatic brain injury at the hands of their abusive partner, the behaviors resulting from that brain injury are often, instead, misdiagnosed as mental illness or lack of motivation or engagement, or uncooperative, sometimes resulting in their being penalized in

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[81] A resource specifically addressing this topic, the Bazelon Center for Mental Health Law's *Fair Housing Information Sheet #8: Reasonable Accommodations for Tenant Posing a "Direct Threat" to Others,* is no longer available online. However, the Bazelon Center's 2011 edition of What "Fair Housing" Means for People with Disabilities addresses a number of different aspects of the "direct threat" issue.

[82] As described in a June 29, 2015 post by the National Low Income Housing Coalition, the Supreme Court's June 25, 2015 decision in "*Texas Department of Housing and Community Affairs v. The Inclusive Communities Project*" upheld the ***Disparate Impact*** principle. The Court found that "the Fair Housing Act of 1968 bars both intentional discrimination and policies and practices that have a disparate impact, i.e., that do not have a stated intent to discriminate but that have the effect of discriminating against the Fair Housing Act's protected classes of race, color, national origin, religion, sex, familial status, or disability." Citing the Fair Housing Act's "results-oriented language," the Court stated, "Antidiscrimination laws must be construed to encompass disparate impact claims when their text refers to the consequences of actions and not just to the mindset of actors, and where that interpretation is consistent with statutory purpose." The NLIHC post explains that "under the disparate impact standard, courts assess discriminatory effect and whether an action perpetuates segregation, whether the discrimination is justified, and whether less discriminatory alternatives exist for the challenged practice."

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child custody cases or regarded as a poor candidate for transitional housing[83] by the very programs that have been funded to help them. As described in the introductory section to the NRCDV's Special Collection:

"A traumatic brain injury (TBI) is defined as a specific type of damage to the brain that is caused by external physical force and is not present at birth or degenerative. A blow (or blows) to the head, shaking of the brain, loss of oxygen (anoxia), colliding with a stationary object and exposure to blasts can cause a TBI. Based on this definition, the use of physical force by an intimate partner during incidents of domestic violence can cause traumatic brain injury as abusive partners often cause injury to a victim's head, neck (including strangulation), and face. In one study, 30% of domestic violence survivors reported a loss of consciousness at least once and 67% reported residual problems that were potentially head-injury related (Corrigan, Wolfe, Mysiw, Jackson & Bogner, 2003).

However, TBI often goes undiagnosed amongst domestic violence survivors. One reason for this is that domestic violence survivors, who also have a TBI, may exhibit symptoms that could resemble those of a mental illness, such as depression, anxiety, tension and/or inability to adapt to changing situations. Additionally, DV/TBI survivors may appear to have behavioral issues, including problems with keeping appointments, following through, or completing tasks that require multiple steps."

Anecdotal information from survivors and advocates indicates that victims with TBI are often questioned in regards to their ability to parent. At a training for domestic violence advocates, a TBI survivor as a result of domestic violence shared how she would forget to pick up her daughter from school, which prompted a call to the Child Protective Services agency in her area. Others have talked about the difficulties they experienced while living in congregate settings where following rules was, at times, problematic. These kinds of behaviors are often not intentional and survivors may even appear to be uncooperative and oppositional. However, it is important to keep in mind that many of these perceived behaviors might be directly related to the TBI. Therefore, it is crucial for domestic violence service providers and health care professionals to understand the prevalence and effects of TBI within the context of domestic violence."

The Special Collection website includes papers on the nature of TBI and its relationship to domestic violence; some screening tools; training materials for staff who will be working with survivors who (may) have a TBI; and materials for staff working with survivors whose children who have experienced TBI. Also, because so many returning combat veterans from Iraq and Afghanistan have TBIs (adversely affecting the behavior of both male and female veterans), the NRCDV hopes to add new resources to its website on that topic. In the meantime, interested readers can visit the Defense and Veterans Brain Injury Center webpage on TBI and the Military or Military.com's Traumatic Brain Injury Overview webpage or the PBS.org webpage on veterans and Traumatic Brain Injury with information and links to relevant materials

(ii) Alabama Department of Rehabilitation Services: Staff Training Resources and Materials for Survivors

The Alabama Department of Rehabilitation Services (ADRS) maintains a resource-rich webpage on TBI and Domestic Violence that includes the following introductory note and links to presentations, tools, staff training and reference resources, and materials for consumers:

"The head and face are among the most-common targets of partner assaults, and victims of domestic violence often sustain TBI. Because batterers seldom assault their partners only once, some individuals suffer repeated TBI. Living with domestic violence can make it difficult for victims to recover as fully as possible from a TBI."

The ADRS webpage on TBI and Domestic Violence acknowledges Dr. Mary Hibbard, Ph.D., ABPP, professor in the Department of Rehabilitation Medicine, Mount Sinai School of Medicine, "for the use of her research, materials, and consultation in creating this project."

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[83] See Chapter 2 ("Survivor Access and Participant Selection").

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- [Linking Domestic Violence and Traumatic Brain Injury](#) and [TBI 101](#)

  - In one study, 30% of battered women reported a loss of consciousness (indicative of brain injury) at least once; 67% reported potentially head-injury-related residual problems. In another study, 75% of battered women sustained at least one IPV-related brain injury, and 50% sustained multiple IPV-related brain injuries associated with memory, learning (e.g., information retention and integration), and cognitive flexibility (i.e., ability to face new/unexpected conditions in the environment.

  - The "typical descriptions" of women who have experienced domestic violence and "do poorly" in domestic violence programs include: "Unmotivated," "Unfocused," "Poorly organized," "Unable to plan ahead," "Unable to follow a train of thought," "Forgetful."

    These are some of the same words used to describe the cognitive challenges of persons with a traumatic brain injury. The traits ascribed to DV survivors characterized by staff as failing to "take advantage of program services" may well be consequences of TBI.

  - Other signs and symptoms of TBI are emotional/behavioral/social changes: depression, anxiety, irritability, impatience, intolerance, loss of emotional control (short fuse), inability to get along with others, difficulty with self-initiation.

- [Traumatic Brain Injury Domestic Violence Screening and Accommodations](#)

  - *How to screen for TBI:* [Brief Screening Checklist](#)

  - *Be aware of the need for accommodations:* [Accommodations - Checklist](#) (addresses: attention, information processing ability, memory issues, personal planning/organizing-related issues, possible problems with communication, emotional changes)

  - *Possible physical consequences of TBI*: slowness, clumsiness, decreased vision/hearing/smell, dizziness, headaches, fatigue, sensitivity to noise and bright lights

  - *How to compensate for some of the possible physical consequences of TBI*: (a) Allow additional time to get from place to place due to general slowness; (b) Keep the environment quiet; (c) Keep noise and lights to a minimum; (d) Keep sessions short to minimize onset of headaches and fatigue; (e) Schedule rest periods and breaks from planned activities.

  - *Possible cognitive consequences of TBI*: reduced concentration, reduced visual attention, inability to divide attention between competing tasks, slow processing speed, slow thinking, slow reading, slow formulation of verbal/written responses, difficulty finding the right words or naming objects, disorganized in communication, impaired interpersonal skills, reduced ability to learn and remember new information

  - *How to address some of the possible cognitive consequences of TBI*: (a) Work on one task at a time; (b) Have the survivor become an active participant in discussions and development of plan; (c) Limit distractions (both visual and verbal); (d) Meet individually in quiet room; (e) Redirect the survivor when their focus is lost; (f) Keep meetings time-limited; (g) Encourage rephrasing or recheck with the survivor to ensure comprehension; (h) Encourage the survivor to take breaks when needed; (i) Slow down the speed of discussions, speaking slowly, making sure the survivor understands; (j) Don't rush the survivor; (k) Offer assistance with completing written forms; (l) Provide cues, if a survivor is having word-finding difficulties (provide alternatives); (m) Help the survivor stay on topic, and redirect when necessary; (n) Ask the survivor to re-state aspects of a discussion to ensure comprehension; (o) Encourage the survivor to prepare an "agenda" in advance; (p) Avoid open-ended questions, and use yes/no or structured formats where possible; (q) Provide a written summary of discussed information to enhance survivor recall; (r) Encourage the survivor to write down instructions/information, and review the notes for accuracy and understanding before the end of the session; (s) Present new information in small, concise chunks; (t) Present information in a

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factual manner, avoiding abstract concepts; (u) Offer several solutions to a problem and encourage the survivor to make the best choice, and help formulate alternative approaches, if needed; (v) Provide written step-by-step "next" steps to be accomplished; (w) Help prioritize and organize tasks to be accomplished, if needed.

> ***Help the survivor compensate for TBI-related changes in her emotions or behaviors***: (a) Be patient, understanding, supportive: (b) Minimize anxiety with reassurance, education, and structure; (c) Avoid focusing only on a survivor's deficits; (d) Don't interpret lack of emotion as a sign of lack of interest; (e) Provide neutral, but direct, feedback if a survivor behaves "inappropriately;" (f) Suggest breaks if a survivor becomes irritable or agitated; (g) Discuss possible short- and long-term consequences of decisions; (h) Minimize the unexpected, and provide advance notice of an upcoming change; (i) Avoid discussion when a survivor is fatigued or over-stimulated.

- Summary Fact Sheet on Traumatic Brain Injury and Domestic Violence

The ADRS webpage on TBI and Domestic Violence also provides links to brochures for survivors (Getting Help, Getting Help (pocket-sized version), Has Your Head Been Injured (pocket sized version)), as well as a poster.

(iii) Staff Training Resources from the Pennsylvania Coalition Against Domestic Violence:

The Pennsylvania Coalition offers links to Comprehensive Training on TBI Screening and Model Practices: Trainers' Guide and Participants' Guide.

(d) Strangulation

According to the Strangulation Training Institute website, "Strangulation has been identified as one of the most lethal forms of domestic violence and sexual assault: unconsciousness may occur within seconds and death within minutes. When domestic violence perpetrators choke (strangle) their victims, not only is this felonious assault, but it may be an attempted homicide. Strangulation is an ultimate form of power and control where the batterer can demonstrate control over the victim's next breath: it may have devastating psychological effects or a potentially fatal outcome." The organization website contains links to library of research, training, and advocacy materials; infographics on the physical, neurological, and psychological impacts of ***partial strangulation*** (also referred to as ***non-fatal strangulation***), including its role in causing traumatic brain injury (TBI), and its potential to cause death days or even weeks after the assault.[84]

See also the Minnesota Coalition for Battered Women's Facts about Intimate Partner Strangulation.

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[84] Utley (2014) calls partial strangulation, "a common but little understood abuse method [whose] long term effects are staggering. What most victims, and many professionals who deal with domestic violence every day, don't know is that it can cause brain damage, pneumonitis, miscarriage, heart attacks, and delayed death, days or even weeks after the assault. Surprisingly, in 50 percent of reported cases, this level of damage can be achieved without leaving noticeable bruises on the outside of the neck. Because external bruising is slight, victims often discount the physically and emotionally traumatic experience, believing "they are not really hurt," and fail to document the abuse. Even fewer seek medical attention. [For example,] in a National Family Justice Center study in which 300 victims reported a strangulation assault, only three victims sought any medical help at the time of the assault."

Snyder (2015) describes the link between strangulation and Traumatic Brain Injury, which is often overlooked by health care providers. In turn, the symptoms of TBI are easily mistaken for lack of reliability on the part of the victim in documenting the violence: "It is not uncommon for victims of domestic violence ... to have trouble remembering the incidents that land their partners in trouble. Their explanation of what happened is cloudy, and law enforcement and courtrooms put the burden of proof on them. To the untrained, they sound like liars. Often, they sound hysterical. What researchers have learned from combat soldiers and football players and car-accident victims is only now making its way into the domestic-violence community: that the poor recall, the recanting, the changing details, along with other markers, like anxiety, hyper-vigilance, and headaches, can all be signs of T.B.I."

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(e) How Trauma and Complex Trauma Can Affect Participant Engagement in Services

Survivors of trauma, including survivors with PTSD and survivors of complex trauma[85], may present with a complicated range of physical, cognitive, emotional, and behavioral responses to that trauma, which may be misunderstood by service providers, in the absence of an awareness of trauma and its impacts. Indeed, with a trauma-informed lens, behaviors that might have been mistakenly labeled as "uncooperative" or "difficult" or "lazy" or stemming from a "lack of motivation" may instead be recognized as manifestations of traumatic brain injury[86], or as coping strategies that reflect the profound impact of the physical, psychological, emotional, and sexual abuse that survivors have lived through and fled. Hopper, Bassuk, & Olivet, 2010), Wisconsin's Violence Against Women with Disabilities and Deaf Women Project. (2011, pp. 13-15)

Program participants who have experienced trauma may continue to be in danger from their former abusive partner or assailant or trafficker, or feel that they (or a loved one) are in danger and need to remain vigilant. In that hypervigilant state of mind, they may be especially vulnerable to being re-traumatized by trauma-related reminders or "triggers" within the service environment -- sights, sounds, smells, or experiences that remind them of the traumatic event(s) they experienced.

Common triggers in service settings include experiences such as meeting with new people, being asked personal questions, being informed about program expectations or deadlines, fear of punishment for having failed to meet an expectation or deadline, receiving a lot of information about next steps, being in a chaotic environment, hearing raised voices or witnessing conflict involving other program participants and/or staff, participating in a medical exam, etc. When faced with such triggers, people may respond in ways that appear unreasonable, confusing, or frustrating to providers. Examples include fight responses like yelling, swearing, or fighting; flight behaviors like withdrawing, avoiding, or ignoring; or freeze responses like seeming confused or disconnected, spacing out, or becoming unresponsive. (Hodas, 2006; Hopper, Bassuk, & Olivet, 2010)

People who have been exposed to chronic or complex trauma may have learned ways of surviving that may be at odds with program expectations or that may compromise the program's or funder's notion of success. Difficulties may include trouble following through on commitments, avoiding meetings and other isolating behaviors, engaging in oppositional behavior with staff, becoming easily agitated and/or belligerent, demonstrating a lack of trust, feeling targeted by others, maintaining involvement in actively abusive relationships, struggling with parenting, and/or active substance abuse (Hopper, Bassuk, & Olivet, 2010).

Help-seeking behavior may also be impacted. People who have experienced complex trauma are more likely to view the world and other people as unsafe, and not-to-be-trusted. Lack of trust and a constant need to be alert for danger makes it difficult for families to ask for or accept help from providers, or to form relationships. Survivors may interpret providers' efforts to help as controlling. When that help doesn't quickly yield results, providers' inability to "fix" or address the need or problem they were targeting may be seen by traumatized survivors as purposeful and punishing. Survivors who have been re-traumatized by what they perceive as unrealistic demands and/or a harsh response by staff may become increasingly wary of further engagement and/or offers of help, and may drop out of services altogether (Fallot & Harris, 2001; Prescott et al., 2008).

