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

### **Chapter 8: OVW Constituencies: Survivors of Domestic Violence, Sexual Assault, Stalking, Dating Violence, and Trafficking**

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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)<sup>1</sup> and the Missouri Coalition of Domestic and Sexual Violence<sup>2</sup> -- 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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<sup>1</sup> 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."*

<sup>2</sup> 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."*

## 1. Executive Summary

The Office on Violence Against Women (OVW) Transitional Housing (TH) Assistance Grant program is statutorily authorized to fund programs providing transitional housing and related assistance to survivors of domestic violence (DV), sexual assault, dating violence, and stalking. Although the various chapters of this report touch on services to address sexual assault and stalking, they are mostly written with a focus on survivors of domestic violence, reflecting the focus of the preponderance of funded programs.

Chapter 8 is the exception to that pattern, addressing the challenges and approaches to serving other OVW TH program constituencies, and in particular, survivors of non-IPV<sup>3</sup> sexual assault. A portion of this chapter is also devoted to the needs, challenges, and approaches in serving survivors of human sexual trafficking.

The Section 2 narrative begins by briefly referencing language in the authorizing federal statute and the OVW's annual solicitation for TH grant proposals. The narrative then reviews summary statistics from the cumulative semi-annual TH program reports from four recent reporting periods, which indicate that more than 85% of participants in OVW-funded TH programs were DV survivors, whereas less than 10% were survivors of sexual assault. These percentages generally match what providers told us about the mix of participants in their programs.

Section 2 includes a brief analysis of why survivors of sexual assault constitute such a small percentage of the overall clientele of OVW-funded TH programs. The narrative posits that the most significant reason is that DV shelters, which provide the majority of referrals into TH programs, are not funded to serve survivors of non-DV-related sexual assault, unless the perpetrator is a family member.

Another reason why TH programs may serve more DV survivors than survivors of non-IPV sexual violence is that whereas fleeing domestic violence typically requires the victim to leave the home she shares with the perpetrator, a victim of sexual assault may not have to leave her home in order to be safe; whether she feels the need to relocate may depend on where and by whom she was assaulted. And unlike a DV survivor, who may not have been allowed access to her or the household's assets by her abusive partner, the victim of non-IPV sexual assault may well be able to access her assets, depending on the perpetrator's relationship to her (e.g., parents or other caregivers may control such assets, whereas a co-worker or acquaintance would not).

Thus, whereas fleeing domestic violence all too frequently precipitates homelessness, rape or sexual assault may or may not be *the precipitating factor* in a woman's homelessness; instead, rape, sexual assault, and the trauma that result may be *contributing factors* to subsequent homelessness; and then, once a woman becomes homeless, a source of recurring victimization and trauma, given the lack of a secure place to stay.

As noted in the narrative, a disproportionately high percentage of homeless women in mainstream shelters -- or unsheltered situations -- are survivors of sexual assault (as children or adults), often with co-occurring trauma, mental health problems, and/or substance use issues. Their lack of a stable living situation and co-occurring mental health, substance abuse, and/or trauma-related issues leave these women vulnerable to further victimization, and their involvement in the mainstream homeless services system, where their homelessness and concomitant behavioral health needs typically overshadow their history of sexual abuse -- which may not even have been documented, due to the stigma, victim-blaming, and guilt attached to disclosing/reporting victimization as a child or as an adult -- making it highly unlikely that they will be referred to an OVW-funded TH program.

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<sup>3</sup> As described in the "Note about the Use of Gendered Pronouns and Other Sensitive Terms" at the beginning of this Chapter, the terms "domestic violence" and "intimate partner violence (IPV)" are used interchangeably in this document. Both terms are intended to include violence and abuse that happens in a "dating" relationship. Both terms would also include stalking by a current or former intimate partner (or dating partner). The term "non-IPV sexual assault" is intended to describe violence perpetrated by someone other than a current or former intimate or dating partner.

The Section 2 narrative concludes with a very brief discussion about the different approaches taken by some TH providers in serving survivors of sexual assault versus DV survivors. For the most part, our provider interviews did not reveal significant differences in programs' approaches to these two constituencies. A number of the staff we spoke with were part of full service DV and sexual assault agencies, which are able to offer in-house access to sexual assault-specific counseling, support groups, and other services. Those staff told us that in most cases, however, the participants in their TH programs were DV survivors who had also been sexually assaulted, rather than women whose primary reason for seeking assistance was sexual assault.

More specific recommendations pertaining to safety planning for survivors of sexual assault, developed by the Victim Rights Law Center (VRLC), are presented in section (3)(c); some of the VRLC's other recommendations, as shared in a special interview,<sup>4</sup> are presented in section (3)(d).

Section 2 concludes with a set of provider comments about the constituencies their TH programs serve.

Section 3 begins with a review of the literature on the interrelationship of homelessness, sexual assault, behavioral health issues (e.g., substance abuse, mental illness, trauma), and childhood sexual abuse. One study suggests that the percentage of homeless women who have experienced rape and sexual assault may be three times the rate for women in the general population. Another study suggested that the rate of rape and/or sexual assault among women who have been sexually victimized as children is twice as high as the rate among women who have not experienced childhood rape or sexual assault. When multiple risk factors are present, the rate of adult victimization is even higher. Mental illness and substance abuse increases vulnerability to sexual assault, as does the very nature of unsheltered homelessness and/or reliance on overnight shelters, which discharge guests into the street every morning after breakfast.

Given the risks attendant to being on their own in a predatory environment, some homeless women decide to offer sex in exchange for protection from victimization by strangers or other homeless persons whom they fear. Other homeless women may exchange sex for food or drugs or other necessities. In turn, women engaged in such exchanges and/or involved in other risky or illegal survival activities tend not to report instances of victimization, because they fear the authorities, because their credibility is poor and they don't expect to be taken seriously, or because they fear reprisals from the men they might report.

Part (b) of the Section 3 narrative frames the challenge that these women -- and teenage girls and boys, including LGBTQ youth and young adults -- face in finding a path out of homelessness. To the extent that these survivors of multiple, chronic, and often ongoing victimization are far less likely than DV survivors to be referred to specialized TH programs, their primary hope is for referral to a mainstream TH or rapid rehousing (RRH) program, or, if they have serious and long-term disabilities, to a permanent supportive housing (PSH) program. In the meantime, these women stay in mainstream shelters or on the street, where they remain vulnerable to further exploitation and sexual abuse, and lack a reliable path to appropriate help.

While specialized TH programs need to be as prepared as they can be to provide housing and services that can support these survivors in healing, stabilizing their living situation, and hopefully, avoiding future predation, the majority of homeless survivors of sexual assault will be served by mainstream homeless programs. It seems critically important, therefore, that those mainstream programs develop the capacity to better serve survivors of sexual assault, perhaps by partnering with local rape crisis centers or full-service victim service providers: (a) to increase awareness of and access to sexual assault services and counseling; (b) to strengthen staff understanding of and sensitivity to the trauma that survivors carry; (c) to support safety planning that is appropriate to the needs of homeless survivors; and (d) to build capacity to offer trauma-informed services.

Part (c) of the Section 3 narrative introduces and summarizes of some of the training materials developed by the Victim Rights Law Center (VRLC) and Transition Projects, an Oregon-based shelter and TH provider, to

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<sup>4</sup> The training director of the VRLC asked that we cite her as the interviewee and identify her as someone that providers could contact with follow-up questions on matters related to addressing the needs of sexual assault survivors.

guide residential service providers in offering **safety planning support** and related assistance to survivors of sexual assault who are homeless and staying in mainstream emergency shelters.

Part (d) of the Section 3 narrative consists of an annotated list of additional resources and reference materials describing the implications and concomitants of sexual assault, and approaches providers can take to support survivors in their recovery from the trauma. Included in the listing is a section on ***Pandora's Project***, a volunteer-staffed largely web-based nonprofit resource "dedicated to providing information, support, and resources to survivors of rape and sexual abuse and their friends and family."

Part (e) of the Section 3 narrative focuses on Military Sexual Trauma (MST). The narrative (a) discusses the nature and prevalence of MST; (b) provides an annotated listing of U.S. Department of Veteran Affairs (VA) resource materials describing the nature of the problem and the need for assistance, the VA's multi-pronged approach, and VA programs to help affected service members and veterans; and (c) provides an annotated listing of non-VA resources.

Part (f) of Section 3 consists of an interview with the Director of Training and Technical Assistance at the aforementioned Victim Rights Law Center (VRLC), which describes itself as "the first law center in the nation dedicated solely to advocating for the civil legal needs of sexual assault survivors." Among the many topics addressed in the interview and presented in the narrative are: (a) the pros and cons of alternate approaches to expanding the capacity of the system to address the needs of sexual assault survivors (e.g., supporting programs with a DV focus in expanding their focus to encompass sexual assault, as opposed to trying to develop new TH programs that specialize in addressing the needs of sexual assault survivors); (b) strategies for creating system capacity to serve teenage survivors, given the fact that 40% of women and girls who have been sexually assaulted were first raped before they turned 18; and (c) how services for survivors of non-DV-related sexual assault might be different from services for DV survivors.

Section 3 concludes in Part (g) with the comments of the two TH providers that specifically addressed their work in serving sexual assault survivors during our interview.

Section 4 begins with a look at the prevalence and demographics of human sexual trafficking. Trafficking is a global problem, as well as a widespread, pernicious, difficult-to-stop, and dangerous-to-escape-from problem in the United States. Trafficking increasingly serves as a lucrative and relatively low-risk business opportunity for gangs and organized criminal enterprises. Trafficking victims include: (a) foreign nationals who have been smuggled into the U.S. and who have few, if any, places to turn for help; (b) women and teenage boys and girls -- including a disproportionate number of Native American children and women -- who have been kidnapped or tricked into the sex industry, often having left behind dangerous and exploitive home situations; and (c) children connected to family-controlled trafficking businesses.

Part (b) of the Section 4 narrative consists of a review of the literature on the needs of trafficking victims, and challenges and strategies for serving them.

Part (c) of the Section 4 narrative consists of an extensive, annotated listing of print and online materials that provide information about: (i) the needs of the women and teenage girls and boys who have been trafficked; (ii) the organizations that assist victims in escaping and recovering from the trauma of trafficking and sexual slavery; (iii) paths to legal immigration status for victims whose lack of status increases their vulnerability; and (iv) training and support resources for providers.

Section 4 concludes in Part (d) with comments from the small handful of providers whose programs purposefully serve survivors of trafficking, including one TH program that specifically targets survivors of trafficking.

## 2. Introduction and Overview

### (a) OVW Statutory Authority, Grant Solicitation, Statistical Picture from Semi-Annual Reports

Pursuant to the authority and provisions of [42 USC §13975](#), the [2015 OVW Solicitation for Transitional Housing \(TH\) Assistance Grant proposals](#) explains that such grants fund "programs that provide assistance to victims of sexual assault, domestic violence, dating violence, and/or stalking who are in need of transitional housing, short-term housing assistance, and related supportive services." (p.6)

Applicants are not required to serve all of these constituencies; in their application, they specify the percentage of grant activities that will address each constituency. As discussed below, the majority of TH grant recipients focus their efforts on serving survivors of domestic violence ("DV survivors").

Recognizing that survivors of sexual assault ("SA survivors") may need services and supports that are somewhat different than the services and supports provided to DV survivors, the OVW's annual solicitation requests the following information from providers proposing to serve SA survivors:

*"A clear description of how your application will address the unique needs of sexual assault survivors by demonstrating through partnership and other alliances the services readily available to those survivors. These partnerships may include cooperative efforts and projects among law enforcement officers, prosecutors, victim advocacy groups, and other related entities that investigate and prosecute incidents of sexual assault, domestic violence, dating violence and/or stalking; and 2) providing treatment, counseling, advocacy, and other long- and short-term assistance to adult and minor victims of sexual assault." (p.17)*

In our interviews with funded (and a few formerly funded) providers, we asked which of the constituencies they serve; about the similarities and differences in their approach to serving the four constituencies; and (in some of our later interviews) whether and how they serve survivors of trafficking.

Most providers said that they serve survivors from all four OVW constituencies, but that they primarily serve survivors of domestic violence or intimate partner violence (IPV), which includes domestic violence, dating violence, and stalking by an intimate partner.<sup>5</sup> Several providers described their focus as IPV, but noted that DV survivors are also often survivors of stalking or sexual assault, which may or may not have been connected to the domestic violence. A small number of providers stated that they exclusively serve DV survivors.

Even the full service domestic violence and sexual assault providers that we interviewed, who described their preparedness to offer in-house access to sexual assault-specific counseling, support groups, and other related services, reported that in most cases, the TH participants who utilized those services were DV survivors who had also experienced sexual assault, rather than women whose primary reason for enrolling in the program had been sexual assault.

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<sup>5</sup> The U.S. Centers for Disease Control and Prevention's (CDC's) publication, Intimate Partner Violence Surveillance Uniform Definitions And Recommended Data Elements (Version 2.0), defines IPV as follows:

*"Intimate partner violence includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)." The CDC defines "intimate partner" as "a person with whom one has a close personal relationship that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship need not involve all of these dimensions. Intimate partner relationships include current or former: (a) spouses (married spouses, common-law spouses, civil union spouses, domestic partners); (b) boyfriends/girlfriends; (c) dating partners; (d) ongoing sexual partners. Intimate partners may or may not be cohabiting. Intimate partners can be opposite or same sex. If the victim and the perpetrator have a child in common and a previous relationship but no current relationship, then by definition they fit into the category of former intimate partner." (Breiding et al., 2015, p.11)*

The four [VAWAMEI semi-annual reports](#) covering the period 7/1/2012 - 6/30/2014 confirm that the large majority -- upwards of 85% -- of persons served by OVW-funded TH programs were DV survivors. Consistently fewer than 10% of TH program participants counted in these reports were cited as having been victimized by someone other than an intimate partner or dating partner. However, quite a few providers indicated that the domestic violence their participants fled included sexual assault, or that the DV survivors in their program had experienced sexual assault at some other point(s) in their lives. Likewise, providers elaborating on their services to victims of stalking, indicated that the perpetrator of that stalking had typically been the intimate partner that the survivor had fled.

Although several providers mentioned serving survivors of dating violence in their TH programs, none discussed specific approaches to serving members of that constituency. (Many of the programs are part of agencies that do outreach/education in local schools to address dating violence.) Nonetheless, the VAWAMEI statistics for the period July 1, 2012 - June 30, 2014 show that between 7 and 9% of transitionally housed survivors were victims of dating violence. Perhaps, because of the sometimes blurred distinction between dating violence<sup>6</sup> and domestic violence, providers didn't see a need to make the distinction in their interview. In retrospect, we should have sought clarification.

### **(b) Why Sexual Assault Survivors May Be Only a Small Part of the Clientele of TH Programs**

A number of providers explained that the reason their programs primarily served DV survivors, was that survivors of non-DV-related sexual assault are not regularly referred for specialized transitional housing by the DV shelters from which most of their participants come. Indeed, as discussed in greater detail in [Chapter 2](#) ("Survivor Access and Participant Selection"), the FVPSA grants that help fund most DV shelters target assistance to survivors of Intimate Partner Violence (IPV) and violence perpetrated by a family member,<sup>7</sup> but not, for example, victims of sexual assault by a supervisor, co-worker, teacher, fellow soldier, or stranger.

***Thus, FVPSA-funded DV shelters would only be in a position to refer survivors whose homelessness was related to either (a) domestic violence or (b) sexual assault perpetrated by a family member.***

Another reason why TH programs may serve more DV survivors than survivors of non-IPV sexual violence is that whereas fleeing domestic violence typically means leaving the home she shares with the perpetrator, a victim of sexual assault may not have to leave her home, in order to be safe; whether she feels a need to relocate may depend on where and by whom she was assaulted. And unlike a domestic violence victim, who may not have been allowed access to her or the household's assets by her abusive partner, the victim of non-IPV sexual assault may well be able to access her assets, depending on the perpetrator's relationship to her (e.g., parents or other caregivers may control such assets, whereas a co-worker or acquaintance would not).

Whereas fleeing domestic violence all too frequently precipitates homelessness, rape or sexual assault may or may not be ***the precipitating factor*** in a woman's homelessness; instead, rape, sexual assault, and the trauma that result may be ***contributing factors*** to subsequent homelessness; and then, once a woman becomes homeless, a source of recurring victimization and trauma, given the lack of a secure place to stay.

As discussed later in this chapter, a disproportionately high percentage of homeless women in mainstream shelters -- or unsheltered situations -- are survivors of sexual assault (as children or adults), often with co-occurring trauma, mental health problems, and/or substance use issues. Their lack of a stable living situation

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<sup>6</sup> The [OVW website](#) defines "dating violence" as "violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim is dating violence. The existence of such a relationship shall be determined based on a consideration of the following factors: (a) the length of the relationship; (b) the type of relationship; (c) the frequency of interaction between the persons involved in the relationship."

<sup>7</sup> See footnote #2 on page 1 of the U.S. Department of Health and Human Services' Family and Youth Services Bureau's [Navigating the Family Violence Prevention Services Program: A Guide for State and Territorial Administrators](#) (2012).

and co-occurring mental health, substance abuse, and/or trauma-related issues leave them vulnerable to further victimization and predation, and their involvement in the mainstream system, where their homelessness and concomitant behavioral health needs typically overshadow their history of sexual abuse -- which may not even have been documented, due to the stigma, victim-blaming, and guilt attached to disclosing/reporting victimization as a child or as an adult -- making it highly unlikely that they will be referred into an OVW-funded TH program.

