

National Center on Domestic Violence, Trauma & Mental Health

Multi-Site Initiative Report: Building Capacity to Support Survivors Who Experience Trauma-Related Mental Health and Substance Abuse Needs

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NCDVTMH MULTI-SITE INITIATIVE REPORT: BUILDING CAPACITY TO SUPPORT SURVIVORS WHO EXPERIENCE TRAUMA- RELATED MENTAL HEALTH AND SUBSTANCE ABUSE NEEDS

I. HISTORY & PURPOSE OF THE PROJECT

Domestic violence (DV) can have significant mental health and substance abuse consequences. Many of the women and children served by domestic violence programs experience these trauma-related effects. Across studies, over 50% of survivors in a range of settings experience the mental health and substance abuse-related effects of domestic violence and other trauma, most commonly depression and posttraumatic stress disorder (PTSD).¹ Historically, however, these issues had not been addressed due to concerns about the ways that survivors have been pathologized and the ways that these issues are used against them by their abusive partners and by the systems where they seek help.

Since 1999, the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)² has been working to build the capacity of the domestic violence and other fields to support survivors who are experiencing trauma-related mental health and substance abuse needs and their children. This work has included raising awareness about these issues, promoting dialogue and supporting internal capacity building among domestic violence coalitions and programs as well as other systems, and fostering cross-sector collaboration.

In 2005, NCDVTMH was designated as a national training and technical assistance center by the U.S. Department of Health & Human Services; Administration on Children, Youth and Families; Family Violence Prevention and Services Program (FVPSP). During its first three-year funding cycle (2005-2008), NCDVTMH conducted several local and national surveys, which overwhelmingly confirmed the need to engage in more in-depth, sustained capacity-

¹ Graham-Bermann, S., Sularz, A.R., Howell, K.H. (2011). Additional adverse events among women exposed to intimate partner violence: Frequency and impact. *Psychology of Violence, 1*(2), 136-149; Warshaw, C., Brashler, P., Gill, J. (2009). Mental health consequences of intimate partner violence. In C. Mitchell and D. Anglin (Eds.), *Intimate partner violence: A health based perspective*. New York: Oxford University Press; Margolin, G., & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review Psychology, 51*, 445-479; Crusto, C.A., Whitson, M.L., Walling, S.M., Feinn, R., Fiedman, S.R., Reynolds, J., Amer, M., & Kaufman, J.S. (2010). Posttraumatic stress among young urban children exposed. *Journal of Traumatic Stress, 23*(6), 716-724.

² Initially this work was done as the Chicago-based Domestic Violence & Mental Health Policy Initiative (DVMHPI), prior to the formation of the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) in 2005.

building work on these issues. NCDVTMH also formed partnerships with four state domestic violence coalitions: Connecticut, West Virginia, Pennsylvania, and Illinois. Over the course of these three years, NCDVTMH provided intensive training and technical assistance (TA) to these coalitions and their member programs.

These efforts were successful and, in the fall of 2008, NCDVTMH received federal funding to begin new partnerships with the domestic violence coalitions in Delaware, Kansas, Alabama, Idaho, and New Hampshire, and with Transformation Detroit, an urban community domestic violence collaborative. Three of the new coalitions—Alabama, Idaho, and New Hampshire—were the recipients of FVPSP-funded Open Doors to Safety grants designed to support their work in this area. In addition to beginning work with these new sites, NCDVTMH continued its partnerships with the domestic violence coalitions in Pennsylvania and West Virginia.

These eight partnerships formed the first NCDVTMH Multi-Site Initiative, which operated from 2008 to 2011.

Goals of the Initiative

The eight partners in this project shared common overarching goals: They wanted to support local domestic violence programs in building their capacity to provide fully accessible, culturally relevant, trauma-informed domestic violence advocacy services and to better serve survivors who were experiencing trauma-related mental health and substance abuse conditions and their children. Furthermore, they wanted to develop cross-disciplinary collaborations with behavioral health providers at the state and local level, in order to generate additional resources for survivors and their children, and they wanted to ensure that those resources were sensitive to both trauma and domestic violence.

This three-year effort included building organizational, community, and state-level capacity in each site as part of a multi-tiered process involving sharing knowledge; developing new skills and enhancing existing skills; and transforming organizational policies, procedures, and culture in order to strengthen the capacity of programs to deliver more comprehensive, accessible, and trauma-informed services.