The following chart, excerpted from Table 3 ("How common trauma reactions may explain some 'difficult' behaviors or reactions within homeless service settings") in Hopper, Bassuk, & Olivet, 2010, p.149, enumerates some of the trauma-related behaviors that shelter staff might take as "evidence" that a survivor is not "ready" or "appropriate" for transitional housing, or that a TH program coordinator might take as "evidence" that a TH participant doesn't "deserve" an extension beyond her baseline six months of assistance:

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[85] See Courtois (2010) and Chapter 11 ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children")

[86] See NRCDV "Special Collection" on Traumatic Brain Injury and Domestic Violence

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"Difficult" Behaviors or Reactions within Homeless Service Settings	*Common Trauma Reactions*
Has difficulty getting motivated to get job training, pursue education, locate a job, or find housing	Depression and diminished interest in everyday activities
Perceives others as being abusive, loses touch with current-day reality and feels like the trauma is happening over again	Flashbacks, triggered responses
Avoids meetings with counselors or other support staff, emotionally shuts down when faced with traumatic reminders	Avoidance of traumatic memories or reminders
Lacks awareness of emotional responses, does not emotionally respond to others	Emotional numbing or restricted range of feelings
Has difficulty keeping up in educational settings or job training programs	Difficulty concentrating or remembering
Is triggered by rules and consequences. Has difficulty setting limits with children.	Feeling unsafe, helpless, and out of control
Seems spacey or "out of it." Has difficulty remembering whether or not they have done something. Is not responsive to external situations.	Dissociation
Has difficulty trusting staff members; feels targeted by others. Does not form close relationships in the service setting.	Difficulty trusting and/or feelings of betrayal
Puts less effort into trying--does not follow through on appointments, does not respond to assistance	Learned helplessness
Has ongoing substance abuse problems	Use of alcohol or drugs to manage emotional responses

The OVW's adoption of the voluntary services model, the elimination by DV shelters and transitional housing programs of unnecessary rules and coercive participant requirements, and implementation by many programs of an "empowerment" approach have all been important elements of the effort to ensure that emergency housing and services are places of healing that don't re-create the kind of abusive environment survivors fled.

However, a few of the comments included in Chapter 2 ("Survivor Access and Participant Enrollment") suggest that these "difficult" behaviors and coping mechanisms are sometimes interpreted as signs that a survivor will "not do well" in a voluntary services environment, and that survivors who haven't demonstrated their ability to "make good use" of shelter program-leveraged resources may not get referred for, or selected by, a TH program. Similarly a few of the quotes in Chapter 6 ("Length of Stay") suggest that some survivors who have been accepted into transitional housing, but have not fully "engaged" in programming, or who have "not taken adequate advantage" of program assistance that might have helped them make targeted "progress," may not be offered the extensions of assistance awarded to TH participants who are "working the program."

These responses to the challenges posed by "difficult" behaviors may reflect staff concerns about the limited capacity of their programs, and their ability to assist only a fraction of the survivors who could benefit from transitional housing, or they may be a reflection of pressure from funders or other sources[87] to demonstrate "better participant outcomes" or to increase program throughput, so that more homeless survivors can be assisted with the same amount of funding. In any case, they illustrate the challenge of creating a trauma-informed program in an operating environment that is characterized by other exigencies and constraints.

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[87] As noted in the Methodology Appendix and elsewhere, 42% of the providers interviewed for this project receive HUD grants to support transitional housing and/or rapid rehousing projects serving survivors of domestic and sexual violence. As described in Chapter 12 ("Funding and Collaboration: Opportunities and Challenges") and elsewhere, these programs are all subject to annual performance reviews in which participant outcomes and program timeframes are evaluated against nationally established standards.

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(f) <u>Mental Health Issues and/or Substance Use/Abuse</u>

(i) *<u>Domestic and Sexual Violence and Poverty: The Context for Co-Occurring Mental Health and Substance Use Issues</u>*

As discussed in greater detail in Chapter 10 "Challenges and Approach to Obtaining Housing and Financial Stability," domestic violence and poverty are mutually exacerbating conditions. Goodman et al. (2009) describe how "IPV and poverty co-occur at a high rate[88], magnify each other's [negative] effects" -- in particular, stress, powerlessness, and social isolation -- "and, in each other's presence, constrain coping options." (p.2) Goodman et al. (2009) note that poverty disproportionately impacts people of color,[89] so that additional barriers related to language, fear of racism, and immigration status "may prevent women from seeking outside sources of support (Humphreys, 2007)." (p.4),

Goodman et al. (2009) explain that acute and chronic stresses associated with poverty -- "substandard and overcrowded living conditions ... unpaid bills, insufficient resources with which to parent their children, dangerous streets, hunger or food insecurity, and a social service system that often thwarts their efforts to help themselves (Burnham, 2002; Evans & English, 2002; Green, 2000; Moane, 2003; Siefert, Heflin, Corcoran, & Williams, 2001)" -- in combination with the violence and abuse perpetrated by their partner, wear survivors down, and they come to "experience and internalize the reality of powerlessness despite their active attempts to protect themselves and their loved ones (Goodman et al., 2003)." (p.6)

Goodman et al. (2009) argue that abused women's "struggle with psychological and emotional issues such as depression, anxiety, post-traumatic stress disorder (PTSD), and drug or alcohol dependence" (p.5) must be understood and addressed with an understanding of the violence, poverty, stress, sense of powerlessness, and social isolation in which it occurs, and which combine to "increase women's vulnerability to specific mental health disorders or ... shape their perceptions and coping responses." (p.10) Instead, the authors contend, when low-income survivors are able to access mental health care, "they may well encounter interventions that are short-term, symptom-focused, and relatively inattentive to the contextual factors such as clients' immediate (and potentially urgent) material needs, not to mention the potentially ongoing threat of violence. ***By failing to include a central focus on the material conditions that perpetuate domestic violence and shape its psychological consequences and coping strategies, current mental health models fail to address the full range of survivors' needs***." (p.16)

These recommendations echo findings from the SAMHSA-funded Women, Co-Occurring Disorders and Violence Study, as described by Morrissey et al. (2005):

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[88] For example, according to the 2010 National Intimate Partner Sexual Violence Survey (Breiding, Chen, & Black, 2014), the 12-month prevalence of IPV impacting women from households with annual incomes of between $25,000 and $50,000 was twice as high (5.9%) as the prevalence among women from higher income households (2.8-3.0%). The prevalence among women from households with annual income under $25,000 was over three times as high (9.7%).

[89] For example, the U.S. Census Bureau's report (DeNavas-Walt & Proctor, 2014) on Income and Poverty in the U.S. documents that:

- Black (12.2%) and Hispanic (9.4%) people are much more likely to be living in deep poverty (incomes under 50% of the federal poverty level), as compared to white, non-Hispanic persons (4.3%) (Table 5, p.17)
- Black (27.2%) and Hispanic (23.5%) people are much more likely to be living in poverty (incomes under the federal poverty level), as compared to white, non-Hispanic persons (9.6%) (Table 3, p.13)
- Black (42.5%) and Hispanic (41.6%) female-headed households are much more likely to be living in poverty than white female-headed households (22.9%) (Table B-1, pp. 45-49)
- The median income of Black ($34,598) and Hispanic ($40,963) households are substantially lower than the median income of white, non-Hispanic households ($58,270) (Table 1, p.6)

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"Research has demonstrated that high rates of traumatic childhood experiences are risk factors for adult psychological symptoms and problematic behaviors. Childhood experiences such as physical and sexual abuse, witnessing violence, and neglect—often in combination with adult trauma—have led some women into lives dominated by prolonged periods of co-occurring mental disorders and substance use disorders. Historically, most treatment settings, regardless of whether they deal with mental health, substance abuse, primary care, or other issues, have not routinely assessed women for trauma or posttraumatic stress disorder (PTSD), leading to under-recognition and under-treatment of these important issues.

Although some programs and systems have begun to address these issues, many still do not. Moreover, women with substance use problems have typically received the message that they need to be clean and sober for some period before trauma or PTSD can be addressed.

The Women, Co-occurring Disorders, and Violence Study (WCDVS) represents the first major federal effort to address the lack of appropriate services for women with co-occurring mental health and substance use disorders who also have a history of physical or sexual abuse. The primary goals of the WCDVS were to develop new service approaches and to evaluate their effectiveness for women with these problems, who have been frequent, or high-end, users of services. The intervention included eight core services, such as resource coordination and crisis intervention; staff knowledgeable about trauma; holistic treatment of mental health, trauma, and substance use issues; and the involvement of consumers in service planning and provision.

. . . . The six-month outcomes ... showed small improvements in mental health symptoms, trauma symptoms, and drug use severity. These effects increased substantially when measured in sites where integrated counseling—the integration of trauma, substance abuse, and mental health issues across or within individual or group counseling—was greater in the intervention than in the comparison condition." (pp. 1213-1214)

"The 12-month meta-analysis and HLM results reported here showed that women in the intervention group improved more on average than those in the comparison group. Among those with severe mental health or trauma symptoms at baseline, proportionally more women in the intervention group attained meaningful clinical improvement. Both the drug use and alcohol use severity effects leveled off relative to those effects at six months, but on average women's substance use did not revert to baseline levels. This pattern suggests that the study intervention achieved results more quickly than care as usual and that the results were maintained over time.

. . . . Both the six- and 12-month outcomes of the WCDVS are consistent with a growing body of literature showing positive results from various approaches to integrated treatment." (p.1220)

Understanding of complex trauma and its treatment are evolving (Courtois, 2004[90], Cloitre et al., 2011); but the importance of an integrated and trauma-informed approach to behavioral health services is clear. (SAMHSA, 2014). SAMHSA's "Trauma Informed Care in Behavioral Health Services (Treatment Improvement Protocol #57), hereinafter (SAMHSA, 2014), provides an extensive literature-based review and summary of the interrelationships of trauma, mental health, and substance use; the importance of understanding each participant's experience of trauma, mental health issues, and substance abuse from an appropriate cultural lens[91]; and the importance of supporting participants' control, choice, and autonomy in structuring treatment/support services. SAMHSA (2007), the most recently updated version of SAMHSA's Substance Abuse Treatment and Domestic Violence (Treatment Improvement Protocol #25), similarly finds that,

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[90] See also Courtois (2010) for an article written for a less clinically oriented audience.

[91] Per SAMHSA, 2014, "To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma, [which, in combination,] influence the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors." (p.26)

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"***Coordinated intervention is crucial. These efforts must address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others***."

(ii) *Serving Survivors with Co-Occurring Mental Health and Substance Use Issues*

Bland & Edmund (2014) is a training curriculum to support victim services providers serving survivors of domestic and sexual violence with co-occurring substance abuse and trauma. The training highlights:

- The high rates of co-occurrence and why they co-occur (e.g., self-soothing after victimization, women blamed for allowing the violence because they were high or intoxicated, coercive substance abuse, drug/alcohol-enabled rape, etc.);

- The barriers that substance abuse poses to accessing and engaging in services (e.g., provider labeling of persons with an alcohol or drug dependence (or mental health condition) as "disruptive when their substance use or psychiatric symptoms become evident," substance abuse provider tendency to focus on the substance use/abuse and not the violence, victim services provider requiring sobriety or participation in treatment as an enrollment criteria; participant unable to sustain focus on other priorities);

- How substance abuse coercion is an element of power and control (e.g., victim reluctance to leave, for fear that they will lose custody of children in court, or that programs will not accept them, due to their addiction or mental health condition; victim dependence on abusive partner to satisfy drug craving; victim reluctance to call police for fear of being arrested for illegal drug use; "increased sense of power from substance use or psychiatric symptoms" inspires false sense of confidence in ability to resist; substance use impairs memory, making their testimony "unreliable");[92]

- The impacts on the body and mind of alcohol and other drugs (including both illicit drugs and over-prescribed sedatives or psychotropic medications to address symptoms after abuse);

  - "The rate of fatal overdoses of prescription painkillers and other drugs among U.S. women quadrupled between 1999 and 2010. According to the Centers for Disease Control and Prevention, since 2007, more women have died from drug overdoses than from motor vehicle traffic injuries, and in 2010, four times as many died as a result of drug overdose as were victims of homicide (CDC Study,[93] p. 539)." (p.27)

  - "In a Canadian study examining patterns of medication use among female survivors of DV, almost half the participants were taking pain and/or psychotropic medications, with almost one third taking antidepressants. Child abuse history, adult sexual assault history, and unemployment were associated with taking psychotropic medications (Wuest et al., 2007)." (p.29)

- Strategies for working with survivors experiencing substance abuse

  - "Each survivor will tell you what they want. . . . Often, advocates ask, "What should I do first?" The most important thing to do is to listen. Generally speaking, there are many paths to safety, sobriety, and wellness. Some survivors may express the need to get safe first. Others will want to work on sobriety, trauma, or mental health first. Some will do a little bit of this, a little bit of that depending on what concern is affecting them most at a given point in time. Survivors will tell you what they want and need when they are ready to share. How much they share and what they choose to reveal

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[92] See also Rivera et al. (2015) (pp. 2,9,16-17) describing some of the mechanisms of substance abuse coercion.

[93] Centers for Disease Control and Prevention. (2013) Vital signs: Overdoses of prescription opioid pain relievers and other drugs among women - United States, 1999–2010. Morbidity and Mortality Weekly Report (MMWR, July 5, 2013) 62(26):537-542. Retrieved December 5, 2016, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6226a3.htm

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will generally depend on many factors including, but not limited to, how safe they feel." Bland & Edmund (2014) (p.41)

> "Before talking about substance use, affirm a person's survival and praise them sincerely for finding their own way to cope. Trauma-informed advocacy includes validating a victim's survival strategies as well as identifying risks. For example: "You deserve credit for finding a way to cope. Tell me what made you able to survive?" Bland & Edmund (2014) (p.44)

Rivera et al. (2015) reviews the research on the co-occurrence of substance use/abuse and domestic violence. Among their recommendations for substance use disorder treatment providers are the following:

- "Without addressing the specific needs of survivors who are also dealing with an abusive partner, substance use disorder treatment may not be accessible or effective, or may even place survivors at greater risk for harm." (p.15)

- "To date, there are two gender-responsive trauma-informed substance use disorder treatment programs that have been rigorously evaluated with promising results: Women's Integrated Treatment (Covington, Burke, Keaton, & Norcott, 2008) and Seeking Safety (Najavits, 2007). However, studies on the effectiveness of modifications or adaptations for IPV survivors are still needed. A recent systematic review of trauma-focused interventions for IPV survivors (Warshaw, Sullivan & Rivera, 2013) identified only one that was developed specifically for survivors dealing with a substance use disorder: *Relapse Prevention and Relationship Safety* (RPRS). RPRS showed some promise in addressing women's substance abuse and IPV victimization (Gilbert et al., 2006)." (p.16)

SAMHSA (2014) recommends that,

"All clinical and direct service staff members, regardless of level of experience, should receive more in depth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid re-traumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace." (p.177)

SAMHSA (2014) encourages staff training in motivational interviewing,[94] which it describes as:

"a client-centered, non-pathologizing counseling method [that] can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance. Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients." (p.180)

Some of the staff interviewed for this project reported having been trained in motivational interviewing, some had heard of it but had not been trained, and some had never heard the term. NNEDV has previously sponsored trainings on Motivational Interviewing[95], and we recommend that such trainings continue to be offered, given inevitable staff turnover and need for refreshers.

