



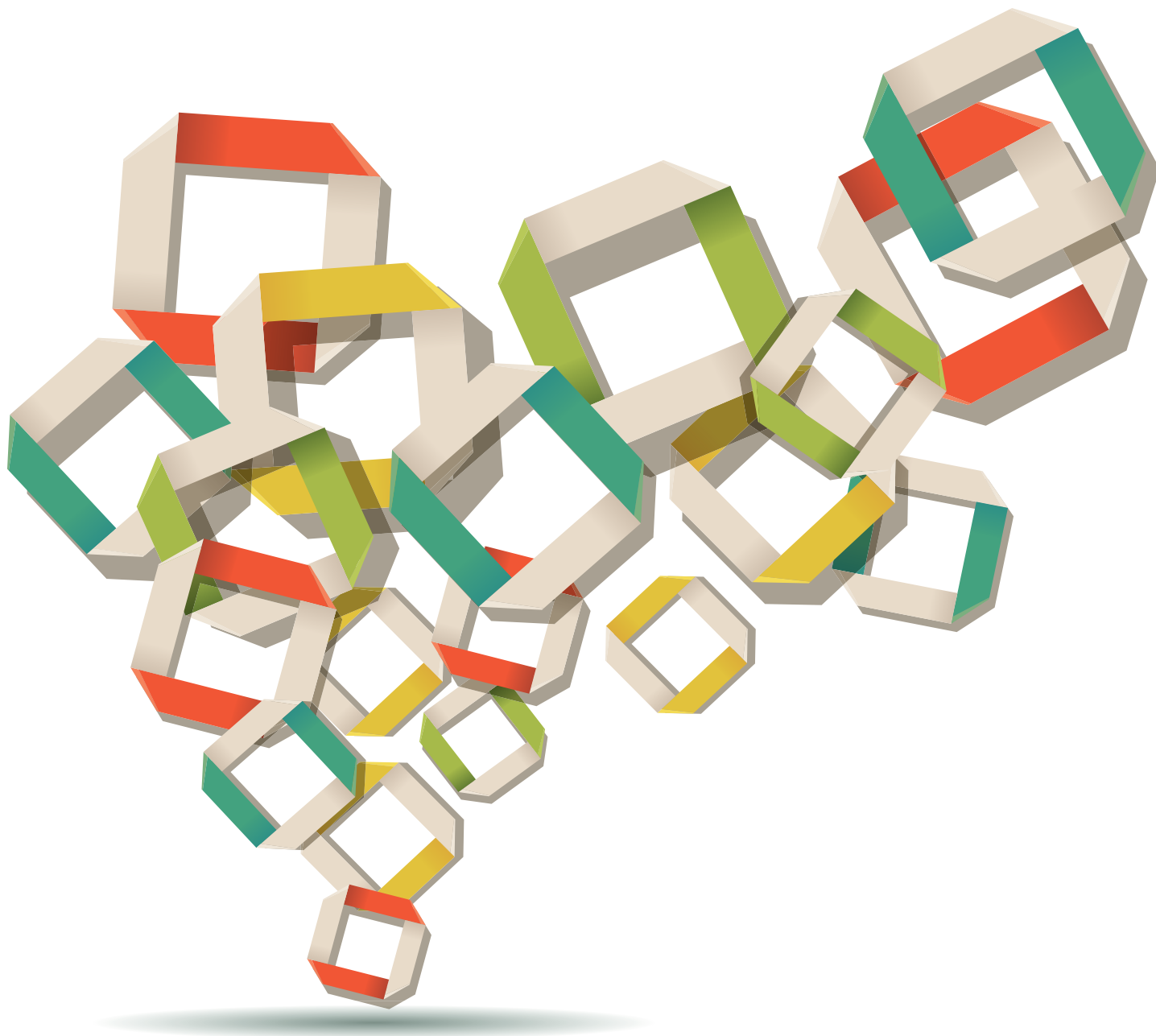
Reproductive and Sexual Coercion

A Toolkit for Sexual & Domestic Violence Advocates

Second Edition (2018)



Virginia Sexual and Domestic Violence
ACTIONALLIANCE



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Virginia Sexual and Domestic Violence
ACTIONALLIANCE

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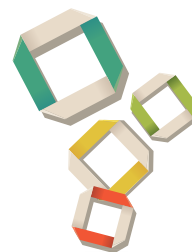
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Introduction

The Virginia Sexual and Domestic Violence Action Alliance (Action Alliance) seeks to build local sexual and domestic violence agencies' capacity to identify reproductive and sexual coercion. This includes: implementing screening for reproductive and sexual coercion, implementing policies and procedures that address reproductive and sexual coercion, fostering partnerships with family planning and reproductive health providers, and doing the above-mentioned work through a reproductive justice framework or lens.

The goal of this toolkit is to help begin conversations and implement new or clarify existing policies within your agency: What is reproductive and sexual coercion? Why is a reproductive justice framework necessary? How can we best support survivors of sexual and intimate partner violence with a better understanding of reproductive and sexual coercion? What are sample policies and procedures my agency can utilize? Who in my community can I collaborate with on this work? We hope this resource provides some answers to these questions while also guiding and supporting further learning on these topics to best support the specific needs of your community.