In addition, the goals of NCDVTMH in facilitating this initiative included the following:

1. Facilitating a process by which sites worked on their capacity-building activities collectively as part of the larger project
2. Defining overarching as well as site-specific goals, tasks, challenges, and strategies
3. Establishing collective as well as site-specific outcomes to be evaluated by NCDVTMH's evaluator
4. Providing multiple opportunities for sites to pool knowledge and resources and learn

- from each other's experiences (through annual meetings with the eight sites, quarterly conference calls, technical assistance (TA) as needed, onsite training, planning and meeting facilitation, webinars, emails, and the NCDVTMH website)
5. Consolidating NCDVTMH's capacity building, training, and TA activities and resources into a more comprehensive approach
 6. Incorporating culturally specific outreach, models, and training
 7. Producing a report on successful strategies, lessons learned, and promising practices,³ which would offer guidance to other states on implementing a trauma-informed approach to providing domestic violence services

Summary of Accomplishments & Lessons Learned

In every site, from the most experienced to those just beginning to work on these issues, substantial progress was made during the course of the Multi-Site Initiative. End-of-grant follow-up surveys conducted in six of the eight sites provide evidence of substantial change as a result of the cumulative efforts of NCDVTMH, the Multi-Site partners, and participating pilot programs. While each site developed its own focus and mix of activities, the efforts of the sites fell primarily into the following overarching categories: At the coalition level, sites engaged in (1) cross-sector collaboration building with state-level behavioral health stakeholders and (2) internal capacity-building in order to, in turn, support member programs. At the local domestic violence program level, pilot programs

Open Doors to Safety:

Capacity-Building Grants for Domestic Violence Programs

Three state domestic violence coalitions (Alabama, Idaho, and New Hampshire) received funding to address the trauma and behavioral health issues faced by victims of domestic violence and their varying needs for support during times of crisis.

Supplemental funding also allowed NCDVTMH to engage in more intensive, long-term capacity-building activities with these three new sites in addition to the five sites with which NCDVTMH was already working. It also allowed NCDVTMH to launch the Multi-Site Initiative described in this report, providing greater opportunities for peer-to-peer information sharing, problem solving, and TA among the eight sites.

³ "Promising practice" does not mean "best" practice or "most effective" practice, which implies that rigorous evaluation methods have been used to examine a program's impact on participant outcomes. Instead, a *promising practice* is defined as one that appears to promote the successful implementation of a program and has the potential to work in other communities with similar interests and goals.

engaged in (1) cross-sector collaboration building with local behavioral health providers and (2) organizational and service changes to support accessible, trauma-informed services. In addition, Transformation Detroit engaged in extensive community engagement activities.

This report showcases these accomplishments, as well as challenges, lessons learned, and promising practices that resulted from the work of the Multi-Site Initiative during 2008-2011. The voices of domestic violence victim advocates at the local and state level, as well as advocacy-based clinicians and researchers, are threaded throughout the narratives in this report. These accounts are intended to encourage and assist other states in developing their capacity to provide accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being.

II. STATE COALITIONS: CHANGES, ACCOMPLISHMENTS & LESSONS LEARNED

A. State-Level Cross-Sector Collaboration: Changes & Accomplishments

Because many survivors do not have access to trauma-informed mental health or substance abuse services, building cross-sector collaboration with mental health and substance abuse providers at both the state and local level was a goal of the sites. Sites hoped that collaborative efforts would result in more effective service provision for domestic violence survivors accessing mental health services. Thus, collaborative work at the state level was a cornerstone of the work in a number of sites. Their successes in those arenas led to increased resources and support for collaborative training and TA activities and to longstanding cross-sector partnerships that have allowed them to be responsive to emerging needs and opportunities as they arise.

As a result of these collaboration-building efforts, many coalitions came to be seen as leaders and experts in trauma-informed practice as well as domestic violence, an accomplishment that has enhanced coalitions' standing among state systems that previously had not fully recognized their expertise. This was also true at the community level, where the result of new partnerships and extensive cross-training and cross-consultation resulted in expedited and enhanced services for survivors and their children, both within shelter settings and in community mental health agencies.