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[94] See section on Motivational Interviewing in Chapter 9 ("Approach to Services: Providing Basic Support and Assistance")

[95] Handouts from trainings in 2013 and 2015 by V. Timmons (Multnomah County Domestic Violence Coordination Office) were formerly available from the NNEDV website, but are no longer online. Multnomah County Office of Human Services currently offers trainings in Assertive Engagement, which incorporates the Motivational Interviewing skill set. Timmons was a co-author of a 2014 paper on "*Motivational Interviewing at the Intersections of Depression and Intimate Partner Violence among African American Women.*" (Wahab, et al., 2014. Portland State University School of Social Work)

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Another approach to working with survivors of trauma that SAMHSA (2014) recommends training on is the Stages of Change Model (Connors et al., 2012). The Stages of Change model has been used to help understand victims'/survivors' evolving understanding of their domestic violence situation (see, for example Chang et al., 2010) and is conceptually linked to Anderson and Saunders' (2003) seminal framing of survivor decision making around leaving as an incremental process, informed by many considerations, and not merely a snap judgment when some "breaking point" is reached. The Stages of Change model is very much resonant with the concept of tradeoffs: rather than suggesting the "inevitability" of a "point of no return," at which a woman decides that she can no longer tolerate the relationship, the stages of change model recognizes the dynamic nature of the process of weighing tradeoffs, and how those tradeoffs change over time.

SAMHSA's (2014) recommendation of the Stages of Change model also addresses its utility in helping survivors of trauma address their co-occurring substance abuse. The authors observe that the confrontational approach employed by some of the more traditional models of addictions treatment to address a client's denial or minimization of their substance abuse issues could re-traumatize a survivor and remind her of the emotional abuse she experienced.

> *"The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of [that] denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the pre-contemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors."* (p.179)

Another cognitive-behavioral approach suggested by SAMHSA (2014) is the Seeking Safety Model, which is listed as an Evidence-Based Practice. The developers of the model describe Seeking Safety as "an evidence-based[96], present-focused counseling model to help people attain safety from trauma and/or substance abuse. It directly addresses both trauma and addiction, but without requiring clients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement."

Najavits (2004) explains that when someone with PTSD is directed by a treatment program to focus on their substance abuse first, it can be perceived as invalidating the trauma history. As a trauma-survivor gets "clean," they commonly experience stronger PTSD-related memories and feelings, which their coping mechanisms may not be strong enough to handle without relapse, and the shame it engenders. "Sadly, clients with the dual diagnosis of PTSD and substance abuse have worse outcomes than those with either disorder alone, and may internalize a sense of failure when they do not succeed in standard treatment programs...." (p.2)

Seeking Safety acknowledges the trauma, recognizes and normalizes the substance abuse as a common response to coping with overwhelming emotional pain, and treats both PTSD and substance abuse at the same time ... but without "digging up" traumatic memories that may be too emotionally upsetting to deal with, given the clients evolving coping skills. It focuses on addressing the need for stabilization and safety, and encourages use of a present-focused approach to trauma-processing, like the cognitive behavioral therapy (CBT) coping skills model, which teaches clients how to decrease symptoms when they flare up, and helps them gain control over current life problems.

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[96] "Since 1992, Seeking Safety has been implemented in more than 15,000 clinical settings and as part of numerous state- and county-wide initiatives. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, military and veterans, and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, the United Kingdom, and Sweden. It has been implemented by peers, paraprofessionals, case managers, domestic violence advocates, as well as all types of professionals. No specific degree or experience level is required."

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According to the Seeking Safety page of SAMHSA's National Registry of Evidence-Based Programs and Practices, the Seeking Safety model "was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety ... has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues)"

The Seeking Safety online library offers links to an extensive range of articles on treatment and research supporting the treatment of addiction and trauma.

Another kind of treatment that survivors with co-occurring substance abuse (or other addiction issues) may explore or may have previously considered is participation in 12-Step programs. SAMHSA (2014) explains,

> *"The 12-Step concept of powerlessness ... may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves.*
>
> *For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse."* (p.179)

SAMHSA (2014) suggests that the TSF (Twelve Step Facilitation) Model (Nowinski, Baker, & Carroll, 1999), for which computer-assisted training is now available, adds the facilitative support of a clinician to help frame the survivor's participation in a 12-step program -- assuming, of course, that a survivor wishes to participate in a 12-step program -- in a way that is more consistent with the goals of healing from the trauma and becoming more empowered.

While the staff of a transitional housing program are not likely to be the implementing some of the more clinical treatment services, for example, addressing substance abuse, it makes sense for them to understand the approach to treatment that they might refer participants to, and to be able to support participants who have agreed to participate in such treatment.

(iii)   *Importance of Cultural Competence in Providing Mental Health and/or Addictions Services*

As described in Chapter 10 (**Addressing Diverse Populations in Intensive Outpatient Treatment)** of SAMHSA's publication ***Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*** (Treatment Improvement Protocol (TIP) Series, No. 47), hereinafter CSAT (2006, Ch. 10), cultural competence is integral to the success of mental health care and alcohol or drug dependence.

> *"Because verbal communication and the therapeutic alliance are distinguishing features of treatment for both substance use and mental disorders, the issue of culture is significant for treatment in both fields. The therapeutic alliance should be informed by the clinician's understanding of the client's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. A common theme in culturally competent care is that the treatment provider—not the person seeking treatment—is responsible for ensuring that treatment is effective for diverse clients . . . . Meeting the needs of diverse clients involves two components: (1) understanding how to work with persons from different cultures and (2) understanding the specific culture of the person being served."* (p.180)
>
> *"Culture is important in substance abuse [and mental health] treatment because clients' experiences of culture precede and influence their clinical experience. Treatment setting, coping styles, social supports,*

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stigma attached to substance use [and mental health] disorders, even [if] an individual seeks help—all are influenced by a client's culture . . . . In this broad sense, substance abuse [and mental health] treatment professionals can be said to have a shared culture, based on the Western worldview and on the scientific method, with common beliefs about the relationships among the body, mind, and environment. Treating a client [with a different worldview] involves understanding the client's culture and can entail mediating among U.S. culture, treatment culture, and the client's culture." (p.179)

"Counselors often feel that their own social values are the norm—that their values are typical of all cultures. In fact, U.S. culture differs from most other cultures in a number of ways. IOT clinicians and program staff members can benefit from learning about the major areas of difference and from understanding the common ways in which clients from other cultures may differ from the dominant U.S. culture.

Members of racial and ethnic groups are not uniform. Each group is highly heterogeneous and includes a diverse mix of immigrants, refugees, and multigenerational Americans who have vastly different histories, languages, spiritual practices, demographic patterns, and cultures. . . . How recently immigration occurred, the country of origin, current place of residence, upbringing, education, religion, and income level shape the experiences and outlook of every individual who can be described as Hispanic/Latino. Many people also have overlapping identities, with ties to multiple cultural and social groups in addition to their racial or ethnic group. For example, a Chinese American also may be Catholic, an older adult, and a Californian, [and] may identify more closely with other Catholics than with other Chinese Americans.

Treatment providers need to be careful not to make facile assumptions about clients' culture and values based on race or ethnicity. To avoid stereotyping, clinicians must remember that each client is an individual. Because culture is complex and not easily reduced to a simple description or formula, generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a large group of people may be misleading and harmful if applied to an individual . . . . Culture is only a starting point for exploring an individual's perceptions, values, and wishes. How strongly individuals share the dominant values of their culture varies and depends on numerous factors, including their education, socioeconomic status, and level of acculturation to U.S. society." (pp. 181-182)

Cultural differences that the authors of [CSAT (2006, Ch. 10)](#) suggest might have a bearing on the acceptability and success of treatment (as well as on the acceptability and "success" of victim services) include (a) the extent of a participant's holistic versus person-centric worldview; (b) level of spirituality; (c) expectations regarding gender roles and constraints; (d) focus on the individual versus focus on the family, extended family, or community; (e) cultural values and expectations (boundaries, how respect is demonstrated, the kind of person -- outside professional or community leader -- who can provide appropriate help); (f) communication norms; (g) level of stigma; (h) trust of providers from the white mainstream; (i) sources of community support for change; etc.

And, as noted above, individual members of a particular racial, ethnic, or cultural community may not share all the norms stereotypically ascribed to members of that community.

(iv) *Provider Experience Serving Survivors with Mental Health and/or Substance Use/Abuse Issues*

Most providers interviewed for this project have experience serving survivors with co-occurring substance use/abuse issues and/or mental health issues -- depression, anxiety, trauma, PTSD, or severe mental illnesses like schizophrenia and bipolar disorder. A number of comments addressed how mental health- and substance use/abuse-related issues can complicate the process of healing from the trauma, and compromise the survivor's ability to engage in program services, her ability to find and maintain employment and/or housing, her ability to parent children, and/or progress towards other stated goals; in some cases, such issues were described as a barrier to services.

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Providers discussed the challenges participants face in accessing and paying for treatment services, especially if they are not covered by health insurance, or if locally available providers do not accept Medicaid patients. Some providers have negotiated access to onsite counseling, either through paid staff or consultants, or through an MOU with another provider. In other cases, participants have only limited access to mental health services, and may be subject to long waits before being able to see a provider. A number of providers expressed concern about a lack of mainstream mental health and substance abuse treatment providers who understand domestic and sexual violence and who offer trauma-informed counseling and recovery services. Several providers mentioned referring participants with addiction issues to local Alcoholics Anonymous or Narcotics Anonymous meetings.

A number of providers cited the importance of developing partnerships with organization that can provide mental health and substance abuse services to survivors. One provider discussed an ongoing relationship with a university that sponsors PhD externships that bring counselors to their programs. Several other programs cited their good fortune in having therapists who volunteer their time.

A number of comments described providers' angst as they watch the clock tick down and clients approach their stay limit, or the end of the program's financial assistance, without their having made the progress needed to secure next-step housing. Providers described the challenges and perceived limitations of the voluntary participation model in working with survivors who struggle with active mental health or substance abuse issues -- and their perception that being able to more assertively promote, or even require, treatment would be in the participants' best interests. Other providers affirmed the central importance of a trusting relationship between staff and participants in having meaningful discussions about seeking counseling services and/or acknowledging and addressing a participant's struggle with an ongoing addiction. Several providers expressed concerns that such strong relationships are difficult to develop with participants in a scattered site units who maintain only very limited contact with program staff.

Several providers mentioned the stigma attached to mental health care, particularly when it is furnished by a mental health provider who bills insurance, including Medicaid, and who therefore must document a diagnosis. One provider spoke about the reluctance of parents to have their children stigmatized with a mental health diagnosis.

Another provider noted that the symptoms that might be interpreted by a clinician as a mental health problem may well be symptoms of the trauma and turmoil attendant to being in and fleeing an abusive relationship; unfortunately, that diagnosis would remain in the survivor's medical record in perpetuity. Indeed, an Issue Brief on "Trauma and Re-Traumatization" produced by the National GAINS Center (part of SAMHSA) affirmed that concern:

> *"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."* [97]

Several providers mentioned alternative therapies and treatments, including, somatic experiencing and EMDR, CBFT [Cognitive-Behavioral Family Therapy or Trauma Focused Cognitive Behavioral Therapy], rapid eye movement treatment, equine therapy, and energy work like Reiki. Native providers mentioned the Red

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[97] The authors of the National GAINS Center Brief cite Kammerer & Mazelis (2006) as the source material for this Brief.

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Road, that is, participation in traditional ceremonies to support healing and sobriety. Ceremonies mentioned include being given a Native name, if they had never gotten one, smudging, and cleansing in a sweat lodge.

Some providers said they operate clean and sober programs and/or don't allow participants to bring alcohol or drugs onto the premises of their unit -- regardless of whether the unit is provider owned, provider leased, or leased by the participant with rental assistance from the provider -- and that violation of that rule might be grounds for termination. Some providers expressed reservations about enrolling participants whose apparent involvement with alcohol or drugs or whose refusal to seek mental health treatment portends an unsuccessful transitional housing experience*.*

Other providers described a more tolerant approach to alcohol possession or use, in the same way that an ordinary lease would not prohibit drinking, and would only address possession or use of illegal drugs on the premises. Still other providers who knowingly open their programs' doors to survivors with drug addictions describe their harm reduction approach to working with, for example, survivors of trafficking, chronically homeless survivors of sexual abuse, and survivors of long-term abusive relationships.

(g) Building Capacity to Serve Survivors with Disabilities

(i) Washington State Coalition disAbility Advocacy Project

An underlying assumption of Washington State Coalition's disAbility Advocacy Project is that addressing the needs of survivors with disabilities is best accomplished when DV and sexual assault programs understand disability and its implications and when disability-focused programs understand domestic and sexual violence and the trauma that it engenders. The webpage for the disAbility Advocacy Project contains tools for expanding disability access and inclusion, protocols (e.g., service animals, intake/screening, safety planning) and online[98] and print training resources to enhance the ability of DV/SA programs to serve and advocate with/for survivors with disabilities.

(ii) D.C. Coalition Against Domestic Violence "Survivors with Disabilities" webpage / Project Peer

For an example of a collaborative effort to build the capacity of disability-focused agencies to serve survivors and the capacity of DV/SA programs to serve participants with developmental disabilities and/or mental health issues, see the "Survivors with Disabilities" webpage of the DC Coalition Against Domestic Violence, and see especially the "Guiding Principles" statement, which was developed as part of Project Peer, a collaboration of eight Washington, DC community-based organizations that share a commitment to improving service access and quality for women survivors with developmental disabilities and/or mental health issues. The Guiding Principles statement also includes an extensive listing of national resources on the intersection of disability and DV/SA services.

(iii) Vera Institute of Justice / End Abuse of People with Disabilities project

The Vera Institute's End Abuse of People with Disabilities webpage provides information about the prevalence of abuse; some of the contributing factors to the such abuse; some of the barriers that prevent persons with disabilities from addressing the problem of abuse with the organizations that provide disability services; some of the barriers that prevent persons with disabilities from accessing help

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[98] The Washington State Coalition Against Domestic Violence offers many online trainings. To access the **"Advocacy for People with Disabilities" training**, scroll down the webpage to the link called "Advocacy for People with Disabilities." The training is an 11-hour course for DV advocates combining reading, study, and experiential learning. The stated goals of the course are to: "(a) Understand how living with a disability impacts the lives of survivors of domestic violence. (b) Learn how people with disabilities are engaged in a civil rights movement, modeled in part on the battered women's movement. (c) Learn practical tools that will help you provide better advocacy for survivors with disabilities. (d) Develop ideas about building community partnerships with disability advocates."

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from victim service providers; and strategies for building partnerships between disability providers, victim services providers, and the disability and survivor advocate communities to enhance the capacity of both disability and victim services providers to address need. Other Vera Institute resources include:

- *Forging New Collaborations: A Guide for Rape Crisis, Domestic Violence, and Disability Organizations,* cited as (Smith & Harrell, 2011), a resource developed by the Vera Institute with funding support from the OVW, which provides guidance around the elements of collaboration, factors that contribute to a successful collaboration, challenges attendant to collaboration and some strategies for addressing those challenges, and why collaboration is ultimately worthwhile.