Finally, a small handful of providers offered comments reflecting their apparent belief that their OVW and/or HUD funding only allowed them to target DV survivors, and not survivors of sexual assault by a perpetrator other than an intimate partner. As discussed in the prior section, the [OVW's annual TH grant solicitation](#) allows, but does not require, funded providers to serve **all four constituencies**. As outlined in [Chapter 2](#) ("Survivor Access and Participant Selection") and other parts of this report, [HUD's definition of homelessness](#) (see "Category 4") likewise establishes categorical eligibility for all four constituencies. Although other HUD regulatory provisions and locally adopted "written standards" may narrow eligibility or prioritize certain segments of the population for assistance, those standards and priorities do not typically distinguish between Category 4 constituencies.<sup>8</sup>

### **(c) Different Approaches to Addressing Sexual Violence versus Domestic Violence**

Most of the providers we asked about their different approaches to serving survivors of domestic violence versus sexual assault did not describe significant differences. They described an across-the-board effort to meet survivors where they are, so that, for example, individual counseling is always tailored to client needs. However, they suggested that other type of services (e.g. budgeting/money management, employment assistance, housing search) are the same for all survivors.

There were, however, a few providers who did distinguish between the needs of DV survivors and survivors of sexual assault. For example, they suggested, survivors of sexual assault might have a lower level of trust about leaving their children in the care of others, or might be uncomfortable being in public areas on their own, and might benefit from staff accompaniment to offsite appointments. Given victims' uniquely personal experience of domestic violence and/or sexual assault, and given that some survivors may have reasons to fear further violence from the perpetrator, while others may not, it seems unwise to do too much generalizing about the

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<sup>8</sup> The [HUD homeless definition](#), which largely determines eligibility to receive assistance from a Continuum of Care (CoC)- or Emergency Solutions Grant (ESG)-funded project, is complex. The portion of the definition that specifically addresses the eligibility of persons rendered homeless due to domestic or sexual violence (known as "Category 4") includes all four OVW constituencies:

*"(4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing."* ([Federal Register Vol. 76 No. 233 p.76017 \(12/5/2011\)](#))

That isn't to say that any homeless survivor from one of the four OVW constituencies is eligible for HUD-funded assistance. As explained in [HUD's ESG vs. CoC Rapid Rehousing Guide](#), an ESG RRH grant-funded program may only survivors who meet HUD's so-called "literally homeless" (also known as "Category 1") criteria:

*"(1) living in a public or private place not meant for human habitation, (2) living in temporary shelter, which includes congregate shelters and transitional housing, or (3) exiting an institution where the individual or family has resided for 90 or fewer days and was living in shelter or in a place not meant for habitation before entering the institution."* (p.3)

Additionally, as explained in [Chapter 2](#) and other chapters of this report, states, counties, and jurisdictions administering ESG grants and Continuums of Care administering CoC grants must develop and implement "written standards" which may further narrow eligibility and establish priorities for HUD-funded TH and RRH assistance.

similarities and differences in the way that victims experience and recover from the trauma associated with domestic violence, as compared to sexual assault by a perpetrator other than an intimate partner.

The Victim Rights Law Center (VRLC), which specializes in matters related to sexual assault, has developed safety planning resources for providers working with survivors of non-IPV sexual violence, which are discussed in section (3)(c) of this chapter. The comments of the VRLC's Director of Training and Technical Assistance, including her thoughts about how the service system might evolve to better serve survivors of non-IPV sexual violence, are presented in section (3)(d).

#### **(d) Providers' General Comments about OVW Constituencies Served**

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

(#01) We serve survivors of domestic violence, including women who are being stalked by their abusers. We've also served women who experienced IPV by someone they were in a dating situation with. Survivors don't have to have been married to receive services.

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(#02) Both survivors of domestic violence and survivors of sexual assault enter the transitional housing program from stays in the shelter. Survivors of sexual assault tend to come into the shelter via participation in our support group or via our nurse examiner program. Through those avenues they get connected with the shelter and they're assigned an advocate based on that. So the advocacy and services they get are specific to their particular needs. Once they go into the transitional program, they receive services from an advocate who is trained to work with both survivors of domestic violence and survivors of sexual assault. Also, just to be clear, when we use the term intimate partner violence, we are using it in its broadest sense. It doesn't have to be someone you've been in a long term relationship with; it could be someone you are dating.

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(#03) I'm not saying we don't see sexual assault with the domestic violence, but that's not our focus. We're not a sexual assault program. Under our HUD grant we aren't limited to only serving survivors of domestic violence. Under the OVW grant, our participants do have to be domestic violence survivors.<sup>9</sup>

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(#04) We primarily serve domestic violence victims, because we have an emergency shelter for victims of domestic violence, and our emergency shelter feeds the transitional housing program. We also serve victims of sexual violence, but they don't usually need shelter from us.

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(#05) All the families we are serving right now are victims of domestic violence. But we can also serve victims of sexual assault or stalking or dating violence if we have an opening, because HUD has broadened the definition of domestic violence to include stalking, dating violence and sexual assault. But we can only serve families, which by HUD's definition, includes at least one adult and at least one dependent child under age 18.

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(#06) Counseling services can be specifically targeted to the needs of the survivor, whether sexual assault or domestic violence. They all go through the same programming; our sessions cover a range of topics that we feel are appropriate for each group, from yoga to finances. We feel that we have a program that applies to all.

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<sup>9</sup> This comment suggests that either this provider misunderstands that, as noted in the narrative, recipients of OVW and HUD TH grants may serve survivors of domestic violence, sexual assault, dating violence, and/or stalking -- or -- perhaps, in their application for OVW funding, the provider specified that it only intended to serve DV survivors.

(#07) We've found that the majority of homeless single parents are DV victims – over 75% of the transitional program participants and probably close to that portion of the clients in our permanent supportive housing.

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(#08) The majority of our clients are women with young children, but we also serve single women with no children, and women with adult children or children who are not in their custody. A lot of the clients who are survivors of domestic violence have also experienced sexual abuse. Some participants have experienced sexual assault by a non-intimate partner, but not domestic violence.

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(#09) (Not a current OVW grantee) In addition to serving survivors of intimate partner violence, we also enroll survivors of sexual assault. We also served a victim of trafficking in the TLP. One person I remember serving had experienced the violence in her home country and had fled here. Historically, we haven't enrolled stalking victims.

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(#10) I don't think there's any difference in the way we provide assistance to survivors of IPV versus survivors of sexual assault, whether it's counseling or housing assistance, or shelter. It is all the same as we would provide anyone else. I think we are so focused on meeting clients where they're at, using trauma informed practices, and ongoing safety planning in any situation. I don't see that it would be that much different.

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(#11) Oftentimes the concerns and trauma experienced by survivors of DV are not the same as the concerns and trauma experienced by survivors of sexual assault or stalking, so we have to analyze things case by case.

When DV survivors have a long history with the stalker, we're able to work with them to try to identify and predict behaviors. It can become kind of complex to maintain a safe environment when participants are off site and kind of on their own. Sometimes, depending on the perpetrator, the behaviors and patterns of a stalker can be very unpredictable and that makes for a unique safety planning challenge.

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(#12) (Not a current OVW grantee) As an agency, we have a dual focus – domestic violence and sexual assault victims. We have a whole residential team that works with those clients. And then we also have what we call a non-residential program for clients that don't need to come stay with us, but they still need advocacy and support around their DV and maybe trying to make a plan to get out.

Our congregate transitional housing and our rapid rehousing programs both receive HUD funding, one from the Continuum of Care program, the other from the ESG program, so for clients to be appropriate, they have to be victims of domestic violence. That's HUD's definition of homeless.<sup>10</sup> We can't serve sexual assault survivors in our housing programs; only in our shelter and non-residential programs. In the past, we had an OVW grant we were able to serve sexual assault survivors.

The approach to safety planning for the two constituencies is the same. What the safety plan might look like is a little bit different. For a survivor of sexual assault, it's more around their emotional safety, physical safety; if one of their triggers is not to be alone, then making sure that when they're going places, they have a phone or they have somebody walking with them. Things like that. For some of our survivors of sexual assault, if they've

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<sup>10</sup> This comment suggests that this provider misunderstands that, as noted in the narrative, recipients of HUD TH grants may serve survivors of domestic violence, sexual assault, dating violence, and/or stalking. As explained in [HUD's Rapid Rehousing: ESG vs. CoC Guide](#), ESG-funded Rapid Rehousing programs may serve survivors from any of the four OVW constituencies, but they must be what HUD considers "literally homeless," that is, living in a shelter, unsheltered, or in a short-term (treatment or incarceration) facility, prior to which they were living in shelter or an unsheltered situation.

gotten their own space, they may not be as frightened of somebody coming into their unit as somebody who's maybe fleeing DV. If it's well-lit, if their perp's not going to show up -- things like that.

And the approach to self-sufficiency isn't really different for the two populations. Our case management around financial literacy and developing a budget, getting job-ready -- those things really aren't different.

It's really the conversations and support around what happened to them is different -- well, not too different -- because there's a lot of intersections with DV and sexual assault, but it depends. Sometimes the sexual assault victims need a therapist, and we have therapists on staff. So, we're able to provide that resource in-house for those clients. But, as far as the regular day-to-day case management around housing, it's not very different.

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(#13) We had a moment in our history of the Center a few years back, where every single woman in our apartments (every woman and almost all of our children) had suffered sexual assault. Everybody. We started reaching out more to the sexual assault center here, and then when we rewrote our OVW grant this last year we actually entered into a formal collaboration with them.

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(#14) I wouldn't really say that we do anything differently when working with DV survivors versus sexual assault survivors. Of course, we do safety planning for both. We let the families, the women in the program guide us. We have support groups here weekly, and they are for both SA and DV survivors. Participants in our program - DV or SA survivors - can see a therapist or a clinical intern for free 12-week sessions. Those interns are also the interns that respond to the agency where victims can go if they've been assaulted.

We do have a closed 8-week group that we do offer here on an annual basis if we have enough interested survivors of sexual assault; so that's a closed group that we would offer to an SA survivor versus a DV survivor.

We just really try to tailor the program around the needs of the individual and we let them kind of guide us.

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(#15) (Not a current OVW grantee) We haven't had any referrals to serve survivors of sexual assault, and we're set up as domestic violence program. But I have noted that especially with our immigrant population, participants have experienced both domestic violence and sexual assault. So we address that too, but it's not our targeted population. Our targeted population is women that are survivors of domestic violence.

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(#16) We wouldn't take a very different approach with survivors of DV, as opposed to survivors of rape or sexual assault. Some types of rape or sexual assault survivors might stay in the shelter instead of focusing on next-step housing. Sometimes we have homeless persons that have been sexually assaulted, or individuals who don't want to go back to their homes because that's where they were sexually assaulted. But most of the time, if they need housing and they don't need shelter, they go through the housing coordinator and if they're eligible for Housing Authority housing, we'll have them apply for that. Or if they need assistance finding housing in the community, we'll work with them on that, too. But our services are basically the same for all of them. It might look different in the way they maybe receive counseling, or maybe the case manager's who's working with them, or a district attorney who's working their case. But services are pretty much the same.

Sometimes homeless women who've been sexually assaulted in a shelter or while they were on the street come to the Rape Crisis Center; they can't go back to the homeless camps or the homeless shelter, so they end up staying at the DV shelter. Especially in the winter, when they open up other shelters, and they're trying to squeeze in as many people as they can to stay out of the cold, we tend to see a little more of that.

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(#17) Although we're focused on intimate partner violence, we do make an exception and enroll folks that have been sexually assaulted, but have not experienced IPV. We are very lucky to have a nonprofit program

dealing with sexual assault right on our campus, including a rape recovery center. They recently added a sexual assault nurse examiner, who can provide onsite sexual assault exams for victims, so they don't have to go a hospital or emergency room. They have a staff person onsite at our transitional program once a week, as well as counselors that are starting to come over to see transitional residents that have experienced that.

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(#18) All the women have in common is that they're all battered or sexually abused and have substance abuse issues. They could be trafficking victims, they could be transgender. We don't say, "We're only working with this population or that population." We've tried multiple things and that seems to work the best for us.

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(#19) Sometimes survivors of sexual assault wouldn't come to the DV system because they may not articulate that they have a DV situation going on. I think most often, those folks are being served within the [mainstream] homeless system. But, of course, sometimes we do serve those folks.

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(#20) For the transitional housing, we serve 100% DV survivors. Our contract with OVW for transitional housing has that in there.

#### **Questions to Consider**

1. What are the similarities and differences, if any, between safety planning for survivors of domestic or dating violence versus survivors of sexual assault?
2. What are the similarities and differences, if any, between safety planning for survivors who are being stalked versus survivors of trafficking, who may be on the run from a trafficker that wants her back?
  - What additional risks to the participant, other participants, and staff are faced by TH programs serving survivors being stalked and/or survivors of trafficking?
  - How can safety for all concerned be reasonably assured?
  - What kinds of risk inevitably remain and how might they be minimized?
3. Apart from safety planning, how might the needs of survivors of domestic violence differ from survivors of sexual assault?
  - Emotional, psychological needs; sense of empowerment vis-à-vis safety; etc.
  - Advocacy, legal advocacy-related needs
  - Income/employment-related needs
  - Housing-related needs

### **3. Serving Survivors of Sexual Assault**

#### **(a) Homelessness and Risk/Experience of Sexual Violence**

As described by [Goodman, Fels, & Glenn \(2006\)](#), being homeless exacerbates a woman's risk of sexual assault and related violence.

*Homeless women, and especially chronically homeless women, who access mainstream shelters or sleep in the rough are "particularly vulnerable to multiple forms of interpersonal victimization, including sexual and physical assault at the hands of strangers, acquaintances, pimps, sex traffickers, and intimate partners on the street, in shelters, or in precarious housing situations.... The most comprehensive and rigorous studies on homeless women conducted to date continue to note the extraordinarily high levels of abuse and*

*victimization that homeless women endure before, during, and after episodes of homelessness.... Homeless women often report multiple episodes of violent victimization at the hands of multiple perpetrators, beginning in childhood and extending into adulthood ... as sexual assaults are layered upon ongoing traumatic conditions such as struggling to meet basic survival needs and living with ongoing dangers and threats."*

In their study of homeless women in four Florida cities, [Jasinski et al. \(2005\)](#) found that more than three times as many of those women had experienced lifetime rape (55.9%) and/or stalking (25.4%) as the national average for women (17.6% rape and 8.1% stalking). More than half of the homeless women in Jasinski et al.'s study who had been raped were raped by someone other than an intimate partner, which is also the case among all women reported on in the National Intimate Partner and Sexual Violence Survey ([Breiding et al., 2014](#)). On the other hand, nearly 80% of the homeless women studied by Jasinski et al. who reported being stalked had been stalked by an intimate partner. Three times as many homeless women in Jasinski et al.'s study had been threatened, beaten, or shot with a gun and four times as many homeless women had been threatened or stabbed with a knife as compared to national data for all women.

[Jasinski et al. \(2005\)](#) explain that "One reason why the experience of violence is so common among homeless women is that their routine day-to-day activities expose them to potential offenders but do not provide them with capable guardians. Sleeping patterns and routines are strongly related to victimization risks."

[Goodman, Fels, & Glenn \(2006\)](#) agree, noting that,

*"[The] condition of homelessness itself dramatically increases women's risk of being sexually assaulted.... The need to serve a maximum number of people with limited dollars, combined with some communities' unwillingness to host shelters in their neighborhoods, often leads shelters to locate within or close to high-crime areas ([Burt et al., 2001](#); [Wenzel, Koegel & Gelberg, 2000](#)). Moreover... many homeless women have little choice but to participate in activities that place them at further risk for sexual assault, such as panhandling or trading sex for needed resources ([Kushel et al., 2003](#); [Lee & Schreck, 2005](#))."*

They explain that there are "complicated tradeoffs" that women make to survive on the streets:

*"A homeless woman may stay in a relationship with a person who abuses her physically or sexually because the risks associated with leaving -- [literal] homelessness, hunger, poverty, violence on the streets, lack of resources for children, risk of further abuse by additional perpetrators -- seem worse than the abuse. Furthermore, the abusive partner may also provide protection and companionship some of the time."*

The risk of sexual assault among homeless women is not only related to the vulnerabilities of being homeless; it is also related to the life circumstances that contributed to her becoming homeless and that surround her continued homelessness. In their review of the literature, [Goodman, Fels, & Glenn \(2006\)](#) observe that

*"A range of factors increase homeless women's risk of adult sexual victimization, including childhood abuse, substance dependence, length of time homeless, engaging in economic survival strategies (such as panhandling or involvement in sex trade), location while homeless (i.e. sleeping on the street versus sleeping in a shelter) and presence of mental illness ([Kushel, Evans, Perry, Robertson, & Moss, 2003](#); [Nyamathi, Wenzel, Lesser, Flaskerud, & Leake, 2001](#); [Wenzel, Koegel, & Gelberg, 2000](#); [Wenzel, Leake, & Gelberg, 2000](#)). Many of these factors ... coexist, interact with, and exacerbate each other over time, creating a complex and distinctive context for each woman. . . .*

*A number of studies have emphasized the correlation between childhood sexual abuse and homelessness among adult women ([Bassuk and Rosenberg, 1988](#); [Davies-Netzley & Hurlburt, & Hough, 1996](#); [Simons & Whitbeck, 1991](#); [Stermac & Paradis, 2001](#); [Wenzel et al., 2004](#); [Zugazaga, 2004](#)). For example, one study of women seeking help from a rape/sexual assault crisis center found that childhood sexual abuse was reported by 43% of the homeless participants, compared to 24.6% of the housed participants ([Stermac et al., 2004](#)).... [Another] study found that homeless women with histories of childhood sexual abuse were twice as likely to experience adult violent victimization as those without such histories ([Nyamathi et al.,](#)*

*2001). For homeless women with serious mental illness, the connection between child sexual abuse and adult victimization is even stronger. In one study of women with serious mental illness and histories of homelessness, the chance of re-victimization for women who had experienced child physical or sexual abuse was close to 100% (Goodman, Dutton & Harris, 1995; Goodman, Johnson, Dutton, & Harris, 1997)...."*

Similarly, [Jasinski et al. \(2005\)](#) reported that 92% of the homeless women in their study who had experienced childhood physical or sexual violence were also victimized as adults.