Several sites, including Alabama, Delaware, Pennsylvania, West Virginia, and Kansas, started their collaboration-building efforts at the state level while still working locally. They invited state mental health officials and leaders to come together with coalition staff, local domestic violence advocates, mental health service providers, and others to discuss and seek solutions for the challenges faced by domestic violence programs in responding to the needs of survivors with trauma and mental health needs. In West Virginia, this process began prior to the start of the initiative, with previous input from NCDVTMH. Other states built on previously established relationships as well. For coalitions doing this work, these

efforts focused on delineating needs, barriers, goals, and strategies for strengthening collaboration with mental health partners; identifying state-level mental health allies and stakeholders and strategies for engaging them; and generating ideas and strategies for improving policy and practice at the local level, within partnering community mental health agencies and domestic violence programs.

These state-level collaborations launched initiatives that increased awareness about the intersection of trauma, mental health, substance abuse, and domestic violence and improved the capacity of their states to address these issues. These included the following:

- Statewide focus groups and needs assessment surveys designed to engage a broad constituency of stakeholders in identifying unmet needs, service delivery gaps, and barriers for survivors and their children; developing strategies to improve services and foster collaboration; and determining training and TA priorities to support the development of trauma-specific knowledge and skills
- Statewide trainings to build the capacity of domestic violence programs to create welcoming, trauma-informed services and the capacity of mental health providers to serve survivors experiencing the traumatic effects of domestic violence
- Efforts to gain the endorsements of state and national certifying boards, with accompanying continuing education credits (CEUs) for trainings conducted, from various professional mental health disciplines
- Initiatives aimed at obtaining dedicated state-level funding for training and planning efforts
- Efforts to establish state domestic violence coalition staff as experts on mental health, domestic violence, and trauma work, which have resulted in their inclusion in numerous statewide mental and behavioral health committees and task forces
- Formation of new partnerships with child welfare, Head Start, children's mental health providers, early childhood learning programs, and home visitation programs to address the trauma experienced by children exposed to domestic violence and to support children's relationships with their non-offending parents

B. State-Level Cross-Sector Collaboration: Lessons Learned

Building cross-sector collaboration often necessitates overcoming fundamental differences in perspective and approach between the domestic violence and mental health fields, as well as challenges resulting from differences in administrative structures, funding mechanisms, and service delivery models, all of which have historically limited collaboration between systems.

In moving beyond these challenges, the sites learned that collaboration between domestic violence and mental health agencies is more effective with an emphasis on the following:

- Clarifying, understanding, and accepting the differences in philosophies, language, missions, and statutory responsibilities of collaborating organizations and establishing an atmosphere of mutual respect
- Recognizing and identifying shared interests in improving the well-being of survivors of domestic violence who have mental health-related needs
- Identifying champions/collaboration leaders who have authority within their respective systems and are in decision-making positions
- Identifying and utilizing resources available for meeting, training, and other collaborative activities
- Making a commitment to invest the significant time, effort, and good will that it takes to improve access to mental health services for domestic violence survivors
- Taking care to ensure sustainability by making efforts to institutionalize any changes made as part of collaborative work so that advances are not lost with shifts in staffing or funding

C. Coalition Capacity Building & Support for Member Programs: Changes & Accomplishments

Coalitions made important changes in their own internal functioning and in the supports they offered to programs. Some hired dedicated staff with clinical backgrounds to oversee and/or implement the project. Others incorporated the work of the initiative into existing positions.

- Alabama, Delaware, Idaho, Kansas, New Hampshire, Pennsylvania, and West Virginia all had dedicated staff for the project but those staff had differing responsibilities, approaches, and funding levels.
 - New Hampshire and Idaho hired licensed mental health counselors with extensive domestic violence experience to provide TA and clinical supervision to all member programs on providing trauma-informed services.
 - Delaware hired a part-time licensed mental health counselor who had held a training position in the state behavioral health system to conduct outreach and training with the mental health provider community and state officials.
- In Alabama, Kansas, Pennsylvania, and West Virginia, existing coalition staff shouldered the responsibilities for the project in addition to other duties.

In addition, in Pennsylvania and West Virginia, state-level mental health entities provided some funding to the coalition to support the Initiative's activities.