- *Culture, Language, and Access: Key Considerations for Serving Deaf Survivors of Domestic and Sexual Violence,* cited as (Smith & Hope, 2015), a resource developed by the Vera Institute with funding support from the OVW, which provides background information on the Deaf community; available data about the perpetration of domestic and sexual violence against members of the Deaf community; ways in which Deaf persons are uniquely vulnerable to such violence and the barriers to accessing victim services; the gap in accessible and appropriate victim services; the role of Deaf-run, Deaf-staffed victim services providers[99] in partially filling that gap; and challenges, strategies, and recommendations for building successful collaboration between mainstream and Deaf providers to build mutual capacity to address violence against Deaf women.

- *Measuring Capacity to Serve Domestic Violence Survivors with Disabilities (for Residential Domestic Violence Programs),* cited as (Smith et al., 2015), a resource developed by the Vera Institute with funding support from the OVW, which helps agencies assess and measure their commitment and capacity to address domestic and sexual violence against Deaf women and women with disabilities. The guide walks readers through the process of developing specific indicators of organizational commitment to the goal and capacity to achieve it; explains the importance of each aspect of commitment and capacity that is measured by a recommended indicator; and suggests a process for organizational adoption and implementation of these indicators. (Also see the *Measuring Capacity to Serve Survivors with Disabilities* project website for additional resources on performance indicators for measuring the capacity to serve survivors with disabilities).

- The DC Coalition's aforementioned Project Peer is a collaboration between eight Washington DC-area organizations that address domestic and sexual violence, provide clinical or peer-driven mental health and/or substance abuse-related services, provide services for persons with developmental disabilities, and/or engage and support consumers in advocating for themselves and other persons with similar circumstances. Their 2010 Strategic Plan document describes how they developed a collaboration charter documenting their shared commitments, roles, and responsibilities; defining a shared vision and mission; identifying core values; assessing what was needed and what steps would need to be taken to achieve the desired outcomes; establishing priorities; and with the help of technical assistance from the Vera Institute of Justice, developed an implementation plan and "guiding principles that our partners will use to improve their organizational policies and practices related to access, identification, response, accommodation, and referrals for survivors of domestic violence and/or sexual assault who have developmental disabilities and/or mental health issues."

- Another example of a collaborative endeavor assisted by the Vera Institute is the *King County, Washington collaboration* between five organizations serving the Seattle/King County-area and providing domestic violence-related services and advocacy, and mental health and substance abuse treatment services generally or specifically serving Latinos and LGBT residents. Their 2010 report, Change Is Possible: Successes, Lessons Learned And Plans: Domestic Violence & Mental Health

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[99] See, especially the website of Abused Deaf Women's Advocacy Services (ADWAS), the Seattle-based organization that pioneered the effort to create Deaf-led resources to address violence against women.

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Collaboration Project created a representative Collaborative Team, developed a collaborative charter "outlining why we were working together and how we would do our work," conducted a needs and strengths assessment "to learn what we were doing well and where we could do better," and created a strategic plan implementation of four sustainable systems change initiatives: related to (a) creating welcoming environments, (b) enhancing staff knowledge, (c) strengthening issues identification and response, and (d) sustaining collaboration.

(h) General Provider Comments on Serving Survivors with Disabilities

Note: Providers interviewed for this project described experience serving survivors with a range of disabling conditions, and described taking a range of different approaches with respect to discussing the disability and the possible need for any reasonable modifications or accommodations. Some providers stated that without making assumptions, they attempt to surface what may appear to be disability-related issues by asking about the survivor's need for assistance, and by finding different ways to offer help to participants in addressing any barriers they may be facing. Other providers offer standard written or posted notices about their agency's A.D.A. policies or grievance procedures, but leave the matter of disclosing a disability and/or requesting reasonable accommodations or modifications entirely or largely up to the participant. (This parallels the continuum of approaches to voluntary services described in Chapter 4 of this report, ranging from staff who consistently reach out, promote, and offer tangible assistance and help finding and getting connected to community resources, to staff who provide basic information about how the program can assist and support participants, and then leave it up to participants to request that help.) *We recommend that OVW provide clarification and technical assistance to providers about its expectations and Fair Housing/A.D.A obligations to serve / offer reasonable accommodations to survivors who are Deaf or who may have a disabling condition, such as a physical or sensory or communication disability, or a cognitive, psychological, emotional, or trauma-related condition*.

Note: Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) We have a building and grounds committee that includes our ADA coordinator, board members, and reps of the disability community. They make sure our building and housing units meet ADA compliance. We have a staff member in a wheelchair who wheels around to make sure. We say it's accessible, but do you have real clearance or are your knuckles going to bump the walls? We do that with several reps of the community. We have a partnership with Partners for Inclusive Communities, and they will come and help us when we have issues around access. We meet four times a year. But if we have a client that's impaired today, we need to make accommodations today, and we can do that; we don't have to wait until the next quarterly meeting.

If a participant doesn't raise the question, isn't aware of the disability or their right to an accommodation, that's a sticky situation. We won't presume someone has a disability. It may look to us like they have one, but it doesn't mean it's our place to have that conversation. The way we frame that is to go to the goal sheet; one goal is physical and mental health. So we might ask if there are any barriers related to their physical or mental health, or their hearing or vision, that interfere with their ability to do activities. There may be a way to have that conversation – "Are there any things you've identified as a barrier or you want help on?" If they opt into the conversation, we'll say, "Let's talk more about that. Tell me from your perspective how this is a challenge." The last thing I'll do is tell someone about their own life. We have a client who isn't literate, and she's been struggling. The advocate said, "I see that you're struggling with this; do you want to talk about it?" as opposed to, "I see you can't read that." We want to have that conversation in a way that's safe for the client.

(#02) I know that we have procedure for ensuring ADA compliance. We do have an employee handbook and resident handbook. Every resident that comes in is given that handbook and they go over it in detail with their advocate. Any time that there's any accommodation that is needed, that will be addressed with our property director who handles all of our leasing. It will be handled through me as adult services director if there is any

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program modifications or alterations that need to be made for someone, whatever the accommodation is. If we can't provide it here on site for whatever reason or if it's not a reasonable accommodation, then we'll do whatever we can to make a referral to another program or agency that's already doing whatever that is.

If and when a need arises, we will address it internally and do what's needed to make those accommodations if they're reasonable. There's a compliance piece, of course, with making sure an apartment is accessible to someone who may have physical disability. But program modifications we do on an as-needed basis.

(#03) Every client who fills out a program application I go over the grievance policy and they get a copy. It tells them if they have an issue with any staff member, they have the right to follow this procedure to make a complaint. So if we didn't offer reasonable accommodations from the beginning, they have this.

(#04) All shelters are ADA-compliant. I believe it's a contractual requirement for scattered housing too.

(#05) We have handicap accessible units, which are critically important, but that isn't everything. We have to look at the bigger picture. For instance, we have to do what we can to make sure that a deaf person has the ability to communicate not only with the case manager in meetings, but also with the people they are living with down the hallway. The staff are expected to look at those matters right off the bat when they do their intake interview, and then to explore options with the client. It isn't a matter of the client's having to request an accommodation or modification of policies and procedures; we see it as an expectation.

(#06) We have policies about accessibility in terms of making sure that our elevator access and our doors – our building is ADA compliant, and that's part of our accessibility policy. When it comes to the actual apartment units, though, that's a little more complex. We don't hold ADA compliant apartments available because we don't have a huge demand for them, but if someone were to need an accessible unit, we would find one for them. Our funding is flexible enough that if we don't have an ADA eligible or qualified apartment in our pool, we will go to landlords and look for one for them. That's not a burden that we would put on the client. We would feel obligated to find one for them, and we would just rent it outright to make sure that the client can get in. Most apartment complexes have some ground level units that are ADA compliant.

(#07) None of our units are accessible so we couldn't serve someone in a wheelchair.

(#08) The housing authority, of course, has to be ADA compliant. Participants with a disability can ask for a reasonable accommodation. One time, one of our participants needed the peek-hole on the door lowered; that involved a reasonable accommodation. We also take therapy animals. If they want extra security locks, they'll ask for the reasonable accommodation. We go to training on fair housing, which we haven't had too many problems with. What I think would be a bigger issue is if someone in a wheelchair were to apply to our program -- if we were going to take them in, we'd have to make sure to get an ADA compliant unit and we don't have one. It would have to be bottom floor accessible or -- probably the housing authority has ADA compliant units, but they may not be vacant; so it would be making the unit assigned to us on the bottom floor ADA compliant. I'm not saying they wouldn't, but that would be a whole process.

If a client needed assistance in doing their house search because of a cognitive or emotional or physical disability, we would find a way to work it out. We had a client that was mentally unstable, and couldn't handle the process of looking for housing. We petitioned the housing authority for reasonable accommodation to let the client stay in her current unit, and they would give our program a different unit. We have different ways that we can work with them to get that done. We just had another client who could not drive, and she was

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completing our program; she got her list together of places where she wanted to look, and I transported her to look at all these different places and then went with her to sign the lease agreement.

(#09) The facility is handicapped accessible. We have a sign posted about participants' rights under the ADA and that they can request reasonable accommodations.

(#10) In working with challenging subpopulations, including persons with disabilities, community partners are the key. We work really closely with them, and it goes to our OVW disability grant. We're focusing right now on survivors with mental health issues or with an intellectual disability. And having the connections we have with our community mental health services, vocational rehab, independent living center, the family life center at the university -- all those things have been such a support because we just couldn't do this all on our own. People's needs are just too great. We have people that we can collaborate with: they know us and we know them. We understand each other's services. We can work creatively to try to find a way to assist somebody who's expressed a need in a certain area that we couldn't meet alone.

(#11) Although we have two houses, only one is operational. We just purchased one this year, and we're doing some construction to it before it opens. That second house is going to be much more accommodating, with ramps and the bathrooms set up so that people can do everything on one floor and don't have to do stairs. We do everything case-by-case, so if someone came in with medical issues, we might find that, at the end of the day, we're not the best placement for them, and then we would work with them until we could find a better alternative for them.

If someone couldn't do chores or meet other expectations because of a disabling condition, we would accommodate that, but we don't really have rules like that anymore. I think that in the culture we set up, the other clients would see that and would help one another out. We've had people who are eight months pregnant and couldn't take the trash out. The other ones step up and do it for her.

(#12) We've offered reasonable accommodations a number of times through our affordable housing program. As long as it's reasonable. In our housing stability program, we had a problem with one landlord who refused to do what they needed to do, but we have not found that to be an issue here. At least with the landlords we've worked with, everybody has been pretty scared of the ADA so they do what they need to do.

If people have certain responsibilities but somebody has a disabling condition that precludes their fulfilling that responsibility, then we work around that. I have a woman with cancer and I have another one that's getting chemo for a liver issue. We work around those issues; it's just something we automatically do. I don't want somebody putting themselves at risk to get in here when we can make some other arrangements. Let me put it this way: it's never risen to the point that a reasonable accommodation needed to be requested.

(#13) We have a form that they can fill out to request a reasonable accommodation or modification to the policies and procedures, but then they could also just make that request verbally. So they would make the request or let us know. We ask at the front end and try to let people know that if there's any way that we could be doing this better or supporting you in a way that would work better, let us know.

If a participant is not empowered enough to request reasonable accommodation, and we see that something's not working, we'll ask, "how can we make this easier? How can we make this smoother?" We frequently ask people about that and how we can do it better and differently.

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(#14) If a participant hasn't asked for an accommodation, but they seem to be having trouble, we ask them about the barriers that get in their way, and what they need help with, and how can we help them in a general sense. We don't ask them about their disabilities and the accommodations they need. We ask everybody that question, not just someone we think might have a disability. So that tends to open up the dialogue around what's going to help you use this housing well, feel safe in the community, and enable you to work on the goals that you've identified for yourself, and not goals that we've tried to give you?

The second piece is that our referrals, for the most part, are coming from our own emergency shelter. So they're informed by the shelter's staff experience of how that person did while living in the shelter. What were we able to observe that may have been challenging or triggering or confusing for someone? What worked really well? What did they find supportive? Who did they connect with? What services were most helpful to them? And what kinds of conversations did staff and resident have to build their trust in the plan that's been working so far? So we take all of the knowledge that's already been accumulated while they were in shelter, and try to use that as a starting point for planning for transitional housing.

(#15) We're collaborating with the state agency serving deaf and hard of hearing persons; our goal is to train DV staff in programs across the state about working with the deaf and hard-of-hearing population, and also to train deaf interpreters about domestic violence and sexual assault, and hopefully to have some of those interpreters sign up to be volunteer advocates. So that when programs around the state are working with deaf or hard-of-hearing survivors, the interpreters would volunteer as specially-trained interpreters.

(#16) (Not a current OVW grantee) If a person is so profoundly depressed and PTSD-impacted that they just can't get out of bed or function, we're going to recognize that and do our best to get them the help they want and need. Try to get them into permanent supportive housing if there's any way possible, or at least some type of permanent housing program where there's a longer-term rental subsidy.

(i)   **Provider Comments about Serving Survivors with Behavioral Health Conditions (e.g., Psychological and Emotional Health, Trauma/PTSD, Substance Use, Traumatic Brain Injury)**

> *Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.*

(#01) Substance abuse and mental health issues are a huge challenge for us. So when we work with survivors with these issues, we try to phrase questions in a way that will lead to a conversation about the substance abuse or mental health problem we think someone might have. But even if we can get them to talk about it, getting them to follow-up and get help is a whole other issue. For some people it's just really hard for them to get themselves to appointments, or get the transportation, or keep paying the bus fare. And if they have kids it can be really complicated for them. And then there's the issue that they really just want housing, and they don't see that if they don't deal with the problem, they're not going to be able to have housing once they leave the program.

(#02) We've got partnerships to address conditions like substance abuse and mental illness. We have a partnership with the local University; they place their psychology PhD externships here, so we can provide free mental health services. We provide care around substance abuse in the context of DV, which is a huge barrier a lot of our clients experienced. This is, we provide that care if the client is interested in accessing those services. If they're not, that's a barrier.

We believe you can't force someone to treatment. We're not here to replace the power and control they had. It's about, how do we establish trust so they feel safe to talk to us about the fact that they're using? We know that lots of people are using substances and it's a secret, or they feel they can't talk about it, or they'll get

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kicked out. We set ground rules that we're not telling you not to use; your housing isn't in jeopardy if you're not in recovery. That approach allows us to have the conversation when they're ready, so they don't feel like it's a punitive situation. We talk about how we all cope with the stressors in our lives; some people eat too much, some use substances. There's a long list of things people do to deal with stressors. Are there any challenges they want us to help with? We're very neutral, non-judgmental. We might have that conversation 15 times, and the 16th time they might be ready to talk about that. Or they you may never reach that point.