[Goodman, Fels, & Glenn \(2006\)](#) observe that

*"Homeless women are more likely than non-homeless women to suffer from substance abuse ([Toro et al., 1995](#); [Wenzel et al., 2004](#)), a mental illness that may include psychosis ([Toro et al., 1995](#); [Wenzel et al., 2004](#)), domestic violence ([Toro et al., 1995](#)), or severe physical health limitations ([Wenzel, Leake & Gelberg, 2000](#)) that make self-defense in a dangerous situation harder. In one of the most rigorous studies of antecedents of sexual assault while homeless, [Wenzel, Koegel, & Gelberg \(2000\)](#) found that women who were dependent on drugs or alcohol; who received income from survival strategies such as panhandling, selling items on the street, or trading sex for drugs or other items; who lived outdoors; who experienced mania or schizophrenia; or who had physical limitations were especially likely to have endured a recent (at most, 30 days prior) sexual assault. . . .*

*One study found that homeless women who had experienced either physical or sexual victimization in the past month were three times more likely to [cite] both drug and alcohol abuse or dependence than homeless women who were not victimized (24.3% versus 7.9%) ([Wenzel, Leake, & Gelberg, 2000](#)).*

*As with so many aspects of homeless women's lives, the causal relationships between substance abuse and victimization are far less clear than the correlation itself. Nevertheless, substance abuse and dependence may put women at risk for victimization in a number of ways, such as by altering women's perceptions of what is dangerous; leading them to engage in risky survival strategies; causing disorientation that may make it difficult to ward off an attacker; making them a target for assault because authorities will be less likely to believe them; or putting them in an environment that involves interactions with criminals. . . .*

*Homeless women with serious mental illnesses such as major depression, schizophrenia, and bipolar disorder are highly vulnerable to victimization. Indeed, in one in-depth study 97% of the participants, all of whom were homeless and had a mental illness, reported experiences of violent victimization at some point in their lives ([Goodman, Dutton & Harris, 1995](#); [Goodman, Johnson, Dutton, & Harris, 1997](#)), with an astonishing 28% reporting at least one physical or sexual assault in the month preceding the interview. Another large-scale study of 1,839 ethnically diverse, homeless women and men with mental illnesses from 15 cities across the US found that 15.3% of the women participants reported being raped in the past 2 months ([Lam & Rosenheck, 1998](#)).... Moreover, these women's ability to get help are greatly compromised by [societal] attitudes that people with mental illnesses do not experience violation as searingly as others; that their accounts of the abuse and assault are 'made up;' ([Goodman & Dutton, 1996](#); [Goodman et al., 1999](#)) or that women with mental illnesses cannot clearly communicate a lack of consent."*

[Jasinski et al. 2005](#) observe that, "victimized homeless women rarely report their victimization to the authorities and even when they do, satisfactory responses are infrequent."

[Goodman, Fels, & Glenn \(2006\)](#) agree, explaining that,

*"Homeless women ... may be afraid to report a rape because they are involved in illegal activities (e.g. drug related, prostitution) or have outstanding warrants from other activities. They may distrust police officers because their only contact with them is when they are kicked off park benches and forced to sleep under bushes that are far from the public eye and therefore more dangerous. For women who engage in street-based sex trade, harassment and abuse by police is so commonplace that [they] no longer perceived police as sources of help. Homeless women of color, immigrants, refugees, and victims of sex trafficking may be even more skeptical about law enforcement and less likely to turn to them for help or protection. Further,*

*law enforcement personnel are not immune from general [societal] attitudes about stigmatized groups such as homeless, mentally ill, prostituting, or substance abusing women, resulting in discriminatory behavior. Last, because homeless women are highly transient, they generally make poor witnesses in victimization cases; and the very public nature of life on the streets means that few women have a place to hide if an abuser or rapist learns she has 'ratted' on him. These obstacles result in shared feelings of helplessness between even the most sympathetic criminal justice personnel and homeless women."*

Similarly, [Goodman, Fels, & Glenn \(2006\)](#) explain that, "When substance use (often 'paid for' by sex) is a factor, the risk of sexual assault increases.... Because these assaults often occur in the context of an illegal act (prostitution) and among drug users, victims may be seen by perpetrators as attractive targets, as they are less likely to report the crime or to be believed or seen as worthy of services and protection by authorities."

### **(b) The Need for a Path to Services for Homeless Survivors of Sexual Assault**

As previously noted, homeless survivors of sexual assault do not typically seek shelter in DV shelters, because they are not part of the constituency that those shelters are funded by FVPSA to serve. Instead, if they seek shelter, it is in mainstream homeless shelters whose staff "are rarely trained to detect and respond appropriately and sensitively to trauma or sexual violence." [Goodman, Fels, & Glenn \(2006\)](#):

*"By their very nature, homeless shelters can worsen women's psychological distress.... Homelessness is inherently chaotic ... with others controlling access to such basic resources as food, clothing, and shelter.... There is little privacy, and entering many programs requires subjecting the private details of one's life to regulation and/or scrutiny. This lack of privacy and power differential can mirror and exacerbate the impact of the violence many homeless women have survived. This combination of chaos, power dynamics and feeling watched can trigger traumatic memories or symptoms that, in turn, make it more difficult to abide by shelter rules or stay 'in control' as shelters require. Many shelters are neither culturally sensitive nor 'trauma-informed,' and have not provided staff adequate training to, for example, deal with women's angry outbursts therapeutically rather than punitively, or recognize the differences between flashbacks and psychosis. Overburdened staff must balance the needs of the individual with the needs of many. A woman whose trauma-related nightmares wake up an entire dorm, for example, may be told to leave."*

To better address these complex challenges, [Goodman, Fels, & Glenn \(2006\)](#) argue that,

*"Collaboration between homeless providers and rape crisis advocates is critical.... Homeless service providers must be given training and support in trauma and its consequences and staff must be given the authority to respond flexibly and appropriately to sexual assault survivors who come to them. Indeed, all homeless women would benefit from a trauma-informed approach since ... homelessness is itself a form of trauma and a significant risk factor for assault; and survivors of child sexual abuse, regardless of economic status, may not remember or label their experience as such, but continue to suffer its damaging effects. However, being trauma-informed goes far beyond staff training. Organizations must examine and reframe their practices and protocols based on an understanding that most homeless women are survivors of trauma, and are likely to be re-victimized if not given emotional support, the ability to have some control over their daily lives, and a safe and calm place to stay 24 hours a day."*

Their recommendation stands in contrast to the fact that most mainstream shelters for homeless individuals are only open between dinner and breakfast, and send their guests into the street as they close for the day.

In much the same way that the foundation of success in OVW TH programs is the relationship between the staff and each program participant, so, trusting, consistent, reliable relationships are a prerequisite for effectively serving homeless survivors of sexual assault. As [Goodman, Fels, & Glenn \(2006\)](#) note,

*"Survivors of sexual assault -- homeless or housed, poor or wealthy -- live with shame and fear. If they are homeless, they are further shamed by society for being poor and requiring help. If they are also women of color; immigrants; refugees; victims of sex trafficking; prostitutes; lesbian, bisexual, and transgender*

*individuals; or women with disabilities, they face even greater stigma and discrimination. At every turn, homeless women are dehumanized by systems that collect information on intake, assess them, process them and attempt to move them forward. The expectation that these women will reach out to strangers for help around issues as deeply personal as sexual assault, whether volunteers at a hotline or an assigned case manager, without time to develop a relationship and a foundation of trust is often unrealistic. . . . Further, it is the authors' experience that poor and homeless women are acutely tuned-in to the possibility of classism, racism and other explicit and subtle forms of oppression imposed by the very people offering them services. Cultural competency training that attends to issues of class, as well as race and position, is critical."*

**Recommendation:** Given the high percentage of homeless women who have experienced rape and sexual abuse; given how the experience of living on the street or staying in shelters exacerbates the risk of further victimization; given how childhood victimization and the resulting trauma heighten the risk of future victimization, mental illness, and substance abuse -- and how, in turn, mental illness and substance abuse heighten the risk of victimization; given that most homeless victims of sexual abuse do not have the option to stay in a trauma-informed DV shelter (unless their victimization was by an intimate partner or family member), or the benefit of a well-defined path from a DV shelter to an OVW-funded TH program; and given all the barriers to seeking help in the aftermath of victimization, and the importance of a trusted relationship in helping to overcome those barriers ... what makes sense as a strategy for improving access by sexual assault survivors to trauma-informed transitional housing?

While specialized TH programs need to be as prepared as they can be to provide housing and services that can support these survivors in healing, stabilizing their living situation, and hopefully, avoiding future predation, the majority of homeless survivors of sexual assault will continue to be served by mainstream homeless programs. It seems critical, then, that those programs develop the capacity to better serve survivors of sexual assault, perhaps by partnering with local rape crisis centers and/or full service victim service providers: (a) to increase awareness of and access to sexual assault services and counseling; (b) to strengthen staff understanding of and sensitivity to the trauma that survivors carry; (c) to support safety planning that is appropriate to the needs of homeless survivors; and (d) to enhance their capacity to provide trauma-informed services.

### **(c) Safety Planning for Homeless Survivors of Sexual Assault**

The discussion that follows is largely informed by the following resources developed by the Victim Rights Law Center (VRLC) and Transition Projects (TP) describing challenges and suggested strategies for serving homeless survivors of sexual violence: (a) the [VRLC/TP \(2013\) film](#), "**Surviving Sexual Violence on the Streets**,"<sup>11</sup> (note that the accompanying discussion guide, cited in the [YouTube page](#), is no longer available); (b) the VRLC's "**Staying Safer on the Streets: a safety planning tool for sexual violence survivors experiencing homelessness**" ([VRLC, 2014](#)); and (c) webinar slides on "**Engaging Homeless Survivors of Sexual Violence**" (Mahr, Borke, & Harris, 2013), which was formerly available on the [NNEDV website](#):

- **Challenges to seeking/accepting services:**

- All the challenges that any other sexual assault survivor might face (e.g., shame, self-blame, denial, discomfort in her own body, isolation, fear, lack of knowledge about rights and resources, lack of available and accessible services, memory loss or confusion linked to the trauma of abuse, etc.)
- Challenges related to the survivor's homelessness (e.g., primacy of their struggle to meet basic needs; resignation and loss of hope; lack of credibility as a homeless person; fear of reprisal by the perpetrator or his allies for reporting the abuse, especially given the survivor's heightened

<sup>11</sup> We thank the VRLC for generously sharing an early copy of "Staying Safer on the Streets" ([VRLC \(2014\)](#)). Readers are encouraged to refer to that and the other listed VRLC/Transition Projects resources and to other references, like the Missouri Coalition's [Understanding the Nature and Dynamics of Sexual Violence](#), to explore this issue in greater depth.

vulnerability while homeless; fear and mistrust of authorities, for example, because of prior negative encounters, or because at the time of her victimization she was engaged in illegal or "undesirable" activities -- e.g., public drinking, drug use, prostitution, trespassing, shoplifting, etc. -- or because she has a reputation or outstanding warrants for such offenses; etc.).

- Challenges pertaining to complex trauma (the combined result of the current abuse, any prior abuse as an adult or child, and the intrinsic trauma of homelessness) and its possible concomitants.<sup>12</sup>
- **Challenges to providing services:**
  - Staff difficulty in broaching the issue of sexual assault with program participants to determine whether a referral for sexual assault services is appropriate (particularly if the program has not been known as a source of supportive services for survivors).
  - Logistical challenges to participation in services (time of day; other competing demands on the time and attention of the survivor; privacy issues, if services are onsite; travel if services are offsite, etc.).
  - Tradeoffs that must be weighed by the survivor -- sustaining an abusive relationship versus losing a protector and becoming more vulnerable to other predators.
  - Confidentiality issues: staff need to know (and explain to the survivor) whether any of their communication with participants (including communication through an interpreter) is "privileged" or otherwise assured of confidentiality, and should work with agency counsel to minimize the risk that any case notes or agency records that might be subpoenaed could reveal identifying, damaging, or incriminating facts about the survivor.

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<sup>12</sup> In her article on [Understanding Complex Trauma, Complex Reactions, and Treatment Approaches](#), Courtois discusses the "after-effects" of complex trauma, a partial list of which includes difficulty modulating anger, tendencies towards self-destructiveness (including methods for emotional regulation and self-soothing that are addictive and self-harming [e.g., over-eating, drinking, cutting/self-mutilation, etc.]); a chronic sense of guilt, intense shame, and diminished sense of self-worth; inability to trust others' motives; despair about being unable to recover from their psychic anguish. Any of these could pose additional barriers to seeking and accepting help. She notes that the symptoms of complex trauma have been historically misunderstood, to the detriment of survivors who needed our compassion and support:

*"Many of the major characteristics resemble the symptom picture of emotional lability, relational instability, impulsivity, unstable self-structure sense of self, and self-harm tendencies most associated with borderline personality disorder (BPD; American Psychiatric Association, 1994). The BPD diagnosis has carried enormous stigma in the treatment community where it continues to be applied predominantly to women clients in a pejorative way, usually signifying that they are irrational and beyond help. In recent years, this diagnosis that has come to be understood as a posttraumatic adaptation to recurrent and severe childhood abuse, attachment trauma, and personal invalidation, giving therapists another way to understand and treat it."*

Courtois notes that individuals with Complex PTSD "can be a difficult population to treat. In much the same way that the [Seeking Safety](#) approach to addressing co-occurring trauma and substance abuse focuses on developing a basis of trust in the supportive relationship between survivor and provider, and a safe space for the survivor to explore her addiction, Courtois explains the rationale of an approach to treating CPTSD that will not re-traumatize the survivor:

*"Psychotherapy is fraught with many complications due to the number of issues symptoms the client might experience, issues with personal safety, and deficiencies in the ability to regulate affect and to apply other life skills. Exposing these clients too directly to their trauma history in the absence of their ability to maintain safety in their lives or to self-regulate strong emotions can lead to re-traumatization, and associated decompensation, and inability to function. . . . The recommended course of treatment . . . involves the sequencing of healing tasks across several main stages of treatment, [including:] (1) pre-treatment assessment, (2) early stage of safety, education, stabilization, skill-building, and development of the treatment alliance, (3) middle stage of trauma processing and resolution, and (4) late stage of self and relational development and life choice. . . . As each stage builds on the previous work, the trauma survivor acquires growing control and mastery, which directly counteract the powerlessness of victimization and its continuing after-effects. . . . Survivors who were once confused by their symptoms and despaired of ever receiving understanding and assistance now have the opportunity to . . . heal, and to get their lives back and on track."*

- **Approaches to providing services, generally, and safety planning, in particular:**

- (1) Partner with a local rape crisis center or sexual assault program, to leverage their help in training provider staff at mainstream and domestic violence-focused shelters and TH programs.
- (2) Create the expectation of support for participants who have survived sexual assault:
  - (a) Use every opportunity -- staff conversations with survivors, posters, outreach messaging to other providers and to potential clients -- to communicate the program's understanding of sexual violence, and how it contributes to and can prolong homelessness, and how the victim is not to blame. Make it as easy as possible to talk about sexual violence.
  - (b) Gently raise the topic in the intake process, and mention any linkages with or options for referral to specialized confidential services that participants can access, including any providers that target their services to specific subpopulations, based on race, ethnicity, gender identity, or sexual orientation.
  - (c) Be transparent with participants about whether any of their conversations with staff are "privileged," and therefore not subject to mandatory disclosure to courts or other official personnel. Alert participants to any mandatory reporting requirements. (If an interpreter is involved, address their commitment to confidentiality.)
  - (d) Validate participants who disclose their experiences of sexual victimization, and offer support, understanding and resources. If they blame themselves, help them see they are not to blame.
- (3) Invite staff from the local rape crisis center or sexual assault program to offer presentations for participants about their services; if there are former consumers who are comfortable sharing their experience receiving services, invite them to do so. Destigmatize participation in the conversation by scheduling it in conjunction with an event that all shelter/TH program participants will attend.
- (4) Safety planning should reflect the realities of the survivor:
  - (a) Safety planning for survivors of non-IPV-related sexual assault is different from safety planning for survivors of domestic violence; the perpetrator isn't someone the survivor lives with and whose habits and patterns she necessarily knows and can anticipate. There could be risk from multiple sources, including potential assailants the survivor knows and some she doesn't.
  - (b) The more time the survivor spends on the street, the more vulnerable she is, although she could also be vulnerable in a scattered-site apartment or an unsecured program location. A TH program, where survivors have some control over when they stay in and when they leave, is inherently safer than an emergency shelter, which gives predators a predictable opportunity to intercept their victims when the facility closes down between breakfast and dinner.
  - (c) Safety planning needs to encompass not only physical safety, but emotional safety. The [VRLC \(2014\)](#) safety planning discussion tool includes "questions addressing how survivors can be safer with their thoughts, which can include negative self-talk, suicidal ideation, and feelings of hopelessness and resignation" and reminds staff "to inform survivors of any mandatory reporting obligations you have **before** asking about suicidality and other forms of self-harm or threats that you may have to report. If you do not feel comfortable or qualified to discuss emotional safety with survivors who are homeless, refer them to a sexual assault advocate or mental health professional that can assist."
  - (d) [VRLC \(2014\)](#) encourages staff to (i) Show participants the safety planning discussion tool before walking through it, so as to allow them to decide which aspects of safety planning **they** want to work on, if they aren't ready or able to address all areas; and (ii) Determine whether the survivor wants to develop a written safety plan (which could be subpoenaed), and if so,

whether they want the provider to fill it out during their discussion, or whether the survivor will do that. [VRLC \(2014\)](#) cautions that "it may be advisable to leave survivor-identifying or perpetrator-identifying information off of the chart in case it is lost, stolen, or seen by others."