Each coalition took a different approach to building their capacity to support member programs in creating trauma-informed services. All sites worked to enhance their own capacity to serve as the primary trainers and TA providers to their member programs on these issues, which required a clear commitment from their leadership and boards. Some coalitions also did substantial work on changing the culture of their organizations, such as by reducing staff hours, increasing staff support, creating time and space for reflection, initiating staff check-ins, and regularly honoring accomplishments. Others invested in developing new sets of skills, tools, training, policies, and standards for programs. Some coalitions responded to specific needs of their programs or crises in their states by developing innovative strategies and programming (e.g., using Skype to deliver distance counseling, developing tools for supporting communities and programs dealing with domestic violence homicides, establishing a statewide network of clinicians who work with domestic violence survivors).

All of the coalitions began to review and revise their member program monitoring, accreditation, or assessment criteria to better meet the needs of survivors who were dealing with the mental health and substance abuse effects of domestic violence and other trauma. Kansas was able to fully integrate an accreditation process that required member programs to adopt a victim/survivor-centered trauma-informed approach to services, with the goal of seeing measurable change in all member programs' capacities over the next five years.

Coalitions directly engaged in support of staff from the programs involved in several ways. All of the coalitions sponsored numerous skill-building statewide trainings for member programs and mental health and other service providers, with training provided by NCDVTMH staff, coalition staff, or other experts in the field. These trainings have reached thousands of domestic violence advocates, mental health providers, substance abuse treatment providers, homeless shelter providers, and others. Listings of some of the training curricula can be found in the Appendix.

Because Alabama, Idaho, and New Hampshire were recipients of Open Doors to Safety grants (described above), they had funding to provide more intensive support to "pilot programs" that were implementing projects to address the needs of survivors experiencing the mental health effects of domestic violence and other trauma.

Other examples of support efforts by coalitions include the following:

- The Idaho coalition established the Domestic Violence Mental Health Counselors Network for all mental health counselors working in or with member programs. The purpose of the network is to share challenges, successes, and training opportunities related to working with survivors, as well as referrals for survivors who may be relocating.

- In Alabama, the coalition facilitated case managers from member programs meeting monthly to discuss trauma-informed services.
- The Pennsylvania coalition convened and led a state-level mental health workgroup made up of staff from eleven member programs to guide the coalition's work.
- Sites also collaborated with each other to produce materials and conduct trainings. For example, the Idaho coalition conducted a training on victim/survivor rights under the Americans with Disabilities Act (ADA), Fair Housing Act (FHA), and other statutes and resulting responsibilities of their member programs and produced an accompanying curriculum for the Pennsylvania coalition.

Three coalitions began to utilize social media in a variety of ways to increase understanding of trauma and its impact in direct service delivery.

- The Kansas coalition developed its social media presence by posting helpful stories, information, and “thinking questions” regularly on Facebook.
- The Idaho coalition began using Skype (with protections (e.g., audio via landline) elucidated by a discussion with Cindy Southworth, MSW Vice President of Development and Innovation at the National Network to End Domestic violence (NNEDV) and Director of their Safety Net Project, at one of the annual Multi-Site Initiative meetings) to provide counseling services to women at a very rural program that had lost its mental health counselor.
- The New Hampshire coalition project director created a blog, posting information about the project as a well as articles about substance abuse, trauma, and mental illness, which was also made available to the general public.

Both Kansas and Pennsylvania saw a marked increase in domestic violence homicides during this time period and addressed the community trauma by creating tools to assist programs with the direction, support, and information needed to respond to these tragedies on multiple levels including managing the crisis; working with the media and the legal system; and addressing the impact on surviving family members, the community, first responders, and program staff and participants who may have known the victims. The Pennsylvania coalition developed a protocol that is available on request.

Additional Activities Generated by the Initiative

While two sites included a focus on substance abuse from the outset (Alabama and New Hampshire), over the course of the project, several other states (Delaware, Pennsylvania, West Virginia, and Kansas) began to incorporate training on trauma-informed responses to substance abuse into their capacity building work as well. For these states, interest in addressing this issue resulted from discussions with other sites and from training and TA on this topic provided by NCDVTMH consultants and staff. Similarly, while the Initiative first focused on adult survivors of domestic violence, over the course of the project a number of

states incorporated NCDVTMH's training, consultation, and TA on working with children exposed to domestic violence and supporting their relationship with their non-offending parents (West Virginia, Idaho, New Hampshire).

D. Coalition Capacity Building & Support for Member Programs: Lessons Learned

Coalitions cited a number of lessons learned about making the transition to doing trauma-informed work themselves and assisting member programs in building their capacity to provide trauma-informed services and support survivors experiencing the mental health and substance abuse effects of abuse.