If a participant isn't initially open to talking about mental health challenges - depression, PTSD, etc. - we'll talk to them about how some people get really angry or really sad. Are these things you've been experiencing, and are these things you'd like to work on? It's not, do you feel depressed? Are you feeling like you can't sleep? If we've earned their trust, they will call us when they are in crisis from PTSD, or when they're feeling manic, and that's an opportunity to talk about how they're feeling and if they want support. Our services are available 24 hours a day, even when they've exited. We struggle when we have clients whose mental health has presented such a barrier that it may not be safe for them to live by themselves, and they're not ready to recognize that. We have clients that hear voices that want them to self-harm; that can be a difficult situation, especially when the client is not wanting to give up their sense of self-determination and autonomy.

(#03) One of our challenges is the prevalence of mental health-related issues that our clients face, and being able to serve them under the voluntary services model, and encouraging them and empowering them to address their mental health issues with professional service providers -- not just with our therapists here, but, if necessary, with a clinician or doctors depending on the severity of their mental illness. It's a challenge because we don't have those resources onsite and we can't require folks to get that treatment. So it's about establishing a relationship with the client and working with them where they are, and encouraging and empowering them to make some hard decisions for self-care, because it affects every aspect of their life.

It's similar to the challenge of working with clients involved in substance use and abuse, whether that use and abuse came out of being in an abusive relationship or being caught in the cycle of poverty. We have to reach out to professionals in our community for help, because that's not something we specialize in here. But we've developed referral resources and can help make the connections for folks who are ready to make changes.

(#04) Another challenge is dealing with the lack of available mental health care for people who need it, but have no insurance. We do counseling, but we're not mental health professionals that can provide treatment prescribe and monitor medication. There are clients whose mental health issues make it hard for them to stay employed, and without income and health coverage, it's hard for them to get the medication and to afford the medication, and they don't have the support they need to stay on their medication. It is a vicious cycle.

Although she is not a doctor and can't prescribe, we are fortunate to have on staff a therapist who has extensive history with alcohol and drug treatment as well as experience working in an inpatient mental health program, and she has been a godsend. Issues around alcohol and drug use come up with probably half our clients -- either their addiction or their abuser's addiction -- and so her experience has been really valuable.

(#05) Mental health counseling is a big part of our focus, and I help them try to find a provider that takes Medicaid or their insurance. Sometimes our participants are apprehensive about making that phone call, so I'll call with them, and I can go with them to an appointment, if they want. I try to meet them where they are.

We have a psychiatrist we can make referrals to, but for some of our scattered site clients, he's more than 60 miles away, and the lack of reliable transportation or gas money can be a barrier to getting that help. There are other resources, but it's a matter of getting them connected so they can access those services. Lack of transportation is at the top of our list because it is a barrier for a lot of individuals. Also, our area doesn't have

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a lot of mental health providers, and it can take a long time before a client can get in to see the provider. It can also be difficult for them to meet as often as they would want.

Another challenge has been drug abuse. I reached out to a program at the University and received some support and guidance and resources about how to address drug use in the program. It's still a challenge.

(#06) If a victim of domestic violence walks in and says they're bipolar but they're not on their medication and they're going through their kind of that manic and depressive cycle, then you have to look at that and think, "They're okay now, but what happens when they go through their depression? What happens if they become suicidal? Are they going to be able to maintain this apartment?" We had a young woman come in the other day who said she was bipolar, had anxiety disorder, borderline personalities. She was depressed and she had just been diagnosed as schizophrenic. And I said the only thing I could do for her was to treat her with respect and integrity and wish her well. Because we're not set up to deal with those types of issues. [100]

(#07) For mental health counseling or other services there are resources available, not many, but we have a free counseling clinic here, and church-based meetings of AA or NA for substance-abuse.

(#08) Our community has long wait lists for services with substance abuse. Programs that offer detox services are either closed because of funding losses, or at capacity. We often have difficulties helping people find appropriate supports when they are ready to address them.

We've built relationships with agencies that do provide that kind of support, but it's difficult because of lack of resources. We worked with the state's behavioral health division to find funding to place a clinician onsite, and that clinician is free for our participants. She can address counseling and mental health but not treatment for substance abuse. It's helpful because often, substance abuse is concurrent with mental health issues.

(#09) Some of our seriously impacted kids need deep end services in the mental health world with people who are trauma-informed. I think they do better there than they do in traditional domestic violence therapy. But those are the kids who are really having a hard time. Many of our women need more than therapy, but we work really hard to try and find other systems that are trauma-informed. Some of the typical mental

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[100] This provider's comment frames some important questions; the answers to those questions would help inform other providers, as well, that face difficult participant selection choices:

(1) Should the basis for the enrollment decision, above and beyond basic eligibility/need criteria, be an assessment of whether the survivor's mental health state and behavior *at the time of enrollment currently pose a threat* to herself or others, or can a provider base her decision on the *possibility or likelihood* that the survivor's future mental health state or behavior will pose such a threat?

(2) In a housing program, as opposed to a standard tenancy, does the provider's decision to enroll a person in their program come with a presumption that the provider is prepared to offer or leverage the services that the person will reasonably need? Or is the program barred by Fair Housing laws from considering such potential needs, even if the program candidate has voluntarily disclosed disabling conditions which might engender such needs?

According to the Bazelon Center for Mental Health Law's (n.d.) Fair Housing Information Sheet #8 - Reasonable Accommodations for Tenant Posing a "Direct Threat" to Others (which is no longer available online), "When evaluating whether an individual with a mental disability poses a direct threat to other tenants, courts should not accept "[g]eneralized assumption," "subjective fears," or "speculation" as conclusive evidence of dangerous behavior.... Rather, courts will require particularized proof of dangerous behavior based on objective evidence before the protections of the FHAA will be denied individuals with disabilities." The Bazelon Center's 2011 edition of What "Fair Housing" Means for People with Disabilities addresses a number of different aspects of the "direct threat" issue.

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health services -- we don't think help. Sometimes they actually compound things. But people sometimes need medicine, so we try to find providers with trauma experience. We've been building our bridges there.

(#10) Our greatest programmatic challenge is addressing the substance abuse and mental health issues that seem to continue to create barriers for people. Substance abuse and mental health issues can contribute to difficulty getting and keeping a job; can contribute to a bad rental history (e.g., if housing was abandoned not because of the abuser or the abuse, but because of the survivor's mental health or substance abuse issues); and can lead to involvement with the criminal justice system. And it's especially difficult to get a job if you've got a felony on your record. Substance abuse and mental health issues don't keep people from coming into our program, but they create barriers to moving out.

We support people in seeking treatment, but we recognize that when people access services from a domestic violence program, they're not necessarily seeking other treatment services. It's a challenge we work with, helping people make that shift to say, "Maybe I also need treatment before I can successfully move on to get a job and maintain my own housing." We work really closely with a women's behavioral health program here in town. We try to address these potential barriers, but ultimately it's the participant's decision. Although, there's sometimes a waiting list for treatment, usually participants can find services within a reasonable time.

We hired a licensed counselor who is dually credentialed in mental health and substance abuse. We also have another full-time mental health therapist on staff. It took us a long time to get there. And both of these people worked in our program for a number of years before they went back to school for those advanced degrees specific to mental health and substance abuse. It's really important to us that they were steeped in our philosophy so they're seeing those issues in the context of the domestic violence.

First of all, just understanding the language of drugs and alcohol is helpful. It's an ever-changing world: the types of drugs, the effects of drugs, things we need to be watching, keeping not only that person safe but their roommate and other people in the program. So just the educational piece has helped. But also just making it a regular part of our services: it's a challenge that we've had for so many years, because we don't turn people away if they're struggling with those issues. A big piece of their job is coaching our advocates and all of us about what we can do to help survivors struggling with substance abuse or mental health issues at the same time that they have been experiencing domestic violence and safety issues.

(#11) Do we ever have participants who have co-occurring mental health, substance abuse, or other behavioral health issues? Yes, and we have had clients who have experienced all of those things. There are mental health care programs in our community that we can refer those individuals to. As part of their case plan with us, they have to show that they've reached out to those programs and have to show proof or confirmation that they're connected with a program that can assist them with their mental health challenges.

We had a client who had a combination of all three: mental health issues, PTSD, and a substance abuse problem. We encouraged her to do was to connect to a program, and we case managed her a little bit more intensely, to make sure she felt supported, first of all, and so if she needed any additional assistance or support, we would be there to provide it. On occasions, if we suspected that she was under the influence, we would administer – with her permission – a drug test. If the results were positive, we would provide additional case management. We would encourage her to work more closely with her treatment program, in order to get to the bottom of her substance use, why she was using, what were her triggers, etc.

If it came to where a participant's use of drugs or their unwillingness to participate in treatment was creating danger to any of the other clients, we would take the next step and work on a process to exit the client from

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the congregate facility and possibly transition them into a scattered site where they would have a little more leeway. But if they're living in the communal house, we need to make sure we have a little more control.[101]

(#12) We don't have clinical staff. We have one clinician that works with our mothers and children in the shelter that is funded through OVW, and she's a part of a different agency that we contract with. Every once in a while, she'll follow participants into transitional housing, but most of the time, we just refer them to outside agencies to address their clinical needs. Most of the family participants have Medicaid coverage or private insurance; a majority of our single participants do not. But we can also refer them to agencies that can provide those services without coverage.

I can think of one participant who was stuck, and seemed resistant to seeking the clinical services that might have helped her get past that. It just took the case manager being persistent to get her to meet. And when we finally met, we just asked her, "What's going on?" and the participant said that she was depressed. We linked her to mental health services and asked if she would be willing for us to speak with the mental health professional. We maintain a relationship with them, so we can track her progress and support her. She wanted us to go to a few of her appointments with her. We went through those steps with her to get her out of that depression. And as she got out of her depression, she went back to school, and ended up graduating. And it took the case manager going off the path of, "You need to find employment," and meeting the participant where she was. She was depressed. She needed that extra support, mental health services to get her to a better place, and then focus on the job and savings once she got her mental health under control.

(#13) We do encourage those who have a history of substance abuse, or are currently using, to go to rehab or Alcoholics Anonymous -- we can support them in that. They're not disqualified if they are currently using or have used in the past. They cannot continue to use drugs on the property. We understand that substance abuse issues can go hand-in-hand with domestic violence and sexual assault, just as coping tools, but we can't ignore that they have drugs on the property. That's when we offer resources for rehab, staying in rehab, and their apartment will still be available for them when they return. We've had clients do that, go into rehab, and then come back to the complex and picked up where they left off.

(#14) One of the most important prerequisites to helping participants address co-occurring behavioral health issues is building a relationship with them and earning their trust. If they're having a problem with alcohol, they have to feel like they can come and tell you, and you're not going to judge them, you're not going to kick them out of the program for it. You're going to keep finding different options to help them through what they're going through. For them to feel comfortable enough to come and tell you that, it takes building a relationship. And we'd rather have them come to us than be afraid to tell us, or start avoiding our program.

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[101] In contrast to the previously footnoted provider comment, the initial portion of this provider's comment does not cite any anticipated threat to the prospective participant or other persons. While the requirement to be "connected with a program that can assist them with their mental health challenges" does not outright "exclude" victims because of their actual or perceived mental health condition, it seems to be "requiring survivors to meet restrictive conditions in order to receive services (e.g., the decision to seek a protection order or counseling is a choice that should be reserved to the victim, and should not be a precondition to services....)"

The provider's subsequent comment about how they would handle the situation if an already-enrolled participant's "unwillingness to participate in treatment was creating danger to any of the other clients" seems consistent with the "direct threat" criteria discussed in the prior footnote. Of course, the "direct threat" would have to be substantiated.

Note also, that the current use of illicit drugs is not protected by Fair Housing laws.

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(#15) We serve people with tri-morbidity: active or latent substance use and abuse, mild to severe mental health impairments, and most people that we serve have some sort of physical disability. Substance abuse treatment, mental health care are not requirements of our program, but we do provide some brokered services on site, since we have specific staff who have mental health and addictions backgrounds, who can do short term stabilization and then help people who are interested connect with deeper resources. I would say for the most part, people are engaged to some degree in some sort of outside support for their disabilities.

Most of the people we enroll are not coming to us from a substance abuse program or a mental health facility, but they have these disabilities; so we're making the referral to get them connected to deeper support services -- to the extent that the participant wants to share that with the community provider. We'll do what we need to do to set the participant up to have the best experience on the opposite end, including providing training or support to the provider, so they understand the participant's special needs.

(#16) We work in the group here with Lisa Najavits' Seeking Safety group model, which addresses trauma and or substance abuse. And a lot of times if the client has co-occurring issues, if they've come here with a diagnosis, such as Bipolar disorder, we strongly encourage them to either get on or stay on their medications. But we also try to teach them how to cope with the anxiety and depression that goes along with trauma, using some of the skills that they've learned in that group manual. Such as, we teach them grounding techniques. A lot of times, I would say almost 100% of the time they have no knowledge of Post-Traumatic Stress Disorder, and they have not had the insight or made the connections between their behaviors, their anxieties, and that trauma. So helping them develop that insight, a lot of times, helps them get a grasp on things, and they feel like they're more empowered to manage it successfully.

Unfortunately, it's hard to find a mental health therapist who understands trauma. It seems like it would be almost unethical to practice if you don't understand trauma, but there you go.

(#17) We don't want her housing to be compromised by the addiction or the mental health issue. Per the lease, and per the program agreement, safety is critical. So if safety in the community is compromised by their behavior or anything that's illegal, then she'll lose her housing. It's a lease violation. So, how can we help them manage so that their housing isn't compromised? For some, that's more harm reduction than abstinence. We just talk about safety planning around the addiction, and that's definitely a situation where our addiction specialists would be providing support to the advocate. And for others, it's talking about, planning around the mental illness. And the hope is that over time, if our work is done well, we can actually help the survivor think about getting more concrete support for the addiction or the mental illness. But initially, we frame it around maintaining their housing. We're low barrier and you got in, and that's great; and we're happy that we can provide you safe housing; now, how can we work with you to keep it?

(#18) Many of our participants have co-occurring behavioral health issues, like serious depression or mental illness, substance abuse, traumatic brain injury, or PTSD. We have substance abuse counselors on staff that can help. We use a harm reduction model, so we don't require abstinence from abusing substances, but we look at decreasing the harm that that it might be causing; and you can't actively be under the influence or using in the co-located units, so we have to make a plan about how they are going to comply with policy.

We have good relationships with the local mental health office and with contracted mental health agencies. We try to get them hooked in there, which often includes case management from that agency. And then as their advocate here, I work closely with that mental health case manager to ensure we're on the same path.

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(#19) We don't screen at the beginning, so if somebody discloses -- and we do ask -- that they're depressed or schizophrenic or they're suffering from PTSD and they're not seeking treatment, that wouldn't prohibit them from coming in, and it wouldn't necessarily prohibit them from working the program successfully. It's only when the issue is unaddressed and becoming problematic for the client and/or the community.

I've had that happen. I had a victim come in and it turns out that she was schizophrenic. We worked with her for four months and she was doing well and then - I'm not a clinician, so I can't say for sure - it appeared to be some type of a psychotic breakdown and we had to discharge her because she refused to seek any type of treatment and became very disruptive to the community.