- (e) [VRLC \(2014\)](#) emphasizes that the discussion about safety should be survivor-centered and framed in terms of choices that the survivor will make. The authors add that, "Safety planning is an ongoing process, not a one-time conversation," and encourage staff to revisit the safety plan periodically to see if circumstances have changed that necessitate an update, or if the survivor has new safety concerns that should be addressed.
- (f) For each aspect addressed -- where she sleeps, where she spends time on the street, how she travels, where she works or attends classes, wherever else she goes, how she uses technology, how she uses drugs or alcohol (or other tools for self-soothing), and, importantly, how she feels about herself -- the [VRLC \(2014\)](#) tool asks the survivor to examine, "how can I be safer?" and specifically:
- What's working and what's not working?
  - When is it better and when is it worse?
  - What are the little fixes and what are the big fixes?
  - What will help and who can help?
  - Next steps.

**(d) Special Interview: Jessie Mindlin, Esq., National Director of Training and Technical Assistance for the Victim Rights Law Center (Portland OR)**<sup>13</sup>

The **Victim Rights Law Center (VRLC)** describes itself as "the first law center in the nation dedicated solely to advocating for the civil legal needs of sexual assault survivors. The VRLC provides direct legal representation to victims of rape and sexual assault throughout Massachusetts and in Multnomah, Washington, and Clackamas Counties, Oregon. "If you have been raped or sexually assaulted, we believe you have the right to make your own choices about how to respond to what has happened to you." VRLC Director of Training and Technical Assistance, Jessie Mindlin, asked to be specifically cited, so readers of this report would know how to reach out to her (503-274-5477 or [www.victimrights.org](http://www.victimrights.org)) for training or T.A. in thinking through their agency's strategy for serving homeless survivors of sexual assault. The following is an edited transcript of our interview with her:

OVW defines "domestic violence" as a pattern of abusive behavior in an intimate partner relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. Domestic violence occurs in both opposite-sex and same-sex relationships and can happen to intimate partners who are married, living together, or dating.

OVW defines "sexual assault" as any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape. Sexual assault of an intimate partner -- coerced sexual contact, marital rape, forced sex after violence, etc. -- is a form of domestic violence.

According to the **National Intimate Partner Sexual Violence Survey of 2011** ([Breiding et al., 2014](#)):<sup>14</sup>

<sup>13</sup> See the VRLC webpage on [Resources for Professionals who work with Survivors](#) for a wide range of helpful materials.

<sup>14</sup> See the CDC's [NISVS Summary Reports webpage](#) for other reports.

- 19.3% of women -- approximately one in five -- will experience rape in their lifetime; and 43.9% -- a little more than two in five -- will experience other kinds of sexual violence (e.g., sexual coercion, unwanted sexual contact, or other unwanted non-contact sexual experiences) in their lifetime.
- 1.7% of men -- about one in sixty -- will experience rape in their lifetime; and 23.4% -- a little less than one in four -- will experience other kinds of sexual violence.
- Among women who are raped, 45.4% of victims are raped by a current or intimate partner, 12.1% are raped by a family member; 2.6% are raped by a person of authority (e.g., supervisor, teacher, clergy, doctor, superior, etc.); 46.7% are raped by an acquaintance; and 12.9% are raped by a stranger. (The numbers add up to more than 100% because some women were victimized by multiple perpetrators and/or experienced more than one rape.) Among men who are raped, 29.0% of victims are raped by a current or intimate partner, and 44.9% are raped by an acquaintance. (Statistics for rape by a family member, a person of authority, or by a stranger are not statistically significant because the overall totals were too small to derive statistics with high confidence.)
- Among women (men) who experience other kinds of sexual violence as described above, 36.0% (40.7%) are victimized by a current or intimate partner.
- Among women (men) who are sexually coerced, 74.1% (69.5%) experience that coercion from a current or intimate partner.

The needs of a sexual assault survivor and the strategies for addressing those needs often differ, depending upon who the assailant is relative to the survivor. When I started training on how to serve sexual assault survivors, it became apparent to me that when I said "sexual assault," many people in the audience heard "domestic violence."

We know from experience that survivors of sexual assault lose their housing for many reasons – including, for example, financial reasons, and reasons related to physical and/or emotional safety. As an example of financial reasons, consider a victim who cannot maintain his or her employment after an assault: she becomes unemployed, can't pay the rent, and has to move or gets evicted. As an example of loss of housing for emotional safety-related reasons, consider a victim who cannot remain where she was living because it feels unsafe; the assault occurred in or near her home, and remaining there is a "trigger." If the rapist is still at large, there is a physical safety issue. A survivor who lives in student housing who withdraws from school as a result of the assault loses her housing as a result of no longer being a student. She may also lose her student visa, and her basis for remaining in the country.

The sexual assault survivor population we're working with right now faces enormous barriers to achieving permanent housing. They have significant histories of substance abuse, mental illness, violence and victimization. One of the significant differences between this population and persons fleeing a particular instance of domestic violence or assault, is the chronic nature of their homelessness. Child sexual abuse and/or domestic violence may have led to their homelessness, and while on the street the victimization continued, in addition to the other challenges. These chronically homeless women are not seeking help from DV providers. That's not their community, in a sense.

When sexual assault is perpetrated by an intimate partner as one more means of control, all of the traditional approaches -- the power and control wheel, safety planning focused around staying safe around a partner, and knowing how to get out of the house with the things you need -- absolutely make sense.

When a survivor is homeless because she was raped by someone with whom she has never had an intimate "relationship," or if she has been homeless and is raped by such a person, the focus on the power and control wheel, the abuser and the cycle of violence, and safety planning around trying to stay safe from an abusive partner isn't really relevant.

I think OVW has done a terrific job structuring its annual TH grant proposal solicitations to make it clear that domestic violence and sexual assault are not the same thing, and to encourage grant recipients to expand and

develop their services for sexual assault survivors. But it will take many years for that to really take root. The investment has to continue.

So how do we build capacity to meet sexual assault survivors' transitional housing needs? My first thought is that we need many different models. And the changes and improvements that we pursue need to reflect the realities of existing programs' capacity, funding limitations, the scarcity of affordable housing, etc.

In some communities, perhaps it makes sense to consider restructuring DV shelters and transitional housing programs so that they are better equipped to address the needs of survivors of non-intimate partner sexual assault. In rural and other areas where the DV-focused shelters and transitional programs are already struggling for funding, for example, it may be unrealistic to think that there will be funding or capacity to support a second system of emergency housing specifically for survivors of non-intimate partner sexual assault. So, we need to give serious thought about how to address the transitional housing needs of these survivors, and whether they can be met by the same program, by different programs sponsored by the same organization, or by different organizations. And, of course, we need the survivors' input. (For example, when we were creating our poster to convey the message to sexual assault (SA) survivors experiencing homelessness that they are not invisible and that a program operated by a local partner was a "safe space" in which to disclose their experience of sexual assault, the SA survivors' input was invaluable.)

The push to combine programs and make them more multi-focused concerns me. I'm aware that in a number of states, funders are encouraging victim service providers toward consolidation. From the sexual violence provider perspective, this is worrisome because there's evidence that the more multi-serviced an organization is, the more diluted SA services become and thus the more SA survivors are likely to go under-served or unserved. Too many programs barely have the resources to do the work they're already doing; to think they have the capacity to develop a whole other capacity is unrealistic.

In my experience, when DV programs respond by attempting to incorporate sexual assault services it rarely results in a comprehensive, integrated approach. The folks doing the DV work are already stretched so thin. The additional time and resources and support it takes to broaden the scope of expertise and services when you're already overtaxed are hard to come by.

If a DV-focused program claims to also serve non-DV-related sexual assault survivors, but doesn't have the expertise and capacity, that's a problem. My message to the folks that I work with is: "say what you do, and do what you say." There's no shame in being DV alone or being SA alone. Each of us should have the capacity and expertise to do what we're doing. Not everyone has to do everything, but we need to make sure that we've got the bases covered. If the only program serving survivors in a 300 mile radius was DV-focused and had absolutely no expertise in working with non-DV-related sexual assault survivors, that would be a problem. But it would also be a problem if a program claimed to be prepared to address both populations without having the expertise to do so.

Given that 40.4% of women and girls are first raped before the age of 18 and another 38.3% are first raped between the ages of 18 and 24 ([Breiding et al., 2014](#)), sexual assault providers need expertise in working with teens and young adults. However, most DV providers don't have that experience or expertise. Sexual assault is a very serious problem among youth and young adults experiencing homelessness. Transgender youth experiencing homelessness suffer from even higher rates of sexual victimization.

Most shelters and transitional housing programs don't house minors without parental consent, either because state law does not allow it, or as a matter of policy. It's important to be aware that in some instances, providers may be able to offer a residential placement to minors without parental consent, and without involving the state's Child Protective Services, if the minor is emancipated under statute or case law (e.g., if the minor has been married or served in the military). Not every minor is treated as a minor by the law all the

time. It is also important to understand the extent of a minor's right to receive services confidentially, which may be different than their right to consent.<sup>15</sup>

Young trafficking victims are a particularly vulnerable segment of the sexual assault survivor population. According to research for a ***Study of HHS Programs Serving Human Trafficking Victims*** (Clawson, n.d.), minors are among the most vulnerable victims, with trafficked girls entering prostitution, on average, at age 12-14, and trafficked boys and transgender youth entering prostitution even younger, at an average age of 11-13. Runaway and homeless youth are particularly at risk through commercial sexual exploitation.

In addition to their trauma-, substance abuse-, and mental health-related needs, trafficking survivors may have unique and heightened safety needs. I've heard law enforcement and others raise security and safety concerns for survivors whose traffickers are still at large. From the traffickers' perspective, victims are a valuable commodity. There's an oft-cited example; if you're dealing in drugs, you sell the drugs and then they're gone. When you're dealing in human beings and trafficking or commercial sexual exploitation, you sell the human and then you can sell them again, and again, and again.

For DV-focused programs to build their capacity to serve victims of sexual assault who were not necessarily also victims of domestic violence, they may need to examine all their policies and procedures, starting with admission criteria. One of the priorities for many shelter programs is a lethality assessment. I understand this. Keeping someone alive is urgent and immediate. Many survivors of sexual assault would probably score fairly low if you're looking at the risk of lethality from the offender. So, if it's a shelter that is always full and has to triage admissions, victims of SA may never be a priority when they don't present risk of immediate future harm. This is not a criticism. It's an example of how providers have to prioritize because they don't have enough resources to meet the needs of all the survivors who need their help.

Safety planning is another area where programs seeking to expand or better serve SA survivors will need new tools and protocols. As I mentioned earlier, safety plans targeted to victims of intimate partner violence that took place in the home -- that caution about getting stuck in the bathroom or any other room in which there is no alternate exit; or that suggest that survivors keep a copy of important papers (e.g., wedding certificate or children's birth certificate, or immigration papers) somewhere safe such as a friend's or relative's home or a safe deposit box -- probably have little to no relevance to a survivor who has been raped by a classmate or a stranger or acquaintance. And they have even less relevance to a survivor experiencing homelessness.

The survivors we've worked with through our transitional housing grant partnership are virtually never employed, are not in school, are older than the typical SA survivor demographic of 12-24, and have no home.

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<sup>15</sup> According to a (no longer available) 2011 Q&A on [Access to Shelter and Housing for Unaccompanied Youth](#) published by the National Association for the Education of Homeless Children and Youth (NAEHCY), "Certain states require the consent of the parent, a court, or a placing agency or state department before a child may be admitted to the identified program or facility. If a state does not require the consent of the parent to stay in a facility or program, it will likely require that the parent receive notification that the child is present at the facility or at least written notification of the policies in place at the facility. As a result, in most cases the shelter or housing program will need to contact the parent and tell the parent where the child is. However, if shelter staff believe the youth is in danger due to parental abuse, the staff can choose to contact child protective services instead of the parent. Also, if the parent cannot be located or reached, the facility will often be required to report the youth's admission to child protective services.

Under a typical state law or licensing requirement, when a youth arrives at a shelter the provider has a certain time period, usually 48 to 72 hours, in which the shelter must notify the youth's parent or guardian of the youth's admission to the shelter. If the youth's parents are not reachable or if contacting the parents would lead to harm for the youth, the shelter should make a referral to child protective services or other analogous state agency."

Also see: (1) Questions #69-79 in [The Most Frequently Asked Questions on the Educational Rights of Children & Youth in Homeless Situations](#), a joint publication of NAEHCY and the National Law Center on Homelessness and Poverty (2017); and (2) [State Educational and Health Care Consent Laws: Ensuring Children in Grandfamilies Can Access Services](#), published by the American Bar Association's in *Child Law Practice Today* (Vol. 33 No.6, June 2014)

As a program when you start asking questions that might trigger a mandatory reporting obligation, you want to be prepared from the outset as to how you will handle that. This includes how you will be letting survivors know – before you ask the question – the impact an answer might have. You want to be sure the survivor is giving informed consent. This same issue may arise in working with SA survivors who are minors. What you don't want to do is to ask questions, get answers, and then say to the minor, "I'm really sorry I didn't tell you this before, but now that you've answered my questions I need to call protective services." As an organization, it is important to properly navigate who are mandatory reporters, how information is collected, and what firewalls are in place, as well as all of the other privacy protections that you need to consider.

As with any program that seeks to be culturally competent, a program serving survivors of sexual assault needs to think about where they are located, what their outreach materials look like, and whether they reflect the community of the people being victimized. And how someone coming in can identify the fact of sexual assault at the point of intake, whether that's at a front desk, by phone, etc. I think there is a real reluctance to ask about sexual violence, because it means talking about nonconsensual sex, and that just makes people uncomfortable. And so getting the staff to a point of comfort is important, in addition to developing the appropriate expertise.

One particular population that is often not discussed are the male victims, whether they've been victimized by opposite or same sex perpetrators.

The transitional housing provider doesn't have to be sexual assault experts, as long as they have that relationship in place with the local sexual assault agency so that someone is having the important discussions with the survivor. And we don't expect a crisis line or a transitional housing program to be able to provide legal services, but rather to be able to identify participants who have experienced sexual assault, and to know that for many survivors, it could be beneficial to talk with a lawyer who could identify legal remedies that otherwise might never be addressed. For many of the women we and our transitional housing partner work with, victimization and violence are at the heart of their homelessness. And it's at the heart of many other of the issues they confront in their life, including substance abuse and mental illness. Unless we confront sexual violence, and start to facilitate healing to the extent possible, the other interventions are less likely to work.

At the end of the day, I don't know whether success in providing transitional housing for a survivor of sexual assault looks that much different than success for a program providing transitional housing for a DV survivor. What success would look like for SA survivors are services that are survivor-centered, that create safe options for survivors, where survivors feel validated and heard, believed and not shamed.

I think one of the critical differences, at least in terms of the legal system, is the extensive victim blaming. No batterer ever stands up in court and said, Your Honor, she wanted me to beat her, it was consensual. But ninety-something percent of the adult sexual assault cases turn on the issue of consent.

It is also important to remember that the sexual assault survivor community is just so broad. The difference between the 13 year-old who's been raped by mom's boyfriend, the 15 year-old who is engaged in survival sex on the streets, the 21 year-old university student who was raped at the fraternity party, the 37 year-old who has been chronically homeless, has a long history of criminal activity, substance abuse, mental illness, and victimization by sexual assault -- those are all really different populations requiring an appropriate trauma-informed response.

How do we as communities create a network of services for these folks? Not everyone has to do everything. What's important is that we think about what survivors need, and how, to the extent possible, we as communities and collaborators can meet the full breadth of survivors' needs. That's what success looks like.