- **Commitment of Time & Resources:** The transition to trauma-informed work requires a clear commitment on the part of coalition leadership and staff to examine their own organizational culture and practices and to provide the necessary training and TA support to member programs. Creating this cultural shift in organizations and communities requires a significant investment of time and resources.
- **Funding for Dedicated Staff:** Coalitions benefit greatly from having dedicated staff for this work and can move more quickly and effectively if they are able to secure funding to support these endeavors. Having dedicated staff also facilitates communication and resource sharing among coalitions and helps to reduce unnecessary duplication of efforts in developing or revising materials (e.g., training curricula, accreditation standards, etc.). Several coalitions found that having the ability to hire a person with clinical training and experience, particularly someone who is versed in domestic violence advocacy, also helped to move the work forward, both in terms of building collaboration with the mental health provider community and in terms of offering training, consultation, and supervision to program staff who are serving women and children with more complex needs. In one state, hiring a clinician at the coalition level made it possible to coordinate supervision and support for clinicians hired at local programs as part of the project. In another state, hiring a dedicated person to oversee the project at the coalition level allowed that person to provide onsite and telephonic consultation to programs, advocates, and to a limited extent, survivors in programs who did not have timely access to mental health services.
- **Guidance on Trauma-Informed Standards from the Coalition:** It is important for coalitions to support the shift to trauma-informed services with trauma-informed standards, protocols, and advocate training. Coalitions may need to revise their standards and training curriculums as needed.

- **Training on Law & Policy:** Coalitions benefit from thorough review of the full range of federal, state, and local law and policy pertaining to mental health, disability, health, and child protection and their intersection with domestic violence.
- **Support for Advocates at Different Stages:** It takes a great deal of time to shift mindsets and behavior. Not all advocates at the program level will need the same forms of TA or be ready to embrace trauma-informed services at the same time. Support for advocates throughout this shift is critical.
- **Support for Programs at Different Stages:** In fostering a paradigm shift, it is also critical to be responsive to the wide variation among member programs with regard to staffing, experience, training, resources, and communities being served. Each member program will be at a different stage of change and will need to be nurtured and challenged as they move forward in providing quality services. There will be programs that will quickly embrace the effort to increase access to services for survivors who are experiencing mental illness or using substances. Other programs may have concerns about worst possible scenarios and feel that lack of staff, facility issues, or liability concerns are reasons not to shelter a particular individual. With increased support, however, these programs can make the shift toward a more accessible and trauma-informed approach to providing services.
- **Trauma-Informed Mission Statements:** It is also helpful to make trauma-informed services implementation part of coalition and local program mission statements.

III. DOMESTIC VIOLENCE PROGRAMS: CHANGES, ACCOMPLISHMENTS & LESSONS LEARNED

A. Domestic Violence Program Capacity-Building: Changes & Accomplishments

Participating member programs in Alabama, Delaware, Idaho, and New Hampshire actively worked to make their services inclusive, client centered, and trauma informed, but they took different approaches. In Alabama and Delaware, the programs specifically focused on creating non-violent, non-rule-based healing communities within their shelters. This involved an intensive reexamination of their admission processes, program guidelines, and core values, and ultimately, a complete revision of their organizations' policies and

Parallel process refers to the ways that organizational stress can affect staff, which in turn can affect the people who are coming for services. For example, when staff are treated with dignity, respect, and empathy, and their own needs are taken into consideration, they are more likely to bring those qualities into their interactions with survivors. Consciously attending to these issues is an important part of the transformation to becoming trauma informed.

procedures. They also worked on implementing reflective supervisory practices and other ongoing supports for staff, including attending to parallel process (i.e., the ways organizational stress can affect staff, which in turn can affect the people who are coming for services) as well as vicarious or secondary trauma. All of these elements contributed to the positive difference these changes made for both survivors in their programs and for staff.

In Idaho, participating programs hired part-time licensed mental health counselors to directly provide new and enhanced mental health services at the programs, since referrals were not always successful due to overtaxed public mental health programs. All of the mental health counselors also provided TA and training to staff and allies to improve the capacity of their programs.