(#20) We see a lot of addiction issues with the population we serve. We don't have any great answers; we work with people individually. We've had people go into rehab and then we try to get them back into housing.

Opiates are a big problem in our area, but addiction issues go way beyond opiates. Our whole community is looking at that really seriously. The whole state is: the provider community, the medical profession, and other organizations. But it really has kind of exploded, and obviously it affects housing.

We see it a lot: mental health issues with co-occurring substance abuse, and a lack of available treatment options. The mental health facilities, where participants with Medicaid have to access care, don't have the staffing, so there's a long waitlist at the local mental health agency, but there's also not great dual diagnosis treatment available. That's a real big challenge. There's not a lot of inpatient treatment for either of the two diagnoses or a combination of the two. It's huge. And there's not a lot private counselors that have a really trauma-informed approach or an understanding of domestic and sexual violence; or they may have met their quota of Medicaid patients and they can't take any more patients. So, those are the challenges.

And it affects mothers as well as single women. The Child Protective Services people are really trying to look at the whole trauma thing and really holding batterers accountable. So, that helps. But the substance abuse issue is kind of a sticky point. Moms lose their kids because of that. We work with them to get appropriate treatment, and to help them figure out how they can get their kids back. It's a long process.

(#21) To be in the HUD-funded rapid re-housing housing program, you have to have the income. Someone who is too profoundly traumatized to work, or whose mental health or substance abuse issues prevent them from working would be much more appropriate for the OVW program, because our support lasts for a year and we offer not only rental assistance, but also emotional support, including free counseling with a therapist at our center; economic advocacy; and help connecting with resources and working through barriers.

The severely permanently mentally ill subpopulation is very underserved; it's a population that needs long term supportive services. Their chronic mental illness makes them more vulnerable to abuse, but also causes some to have a lot of barriers when they're in a transitional living program, and those kinds of clients need a lot more supportive services than a one year TLP can offer.

If someone is in crisis, you can't immediately transition them to independent housing, look past the PTSD, and say okay, turn off the lights and sleep alone in your house for the first time. I think the idea with some rapid rehousing is that giving someone a house allows them to feel safe, so they can move on with their life -- but it's not quite that simple when you're talking about people who have been traumatized and have complex trauma histories, dual diagnoses, substance abuse issues, or shaky sobriety.

(#22) (Not a current OVW grantee) I'd say that we struggle with participants that are very fresh in their sobriety, and maybe dually diagnosed persons. If they're taking care of their mental health, it's not an issue; it's only when they don't. If they've already been through and been terminated by multiple programs for lack

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of -- I won't say compliance, it's an ugly word, but they haven't done well in any program -- if they're blaming someone else, and not taking responsibility for the failure in all these programs; if you see, for example, issues of severe mental illness; or if they've sobered up on their own, but don't have any supports around maintaining sobriety; and if they are parents -- we're really careful because when someone is a parent and is actively using, it's absolutely impacting both their child and their roommates. We have more leeway with a single person that's struggling with sobriety than with a parent. Because with a parent, you're starting to file neglect and abuse cases, and the child may be in danger, and we can't be a buffer because they're in a scattered site apartment, and it could turn very dangerous very quickly. So that's where we would hesitate. But we certainly have served persons with mental health or substance abuse issues.

(#023**)** We serve people with all types of disabilities. I would say that the most frequent disability diagnosis is related to mental health. We serve participants who are deaf or hard of hearing, who are blind, who use wheelchairs or other mobility supports, or who have chronic health conditions. I think the key to accessibility is that we're not screening anybody out. The question we ask is, "What do you need from us to use this housing well, and to be safe and have the support you need?" And they tell us, and we try and meet whatever needs they have. Our onsite units were designed to be accessible: there were sight and sound accessibility features built in. Some of the units are completely accessible to people who use a wheelchair or have other mobility limitations, and then we just try to make any additional accommodations as needed.

We also have a partnership with a health clinic and mental health clinic that offer onsite services at our shelter each week. And we have other health partnerships and a counseling program in our shelter as well. So in terms of trauma-related and other mental health issues that might come up, there are fairly easy points of access to get support around identifying, coming up with plans to support and/or treat any issues that shelter residents may be confronting. And they can either continue to use that clinic during their time in transitional housing, or they can get linked to community resources, whichever feels like their best option for support.

The residents of our transitional housing programs can access services from our health partners. If they've built a strong connection with their shelter-based counselor, and are having trouble accessing that kind of support from other sources, we make available some bridge counseling if they continue to need the help.

Our resource center has a counseling program that offers individual counseling for adults and children who have experienced domestic and sexual violence, or trafficking. We have drop-in support groups. We have small closed groups. Counsellors are experienced and have training in [somatic experiencing](#) and [EMDR](#) as well as other, more traditional counselling methods. They offer family counseling work and play therapy for children. We offer telephone counseling for participants who can't come onsite for reasons of safety or access barriers, like a disability or lack of transportation. It's very common that women coming to us aren't eligible for Medicaid, and haven't had access to health care. So being able to offer in-house health services is huge.

(#24) One of our toughest challenges is getting through to survivors who are under the influence of alcohol and drugs. Sometimes, while they're ready to leave their abusive partner or flee an unhealthy situation, they're not ready to address that addiction. It doesn't cause a lot of problems from a service perspective, but they don't seem to get as far as some other program participants who are not facing addiction issues.

(#25) Our state hasn't implemented Medicaid expansion. But we do have a volunteer clinic with physicians, dental care, mental health care, that can be accessed for absolutely no charge. That's a godsend for people in town, but it's not available in outlying areas. We can get emergency care for physical conditions. One of the things that I'm most concerned about is accessing mental health care. We have one provider in nine counties that accepts Medicaid for mental health services. They are beyond overwhelmed and even when we have, for instance, children who have witnessed or experienced abuse, who are having all kinds of issues at school, or who have been in shelter who are failing academically, who are just struggling on every level you can imagine

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– unless they are at a point of needing to be hospitalized, they're not being triaged into the system. We're attempting to find ways to get some additional assistance for them. A child therapist who just moved here is going to volunteer and work with our children. I'm thrilled about that because the lack has been an ongoing concern. The more populated areas have some good care but we struggle with the mental health side.

(#26) Difficulty accessing mental health or addiction services when they're needed is one of our significant challenges. The primary issue is the waiting list at our local mental health agency. Sometimes we need that immediate attention. Of course we do have the emergency room that we can utilize. But sometimes, things come up for women during different parts of the program. They might do really well for a few months and then addiction or substance abuse issues come up again that they might not be ready to deal with.

(#27) We're fortunate – we have a licensed counselor on staff and another part time licensed counselor on staff right now and both the housing department and the domestic violence department can make referrals to that counselor for clinical and mental health services. The counselors on staff are internal and no matter which campus the client is at, the counselor can go there and meet them.

For those that require the assistance of a psychiatrist, we have a partnership with our local mental health authority that can see our clients in their clinic. We have master's level staff here, and we can refer if they need assistance at the level of an MD. We worked to form a partnership with a psychiatrist who is familiar with the dynamics of domestic violence; we interviewed several psychiatrists and were lucky enough to find one that had experience with domestic violence victims and has done a lot of work with CBFT [Cognitive-Behavioral Family Therapy or Trauma Focused Cognitive Behavioral Therapy].

Whether a woman has to travel to get help or whether she can meet with someone onsite is a consideration. We have provided some transportation, which is a big need, if they can't get there on their own. At times, if staff is available, we have transported them to those services.

(#28) When participants have PTSD or behavioral health issues, and maybe substance abuse, that's where trauma-informed care comes in, and understanding conflict resolution and de-escalation. Everybody is trained annually to deal with all three issues and to be able to de-escalate situations. We try to stop things before they escalate to a physical argument. When you think in a trauma-informed way about why they're reacting the way they are, it helps you be a little more patient and understanding, so you can explain to other individuals who might be affected by their behavior.

If we do have an individual who has mental illness, for example, somebody with schizophrenia who is not medicated or is choosing not to take medications, or if they fled the domestic violence and left their medications in their house, we can offer assistance and we have relationships with our community's mental health crisis services. They'll come here and do an assessment and work with them to get them back on their medication. We also have the mental health co-op and they have psychiatrists on hand to help people with their medication and also provide some therapy.

For the issues of drug abuse, we again utilize the community mental health crisis center, as well as another organization that hosts AA meetings and some drug abuse counseling. We try to create a relationship where participants feel safe enough to tell us when they are involved in drug use, or have other issues that might pose a problem, so that we can address those issues up front. And most of our participants do tell us. And if they don't, it comes out anyways. We try to work with them and give them different options for help.

(#29) PTSD and substance abuse are pretty much synonymous with domestic violence and sexual assault. It would be a rarity for me not to encounter somebody that is dealing with PTSD or substance abuse. To be in the transitional housing program, they have to be substance free. If our counseling or therapy can be helpful

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to them in addressing the PTSD or mental health issues, we recommend that they continue with those services; it's up to them. Most of the time they do, because they notice the progress. That's one nice thing about being in shelter before going into transitional housing: they've had a chance to be in therapy here and most of the time, they can see the progress, the change it's made in their life, and they want to continue that.

(#30) I used to work at an agency in an urban area where there were a lot of different programs and the domestic violence program could say, "I don't think that you're the best fit here, but there's this other place that might have better services for you." In our community, we don't really have that option. It used to feel like it put us in a position of having to take anybody who asks for help. And what you find, then, is that you really **can** serve anybody. People have behavioral health issues, substance abuse issues, and/or trauma issues, and serving those folks is (a) really important, and (b) not something you need a clinical degree to do. I'm not saying we can provide somebody's clinical services. I'm saying we haven't noticed those kinds of issues getting in the way to the degree that you would want to screen somebody out.

(#31) (Not a current OVW grantee) The Housing First model says that a person should be able to continue in their addiction and that's not really our philosophy. So if somebody is actively using and doesn't really want to address it, this program is not a good fit. But if somebody has a history of addiction and they're open about it, and they seem to want to deal with it, then we are a good fit. I have a lot of experience working with people with addictions, that's my background. I really believe that people are capable of overcoming addictions, and so we have a very generous and welcoming approach to people, as long as they're willing to be accountable for their behaviors. Somebody can slip; as long as they're working with us and they're open and honest about it, we're happy to work with them. Remember: this is not for chronically homeless single individuals. These are people with children, so it's a different story if you have a two-year-old and you're falling asleep drunk versus if you're in your own home and nobody's depending on you. We have a couple of people in our program now who are drinking, but they're working with us, and there's no threat of eviction because of the addiction. As a matter of fact, I think they've found that this is a good place to try and work it through.

There's still a stigma for some people that if your child needs mental health services, then somehow you're a bad parent; that's especially true for people from other cultures. I remember even when I was younger that if somebody was seeing a therapist, then something was wrong with them, so that kind of stigma can still be true in a lot of poor communities and it can be true in a lot of foreign-born communities. Our therapist is a marvelous woman, warm and engaging and smart and she does groups on wellness. The people meet her as the wellness instructor and so they already know her and if they want to talk to somebody about the trauma in their life, they say, "I want to talk to so-and-so." So we've gotten them to the person who can help them in a way that is very gentle and non-stigmatizing. She's not Doctor Guilty. She's Suzie So-and-So. But it's still not easy to get children into counseling; sometimes it takes months of conversations before a parent says, "you know what? I think that's the right thing."

(#32) I think clinical support needs to be available. We don't readily have that in our house, but we have therapists, we have psychiatrists, we have people we can send you to that we have great references for. We have volunteer therapists that actually come to our site and out of the kindness of their hearts, do one-on-one therapy, and they're all women who have either been in the life or they're just really invested because they've loved someone deeply who has been in that lifestyle, so they have experience with it. Whether you offer that onsite or not probably depends on how big your program is: if it's four units, you wouldn't, but if it's 12 units, it would be very helpful if the provider came onsite.

We use a voluntary participation model; participants are voluntarily coming to be part of our programming. We don't have a lot of rigid restrictions. We use a harm reduction model, simply because if you're coming off the street and you were high yesterday, I can't assume you're not going to be high tomorrow. But if you're

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going to sit downstairs and smoke crack all day, that's not acceptable either. If you pick up again after you've been in the program, and you want to go into treatment, we can help you enroll in treatment and still keep your spot. We can be flexible with that. If you've been sober for three months and your pimp called and is starting to stalk you and you come back drunk, we understand exactly how that happened and we'll work with you to figure out how we can help you better equip yourself for that.

We deal with difficult behaviors day-by-day, and sometimes minute-by-minute. It's very situational. I'm the first one to admit, if a person is a little bit out of our scope right now because they're very violent or because their mental health is so unstable or because they've been so abusive to themselves. Oftentimes those individuals have already had hospital stays, or they've been committed. There's just a lot of stuff they've already been through with the system, and they are often aware of what they need. We do a pretty good job with the intake, making sure we're as equipped as possible with information they're giving us.

I'll give you an example. I have a couple women who have been in the lifestyle a very long time, since they were kids, and they're both relatively young still, in their mid-40's, but they started at 14 or 15. And they're both with us right now and they're both at different levels of taking care of their mental health. We had a house meeting the other night and one of them had a serious emotional outburst directed at another participant. Fortunately, when it was all said and done, the two participants had worked it out and were able to hug each other. We haven't had a lot of extreme and violent behavior in the house. We've had a couple of situations, but the community lets me know everything 24/7. And half the time it's not true but at least I catch wind of it so I can figure out if there's something we need to be concerned about.

(#33) Supporting participants with clinical mental health needs can be a struggle sometimes. A local agency offers mental health services and they're able to come onsite to serve our clients; our county hospital has a program through their psychiatric unit that clients can access to receive mental health support and medications. So, many of our clients that are moving into housing from the shelter have had the option of accessing services, and they get assessed and enrolled. Most recently, the hospital program has added some prescription copays for clients, so that's a bit of a struggle we're trying to work around; on the other side, the local mental health agency I mentioned might have a limit on how many prescriptions they get per month. A lot of our folks are accessing those services, and our case managers work with them to ensure they don't lose the benefit: if they don't fill out a certain form at six months, they might get dropped and have to start over.

Most of our clients who need mental health services can access those services, although sometimes there's a bit of a wait time; the stopgap is that they can go through the county program until the local agency program kicks in. It's not perfect, but I wouldn't say that clients are left hanging without access. We also have a mental health team that comes out, so if anyone is in severe crisis, the team will come onsite or to a person's home.

Sometimes when survivors move into their scattered site unit, and they're starting a new routine, and the adrenaline rush of getting everything taken care of in shelter is over -- the protective order, the mainstream benefits, their child's situation, etc. -- they're more isolated and the trauma catches up with them, and that's when they need more of the counseling and the support groups. Fortunately, they retain their access to those mental health services, as long as they've kept up with the required paperwork. And our agency offers all kinds of other support services beyond the OVW-funded case management. So if they want their children in play therapy, they can have their children in play therapy. And if they want to see a therapist, they can see a therapist. And if they want to go to a parenting class, there's a parenting class available to them. All for free.