**(e) Useful Resources on Sexual Assault (alphabetically listed)**

**(i) [Davies \(2007\)](#) - "Helping Sexual Assault Survivors with Multiple Victimitizations and Needs"**

Although the guide was nominally written "for administrators, staff, and volunteers from rape crisis centers (RCCs) and victim advocates working within criminal justice system agencies," it provides insights that will be helpful to providers serving homeless survivors in shelter and TH programs, as well. Given the cumulative impact of trauma experienced by survivors of multiple victimizations, the criminal nature of sexual assault, and survivors' fundamental needs for income and housing, Davies (2007) specifically addresses challenges, key issues and considerations, and recommended staff competencies/support/supervision for programs addressing survivor needs related to (a) mental health / trauma / substance abuse; (b) the criminal justice system; and (c) government systems providing economic and housing assistance. Some of her more generally applicable points include:

- **No One-Size-Fits-All Approach:** In the same way that the heterogeneity of the DV survivor population and the huge variation in program operating environments makes it impossible to describe a one-size-fits-all set of best practices in providing transitional housing to survivors of domestic violence, [Davies \(2007\)](#) cautions that her publication "is not intended to describe best practices. Survivors with multiple victimizations / multiple needs (MV/N) have diverse backgrounds, experiences, and perspectives. Because of their differences, they would not be well served by an overly prescriptive advocacy approach. Nor is the Guide intended to create standards of practice for agencies serving survivors MV/N. Such standards would be impractical, given the significant variations among agencies serving sexual assault survivors, in terms of mission, organizational structure, local demographics, available resources, populations served, and services offered." (p.11)
- **Assume that All Sexual Assault Survivors Have Experienced Multiple Victimizations and Have Multiple Needs (MV/N):** "Given that over half of rape crisis center clients are likely to be survivors [with] MV/N, and the reality that survivors may not disclose [those] multiple victimizations or multiple needs, a universal approach is practical. A universal approach means that all survivors are offered services and advocacy in a way that is effective for survivors MV/N. If an advocacy approach improves understanding of the issues survivors MV/N face, removes barriers to services, improves cultural skills, and responds to mental health and financial needs, then it will benefit all survivors. Also, the support, training, and supervision necessary for effective advocacy with survivors MV/N will benefit all survivors and staff." (p.18)  
 "Understand how multiple victimizations can affect a survivor. View those effects as a reaction to violence, rather than something wrong with the person." (p.19)
- **Advocacy Must Be Survivor-Defined:** "Far too often, people in the lives of survivors [with] MV/N were abusive or let them down, service providers responded ineffectively to them, and systems ignored or added to their pain. Each survivor [with] MV/N ... has a unique perspective of these realities and lives with the effects of such bad experiences. Their culture will also impact their perspective of their experiences, from how they are affected by the violence to the way in which they seek and use services.  
 . . . . For advocacy to be based on the perspectives and needs of survivors [with] MV/N, it must be flexible, skilled, and responsive to survivors from diverse cultures experiencing different effects of violence. To overcome the distrust that survivors [with] MV/N may have in people and systems in general, it is essential that advocates nurture a respectful working relationship with them. . . . Although the relationship is collaborative, clearly defined roles and boundaries are essential. Being respectful also entails explaining what decisions survivors [with] MV/N will have the opportunity to make and those that are not within their power. For example, a survivor might choose to report a crime to the police, but lose control of the process once law enforcement is involved. Advocates must also inform survivors if resources they need or want are not available. . . .

An advocate's culture, including socio-economic class may add an additional power dynamic. Advocates need a constant awareness that with this role comes privilege, an understanding of how to use the relationship to empower and assist survivors [with] MV/N, and skill to identify and correct any misperceptions about the relationship [and] to avoid the unintentional misuse of their power." (pp.15-16)

***(ii) [Missouri Coalition Against Domestic and Sexual Violence \(2016\)](#) - MCADSV Standards for Sexual Violence Programs***

A comprehensive enumeration of the Missouri Coalition's standards for how a Board of Directors should be organized; how a program should be administered, including the rights of survivors receiving services, the written policies required, what data is collected and stored and when and how it is destroyed, and how client confidentiality is protected; how confidentiality should be protected, and how participant consent is requested and obtained; how the provision of services is documented, what information is not included in order to protect the survivor, how survivors can access their records, etc.; how survivors with limited English-speaking capability are assisted with language services, and how survivors who are blind/visually impaired or deaf/hard of hearing are assisted; how staff are trained (and the curriculum); and how each of the specific roles/positions in the program (advocate/case manager, court advocacy, hospital advocacy, advocacy with law enforcement, etc.); and how volunteers are utilized and trained.

***(iii) [Missouri Coalition Against Domestic and Sexual Violence \(2014\)](#) - Understanding the Nature and Dynamics of Sexual Violence***

A comprehensive look at the different forms of sexual violence; the range of impacts on survivors (e.g., short-term, long-term, physical, emotional, sexual, psychological, cognitive, etc.); strategies for supporting recovery and empowerment and preventing re-victimization; specific strategies for working with survivors with disabilities, immigrant and refugee survivors, LGBTQ survivors, male survivors, and older adult survivors; supporting survivors in their interface with the medical system and in addressing the potential and actual health consequences of rape and sexual assault; and supporting survivors in their interface with the legal/criminal justice system.

***(iv) [National Sexual Violence Resource Center](#) - [Sexual Assault Demonstration Initiative \(SADI\)](#):***

- [Trauma-Informed Advocacy and Services \(2012\)](#) - A brief annotated bibliography of articles and books.
- [Final Report \(2017\)](#) – “The Sexual Assault Demonstration Initiative (SADI) was funded by the Office of Violence Against Women (OVW) to enhance sexual assault outreach, services, and community partnerships in dual/multi-service programs. Sexual violence affects thousands of women, men, and children each year. Survivors of sexual violence do not always seek crisis-focused support immediately after their victimization, and in fact may not seek support for months or years after the assault. They are not likely to see a shelter or a domestic violence program, or a dual/multi-service program that emphasizes domestic violence services, as a place to access support. In part, this is because dual/multi-service programs as a whole do not have an established history of providing the kind of comprehensive and relevant support that stand-alone rape crisis programs have (Bergen, 1996; Johnson, Crowley, & Sigler, 1992; Patterson, 2009).

Through the SADI, selected sites were provided funding and technical assistance to enhance their sexual assault services through organizational change. The three overarching goals of the SADI were to:

- Increase outreach to populations experiencing sexual violence but not currently accessing services
- Develop models of service provision that prioritize the needs of sexual assault survivors beyond immediate crisis responses currently offered
- Document the resulting increases in the numbers and types of sexual assault survivors who access those newly enhanced services.

While these goals focus on services to survivors, an important principle of the SADI was that enhancing services and sustaining those services can only be achieved and sustained through organizational change. Therefore, the SADI focused on both organizational change (policy, structure, staffing, culture) and programmatic change (service provision, outreach, materials, training)....”

The report reviews the experience and lessons learned from the project and makes recommendations for dual/multi-focused provider organizations seeking to strengthen their ability to serve survivors of sexual assault, as well as for funders and technical assistance providers seeking to bolster such efforts.

**(v) [Pandora's Project \(website\)](#)**

Pandora's Project is a volunteer-staffed nonprofit "dedicated to providing information, support, and resources to survivors of rape and sexual abuse and their friends and family. We have been devoted to recovery and healing since 1999. Pandora's Project offers peer support to anyone who has been a victim of rape, sexual assault, or sexual abuse through our [online support group, Pandora's Aquarium](#). We believe that connecting with other rape and sexual abuse survivors is an important part of healing. Our online support group includes a message board, chat room, and blogs. It is free to join and is safely moderated by a diverse group of survivors. . . . Healing knows no timeline. If you were just raped or were sexually abused when you were a child, if this is your first step in recovery or you've already been through counseling and want to connect with other survivors, Pandora's Project is here to support you. The rape and sexual abuse online support group has specific forums for men and women, teens and older survivors, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) rape and sexual abuse survivors, and friends and family of survivors. . . . You will also find support for issues common in healing after rape, sexual assault, & sexual abuse: flashbacks, depression, and PTSD; self-injury and self-harm; eating disorders; relationships, sex & intimacy; spirituality; pregnancy & parenting; & legal concerns."

The website contains [Links to Crisis Support & Hotlines](#), an extensive list of [articles and essays about rape and sexual abuse](#) addressing such topics as [Rape & Sexual Assault](#), [Child Sexual Abuse](#), [Relationship Violence](#), [Self-Care after Sexual Violence](#), [Recovering from Trauma](#), [Volunteering & Activism](#), [Secondary Survivors \(Friends and Family\)](#), [Stalking](#), [Relationships, Sex & Intimacy](#), [Parenting after Rape and Sexual Abuse](#), [LGBT Issues](#), [Legal Action](#), [Self-Injury](#), and [Eating Disorders](#). The website also contains a [recommended reading list](#).

**(vi) [Rand National Defense Research Institute - Harrell et al. \(2009\) - A Compendium of Sexual Assault Research](#)**

A comprehensive (300+ pages) summary of the literature on sexual assault, compiled for the Office of the Secretary of Defense, with chapters on victim risk factors, perpetrator risk factors, the role of alcohol, context and prevention of sexual assault, recovery and coping, sexual assault disclosure, health care programs and services, victim programs and advocacy services, investigative and legal processes. These chapters are followed by an annotated bibliography.

**(vii) [Washington Coalition of Sexual Assault Programs \(Resources and Publications\) \(website\)](#)**

- Publishes a periodic "[Research and Advocacy Review](#)" describing and summarizing national research pertaining to sexual assault, for example: Male and Female Rape Myths Affect Bystander Intervention; The Sexual Abuse to Prison Pipeline - The Girls' Story; False Allegations of Adult Sexual Assault; Sexual Assault Survival of Adult Women; Emergency Contraception and Weight; National Intimate Partner and Sexual Violence Survey 2011 Findings; Without My Consent Survey of Online Stalking, Harassment, and Violations of Privacy; Utilizing Findings on Victimization by Sexual Orientation; etc.
- Publishes a biannual journal "[Connections](#)" containing articles relevant to sexual assault. Each addition addresses a different theme, for example: Advocacy with Incarcerated Survivors of Sexual Violence in Washington State; Advocacy with Latin@ Immigrant Survivors of Sexual Violence (in English and Spanish); Reproductive Justice; Building Relationships & Resources with Tribal Communities; Male Survivors of Sexual Violence; Commercial Sexual Exploitation of Youth; Strategies For Supporting LGBTIQ Survivors; Meeting the Long-Term Health Care Needs of Survivors; Technology Safety; etc.

- Develops and disseminates "[Special Editions](#)" -- toolkits, factsheets, resource guides, and other publications of the WCSAP -- on such topics as: Accreditation Toolkit, Know Your Rights, How do I Create a Safety Plan with Farmworker Victims of Sexual Violence?, Creating Trauma Informed Services: A Guide for Sexual Assault Programs and Their System Partners; Reproductive Health Advocacy Strategies for Sexual Assault Survivors; What Advocates Need to Know About Therapy: With Considerations for Children, Teens, and Families; A Child Sexual Abuse/Assault Advocacy Guide; Children Are Victims and Witnesses of Crime; Sexual Assault Service Delivery Implications for People with Disabilities; Creating Accessible Sexual Assault Services for People with Disabilities; Creating Partnerships with Faith Communities to End Sexual Violence; Working with Correctional Facilities: Advocacy for Incarcerated Survivors; Practice Guidelines for Working with Pregnant and Parenting Survivors.
- [Circle of Hope: A Guide for Conducting Psychoeducational Support Groups \(Second Edition\)](#) (2014) - (as described in the Introduction to the Guide:) "A particularly successful method for working with survivors of sexual assault and trauma is to bring survivors together in groups. Groups are an effective tool in giving hope and providing support, validation, connection, healing, and empathy. At the core of all sexual assault trauma is disempowerment and disconnection. To assist in recovery, empowerment and connection are key factors. It is amazing to witness the transformation that many survivors make because of these groups—because they realize they aren't alone, because they realize that people care, because they learn that it wasn't their fault, and because of the hope that comes through connection and validation. The relationships that members develop may be some of the most positive and supportive in their lives. Because these groups can have such a profound impact on survivors of sexual assault, it is vital that as advocates we possess the skills and knowledge to effectively facilitate groups. Hence, the purpose of this manual: to provide a roadmap of sorts, to navigate through the world of psychoeducational support groups.

This manual is considered a basic guide, written with beginner facilitators in mind. It offers practical guidance and recommendations for facilitation and design of psychoeducational support groups. The sources include existing research and literature about groups, the Office of Crime Victims Advocacy (OCVA) support group standards, and the experiences of those who participated in writing this manual. We encourage experienced group facilitators to add their own wisdom and experience to the information presented here as they conduct support groups." (p.1)

(viii) [Sexual Assault Resource and Counseling Center of Lebanon County / Pennsylvania Coalition Against Rape \(2007\) - Reaching Latino Victims of Sexual Violence: A Marketing Toolkit](#)

Findings and recommendations from focus groups with Latino adults and teens that discussed sexual violence.

**(f) Military Sexual Trauma**

**(i) U.S. Department of Veterans Affairs (VA) Definition**

Per the "Overview" tab of the VA Mental Health Services' [Military Sexual Trauma](#) webpage:

*"Military sexual trauma (MST) is the term that the Department of Veterans Affairs uses to refer to sexual assault or repeated, threatening sexual harassment that occurred while the Veteran was in the military. It includes any sexual activity in which one is involved against one's will – he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or with implied faster promotions or better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; and/or threatening or unwelcome sexual advances. Both women and men can experience MST during their service."*

### **(ii) Incidence Rates**

According to the [FY 2016 Annual Report on Sexual Assault in the Military](#), issued on April 21, 2016 by the U.S. Department of Defense's (DoD) Sexual Assault Prevention and Response program, there were 6,083 reports of sexual assault in Fiscal Year (FY) 2015, down a little less than 1% from FY 2014.

According to a [May 1, 2015 Department of Defense press briefing](#) on the prior year's report, the DoD now estimates that "22 percent of active-duty women and 7 percent of active-duty men<sup>16</sup> may have experienced some form of sexual harassment [in FY 2014]." Acting Under Secretary of Defense for Personnel and Readiness Brad Carson stated that, "We now estimate receiving a reported sexual assault from about one in four military victims, up from one in 10 military victims in 2012" and that "DoD authorities [took] disciplinary action against 76 percent of military [perpetrators]...." A study by the Rand Corp. suggested that "those who indicated experiencing sexual harassment under gender discrimination are also more likely to indicate experience -- to experience a sexual assault." By comparison, "men that have experienced a sexual assault ... are more likely than women to describe the event as hazing and non-sexual."

Based on a behaviorally explicit survey, the Rand Corp. estimated that 4.9 percent of active-duty women and 1 percent of active-duty men, a total of about 20,300 active-duty personnel, experienced "unwanted sexual contact," i.e., sexual assault, in FY 2014.

### **(iii) VA Resources**

- The webpage of the U.S. Department of Veterans Affairs' [Vet Center Program on Military Sexual Trauma Counseling](#) states that

*"Military sexual trauma counseling may include individual or group counseling, marital and family counseling, referral for benefits assistance, liaison with community agencies or substance abuse information and referral to help you deal with the emotions of military sexual trauma and regain confidence in your everyday life. . . . Any veteran who was sexually traumatized while serving in the military is eligible to receive counseling regardless of gender or era of service. . . . Medical services are available at your local VA Medical Center and can be accessed by contacting the Military Sexual Trauma Coordinator (or Women Veterans Program Manager). Assessment and referral for sexual trauma counseling are available [at] all Vet Centers. On site counseling is available at selected Vet Centers across the country."*

- The [Military Sexual Trauma webpage of Benefits.Gov](#) states that,

*"[The] VA provides free care for conditions resulting from experiences of sexual assault or repeated, threatening sexual harassment that occurred in the military. Both physical and mental health treatment (including medications) related to these experiences are provided free of charge to male and female Veterans."*

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<sup>16</sup> A May 1, 2014 NY Times article ([Cooper, 2014](#)) cited a DoD official's observation that "getting more men to report is difficult because many men in the military believe that filing such reports will give the appearance that they are weak, and will set off questions about their sexual orientation." An April 3, 2011 Newsweek story ([Ellison, 2011](#)) observed that,

*"While many might assume the perpetrators of such assaults are closeted gay soldiers, military experts and outside researchers say assailants usually are heterosexual. Like in prisons and other predominantly male environments, male-on-male assault in the military, experts say, is motivated not by homosexuality, but power, intimidation, and domination. Assault victims, both male and female, are typically young and low-ranking; they are targeted for their vulnerability. Often, in male-on-male cases, assailants go after those they assume are gay, even if they are not. 'One of the reasons people commit sexual assault is to put people in their place, to drive them out,' says Mic Hunter, author of Honor Betrayed: Sexual Abuse in America's Military. 'Sexual assault isn't about sex, it's about violence.'"*

*Veterans can apply for service-connected disability for conditions resulting from military sexual trauma, but the provision of free care is not dependent upon becoming service-connected. Go to ['Veterans' Compensation for Service-Connected Disabilities'](#) for more information on how to apply.*

*Special eligibility rules apply. Veterans may be able to receive this benefit even if you are not eligible for other VA services. There is no length of service, income, or other standard eligibility requirements. Veterans do not need to be service-connected or have been given a specific diagnosis (e.g., posttraumatic stress disorder [PTSD]).*

*Incidents do not need to have been reported at the time they occurred, and Veterans do not need any documentation that the incidents occurred. Military Sexual Trauma (MST) may have happened on or off base and while a Veteran was on or off duty. The perpetrator's identity (e.g., Service member or civilian) and relationship between the perpetrator and the victim are not factors in eligibility for care. There are no limits on length of treatment for MST-related conditions.*

*To apply for this program, contact the Military Sexual Trauma Coordinator or Women Veterans Program Manager at [your local VA facility](#) or speak to your current VA health care provider. If you have questions: (a) Visit [the VA's] [Inquiry Routing & Information System \(IRIS\)](#) to search Frequently Asked Questions or ask a question online. (b) Call 1-877-222-8387."*

- Per the "Overview" tab of the VA Mental Health Services' [Military Sexual Trauma](#) webpage:

*"All Veterans seen at Veterans Health Administration facilities are asked about experiences of sexual trauma because we know that any type of trauma can affect a person's physical and mental health, even many years later. We also know that people can recover from trauma. VA has free services to help Veterans do this. You do not need to have a VA disability rating (i.e., "service connected") to receive these services and may be able to receive services even if you are not eligible for other VA care. You do not need to have reported the incident(s) when they happened or have other documentation that they occurred."*

The "Overview" tab also contains (a) a link to a [fact sheet about Disability Compensation for Personal Assault or Military Sexual Trauma](#); and (b) a link to a short video explaining "the types of incidents that constitute MST, the effects of MST on survivors, and the services available to Veterans who have experienced MST."