In New Hampshire, the coalition's Trauma Specialist began to provide in-depth assessment and case consultation with the programs and also developed training programs to enhance staff skills. The Trauma Specialist traveled to each participating program twice a month and also met with shelter residents in order to model for advocates more nuanced ways of working with survivors experiencing mental health and substance abuse-related needs. The Trauma Specialist also reviewed member program policies and procedures and worked with each program to ensure they were responsive to the advocacy needs of survivors experiencing the mental health and substance abuse effects of domestic violence.

Data from Idaho and Pennsylvania show significant changes at the domestic violence program level. Pennsylvania accomplished changes at multiple levels, including changes in policy (e.g., criteria for shelter admission, types of staff support such as leave policies and supervision, rules for shelter), practice (changes in intake, increase in self-rating of ability to address survivors' mental health needs, increase in mental health referrals), and collaboration (increase in cross-training and access to services). Many of these changes were more dramatic among programs that had participated most extensively in trauma-related training by NCDVTMH.

States receiving Open Doors funding were more able to make significant changes. As part of the Alabama Open Doors project, two domestic violence programs were involved in intensive efforts to become more inclusive, accessible, and trauma-informed. Staff in these two programs reported substantial changes in policy, practice, and collaboration. Furthermore, in Idaho, a comparison between programs within the state that had participated in the Open Doors initiative and those that had not found marked differences between the two groups in policy, practice, and collaboration.

In Delaware, Kansas, Idaho (and earlier, West Virginia), end-of-grant follow-up surveys with individual practitioners revealed changes in practice and perceived knowledge, comfort, and skill over time; these changes were attributed to the states' trauma initiative/training.

In particular, individuals reported changes in

- the way they conduct assessments,
- the time they take to hear a survivor's story more fully,
- their understanding of trauma responses,
- their awareness of judgmental reactions to survivors,
- their awareness of their own reactions when working with survivors,
- their awareness of the ways the work affects them and their colleagues,
- their strategies for dealing with the feelings they experience in working with survivors,
- their likelihood of sharing resources and working with other service providers in the community,
- their confidence (or self-rating of their ability) in working with survivors who are experiencing mental health conditions, and
- their rating of the importance of collaboration between domestic violence and mental health agencies.

In most instances, these changes were more dramatic for individuals who had received formal or more extensive training. Thus, not only were the programs that received more training and TA from NCDVTMH more able to make changes, but individuals at those programs who received more training were more able to make changes than those who did not.

In New Hampshire, local evaluators for the Open Doors project found similar outcomes: shifts over time in confidence, awareness, understanding, and practice among program advocates. Here, NCDVTMH's role was to provide formal training to advocates and mental health practitioners, and regular training opportunities, TA, and support to the Trauma Specialist hired by the state coalition. The Trauma Specialist, in turn, provided regular in-person support and consultation to the local advocates.

B. Domestic Violence Program Capacity Building: Lessons Learned

Change for survivors as well as domestic violence program staff happens over time—lots of time. It takes substantial time to review and change policies, procedures, and practice; to process and reinforce changes; and to support staff in times of stress or conflict when they are at greater risk for reverting to old rule structures and practices. It is critical that executive directors at domestic violence programs understand that this process will take time and will require ongoing administrative support and review.

- **Ongoing Staff Training:** Staff training must be ongoing and supported through regular follow-up and reflective supervision.
- **Multiple Levels of Staff Support:** Staff support must be provided at multiple levels, including supervision (especially supportive, reflective supervision), flexible leave

- policies (as needed to prevent and address secondary trauma and compassion fatigue), and flexible staffing policies to respond to emotional needs of staff that arise in the course of their work. Attention to staff culture, creativity, and informal sources of support also needs to be incorporated into the workplace, including staff meetings.
- **The Shelter as a Community:** Consistent with NCDVTMH’s framework, and a core aspect of the Sanctuary™ model, which one of the domestic violence programs had implemented prior to the outset of this project, is viewing the shelter environment as a community to which everyone (staff and residents) is responsible and accountable. Instead of rules that are imposed by the program, community members discuss and determine what will work best for them in a way that balances the needs of the group with the needs of individuals. This type of structure is grounded in principles of mutual safety and respect. Creating and instituting mechanisms to support this type of process is essential (e.g., regular community meetings). Developing mechanisms to ensure the involvement of survivors in program oversight is critical as well.
 - **Commitment from Leadership:** It is critical to obtain buy-in and a commitment to change on the part of the agency’s administration and board of directors and to provide them with sufficient information to fully understand what it means to become trauma informed.
 - **Coalition Support:** Support from the state coalition is essential for programs undertaking this type of change. This includes ongoing training, TA, and consultation; assistance with revising policies and procedures; assistance in finding and obtaining funding; and opportunities to network with other programs and engage in peer-to-peer learning.
 - **Integrating Clinical Staff:** For programs that choose to hire clinical staff, it is important to take the time to develop effective ways to ensure their integration as staff members, to clarify roles, and to reassure advocates of the equally critical importance of their work. Programs should avoid creating hierarchies based on professional degrees or status and ensure that everyone is valued for the importance of their contributions.
 - **Language & Time for Reflection:** Part of the shift to becoming trauma-informed involves paying attention to the language all staff, supervisors, and administrators use and creating supervisory structures that support staff’s ability to be reflective about their own feelings, responses, and behavior.