(#34) We have a couple of really strong partnerships in the community that are specific to emotional wellbeing and illustrative of how trauma informs the work we are doing. We work very closely with a female health program in our county and with local therapists. We have staff from those organizations that meet with our clients on a weekly basis, and we make referrals to them.

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We have a longstanding relationship with our local substance abuse program, and we provide joint services, meaning that we provide consultation support to the local substance abuse program on issues of safety and sobriety and they provide substance abuse services on our shelter campus and to our clients in outreach. If we have a person with substance issues in our transitional program, they can participate in those dual services. And those dual services are typically support groups that are co-facilitated by a staff member from the local substance abuse program and one of our staff. Also, that substance abuse provider has transitional housing, and they give our shelter clients priority. If we don't have any transitional units, and we have an individual in our shelter struggling with sobriety or maintaining sobriety but dealing with poverty issues, we can often work with them to get priority placement into their transitional housing units.

(#35) We have two 5BR homes for single women and two 5BR homes for women with children. We own one of the homes and lease the other three. One of the homes is geared towards female vets, but the thing all the women have in common is they're all battered or sexually abused and have substance abuse issues. They could be trafficking victims; they could be women who came out of prison; they could be transgender; we don't say we only work with this or that population. Each home has four client households and a house manager who's been through our program or a similar program. We had a professional that served as a house manager and that didn't work. The women participate in a resident advisory committee that advises us on their needs and what they want. We do a lot of peer support-type programming and that seems to work well.

Women seem to respect and listen to other people who have faced or been through the same challenges and issues. We have professionals leading groups, but even with those groups, the co-leader is always a peer, somebody who's been through the program, even if it was with another agency.

PTSD issues -- that's what's different about serving veterans versus other women survivors of domestic violence. It's a big difference, too. I'd say 99% of the female vets we serve were sexually abused or raped by our own troops, and the PTSD issues are just overwhelming for us. So we partner with a Veterans organization and we collaborate on groups and different services for those women. They get free transportation, too, whether it's doctor's appointments or just the different things they do for vets that we don't have services for. Honestly, the female vets that stay with us don't care whether they're living in a house with just other female vets.

(#36) One of the things we've seen over the years, in addition to women getting screened out of programs, is how many labels are put on battered women unnecessarily -- and clinicians are a direct link to that, because a lot of domestic violence shelters now bill insurance companies, and insurance companies need diagnoses. So they have clinicians on staff saying "They're bipolar," or "They're this and that." That's appalling to me: To me, nobody should be diagnosed within the first six months of getting clean and sober because their behaviors -- that's a good average time for them to really get it out of their system. Because once they're labeled with those diagnoses, that's going to follow them everywhere. I'm personally opposed to all the labels that so many battered and sexually abused women are diagnosed with in the initial stages and all the medication -- even if they're not an alcoholic or drug addict. If you interview a woman the day after her crisis versus six months later, you can see the difference without her having had any medication.

(#37) We don't do "mental health assessments." We provide "trauma-informed services," without any diagnoses. We don't bill to insurance, so we don't have to classify a mental health diagnosis to justify the cost. When we talk with a survivor about her child, we just frame it as "your child has been exposed to trauma just as you have; it doesn't mean there's something wrong with you or your children. It just means that something traumatic happened to them that can have long-term effects. The more strategies they have for coping and dealing with the traumas, the more successful they'll be in overcoming any effects from that trauma."

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(#38) If somebody has an addiction problem, we would refer them to an agency we work with, where they can go and get assessed, and get the help they need. I think it would be a good idea to have them go through some sort of program before placing them in an apartment where they'll be by themselves. It's the same thing with mental health. We have an agency that partners with us. They'll assess our clients. If it's something minor, like she's a little depressed -- well, being in a shelter and going through what she's gone through, that's expected. Or, if it's something more major, we prefer for them to be stable and on medication before they're living on their own, because if they aren't healthy, will they be able to live by themselves without that extra support of the mental health counseling or whatnot? [102]

(#39) Most of the women that we work with that have mental health issues are under care, which is good. We help facilitate that and promote that as much as we can. We do get some women who have mental health issues who are not under care and who are very difficult, very challenging to work with. And we do everything we can to assist those women with meeting their needs, which is very challenging because in the rural areas there are very few services. Indian Health Service has a psychiatrist that comes down once a month and a lot of times they don't have the time to see adults, they see children only. Folks are forced to see their social service department and go in there for counseling. It's a very bleak situation, mental health services in the rural areas on reservations. And we have very high rates of mental illness - depression, bipolar, and so on.

This is where some of our traditional ceremonies and healing come into play; it helps her get grounded and brings calm to her daily chaos. And so we'll do anything we can to help facilitate that. It's not only the biomedical technology but also traditional medicine and traditional ceremony and healing are very important. We have a treatment center which is real good, and they will also refer you out to other facilities. However, once again, turning to your traditional beliefs and participating in ceremony often helps with your sobriety; helps you to achieve it and to maintain it. The [Red Road], as it's called, is very helpful for individuals who are being challenged by those kinds of issues.

(#40) Are we doing a good enough job of reaching women who may have mental health issues or may be dealing with depression or substance abuse issues? I would say that's probably not one of our strengths, because we serve primarily women who are coming through shelter or counseling services that these programs offer, and we're dealing with domestic violence programs, so it's whoever reaches out to them. And we know that's a pretty small percentage of the population.

(#41) We have so many resources available here. Mental health providers - some people will choose to access tribal resources and the counselors and therapists here. I don't know how much expertise they have in the dynamics and multilayered impacts of domestic violence. And I think very few of them are really competent in processing sexual abuse trauma. We have a lot of medical and mental health agencies that, with the tribal healthcare available to them, they can contract out to non-tribal areas if they want. And we do have therapists with expertise in rape trauma syndrome and that sort of thing available. Some people don't want to deal with their trauma in that way. They don't want to formally sit down. The tribe has just brought in [rapid]

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[102] Since current use of illicit drugs is not protected by Fair Housing or A.D.A., requiring a prospective participant to enter a treatment program is perfectly acceptable. If their addiction involved alcohol, that would be a different story. If a person with a mental illness must be assessed and/or participate in treatment as a condition of enrollment in the program, that would constitute the kind of "restrictive condition" that the OVW warns against in its [annual solicitation for TH grant proposals] (p.4). Program staff may promote the benefits of treatment and medication in their conversations with such participants; however, requiring that a survivor be in treatment and on medication as a condition of participating in a TH program would cross the line defined by the OVW program guidelines and Fair Housing laws.

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eye movement treatment[103] and we also open the doors to treatment such as equine therapy and energy work around trauma and Reiki, which our partners at the tribe's domestic abuse program are all masters in. We offer different options to talk therapy -- having to repeatedly talk about what happened to you. Maybe you're stuck in the trauma and the emotion of it and you can't get to that lateral processing. So looking at other options for processing their trauma is super important. Clinical is a piece of it, but having a lot of other options available has been really helpful to clients.

I have a dog that's a certified good canine companion that can come into homes with me and work with clients. And he is one of the most powerful healing tools for a lot of people in their household, especially the kids. He's safe. He's like a giant teddy bear, and they can talk to him all they like. There's no judgment or feedback that comes from that. We connect people with art therapy, with just a lot of different resources beyond mental health talk therapy.

Another thing that's really helpful in people processing their trauma is going through the ceremony of receiving a Native name, if they were never given one.[104] We often see enormous shifts once they've received their name and that sense of identity. We built a sweat lodge[105] in the backyard of one of our employees that we use as part of the healing from trauma, and the ceremonies that go with that. And we connect people with resources in the community to do cleansings of the household,[106] if they are staying in the same household as where they were abused. So the trauma, under their belief system, is dealt with in different ways.

Questions to Consider

1. "Reasonable accommodation" can mean any of a number of possible changes to program policies, procedures, and practices, including changes that some provider staff might never have imagined. A survivor of domestic violence who has been in a controlling relationship in which her needs and preferences were largely ignored might not be able to envision such accommodations, and even if s/he could imagine them, might not feel empowered or self-confident enough to ask for them. In the same way that employment counseling often includes an introduction to a variety of professions that a job-seeker might not have known existed, how might a provider explain the range of possible accommodations that the program could offer to facilitate the survivor's participation?

- How could the provider discuss those accommodations in a way that avoided putting a survivor on the spot to disclose a disability that she wasn't ready to discuss?

2. How does the type of program housing (congregate versus clustered unit versus scattered site unit, provider-owned versus provider-leased versus participant-leased) affect the challenge and approach of working with a survivor who is struggling with mental health issues or addiction?

3. To what extent should the duration of rental assistance impact the decision to serve a participant with mental health or addiction issues who does not appear ready to seek treatment as part of their effort to move forward?

- Is providing that survivor with six months of housing assistance a good use of the funding, if it gives them six months of safety and respite from abuse that they will not otherwise have after they are discharged from the shelter where they have been staying? Is offering those six months of assistance to another survivor who will likely use the time to strengthen their employability and financial situation a "better" use of the money?

4. To the extent that a survivor has a mental health or substance abuse issue, but cannot access or afford treatment in the city, town, county, or region where they are hoping to live, is it better for them to be served by a local program that cannot help them access treatment, or to be assisted in at least temporarily relocating to a city or state where

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[103] See Posmontier et al. (2010) for a description of the research documenting EMDR as "an effective, low-cost, brief intervention therapy for treatment of acute and chronic PTSD in victims of sexual violence."

[104] See for example, Linda VanBibber's essay, "What Is Your Spirit Name?", and Dr. Elisabeth Pearson Waugaman's essay, "What's in a Name? Names and Identity: The Native American Naming Tradition."

[105] See, for example, The Native American Sweatlodge: A Spiritual Tradition, an essay on the Barefoot's World website.

[106] See, for example, Smudging and the Four Sacred Medicines, an essay on the Dancing to Eagle Spirit Society website.

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treatment would be more accessible? (More typically, DV providers assist in relocation when the safety of the survivor is at risk if they remain in the vicinity of the perpetrator of the abuse.)

5. To the extent that a survivor's apparently "unproductive" attitudes and behaviors -- unmotivated, unfocused, poorly organized, uncooperative -- may well be symptoms of traumatic brain injury or PTSD, when, if at all, is it appropriate for a provider to determine that such a survivor is a "poor fit" for their transitional housing program, such that they should not be enrolled, or should not be extended past the minimum six months required by OVW?

6. Under what circumstances is it reasonable for a provider to deny enrollment to a survivor who meets all the funder's and provider's eligibility criteria, but who apparently has a mental health or substance abuse-related condition for which they seem disinclined to seek treatment?

• Under what circumstances is that kind of reason for rejecting an applicant for transitional housing tantamount to requiring participation in services as a condition of receiving housing assistance?

9. Appendix A: Project Description and Methodology

(a) Project Description: Summary

Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot provides an in-depth look at the challenges and approaches taken by Office on Violence Against Women (OVW)-funded providers to address the needs of survivors who have become homeless as a result of having fled domestic violence, sexual assault, dating violence, and/or stalking.

The information in the twelve chapters of the report and accompanying webinars, broadsides, and podcasts comes from 124 hour-long interviews with providers and an in-depth review of the literature and online resources. Our analysis of provider comments was informed by the insights of a small project advisory committee (Ronit Barkai of Transition House, Dr. Lisa Goodman of Boston College, and Leslie Payne of Care Lodge) and the reviews and comments on the initial drafts of chapters by Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative).

Although the components of a transitional housing (TH) program -- a place to live and staff support for healing, decision making, and taking next steps -- are simple, the complexities attendant to providing effective survivor-centered assistance are many, as illustrated by the following enumeration of topics covered in the report (which, in many cases, only scratches the surface):

• Chapter #01 - *Definition of Success & Performance Measurement* - Explores how funders and providers define and measure success and program performance; how participant-defined goals are tracked; how participant feedback is collected; and how the definition and measurement of success affects program decisions. Highlights innovative performance and participant outcome metrics. Discusses approaches to collecting, storing, releasing, and destroying data, and the software used to collect, analyze, and report on program data.

• Chapter #02 - *Survivor Access and Participant Selection* - Explores the distinct and overlapping roles of domestic violence (DV) shelters and transitional housing; the pathways that survivors take to get to transitional housing, and how providers select participants from among "competing" applicants for assistance; why providers might decline to serve certain candidates; who is and isn't served; and the regulatory and legal framework within which those processes occur.

• Chapter #03 - *Program Housing Models* - Explores the strengths and challenges of alternate approaches to housing survivors in transitional housing and transition-in-place programs. Examines the pros and cons of time-limited housing vs. transition-in-place housing, congregate vs. clustered vs. scattered site housing, and provider-owned vs. provider-leased vs. participant-leased housing. Discusses how the type of housing can affect participant selection and the services offered.

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- Chapter #04 - ***Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement*** - Examines the challenges, strategies, and implications of taking a survivor-centered/voluntary services approach, and how such an approach is integral to operating a trauma-informed program. Explores the potential impacts of funder expectations, choice of housing model, staffing patterns, and diverse participant needs and circumstances. Presents comments illustrating the range of providers' interpretations of and responses to the voluntary services requirement, including their approaches to supporting participant engagement and to addressing apparent lack of engagement. Discusses the concept of empowerment, presents comments illustrating the diverse ways that providers see and support survivor empowerment, and cites an innovative approach to measuring safety-related empowerment.

- Chapter #05 - ***Program Staffing*** - Explores program staffing levels and the kinds of positions providers maintain; the attributes and qualifications that providers look for in the hiring process; and how they assess the value of having a clinician on staff, having child-focused staff, and having survivors on staff. Examines how programs support and supervise staff, and their approaches to staff training. Presents comments illustrating providers' diverse perspectives about utilizing volunteers, and describing how programs that do use volunteers screen, train, and support them.

- Chapter #06 - ***Length of Stay*** - Explores funders' and providers' approaches to limiting or extending the duration of housing assistance and services, and the implication of those approaches.

- Chapter #07 - ***Subpopulations and Cultural/Linguistic Competence*** – Discusses cultural and linguistic competence and how providers understand and work to achieve it in their programs. Presents diverse perspectives from the literature and online resources and from provider interviews about the challenges and approaches in serving specific subpopulations, including African American, Latina, Asian American, Native American/Alaska Native, Immigrant, LGBTQ, older adult, deaf, disabled, and ex-offender survivors. Includes an extensive review of the challenges, approaches, and legal framework (e.g., non-discrimination, reasonable accommodation, fair housing) in serving survivors with disabling conditions that affect their mental health, cognition, and/or behavior, including trauma/PTSD, substance dependence, traumatic brain injury, and/or mental illness. Highlights OVW-funded collaborations to enhance the capacity of victim services providers to serve survivors with disabilities and of disability-focused agencies to serve consumers who are also survivors.

- Chapter #08 - ***OVW Constituencies*** - Focuses on the needs and approaches to meeting the needs of survivors of sexual violence -- including survivors of rape and sexual assault, homeless victims of sexual violence, survivors of Military Sexual Trauma, and survivors of human sexual trafficking. Explores possible reasons why survivors of sexual assault constitute only a small percentage of the participants in OVW TH grant-funded programs, even though provider comments generally indicate an openness to serving such survivors. Includes a conversation with senior staff from the Victim Rights Law Center discussing possible options for expanding system capacity to serve sexual assault survivors.