- Per the "Programs and Services" tab of the VA Mental Health Services' [Military Sexual Trauma](#) webpage:

*"While MST can be a very difficult experience, recovery is possible. At the VA, Veterans can receive free, confidential treatment for mental and physical health conditions related to MST. You may be able to receive this MST-related care **even if you are not eligible for other VA services**. To receive these services, **you do not need a VA service-connected disability rating, [and you do not need] to have reported the incident when it happened, or have other documentation that it occurred.***

***Eligibility for MST-related treatment is entirely separate from the disability claims process.***

*[Footnote: As with other injuries or disabilities incurred during service, Veterans can file a claim to receive compensation for any MST-related injuries or disabilities that began or got worse during their military service.]"*

The Program and Services tab describes the following VA and Vet Center services "to meet Veterans where they are at in their recovery:"

- "Every VA health care facility has providers knowledgeable about treatment for problems related to MST. Because MST is associated with a range of mental health problems, VA's general services for [posttraumatic stress disorder \(PTSD\)](#), [depression](#), [anxiety](#), [substance abuse](#), and others are important resources for MST survivors."

- "Many VA facilities have specialized outpatient mental health services focusing specifically on sexual trauma. Many [Vet Centers](#) also have specially trained sexual trauma counselors. A list of VA and Vet Center facilities can be found online by using the [VA Facility Locator](#). Veterans should feel free to ask to meet with a clinician of a particular gender if it would make them feel more comfortable."
- "VA has programs that offer specialized MST treatment in a residential or inpatient setting. These programs are for Veterans who need more intense treatment and support. Because some Veterans do not feel comfortable in mixed-gender treatment settings, some facilities have separate programs for men and women. All residential and inpatient MST programs have separate sleeping areas for men and women."
- "Knowing that MST survivors may have special needs and concerns, every VA health care facility has an MST Coordinator who serves as a contact person for MST-related issues...."
- "Veterans can also call VA's general information hotline at 1-800-827-1000. Information in Spanish is available in this [brochure on MST](#) (PDF)."
- "Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is national VHA policy that all Veterans seen in VA health care are screened for experiences of MST. . . ."
- "Every April, VA facilities throughout the country host awareness and informational events in honor of Sexual Assault Awareness Month. VA has partnered with the Department of Defense to make information about VA's MST services available to staff and Service members, particularly those Service members being discharged."
- The "Articles and Fact Sheets" tab of the VA Mental Health Services' [Military Sexual Trauma](#) webpage contains the following additional information:
  - (Fact Sheet) [Military Sexual Trauma](#): "Provides background information about MST: (a) what is military sexual trauma (MST)? (b) How common is MST? (c) How can MST affect Veterans? (d) How has VA responded to the problem of MST? (e) How can Veterans get help?"
  - MST Brochure for Veterans [English](#) / [Spanish](#) – "Provides an overview of issues related to MST and how to access VA services."
  - Men and MST – "Educational brochure [English](#) / [Spanish](#) and Infographic [English](#) / [Spanish](#) – These resources provide information on men's recovery from MST."
  - [Top 10 Facts about VA Services for MST](#): "Quick reference information for non-VA service providers about VA's MST-related services."
  - (Fact Sheet) [VA's Health Care Services for Military Sexual Trauma \(MST\)](#): "Summary of the eligibility requirements and the types of MST-related services available through VA."
  - (Fact Sheet) [VA Disability Compensation for Conditions Related to MST](#) - "Veterans can [apply for disability compensation](#) for any current difficulties that are related to their service, including difficulties related to MST. Veterans **do not** need to have a VA disability rating in order to receive free MST-related treatment through VA."
  - (Article) [Don't Suffer in Silence: VA Offers Help for Military Sexual Trauma \(MST\)](#): "Air National Guard Veteran Jennifer Norris and Army Veteran Rowdy Grigsby share their stories."
  - (Article) [Military Sexual Trauma: Stories from Survivors](#): "Two MST survivors, John and Glenda, share their stories of recovery from MST. They also describe how taking advantage of free services from the VA helped with this process."

- (Article) [Veteran Learns to "Face her Demons" with VA PTSD Treatment](#): "Michelle Covert had PTSD for 24 years but didn't know it. Today, thanks to her treatment at a VA hospital, she is working, happy and determined to be a 'voice of hope.' "
- (Article) ["I made it!" Massachusetts Veteran with PTSD turns his life around](#): "Rich Adams was sexually assaulted while in the Navy and retreated into a life of shame and anger. Treatment has turned his life around dramatically."
- (Article) [The 'Invisible Monster': A Homeless Female Veteran's Journey to Take Back Her Life from PTSD](#): "Casondra Williams struggled after experiencing MST during her service. It took courage to reach out for help from the VA, but doing so has helped her take her life back."

Also on the Other Resources

- [MakeTheConnection.net](#): "MakeTheConnection.net is a one-stop resource where Veterans and their families and friends can privately explore information on mental health issues, hear fellow Veterans and their families share their stories of resilience, and easily find and access the support and resources they need."
  - ✓ [Infographic on MST](#)
  - ✓ [Video Testimonials](#) "from Veterans about their own experiences addressing the effects of military sexual trauma."
- [DoD Safe Helpline](#): "DoD Safe Helpline is a crisis support service for members of the DoD community affected by sexual assault. Through the Safe Helpline, you can 'click, call or text' to receive anonymous one-on-one advice, support, and information 24/7. You can go to [www.safehelpline.org](#) for a live chat or to view resources. From anywhere in the world, you can call 877-995-5247, or text your zip code or base/installation name to 55-247 inside the US (202-470-5546 outside the US) to get the contact information for your nearest Sexual Assault Response Coordinator."

**(iv) Other Resources**

- National Sexual Violence Resource Center: [Special Collection: Sexual Violence in the Military](#) - The website features an extensive collection of resources pertaining to MST, including articles and research papers describing the extent of the problem in the armed forces and the military academies, among active duty personnel and veterans; examining the causes and how it might be addressed; reviewing the circumstances under which the Department of Defense's Sexual Assault Prevention and Response Office was created, and the work that SAPRO has done to shed more light on the problem and instigate steps to address it; and the steps that have been taken to address MST, and resources available to victims.
- National Resource Center on Domestic Violence: [Special Collection: The Intersection of Domestic Violence and the Military: Working Across Disciplines](#) - As described on the webpage, "The purpose of this collection is to: (a) Examine the prevalence of Traumatic Brain Injury (TBI), and Post Traumatic Stress Disorder (PTSD) (including relevant references to Military Sexual Trauma (MST)) among veterans returning from the wars in Iraq and Afghanistan; (b) Examine the implications for the domestic and sexual violence fields of veterans returning with co-occurring issues (PTSD, TBI, MST); (c) Provide information related to best practices when addressing these co-occurring issues through a multi-systems approach; (d) Explore some of the challenges experienced by female service members and veterans through the lens of violence against women; and (e) Increase awareness about organizations that are currently working to address TBI, PTSD, MST and domestic violence (DV).

There are articles on the hidden injuries of war - the psychological and cognitive injuries from TBI and trauma, and their implications for retuning veteran; a discussion about the challenge of sorting out how

domestic violence may be related to traditional issues of power and control, or how it may be a consequence of brain injury or trauma; and resources for affected veterans and active duty personnel.

- National Sexual Violence Resource Center: [\*Sexual Violence in the Military: A Guide for Civilian Advocates\*](#) - a comprehensive report looking at the nature and prevalence of the problem, the challenges to reporting abuse and the systems put in place to overcome those challenges; the strategies that have been developed to prevent MST, and the resources available to active duty personnel and veterans.

### **(g) Provider Comments on Serving Sexual Assault Survivors**

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

**Note:** Only two of the providers that we interviewed had specific comments about their approach to serving survivors of sexual assault, and only one of those programs focused on serving that constituency. Their comments follow.

(#01) In 2009, we were thinking about the women we were serving and looking at some of the root causes for their homelessness. What came up was this issue of sexual violence, and we had a hypothesis that once we started peeling back the layers, we would see childhood sexual abuse and later vulnerability and the experience of sexual violence prior to homelessness -- with homelessness being the result of all that violence.

Sometimes survivors of sexual assault are also survivors of domestic violence, but not always. We don't assume that any of them have been survivors of domestic violence. As they develop their relationship with us and talk about their experience, it has come out that a lot of the violence occurred initially in their childhood in the form of childhood sexual abuse. When they were again violated -- while either sleeping outside or in some other situation where they were vulnerable and taken advantage of -- that was layered on top of their earlier trauma history.

We're not specifically a sexual assault organization, we're an organization that addresses homelessness and helps homeless people transition to housing -- but we recognize that this is an under-served population within that larger population that we're serving. So we talk a lot about partner violence versus non-intimate partner violence and the differences between domestic violence and sexual violence.

We also see women who have been trafficked. It's becoming more and more prevalent and as new resources pop up, and we learn about them, we connect women to them. A lot of the women that we serve would not describe their experience as having been trafficked. They would describe it as travelling as a sex worker.

There's no access for women who've been sexually assaulted into the DV programs in our community. They say that they serve sexual assault survivors, but when a single woman who has experienced sexual violence is attempting to access a domestic violence program, they're just not their priority. And so we're doing safety planning with women, trying to connect them with whatever support services we can as they're searching for housing. But the housing search process can sometimes take two to three months to find an affordable unit.

So we're looking at whatever resources the woman may have available -- whether she can enroll in the program and she can stay with a safe friend two days a week or we need to prioritize her into our short-term housing or whether we should prioritize her for our very limited access to hotel vouchers, if that's literally the only option that we have for her. The reality is that most women end up sleeping outside or they end up sleeping, staying, trading goods or services to stay in someone's apartment, regardless of it's a safe. They having to weigh the safety of staying in someone's unit or sleeping outside alone.

The impact on their eligibility for HUD housing of couch surfing is certainly something we're really conscious of and we explore that option with people every time we're working with them, but we ultimately want to ensure that people are safe and don't ever want to compel someone to stay outside and to increase their vulnerability for the sake of having access into a housing program. We will figure something else out for them.

(#02) The greatest difference I would see between survivors of sexual assault and survivors of domestic violence is the level of trust with their children in the care of others. I think one of the biggest differences with clients that have had sexual violence in their life is that they're very reluctant to put their children in any form of childcare. Very reluctant. I think that's one of the biggest barriers. So we encourage them to seek out specialized mental health treatment around their trauma because the trust level is just very different for people that have had sexual violence in their life, as opposed to domestic violence.

But often, we see with sexual assault, if it's not an ongoing relationship and it was an isolated event, although there might have been reoccurring ones, then feeling safe in public is very different. Someone might say, "You need to go get this medication," and they won't access their medication because they don't want to be alone in public. And there's a lot of withdrawal and a lot of isolation that comes with that. Accompanying people to their appointments probably occurs more with our sexual assault clients.

In terms of safety planning, with domestic violence, there's one predator, and with sexual assault, everyone is a potential predator. For the most part though, in this community, I would say 80% of the time, the sexual abuser is within the family or very connected, or it's an intimate partner relationship. So those dynamics are a little similar. In the past, when I was working exclusively with sexual assault survivors that were not Native American—it was very different. It was a lot of acquaintances.

### **Questions to Consider**

1. How might a TH program alter its approach to filling vacancies, in order to expand access for survivors of sexual assault?
2. How might the safety needs of survivors of sexual assault from different demographics vary (e.g., age, race, linguistic community, ethnic community, LGBTQ, socioeconomic class, immigration status)?
  - What challenges might such variation pose to a TH program?
  - What can a provider do to address the physical and emotional safety needs of survivors of sexual assault?
3. What are the pros and cons of operating a TH program that serves both DV survivors and S/A survivors?
  - Does the housing model -- congregate versus clustered versus scattered-site -- make a difference in how well a TH program can serve a mix of survivors from these two different OVW constituencies? Explain.
  - Is there a compelling reason for creating a program that specifically focuses on S/A survivors?
4. How important to the healing process from sexual assault is peer support? Can DV survivors and S/A survivors provide each other with the peer support they each need?
5. What can program staff do to help ensure that survivors of prostitution or trafficking are not subjected to judgments by other survivors of domestic or sexual violence that could undermine their healing?
6. Given that guests/participants in mainstream shelters and TH programs often do not disclose their history of victimization to staff in those shelters and TH programs, how can OVW-funded TH programs effectively reach out to those survivors to ensure that they know about, and have the opportunity to apply for slots in, those OVW-funded TH programs -- or -- to ensure that they know about and have the opportunity to access non-residential services for sexual assault survivors?
  - How might such outreach -- and the willingness of survivors in mainstream programs to follow up on that outreach -- be impacted, if at all, by the fact that VAWA-related data confidentiality protections do not apply to mainstream shelter and TH programs? (i.e., if they are in a mainstream shelter or TH program, their personal data has already been entered into the HMIS, and if they are in a TANF-funded family shelter, their data has probably been entered into the HMIS or a TANF data system.)
  - If the mainstream provider entered that survivor's information into their database, but the OVW-funded provider did not, how could survivor confidentiality be protected?

- If there were a way for mainstream providers to reserve slots in their TH programs and partner with OVW-funded TH providers to provide the specialized services for homeless SA survivors filling those slots, would that adequately broaden access by S/A survivors to OVW-funded TH programming?

## 4. Serving Survivors of Human Sexual Trafficking

### (a) Overview: Prevalence

There are apparently no accurate statistics<sup>17</sup> on the number of victims of sex trafficking in the United States, let alone good information about the demographics of the victims. ([Stransky & Finkelhor, 2008](#))

[Banks & Kyckelhahna \(2011\)](#), a Bureau of Justice Statistics review of suspected incidents of sexual trafficking (during 2008-2010) with reliable demographic information about the victim, reported that in 55% of the cases, the victim was a minor; in another 32%, the victim was a young adult age 18-24. That is, 87% of sexual trafficking victims identified in the data analyzed were under the age of 25.

A study by [Mitchell, Finkelhor, & Wolak \(2005\)](#) of sex trafficking cases involving minors that ended in arrests or detentions by U.S. law enforcement agencies found that 10% of the minors were 13 or younger, 33% were 14 or 15 years old, and 55% were 16 or 17. Ninety percent of these victims were girls. In 69% of these cases, the juvenile was classified as a victim; in 31% of the cases, s/he was classified as a delinquent; the older the child, the more likely they were to be seen as delinquent.

While there is a trend towards treating the trafficked person as a victim, and not as one of the perpetrators, that trend has not been uniformly adopted across the country.<sup>18</sup> As a result, in addition to the challenges of providing residential services for a class of victims who are technically unemancipated minors, providers face the challenge of reaching out to and winning the trust of young victims who fear being treated by the authorities as "offenders" if they seek help in escaping from their trafficker.

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<sup>17</sup> As of September 30, 2016, the [National Human Trafficking Hotline](#) had received 4,177 reported cases of sex trafficking; since 2007, they had received 20,778 reported cases of sex trafficking. However, reported cases are only a fraction of the total number of instances of sex trafficking.

<sup>18</sup> The executive summary of [Finklea's \(2014\)](#) report for the Congressional Research Service, [Juvenile Victims of Domestic Sex Trafficking: Juvenile Justice Issues](#), explains the barrier posed by state laws that treat trafficked minors as offenders:

*"Under the Victims of Trafficking and Violence Protection Act of 2000 (TVPA; P.L. 106-386) ... sex trafficking of children is a federal crime; moreover, an individual under the age of 18 who is involved in commercial sex activities is considered a victim of these crimes. Despite this, at the state and local levels, juvenile victims of sex trafficking may at times be treated as criminals or juvenile delinquents rather than victims of crime. . . .*

*A number of factors may, alone or in combination, contribute to the criminalization of juvenile trafficking victims. One is a lack of victim identification and an awareness of key indicators that may help in identifying victims. Even in states that statutorily consider juveniles involved in commercial sex to be victims, law enforcement may not have received sufficient training to be able to identify victims. Another factor is a lack of secure shelters and specialized services for victims; despite knowing that the juvenile is a victim, law enforcement may charge the individual with a crime so as to place the victim into one of the only available safe and secure environments—a detention facility within the juvenile justice system. . . .*

*Because the federal government considers juveniles involved in prostitution as victims of trafficking, and because much of the policing to combat prostitution and sex trafficking—both of adults and children—happens at the state level, federal policy makers have considered how to influence states' treatment of trafficking victims (particularly minors) such that state policies are more in line with those of the federal government. Financial incentives from federal grants and victim compensation funds could be provided through a variety of avenues. These routes include TVPA-authorized grants, juvenile and criminal justice grants, Violence Against Women Act (VAWA; P.L. 113-4)-authorized grants, and the Crime Victims Fund."*

## **(b) Overview: Needs**

A 2007 report for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services recommended population-specific residential programs to serve juvenile victims of sexual trafficking (and as noted below, two leading programs employ trafficking survivors as integral members of the program staff). ([Clawson & Goldblatt Grace, 2007](#))

One provider we interviewed argued that operating a residential program serving juvenile survivors of sex trafficking would require a higher level of staffing and a different kind of licensure in most states than standard TH programs for adult survivors of domestic violence or sexual assault; and that the only model appropriate for serving juveniles would be a congregate residence with sufficient security to protect participants from the traffickers they had fled.