- **Empowerment & Accessibility:** It can be helpful to engage in discussions about what “empowerment” means—to the program, to advocates, and to survivors—in the context of working with survivors who are dealing with trauma, mental illness, and/or substance abuse. For example, some advocates have had to rethink what it means to take an empowerment approach when supporting survivor choice and agency while also ensuring survivors have the resources and supports they need to fully access services and meet their own goals.
- **Flexibility:** Part of providing accessible and trauma-informed services is being flexible with regard to how services are delivered and expectations of survivors. This includes being flexible with regard to scheduling, appointment times, and program requirements; ensuring programs are fully accessible; and tailoring services to meet individual survivor’s needs.
- **Involvement of Communities Being Served:** Involving people from the communities being served as staff, as leadership, as board members, and as volunteers—and engaging them in designing services that are inclusive, welcoming, and relevant to survivors from a range of cultures, spiritual preferences, abilities, ages, and backgrounds—is a core element of trauma-informed work.
- **Crisis Intervention Training:** Staff should also be trained in trauma-informed, empowerment-based approaches to crisis intervention, meaning ways of working with survivors who are in emotional crisis that are survivor-defined and keep respect, connection, and transparency at the center.

C. Community-Level Collaboration: Changes & Accomplishments

As part of the Multi-Site Initiative, domestic violence programs built or strengthened collaborations with mental health and other service providers within their communities and launched initiatives and activities that expanded the community’s awareness of and capacity to address trauma and mental health in the context of domestic violence. Examples of community-level efforts include the following:

- Cross-training between local domestic violence programs, local community mental health centers, and other service providers, including substance abuse and homeless services providers
- The creation of cross-training planning teams comprised of representatives from local domestic violence and mental health service organizations to develop core training programs for their local mental health providers
- The development of procedures for payment for mental health and substance abuse services that make services financially accessible for survivors

- The identification of residential substance abuse services for survivors that protect survivor confidentiality
- The development of written collaborative agreements between local domestic violence programs and mental health providers that resulted in easier and more coordinated access to services
- The facilitation of community forums and needs assessments that engaged the community in talking about the mental health and trauma-related needs of survivors
- A member of the community becoming part of a steering committee overseeing the work in one site
- The community raising money and locating resources to assist survivors and local programs
- Local programs becoming members of community-wide mental health coalitions
- The use of graduate-level counseling and social work students to deliver mental health services with appropriate training and supervision
- DV advocates being onsite in social and rehabilitative service settings to ensure that survivors receiving cash benefits (TANF) are ensured trauma-informed services
- The development of a multi-disciplinary Needs Assessment and Planning Committee

One site, Transformation Detroit, took an entirely different approach. Rather than focus on the coalition or program level, they focused on the entire, ethnically diverse but largely African-American community of Detroit. They began as a volunteer collaborative initiative with a focus on identifying community needs, mobilizing community resources, and eventually developing a culturally specific approach that would be responsive to the needs and resources of their community. NCDVTMH training and consultation meetings with project staff provided additional knowledge about trauma and mental health that enhanced the project's capacity as they engaged in their community organizing efforts. Knowledge of system practice and perspectives helped project staff to identify key questions and potential community partners. During the course of the project, Transformation Detroit conducted an extensive community needs assessment. These activities were central to the project's successes in expanding community collaborations; reinforcing the importance of a trauma-informed approach to DV; and enhancing the credibility, visibility and resources available to the local project.