- Chapter #09 - ***Approach to Services: Providing Basic Support and Assistance*** - Explores different frameworks for providing advocacy /case management support (e.g., voluntary services, survivor empowerment, Housing First, Full Frame) and how motivational interviewing techniques could be helpful. Discusses survivor safety and how safety is assessed and addressed (e.g., danger and lethality assessment instruments, addressing batterer- and life-generated risks as part of safety planning, safe use of technology). Looks at strategies and practices for supporting community integration, and providing follow-up support to program alumni.

- Chapter #10 - ***Challenges and Approaches to Obtaining Housing and Financial Sustainability*** - Examines the challenges survivors face in obtaining safe, decent, affordable housing and the approaches providers take to help them, and some useful resources. Explores the added challenges posed by poverty, and approaches and resources leveraged by providers to facilitate access to mainstream benefits, education

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and training, and decent employment. Other areas of focus Include childcare and transportation, resources for persons with criminal records, workplace-related safety planning, and approaches and resources for supporting survivors in enhancing key skills, including financial management.

- Chapter #11 - *Trauma-Specific and Trauma-Informed Services for Survivors and Their Children* – Discusses the nature, impacts, and manifestations of trauma; approaches to addressing trauma; what it means to be trauma-informed; and the steps providers take -- and can take -- to become more trauma-informed. Reviews the impact of trauma on children and families, especially the trauma of witnessing abuse of a parent; and discusses the challenges posed and approaches taken in addressing the effects of that trauma. Includes brief sections on custody and visitation.

- Chapter #12 - *Funding and Collaboration: Opportunities and Challenges* - Examines sources of funding for TH programs, focusing on OVW and HUD grants -- the regulatory requirements, strengths and constraints of each funding source, and the challenges of operating a program with combined OVW/HUD funding. Explores the potential benefits, challenges, and limitations of partnerships and collaborations with mainstream housing/service providers, including confidentiality issues. Presents provider comments citing the benefits of being part of a statewide coalition; discussing the opportunities and challenges of participating in a Continuum of Care; and illustrating the range of gap-filling service agreements and collaborations with mainstream providers. Highlights published reports describing successful collaborations.

Although the report chapters attempt to divide the component aspects of transitional housing into neat categories, the reality is that many of those aspects are inextricably linked to one another: the definition of success, the housing model, and sources of funding play a key role in how services are provided; the housing model, sources of funding, and length of stay constraints can play a role in influencing participant selection; the subpopulations targeted and served and the program's approach to cultural/linguistic competency, the program's understanding and embrace of voluntary services, survivor-defined advocacy, and what it means to take a trauma-informed approach all inform how the program provides basic support and assistance; etc.

(b) Project Description: Overall Approach

This project was originally conceived as a resource guide for "promoting best practices in transitional housing (TH) for survivors of domestic and sexual violence." However, over the course of our conversations with providers, it became clear that while there are certainly commonalities across programs -- for example, the importance of mutual trust and respect between participants and the providers that serve them, and the fundamental principles of survivor-defined advocacy and voluntary services -- there is no one-size-fits-all "best practices" template for providing effective transitional housing for survivors. Instead, there are a multitude of factors which go into determining providers' approaches:

Survivors from different demographics and circumstances may experience domestic and sexual violence differently and may respond differently to different service approaches. Age, class, race, cultural and linguistic background, religious affiliation, gender identity, sexual orientation, military status, disability status, and, of course, life experience all play a role in defining who a survivor is, how they experienced victimization, and what they might need to support healing and recovery. Each survivor's history of violence and trauma and its impact on their physical, physiological, emotional, and psychological wellbeing is different, and their path to recovery may require different types or intensities of support.

Where a program is located and how it is resourced plays a significant role in shaping a program, the challenges it faces, the opportunities it can take advantage of, the logistics of how housing and services are provided, and the kinds of supplementary resources the program might be able to leverage from other sources. Different parts of the country have different types of housing stock, different housing markets, different levels of supply and demand for affordable housing or housing subsidies, and different standards for

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securing a tenancy; different regions of the country have different economic climates, different labor markets, and different thresholds for entering the workforce; depending on where they are located, low income survivors could have very different levels of access to emergency financial assistance, health care, mental health care, addiction services, child care, transportation, legal assistance, immigration services, and/or other types of supplemental support.

"Best practices" for a stand-alone TH program in which a part time case manager serves a geographically scattered clientele in a rural, under-resourced region will mean something different than "best practices" for a well-resourced, full-service metropolitan-area provider that affords participants access to different types of transitional housing; that can leverage the support of culturally and linguistically diverse in-house staff and volunteers, that can contribute the services of in-house therapists, child specialists, employment specialists, and other adjunct staff; and that can rely upon nearby providers for additional gap-filling services.

"Best practices" in providing transitional housing for a chronically poor survivor whose education was interrupted, who has never been allowed to work, and who suffers from complex trauma as a result of childhood abuse may well look different from "best practices" in serving a survivor who is better educated, has a credible work history, but who was temporarily impoverished due to her flight from an abusive partner.

"Best practices" in serving a recent immigrant, with limited English proficiency, who lacks legal status, whose only contacts in America are her abusive partner's extended family -- will likely look different from "best practices" in serving a teenage girl who ran away from sexual abuse in her small town home, only to end up pregnant and in an abusive relationship, which she fled when he threatened to hurt her baby -- which, in turn, will look different from "best practices" for serving a middle-aged woman who tolerated her husband's abuse for years, because he supported the family and because she couldn't, and because keeping the family together was what her community and her church expected her to do, and what she would have continued to do until he finally went too far.

While there are commonalities to the approaches taken by the diverse programs awarded OVW TH grant funding, the very nature of the kind of "holistic, victim-centered approach ... that reflect[s] the differences and individual needs of victims and allow victims to choose the course of action that is best for them," called for in the [OVW's annual solicitation for TH grant proposals](), argues against too many generalizations about one-size-fits-all "best practices."

Recognizing that survivors from a broad spectrum of demographics and circumstances may have different needs and priorities and goals, may have and/or perceive different options for moving forward in their lives, and likewise, may have different definitions of "success," the OVW refrains from asking its TH grantees to render judgments about the quality of specific program outcomes.

In the absence of a consistent measurement of success and a framework for measuring differences in clienteles and program operating environments -- that is, lacking a data-informed basis for assessing whether a particular intervention constitutes a "best" practice -- we chose to take a more descriptive approach for this report. Drawing from providers' own words, the literature, and online resources, we have attempted to frame and provide context for the broad range of challenges and choices that providers face; to describe and offer context for and examples of the approaches they take in furnishing transitional housing for survivors; and to highlight some of the unresolved issues and difficult questions that providers wrestle with.

(c) Project Methodology: Collection and Analysis of Data from Provider Interviews

(i) *Development and Implementation of the Interview Protocol*

Drawing from information gleaned from the literature and online resources, and from some of the project and advisory team members' personal experience in working with transitional housing programs and/or providing services to survivors of domestic violence, we developed a list of topics and potential questions that we hoped to cover in our provider interviews.

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Because there were so many potential subjects to discuss and only an hour to have those conversations, we divided the topics into separate interview protocols. In addition to basic descriptive information ("universal topics")[107] that would be collected in each interview, we defined four distinct sets of topics[108] that would be sequentially assigned as interviews were scheduled. Over time, we eliminated certain areas of questioning from the interview protocol if we were not getting new information, and added topics or questions, as we identified gaps in our information. By the time half the interviews had been completed, the four lists of topics/subtopics had been condensed into three lists/interview protocols.

Pursuant to early discussions with the OVW, we agreed that the initial protocol would be "field-tested" by conducting interviews of staff from nine TH providers that the OVW identified and reached out to on our behalf. We also agreed that our interviews would be conversational and driven by the providers we were interviewing. That is, *although we had lists of topics and questions that we might want to address, we would follow the lead of the provider to make sure we covered any issues or concerns or approaches that they wanted to highlight. Rather than asking a uniform series of questions, we would use our protocols as guides, rather than as interview scripts*. To realize this objective, our team worked together to make sure we had the same general understandings of the protocol and the purpose of the interviews. The nine initial interviews were all conducted by pairs of team members, to facilitate full-team participation in our review of those interviews and in any revisions to the protocol based on that review.

Our team followed up the OVW's initial outreach to the nine providers with emails elaborating on the project (and attaching the OVW's initial letter), and providing supplemental information emphasizing the voluntary nature of participation and how *provider responses would be kept confidential*.

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[107] *"Universal" Topics*: Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary vs. transition-in-place; congregate vs. clustered vs. scattered-site; provider-owned vs. provider-leased vs. participant-leased); target constituency (e.g., survivors of domestic violence, sexual assault, etc.); type/number of direct services staff, use of consultants, involvement of other agency staff; other DV- or non-DV-focused programs operated by agency; how survivors access program and participant selection/prioritization; how staff understand the different roles of DV shelter vs. TH; characterization of service area (e.g., metropolitan area, small city, suburban, rural, mixed); program definition of a "successful" outcome and how program promotes success; how program implements voluntary services; maximum, typical, and targeted length of stay; other sources of funding; involvement with local or regional network of DV-focused providers and/or with Continuum of Care; most significant challenges faced by program; perceived differences between TH for other homeless populations and TH for survivors of domestic violence/sexual assault.

[108] *Group 1 Topics*: staffing details (roles, training, support, etc.); use of volunteers (roles, reasons for/against using, training and support); program philosophy and underlying approach (e.g., trauma-informed, empowerment, survivor-centered, etc.); consumer involvement (Board membership, advisory roles, options for current participants).

Group 2 Topics: assistance obtaining housing (challenges faced, strategies used, partnerships, etc.); employment assistance (challenges faced, strategies pursued, partnerships, etc.); approach to working with participants with significant barriers (e.g., economic, mental health, substance abuse issues, etc.); child- and family-focused services (what triggers needs assessment, needs assessed, how needs are addressed and by whom, interface with schools); follow-up services (type offered, challenges faced, insights into utilization patterns).

Group 3 Topics: challenges, advantages, and reasons for choosing type of program housing and approach to offering financial assistance with housing-related costs; distinctive subpopulations served (population-specific challenges and approach, challenges/approaches pertaining to serving a mixed clientele, etc.); meaning and dimensions of cultural competence; approach to ADA compliance in serving persons with disabilities; collaborations (strategies, challenges).

Group 4 Topics: program rules and the consequences of violating them; performance measurement (formal vs. informal approach, specific measures, whether/how participant progress is measured and used to gauge program performance, impact on program design) ; approach to data collection (software used, data collected above and beyond funder requirements, compliance with HUD comparable data base requirement); funding opportunities and constraints (challenges/strategies for government and non-government funding); challenges and benefits of collaboration with local/regional HUD-funded planning entities (Continuum of Care, Consolidated Plan).

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Each interview began with an introduction of the project; an explanation of how we intended to create a resource document that would describe the what, how, and why of providers' efforts **in their own words**; a request to record the conversation; and an assurance that **once the project was over, recordings and transcripts would be deleted, so that all that would be left would be anonymous comments**. We followed this same procedure throughout the project, eventually reaching out to almost 250 providers and securing the participation[109] of over 50%. Early on, we modified the process, per the request of some of the providers, and began sending a tentative list of topic areas along with the email confirming the date and time of each interview. The email emphasized, however, that the provider should feel free to steer the conversation as they saw fit, to make sure we covered any issues, concerns, or approaches that they wanted to highlight.

Starting with the first "field test" interviews in June 2014 and ending in February 2015, the project team completed interviews with 122 TH providers and one legal services provider that partnered with a TH provider (the Victim Rights Law Center, which asked to be specifically identified), and conducted a joint interview with two providers of LGBTQ domestic violence-related services (identified by Project Advisory Team members, in response to our request for help identifying experts who could help fill that information gap). The project director conducted 62% of the interviews and read the transcripts of all the other interviews.

Of the 122 providers, 92% (112 providers) were current recipients of OVW TH grants; another eight providers had recently lost their OVW grants and, at the time of their interview, were either operating a TH program with other funds, or had ceased TH operations. (Some of these providers subsequently received OVW TH grants.) Only two of the 122 TH providers interviewed had never received OVW TH grants (and were HUD- or state-funded). Fifty-one (42%) of the TH providers we interviewed were current recipients of one or more HUD Continuum of Care Transitional Housing (TH) or Rapid Rehousing (RRH) grants and/or a HUD Emergency Solutions Grant (ESG) RRH grant.

(ii) *Processing of Interview Data*

All interviews were submitted to a transcription service and the transcript was reviewed for accuracy (and corrected, as needed) by the project director. Transcripts of the interviews were entered into NVivo, a qualitative data analysis software, and then sentences or paragraphs that pertained to each of 27-30 project-defined topic areas[110] were coded as being related to that topic area. The project director performed the large majority of coding, and reviewed (and, as needed, modified) all of the coding decisions by the project associate, thereby ensuring coding consistency.

The selected provider comments pertaining to each topic area constituted a voluminous amount of data, and had to be boiled down, so that they could be shared with our Project Advisory Team members, and eventually incorporated into the report. Interview comments were edited for clarity and brevity, with an absolute emphasis on retaining the voice and essential message of provider comments. The interviewer's voice was removed. Names of people, places, and programs were removed and replaced with generic references to ensure confidentiality and anonymity, as had been promised to providers at the outset of each interview, and in our outreach correspondence. The project director did the overwhelming majority of all such editing, and reviewed (and, as needed, modified) all edits proposed by the project associate.

These compilations of provider comments (still averaging 20-30 pages, after editing) were shared with members of our Project Advisory Team and reviewed and discussed in a series of thirteen 90-minute meetings over the course of several months. Insights from those conversations, as well as information and perspectives

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[109] We actually secured the participation of 130 providers; however, six interviews were not included in the analysis because the interviewee was not adequately familiar with the TH program, or the program was too new to have any experience, or the provider no longer operated the TH program and no longer had staff who could answer our questions.

[110] Several codes were consolidated as the coding process evolved.

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from the literature and online sources were integrated into narratives that supplement the extensive presentation of provider comments in each of the twelve chapters.

Although this is a qualitative study and not quantitative research, we have included the large majority of the provider comments pertaining to each of the covered topics to provide the reader with not only a ***sense of the range of challenges, approaches, and philosophies***, but also with a ***sense of the frequency with which they were mentioned or reflected in provider comments***. Some of the comments will seem very similar to one another, some will differ by nuance, and some will be dramatically different.

This report does not include the very important perspective of victims/survivors. Collecting the feedback of survivors served by OVW TH grant-funded programs was deemed by the OVW to be outside the scope of the Technical Assistance grant that generously funded this project. Although our "***Snapshot of Transitional Housing for Survivors Of Domestic and Sexual Violence***" is missing that perspective, we hope it is nonetheless useful to the dedicated providers, researchers, and government officials who are committed to supporting and strengthening these and other efforts to address the scourge of domestic and sexual violence.

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