Only one of the providers we interviewed specialized in serving survivors of sexual trafficking. Although that provider did not think that it was essential for survivors of trafficking to receive residential services in a program reserved for people who have been in "The Life," she did think it was essential for the program to be staffed and supported by people who understand what trafficking is about, how people get into The Life, and the challenges of leaving it. A study and 2009 report commissioned by the Office of the Assistant Secretary of Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services similarly observed that,

*"The appropriateness of services also extends to examining the culture of the environment in which the service is offered. For example, service providers noted that providing services to victims [of sexual trafficking] who were living in shelters could be difficult and some environments could result in re-victimization. In particular, providers shared examples of sex trafficking clients being placed in domestic violence shelters and then facing humiliation and isolation. For international sex trafficking victims, the isolation was usually attributed by service providers to language barriers and cultural differences. But for domestic victims of sex trafficking, the humiliation and isolation, according to service providers and some victims, was attributed to perceptions that domestic victims [of sexual trafficking] were prostitutes or willing participants, rather than victims of abuse and crimes. These misperceptions reflected yet again a general lack of understanding and knowledge of human trafficking, not only among service providers but also in the general public."* ([Clawson et al., 2009](#), Sec. 5.2)

The summary of needs of sexual trafficking victims by [Clawson & Dutch, 2008b](#)) and challenges facing providers that serve those victims includes all the needs and challenges discussed by providers interviewed for this project who serve survivors of domestic and sexual violence -- and more. Providers serving survivors of sex trafficking must place a heavier emphasis on safety and security, given the threat posed by traffickers seeking to recover their valuable chattel, and must be prepared to address survivors' feelings of shame and humiliation, of denigration by law enforcement and the general public, and of being treated as less deserving of sympathy or support than other survivors, if they've shared a residential program:

*"When service providers and law enforcement personnel were asked to describe the needs of victims of human trafficking, a common response was, "What don't they need?" The safety needs of victims were identified as the first priority by all of those working with victims. According to law enforcement and providers, screening for safety needs (for both the victims and providers) is part of every assessment they conduct. Safety needs are often met when the next priority need for (safe) emergency housing is addressed. Other emergency needs include food and clothing and, for international victims, translation services to avoid feelings of isolation and to facilitate communication regarding other needs.*

*Once emergency needs are met, other needs ... include housing (transitional and permanent for adults, and foster care or permanent placement for minors), legal assistance (e.g., help in understanding legal rights, legal representation and, for international victims, assistance with filing T-visa applications, and immigration petitions), and advocacy (e.g., assistance retrieving identification documents, completing*

*applications, attending appointments, and navigating the different U.S. systems, including criminal justice, child welfare, immigration, human services, transportation, etc.).*

*Additionally, service providers and law enforcement note that most victims also need health screening (tuberculosis, sexually transmitted diseases, pregnancy), vaccinations/immunizations, medical treatment for physical injuries, and dental care. Other service needs include child care (for both adults and minors with children), education (GED assistance, enrollment in school, technical training/certification), life skills training (including assisting some international victims with operation of basic household appliances, using public transportation, using a telephone, mailing a letter, etc.), job training, finding employment, financial management, and where appropriate, family reunification or repatriation.*

*In addition to the above service needs, service providers report that all victims of trafficking have some type of mental health need. Specifically, service providers indicated that as a result of the trauma experienced, victims need trauma counseling and for domestic minor victims in particular, they often need anger management, conflict resolution, and family counseling.*

*While the needs are relatively similar regardless of whether someone is an international or domestic victim, adult or minor, one point is clear—the magnitude of these needs varies for each victim depending on his or her circumstances. For example ... while obtaining identification documents (e.g., passports, birth certificates, drivers licenses) is reported to be an important need for all victims in order to access services, it is especially important for international victims to have some form of identification or legal documentation on hand. One service provider told of an incident where a client was removed from public transportation and placed in detention because the client did not have any identification on his/her person and had not yet received his/her certification letter indicating he/she was a victim of human trafficking.*

*... International victims, often in the U.S. illegally, have more complex legal needs [than domestic victims] usually related to their immigration status. This includes needing representation at deportation hearings, assistance with applications for T visas and derivative visas, and renewal applications.<sup>19</sup>*

*While it is not necessarily unique to domestic victims, service providers report that domestic victims often present with serious substance abuse issues. Some providers report that while international victims also need assistance with similar problems, they are less likely to admit they have a problem out of shame, fear of stigma, or denial that their substance abuse constitutes a problem. In some cases, the service providers do not want to indicate this as a need of international victims for fear access to treatment records will be subpoenaed and used against the victim in a legal case (criminal, civil, or immigration).*

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<sup>19</sup> As described on the webpage of the [Immigration Center for Women and Children](#), the Victims of Trafficking and Violence Protection Act of 2000 created two categories of non-immigrant visas -- U Visa for victims of certain crimes (including, but not limited to rape, sexual assault, domestic violence, and trafficking) 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 will likely be helpful in investigating or prosecuting the criminal activity. (See the U.S. Department of Homeland Security's "[U Visa Law Enforcement Certification Resource Guide for Federal, State, Local, Tribal and Territorial Law Enforcement](#).")

To receive a T Visa, a survivor must document that she is a victim of "severe forms of trafficking" and must be willing to assist with the investigation and prosecution of trafficking cases over a three-year period. A U.S. Department of Health and Human Services (HHS) [fact sheet](#) states that "The certification process typically takes only a few days after HHS is notified that a person has made a bona fide T visa application or has been granted continued presence status (both of these actions are done by the U.S. Department of Homeland Security)."

Also per the fact sheet, "A recipient of a T visa, after three years, may be eligible for permanent residence status if he/she [is] a person of good moral character; [has] complied with any reasonable request for assistance in the investigation during the three-year period; [and will] suffer extreme hardship if [deported]." The [Immigration Center](#) website indicates that for a T Visa, documented cooperation is helpful, but not required, especially if a victim is under 18.

*Regardless of the victim, law enforcement and service providers stress that it is not so much the type of needs that vary by victim, but the duration of services required to address those needs and the level of difficulty obtaining such services." (excerpted from the beginning of Part 2 of the Report)*

In another report from the ASPE-sponsored series, "Study of HHS Programs Serving Human Trafficking Victims," [Clawson & Goldblatt Grace, 2007](#) cited apparently broad consensus among providers that,

*"Programs for domestically sex-trafficked girls must be run by individuals who live and breathe trafficking in contrast to administrators lacking that expertise and specialization. Because domestically sex-trafficked girls have been exploited primarily by males, programs believe it is important to begin their recovery in an all-female environment and therefore advocate for hiring only female staff.... However, some providers advocate[d] for the appropriate use of male staff to demonstrate the possibility of a relationship with a male that is non-exploitative. As described by providers, it is of primary importance that staff truly understand minor victims of domestic sex trafficking and the impact of their life experience." (excerpted from Section 3)*

The authors further observed that,

*"This need to hire staff with an authentic understanding of The Life and a natural ability to connect with domestically sex-trafficked girls has led [some providers, like] [SAGE \[Standing Against Global Exploitation, SF, which went disbanded in 2015\]](#) and [GEMS \[Girls Education and mentoring Services, NY\]](#) [to] prioritize hiring women who were sexually exploited, including minor victims of domestic sex trafficking [who] have successfully exited The Life. SAGE explains the rationale for using a peer support model as follows: Clinicians spend 75% of their time establishing trust, while peers can start from a place of trust. One provider remarked that someone who has exited can convey hope in a way those of us who haven't been there cannot, while another commented that survivors show that people can survive and pull themselves out. Among the benefits of survivor mentoring is that hearing the life story of someone who has been trafficked for sex often paves the way for girls to open up.*

*Regardless of whether a program employs survivors or not, it is important for all staff to be well trained to understand sexual exploitation, the realities of prostitution and sex trafficking, the methods of recruitment, the physical/psychological/spiritual impact of the trauma, potential methods for exit, an overview of youth development programming, and appropriate boundaries and healthy working relationships." (excerpted from Section 3)*

The National Sexual Violence Resource Center's publication, "[Assisting Trafficking Victims: A Guide for Victim Advocates](#)" provides background information on trafficking and the difference between prostitution and trafficking, tips for advocates on how to identify a trafficking victim, recommendations on the role of victim advocates, strategies for communicating with trafficking victims, an overview of the range of potential needs (e.g., housing, medical care, material assistance, counseling and information, immigration assistance, legal assistance, employment, education/training, etc.), online resources to support the efforts of victim advocates, and reference materials. The Guide for Victim Advocates is part of an [Assisting Trafficking Victims Information Packet](#), published in 2012, which also includes an [Annotated Bibliography](#), a [Technical Assistance Bulletin](#), an [Overview](#), a [Research Brief](#), and a [Resource List](#).

A Transitional Housing Toolkit for Anti-trafficking Service Providers<sup>20</sup> (hereinafter, [Alimchandani & Lemma, 2006](#)) offers an interesting and detailed overview of the planning and process of creating a transitional housing program from scratch. An effort by Project Hope International which followed that approach was aborted when a property they were in the process of acquiring for program housing experienced flooding that revealed some structural problems.

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<sup>20</sup> The [Transitional Housing Toolkit](#) was developed as a Masters project by graduate students at the Kennedy School of Government at Harvard University for Project Hope International.

### **(c) Trafficking-Related Resources**

#### ***(i) [U.S. Office on Trafficking in Persons](#) (in the U.S. Department of Health and Human Services)***

The U.S. Office on Trafficking in Persons, in the Administration for Children and Families (ACF), in the U.S. Department of Health and Human Services (HHS) maintains a [website](#) with links to:

- [Services Available to Victims of Human Trafficking: A Resource Guide for Social Service Providers](#), providing information about community and government-funded resources for assisting survivors of human trafficking (not exclusively survivors of sex trafficking), including food, shelter, clothing, medical care, legal assistance, and job training. As described on the website, "the booklet outlines the types of Federal benefits and services available to trafficking victims in various immigration categories. Included in the guide is a chart for each Federal program that describes eligibility information for certified adults, children with letters of eligibility, lawful permanent residents, U.S. citizens, and others."

The guide also provides information (and links to relevant webpages) on how a foreign national trafficking victim can obtain a [Certification Letter](#) (allowing adult victims of trafficking who are not U.S. citizens or Lawful Permanent Residents (LPRs) to be eligible to receive the same type of federal and state benefits and services as a refugee) or [Eligibility Letter](#) (allowing children who have been trafficked, but who are not in the country legally to become eligible for federally-funded benefits and services that would not be available without a legal immigration status) from the HHS Office of Refugee Resettlement.

- [Fact Sheet on Assistance for Child Victims of Human Trafficking](#), providing definitions, reporting guidelines, and instructions for requesting assistance on behalf of a child victim.
- [National Human Trafficking Resource Center \(NHTRC\)](#) webpage. The NHTRC is a toll-free, national hotline (call 888-373-7888 or email [nhtrc@polarisproject.org](mailto:nhtrc@polarisproject.org)) "provid[ing] urgent assistance 24 hours a day, every day of the year. The purpose of the NHTRC is to increase the identification and protection of human trafficking victims in the United States by providing callers with a range of services, including crisis intervention; urgent and non-urgent service referrals; tip reporting to appropriate local, State, or Federal law enforcement authorities; and comprehensive resources, training, and technical assistance for the human trafficking field and those who wish to get involved."

#### ***(ii) Resources for applying for a T Visa, U Visa, and VAWA Visa***

- U.S. Department of Homeland Security / U.S. Citizenship and Immigration Services (website) [Victims of Human Trafficking: T Nonimmigrant Status](#) - An explanation of T Visa eligibility, how to apply for it, an FAQ, and supporting resources.
- U.S. Department of Homeland Security / U.S. Citizenship and Immigration Services (website) [Battered Spouse, Children, and Parents](#) - An explanation of the VAWA Self-Petition eligibility, how to apply for it, an FAQ, and supporting resources.
- U.S. Department of Homeland Security (n.d.) [U Visa Law Enforcement Certification Resource Guide for Federal, State, Local, Tribal and Territorial Law Enforcement](#) - A comprehensive guide to eligibility and the process of applying for a U-Visa, and supporting resources.
- [WomensLaw Immigration Law webpages](#) providing user-friendly information on eligibility and the process of applying for:
  - a **T-Visa** (for noncitizen survivors of human trafficking);
  - a **U-Visa** (for immigrant victims of crime -- including domestic violence, rape, trafficking, incest, sexual assault and abusive sexual contact, prostitution and sexual exploitation, stalking, female genital mutilation, involuntary servitude, etc. -- who are or will be helpful in the investigation or prosecution of the crime);

- a **VAWA Visa** (for spouses, children, and parents that have been abused by US citizens or legal permanent residents);
- **Refugee status** (for immigrants *living outside the U.S.* who are afraid to return to their home country due to a fear of persecution, mistreatment, or abuse); or
- **Asylee status** (for immigrants *living in the U.S.* who are afraid to return to their home country due to a fear of persecution, mistreatment, or abuse).

**(iii) [Study of HHS Programs Serving Human Trafficking Victims](#) (Clawson, n.d.)**

A comprehensive series of reports on human trafficking funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office of Refugee Resettlement (ORR), and U.S. Department of Health & Human Services, and resulting in the following publications, as described on the [project website](#):

- **Medical Treatment of Victims of Sexual Assault and Domestic Violence and Its Applicability to Victims of Human Trafficking** ([Williamson, Dutch, & Clawson, 2010a](#)) - Examines the procedures and protocols that currently exist for assessing and treating victims of domestic violence and sexual assault in health care settings in an effort to begin evaluating their applicability to victims of human trafficking. This topic was identified at the National Symposium on the Health Needs of Human Trafficking Victims.
- **Evidence-Based Mental Health Treatment for Victims of Human Trafficking** ([Williamson, Dutch, & Clawson, 2010](#)) - Examines the evidence-based research for treating common mental health conditions experienced by victims of human trafficking. This topic was identified at the National Symposium on the Health Needs of Human Trafficking Victims.
- **Study of HHS Programs Serving Human Trafficking Victims, Final Report** ([Clawson et al., 2009](#)) - This is the final report produced under this project and includes an executive summary at the beginning of the report. The report summarizes and synthesizes all of the information obtained under the literature review, the site visits, and the National Symposium on the Health Needs of Human Trafficking Victims, and draws upon the issue briefs produced under this project.
- **Human Trafficking Into and Within the United States: A Review of the Literature** ([Clawson et al., 2009a](#)) - A "comprehensive review of current literature on human trafficking into and within the United States [focusing on] what the social science or other literature has found about the issues of identifying and effectively serving trafficking victims. A more specific focus concerns the phenomenon of "domestic trafficking" (trafficking involving U.S. citizens or lawful permanent residents, often within the U.S.), the impact on domestic youth, and the availability and/or effectiveness of services for these victims."
- **National Symposium on the Health Needs of Human Trafficking Victims, Post-Symposium Brief** ([Williamson, Dutch, & Clawson, 2009b](#)) - "Overview of the major topics discussed at the National Symposium on the Health Needs of Human Trafficking Victims sponsored by ASPE and held in Washington, DC, September 22-23, 2008. The brief focuses on the post-presentation discussions and suggestions of participants. The Brief contains links to the Symposium materials."
- **Addressing the Needs of Victims of Human Trafficking: Challenges, Barriers, and Promising Practices** ([Clawson & Dutch, 2008b](#)) - "Focuses on the needs of victims of human trafficking and the services available to meet those needs; ... discusses challenges and barriers to providing services to victims, international and domestic, adults and minors; and highlights innovative solutions to these challenges and promising practices to overcome barriers."
- **Case Management and the Victim of Human Trafficking: A Critical Service For Client Success** ([Clawson & Dutch, 2008a](#)) - "Focuses on the importance of case management in working with international victims of human trafficking from the point of identification until a victim reaches self-sufficiency. This brief looks at the characteristics of an effective case manager along with the benefits not only to victims, but also other

key stakeholders, including law enforcement and service providers. This brief also examines the challenges to effective case management and the implications for victim recovery."

- ***Treating the Hidden Wounds: Trauma Treatment and Mental Health Recovery for Victims of Human Trafficking*** ([Clawson, Salomon, & Goldblatt-Grace, 2008](#)) - "Focuses on the trauma experienced by most trafficking victims, its impact on health and well-being, some of the challenges to meeting trauma-related needs of trafficking victims, and promising approaches to treatment and recovery. While this issue brief touches on trauma across human trafficking populations, it has a special emphasis on trauma resulting from sex trafficking of women and girls."
- ***Identifying Victims of Human Trafficking: Inherent Challenges and Promising Strategies from the Field*** ([Clawson & Dutch, 2008](#)) - "Focuses on the identification of international and domestic victims of human trafficking in the United States. Critical to identifying someone as a victim is knowing first who meets the legal definition of a trafficking victim. This brief presents the inherent challenges to identifying victims based on the legal definition, as well as promising strategies undertaken by law enforcement, service providers, and other organizations to identify and reach victims."
- ***Finding a Path to Recovery: Residential Facilities for Minor Victims of Domestic Sex Trafficking*** ([Clawson & Goldblatt Grace, 2007](#)) - "Focuses on minors who are victimized by sex traffickers across the U.S.; ... provide[s] practical information about the characteristics and needs of these minors; and describe[s] the type of residential programs and facilities currently providing services for this population. The promising practices discussed here were identified by directors and staff of residential facilities housing and serving minor victims of domestic trafficking, juvenile corrections facilities, programs for runaway and homeless youth, child protective services personnel, and law enforcement."