D. Community-Level Collaboration: Lessons Learned

Building collaboration with community partners helped programs to meet the trauma-related needs of domestic violence survivors and their children more effectively. Strategies that programs found most helpful included reaching out to a range of agencies and organizations; creating opportunities to identify common needs, values, and goals and to discuss the need for both DV- and trauma-informed approaches; taking the time to get to

know how each others' systems worked, including the constraints they operate under; sharing knowledge, skills, and resources; and collectively generating support from key leadership in government, professional organizations, community groups, and local agencies. Ultimately, one of the most helpful factors was finding people in other organizations and systems with shared values who were willing to take the time to improve responses in their community and who were able to find creative ways to do so.

Participating programs described a range of lessons learned based on their experience:

- Having all project/program staff and collaborative partners involved from the outset of proposal development increases the level of cooperation and investment as a project moves forward.
- When doing cross-trainings, it is important to be strategic. Trainings should be interactive and help participants to engage in critical thinking rather than just providing information. It is helpful to survey participants prior to the training to determine what they see as the most critical issues.
- Changes in each partner organization (as well as the collaborative itself) need to be institutionalized so that progress is not lost with staff turnover, shifts in funding, or changes in the political climate.
- Clarifying, understanding, and accepting the differences in philosophies, language, missions, and statutory responsibilities of partnering organizations is critical to building sustainable collaborations.
- Developing and coordinating referral protocols with partner agencies can facilitate victim/survivor access to shelter, support, and mental health services.
- Developing comprehensive, wrap-around service approaches utilizing the services of community partners may be the best way to meet complex needs.
- Building ongoing partnerships with organizations representing the range of communities being served is also critical to assure survivors and their children have access to culturally relevant services wherever they seek help. It can also help collaborative members to better understand the range of issues and constraints survivors may face and the options and resources available to them.

IV. SUSTAINABILITY

Lack of sustainable funding is a critical barrier to providing trauma-informed domestic violence and mental health services effectively.

All sites and pilot programs involved in this project called for a funding mechanism to support the continuation of trauma-informed domestic violence services that thoroughly address the complex needs of survivors. Increased non-restricted funding would allow programs to enhance services to meet the evolving needs of victims and survivors, and for the necessary coalition-level support for them. The valuable accomplishments of the

projects described in this report illustrate the importance of continuing this work and the urgent need to create funding streams to support it.

Increased funding would allow program development, growth, and enhancement by enabling programs to

- increase shelter and transitional living space to accommodate longer stays, which would enhance safety, stability, and self-sufficiency;
- hire additional domestic violence advocates and licensed clinicians to provide trauma-informed as well as trauma-specific services;
- create and replicate new strategies and service models;
- develop culturally specific interventions that meet the needs of diverse communities and programs;
- underwrite training and collaboration activities with state and local partners; and
- underwrite travel costs, including staff time, and direct transportation costs for workers and program participants when time and distance present barriers to training and development opportunities.

IV. CONCLUSION

In sum, as a result of the committed work of everyone involved in the Multi-Site Initiative, each site met their goals of developing the internal capacity of coalitions and programs to respond to survivors and their children, and many sites were also able to strengthen relationships between domestic violence advocates and the mental health, substance abuse, and child-serving service communities at both the state and local levels. Finally, while all sites were able to create systemic change in some way, these changes were most sustainable in those sites that received supplement funding to support this work. Overall, these results support a continuation of this work as well as continued efforts to ensure stable funding so as to secure for the long-term the changes that are necessary to the safety and well-being of survivors and their children.

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- ❖ Alabama Coalition Against Domestic Violence (ACADV) with pilot programs at Crisis Services of North Alabama (CSNA) and SafeHouse of Shelby County
- ❖ Delaware Coalition Against Domestic Violence (DCADV and People's Place)
- ❖ Transformation Detroit, co-sponsored by the Michigan Domestic Violence Prevention and Treatment Board and the Institute on Domestic Violence in the African American Community (IDVAAC)
- ❖ Idaho Coalition Against Sexual and Domestic Violence (IDVSA) and seven IDVSA member domestic violence programs located in Bingham, Teton, Bannock, Canyon, Gem, Washington, and Valley counties in southern Idaho
- ❖ Kansas Coalition Against Sexual and Domestic Violence (KDSDV)
- ❖ New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV) and its member programs
- ❖ Pennsylvania Coalition Against Domestic Violence (PCADV)
- ❖ West Virginia Coalition Against Domestic Violence (WVCADV)