**(iv) National Children's Advocacy Center NCAC / Child Abuse Library Online (CALiO)**

- [NCAC bibliography of the professional research regarding trafficking of minors](#) - click on the link in the middle of the page for "Trafficking and Commercial Exploitation of Minors"
- The [Child Abuse Library Online \(CALiO\)](#) provides access to national and international research on human trafficking and sex trafficking of minors. In the "Browse by Topic" section of the webpage, click on "Minor Sex Trafficking."
- NCAC provides free access to its [online library of recorded webinars and trainings](#); resources pertaining to trafficking include:
  - The Commercial Sexual Exploitation of Children: Identification, Intervention, and Collaboration
  - Healthcare Needs of the Child Victim of Commercial Sexual Exploitation
  - Intervene: Identifying and Responding to America's Prostituted Youth
  - Commercial Sexual Exploitation of Children 101

**(v) Asian Pacific Institute on Gender-Based Violence (API-GBV)**

The APIGBV maintains a [webpage on Trafficking](#) with extensive resources, including:

- A [Resource Guide](#) (updated in 2014) providing contact information for federal agencies providing trafficking related services, non-governmental organizations (NGOs) providing trafficking-specific services, and government and non-profit organizations providing health services, legal services, interpretation/translating, and services specifically targeting children who have been trafficked.
- A PowerPoint presentation on [Family Controlled Trafficking](#)
- [Trafficking: Considerations & Recommendations for Battered Women's Advocates](#) ([Dabby F.C., 2013](#)), a guide for advocates who intervene on behalf of trafficking victims who have been arrested, who need

legal representation, who are in ongoing danger from their traffickers, who need shelter, who need medical care, and/or who suffer from complex trauma.

- [Health Issues Affecting Trafficked Individuals](#) (2008), a brief looking at the health and trauma-related problems facing trafficking victims and the challenges accessing needed care.

**(vi) National Indigenous Women's Resource Center (NIWRC) / Minnesota Indian Women Sexual Assault Coalition (MIWSAC)**

- **Shattered Hearts: The Commercial Sexual Exploitation Of American Indian Women And Girls In Minnesota** ([Minnesota American Indian Women's Resource Center \(MIWRC\), 2009](#)) - a high impact study of the devastating effect that prostitution and the sex trade is having on Native women and girls in Minnesota, and by extension, other poor Native communities. (1) Historical context of generational trauma (four centuries of exploitation, victimization, and efforts to eradicate Native culture); (2) Demographics, levels, patterns, and impacts of involvement in prostitution and the sex trades; (3) Barriers to exiting prostitution and the sex trades; (4) Conclusions and recommendations.
- **Garden of Truth: The Prostitution and Trafficking of Native Women In Minnesota** ([Farley et al., 2011](#)) - a chilling study of the human impact of prostitution and the sex trade on Native women in Minnesota, informed by detailed interviews of 105 women in prostitution. The report details the physical and sexual abuse as a child; the physical and sexual assaults as a prostitute; the resulting physical injuries, traumatic brain injuries, PTSD, and mental health conditions; the racism inherent in the prostitution of Native women; the overwhelming (92% of women) desire to get out of the business, and the many needs that must be addressed if these women are to successfully escape prostitution and trafficking: housing, counseling, skills to earn a living, health care, substance abuse treatment, legal assistance, childcare, etc.
- **Sex Trafficking of Native Women / LGBT and Two-Spirit Youth / Minnesota Trafficking Studies** ([Brunner, Stark, & Pierce, 2015](#))- slides from a presentation addressing three interrelated topics: (1) Historical context leading to present day high levels of domestic violence and sexual assault of native women, traditional trauma-informed approaches to supporting victims. (2) Victimization and impact of human sexual trafficking of LGBT and Two-Spirit youth (Native and non-Native focus). (3) Minnesota studies of impact of human sexual trafficking of Native women.
- **Trafficking and Prostitution: What Tribal Leaders, Advocates, and Service Providers Need to Know to Develop a Tribal Response** ([Julian & Watson, 2015](#)): slides from a presentation addressing the similarities and differences of battering, prostitution, trafficking and their impact on the victim, and how the Native American community can respond. (slide on p12)

**(vii) Michigan Coalition to End Domestic & Sexual Violence (MCEDSV)**

The MCEDSV website provides access to the three-part series "[Supporting Survivors of Human Trafficking Webinar Series](#)"

- Webinar 1: What is Human Trafficking and How Common is it in Michigan? (11/3/2015): (a) What is human trafficking? (b) What we know about human trafficking in Michigan? (c) Overlaps between human trafficking, domestic violence, sexual assault and stalking
- Webinar 2: Best Practices in Assessing for Human Trafficking (12/1/2015): (a) Assessing for human trafficking and collaborating with the clinic; (b) State of the movement; (c) Important role of DV/SA advocates in this movement
- Webinar 3: Primary Legal Issues Related to Working with Survivors of Human Trafficking (2/2/2016): (a) Immigration Law; (b) Working with minors; (c) Victim - witness advocacy

#### **(d) Provider Comments**

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

**Note:** Only a handful of TH programs commented on their experience serving survivors of human sexual trafficking, and only one program specifically targeted that population. Their comments follow.

(#01) We serve all of the OVW constituencies, and also survivors of human trafficking. We have a human trafficking committee in the agency and for the last few years we've done staff training on human trafficking. And we have developed better skills in assessing for human trafficking - on our hotlines, in our shelter, in our counseling program, and in transitional housing. We recognize that we have had victims who have come to us as DV and/or sexual assault victims who were also victims of human trafficking, either present or past.

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(#02) We've struggled in this state to identify and keep victims of human trafficking safe. And long-term transitional housing seems to be a huge need. But we do have this agency that's traveled across the state to help, and they've actually placed two of their survivors into our transitional housing program.

Survivors of trafficking have unique safety needs. We had someone in an apartment and she was surrounded by her traffickers. We tried to figure out how to get her out of there safely; because if she leaves, she's still at risk because her traffickers want her back. While the woman is safe with us, the trafficker is "losing" money. And they're local traffickers, local victims, so even though this is a relatively large city, it feels like a small town. And it's difficult for them to find safety, especially if they're from this area.

We used other grant funds, not transitional housing, to help one victim to relocate out-of-state. And we transported, through our rural advocates, another victim from one side of the state to the other.

If they are fleeing their trafficker, our shelter will take them in as homeless, and then we can serve them. If they're staying in a shelter and/or are couch surfing or staying with friends, we can treat them as homeless. The challenge is they don't necessarily see themselves as victims or as homeless. If it's more about coercion and control than physical or sexual abuse, it's harder for them to see themselves as victims of violence.

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(#03) Our transitional program serves victims/survivors of domestic violence, sexual assault, stalking and trafficking. The overall numbers of domestic violence and sexual assault cases are going up, as well as the numbers of girls and young women caught up in trafficking. A good number of the women being trafficked are from a Native American reservation near the drilling area. Many of these young women don't see themselves as victims until later on. I think one of the biggest challenges is their safety. It's really hard for them to consider independent housing in the community when their pimps are out looking for them; they're afraid of the punishment they'll face for having left, of being forced back, and of not having a real alternative.

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(#04) There is so much trauma that goes with sex trafficking, and having a safe place where someone can come right from the streets, straight into the house, and start that process of healing, whether it's sleeping, starting therapy, or just having a safe place to lay your head and lock the door, is a real critical to our women. We know that the women here who have been in the lifestyle for a long time have endured physical and emotional pain.

For example, one of our women pretty much came from the street. We brought her in and she must have slept for at least for three or four days. She slept with her door open, because closing or locking the door can be a trigger for people, especially when you've never been able to unlock your own door or someone is holding you captive. If a woman is leaving a pimp or leaving a trick and that person has pretty much controlled them, then taking a shower with the door closed probably hasn't happened. Locking the bedroom door, because she feels safe by herself in there probably hasn't happened. Being able to walk through the house

without someone wanting to know her every move probably hasn't happened. Going to the grocery store with our advocate and spend her own money on the food that she wants to buy probably hasn't happened.

Many of these women are very savvy on survival skills, but they don't have the life skills to manage an apartment. So having this house is very critical to our support, creating a safe place for them, and then teaching them basic life skills. We have some younger survivors and some women who are older; I think the needs are similar, but not the same. They're both coming right off the street, they're both in that same vulnerable state. But one may progress quicker simply because she's older and more experienced, and began her life on the street at a later age, and the other one might be just as street savvy, but she might have been running in the street for years, and is developmentally much younger.

It's a matter of where the individual is when they come to us, so we offer different programming to each person. We have all the survivors that come through our housing participate in a 14-week, intensive group that examines sex trafficking as a slave-based system, the impact it has on victims' lives, and issues related to addiction and recovery for the women and girls who have experienced sex trafficking, prostitution, and/or sexual exploitation. In that group, we break it down by age, so our younger people would sit with the older people for a little while and then they'd break into their own age groups, under 24 and over 24, and have their own group and then come back together.

Right now, we've got someone with pretty severe PTSD from the lifestyle and she's very, very fearful so we're working with her very slowly, gaining trust, talking, trying to understand, and she's trying to understand us. We have another gal who's been in the life, came out of the life, been in the life, and now is out of the life, who is a lot more vocal about her needs and wants, so we have to meet her where she's at in the process. Our 18-year-old might not even know what's going on in that house because she's in school all day, coming home to eat dinner. She's on probation and has a probation officer, and also has visitation with her family on Sundays. It's just all very different according to what their needs are.

Age makes a difference in our approach. Our older survivors like knowing that someone's there for them, like being able to go to that person for support, but they also like knowing that they're there on their own terms. With the younger youth, we need to be there whether it's their terms or not, because they'd run the place if we weren't in there running it for them. They've been in such trying and turbulent situations, and the only thing that's really gotten them through is their own strength, so now they're bringing all that "I took care of myself" stuff to the table and it takes a while for them to trust that they don't need that here.

I find that a lot of people don't know about sex trafficking, or they think there's a simple fix, like "maybe you were in the wrong place at the wrong time," but that's not the case. There is a lot of trauma and a lot of abuse that has been endured and often, the youth don't come forth and tell you everything that happened to them because they don't trust you and they don't know whether you're going to be there tomorrow to help them.

A lot of the young women haven't shared their situation with their parents because they don't want to disappoint them or they're afraid of the consequences, so we had to work with that. I do have to get parental consent for all of the young ladies who come in to our residence for minors. Under the requirements of our state license, we had to make every attempt to contact the parent. If the dad is the pimp, I don't want to call him, because I don't want him to know where this girl is. If a teen left home because of physical or sexual abuse or intolerance of their sexuality, I'm not sure what I'd say: that's a question for our outreach workers.

There is a lot of fear with our younger trafficking survivors about coming to these programs. One, they're worried who's going to find out and will something happen to them legally; two, they're just worried about their safety in general; and three, if they're fleeing a pimp, they're very worried about that because that pimp knows everything about them, so there is a lot of fear about that. If a pimp really knew their routine or knew where they went to school or that they'd be at this place at this time, I'm pretty sure they'd try to go and take her from that location. I think you have to be safe all the time because you just don't know. In our youth house, that was our concern right up front. We had a very high-tech camera and buzzer system with infra-red sensors -- for both the girls' safety and the staff's safety -- kind of to say, "We've got you."

Relationship building with a young trafficking survivor takes a long time. I've had someone in one of our sites for 97 days and she's just starting to tell me stuff, so it took her a long time to trust that we would allow her to be her, we'd be there for her. We take her to and from school, serve her dinner, hang out with her, and check on her grades. We do a lot of surface stuff but she only recently started opening up and talking to us.

I don't think I can express enough how important the relationship building is. How incredibly important that you say you're going to do this and then you do it. And how that just creates this beautiful effect on people, and then how that gains trust, and how that starts to help with outcomes. The community needs to expect that every time they come to you, you'll provide the service you say you're going to provide. I do not allow the staff to say, "maybe" to anybody, because gray areas are how we wind up in situations we shouldn't be in. Either your "yes" is "yes" or your "no" is "no," and if you don't know, then you say you don't know, and then we work together to figure out the solution or a compromise or something.

If you keep coming to me and I keep providing you with the same me every time, so you know who I am, that's what works. I'm always truthful and I always hold my transparency, because that's what's helped me be successful in direct service. I am not a survivor and if a client asks me, I will say "no, I'm not a survivor so I can't say I've walked your lifestyle, but I want you to know that I care about you and care about what has happened to you and I want you to know that I'm here to support you." So being very transparent.

A lot of that is removing your own expectations and allowing the client to have their expectations and just meeting them where they are. I can't change any of that, so I'm going to meet you where you're at because that's how I can be the most supportive. Now, am I not going to verbalize to you that I believe that what you're doing could be of potential harm? Of course I am. I need to do that, because that's why you're sitting in front of me. But I also need to support you where you're at.

Because if someone's saying, "I'm having a really hard time making money. I'm going to go back to prostitution," I can't tell them "no" but I can't tell them "yes" either. What I can do is listen. I can ask non-judgmental questions, "Why do you feel like that's your best option?" I can break that down to really figure out what's going on. What I won't say is, "No, don't do that. You're going to lose housing. You're going to lose this or that." I'm just going to meet you where you're at, allow you to say what you need to say, but let's break that down to figure out really what you're asking for or what your need is.

Now, I may be 100% against prostitution but I work in a community where that's how the ladies are getting to us. I can't bring that into work if that's what I truly believe. It's all about that relationship building, all day.

And this is about not just relationship building in the house but getting out to community members, and going over to the police department and just talking to them, letting them know what's happening and inviting them to come have lunch with us or come to a house meeting and meet our girls. They're fearful of you, but I want them to see that you're okay and you're here to support us, and maybe stepping outside of what you're most comfortable with to engage other people in what they're not comfortable with. So we can all work better together and have better outcomes.

A lot of women believe in a higher being. We might be able to bring it back to that. If your higher being doesn't have an expectation of you and you're going to truly do the best you can with the resources or the know-how you have today, that's all you can do today. But let's try to improve tomorrow, maybe learning more, knowing more, taking care of ourselves differently. It's being present like that that is so critical.

We use a voluntary participation model; however, for safety reasons, we do require participants to sign in and out; to give us their calendar for the week, so that we know where they're at; and if they want to go for an overnight, to let us know where they're going; and if they're going to be gone more than that, to call us every day to check in. If someone comes back with a black eye, we might just say we're not going to let you go out again before we have a conversation about what happened and why it happened and what safety nets we need to provide for you.

And 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 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.

I've thought a lot about whether survivors of trafficking need their own program or whether they can be served in shelters or transitional housing programs that serve survivors of DV or sexual assault. My personal opinion is that survivors of trafficking can be served in the basic shelter system but I think there needs to be an expert within that system that they get referred to quickly. So you leverage that expert assistance, but meanwhile, you're providing that safe place.

### **Questions to Consider**

1. Given the huge variation in age and background of victims of trafficking -- including survivors who have been in The Life since their young adolescence, survivors who have years of trauma to heal from, survivors who are still in their teens, survivors who are in their 20s or 30s, international survivors who were brought to the U.S. and have no community here -- what kind of flexibility do programs need with respect to length of stay, types of supports, and eligible spending categories?
  - Can all survivors be expected to move on to stable housing within the usual time limits?
  - If not, what provisions need to be made for survivors who are not ready to move on?
2. There is sometimes debate about the difference between prostitution and human trafficking, and so, who should be served by programs to address trafficking and/or sexual assault. The National Sexual Violence Resource Center's publication, "[Assisting Trafficking Victims: A Guide for Victim Advocates](#)" cites an unpublished manuscript from Krista Hoffman, a criminal justice training specialist with the Pennsylvania Coalition Against Rape which suggested that
  - (a) "**Prostitution** ONLY involves **adults** doing sexual acts, erotic dance, or having pornographic images/videos taken of them in exchange for anything of value, including money, food, shelter, protection, being given to the adult."
  - (b) "**Sex Trafficking** includes ANY [situation in which] **adults** are compelled through mental/physical force, fraud, or coercion to do sexual acts, erotic dance, or have pornographic images/videos taken of them in exchange for anything of value, including money, food, shelter, protection, being given to the adult or a third party."
  - (c) "**Sex Trafficking** includes ANY [situation in which] **minors** are involved with sex acts, erotic dance, or having pornographic images / videos taken of them in exchange for anything of value, including money, food, shelter protection, being given to the minor or a third party." (p.5)
  - To what extent, if any, should a program that serves survivors of sexual assault and trafficking exclude women (or men) who seek to leave behind their work as prostitutes?
  - Can survivors of prostitution and sex trafficking be served in the same program?
  - Can survivors of prostitution or sex trafficking be served in the same program as survivors of domestic violence or sexual assault?

## **5. 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.
- [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 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 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 clientele 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.

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")<sup>21</sup> that would be collected in each interview, we defined four distinct sets of topics<sup>22</sup> that would be

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<sup>21</sup> **"Universal" Topics:** Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary versus transition-in-place; congregate versus clustered versus scattered-site; provider-owned versus provider-leased versus 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 versus 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.

<sup>22</sup> **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).

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.**

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<sup>23</sup> 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.

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**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 versus 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).

<sup>23</sup> 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.

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<sup>24</sup> 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 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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<sup>24</sup> Several codes were consolidated as the coding process evolved.

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