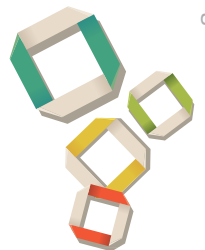
Framework

SisterSong is a Southern based, national membership organization with the purpose to build power and improve policies and systems that impact the reproductive lives of marginalized communities. They define Reproductive Justice as, “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”¹

Reproductive Justice is an intersectional framework that understands reproductive health in a full and holistic way. Reproductive Justice is just as much about being able to parent children without fear of police brutality, having access to mental health resources, and respectful and competent healthcare for trans people as it is about access to safe and legal abortion care. At the Action Alliance, we believe a Reproductive Justice framework is essential to our conversations about reproductive and sexual coercion. This framework creates space in our conversations to talk about coercion and reproductive health beyond a limited understanding of choice and shift towards conversation around access and how larger structural and cultural systems limit or impact the ways marginalized people and communities have choice or make choices.

If this framework is new to you, we recommend reviewing resources from SisterSong and other organizations leading the movement in Reproductive Justice.

¹ SisterSong. (n.d.). Reproductive justice. Retrieved from: <https://www.sistersong.net/reproductive-justice/>

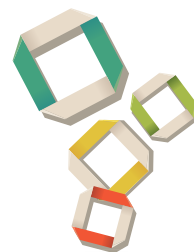


Background

Between June 2012 and May 2013, the Action Alliance and the Virginia Department of Health built on the success of Project Connect, a groundbreaking multi-state initiative of Futures Without Violence and the Office on Women's Health, by developing a pilot project to build the capacity of four local domestic violence programs for reproductive and sexual coercion screening within the context of intimate partner violence. During the pilot process, gaps in services and resources were identified leading the Action Alliance to create more training and identify a set of resources that would help increase local and sexual and domestic violence agencies ability to successfully address reproductive and sexual coercion.



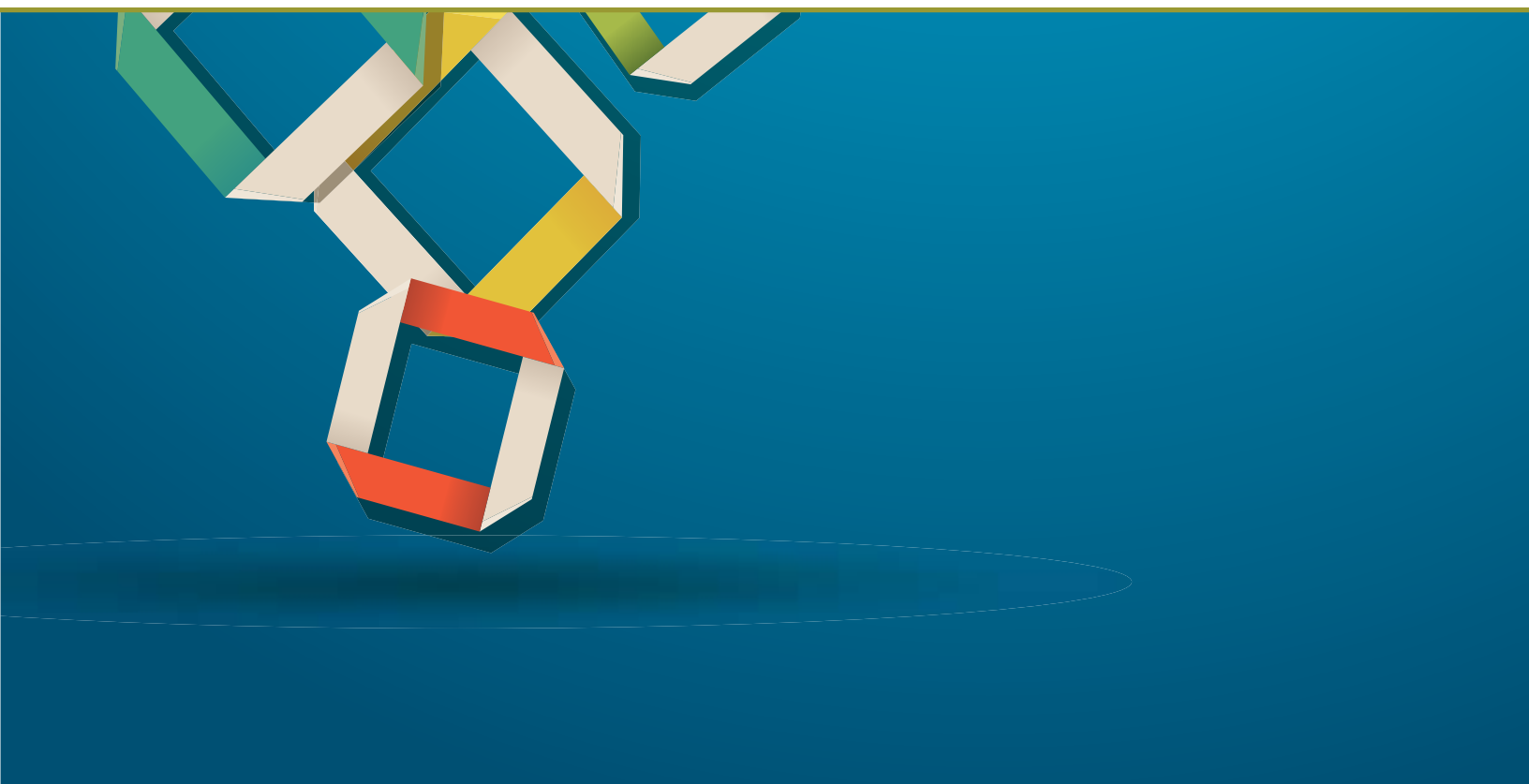
Project Connect seeks to develop comprehensive models of public health prevention and intervention that can lead to improved health and safety for victims of sexual and domestic violence. Virginia was one of Project Connect's first nine pilot sites nationwide. For several years, Virginia's Project Connect initiative focused on working with family planning and reproductive health providers and home visitors. The Virginia Department of Health's Division of Prevention and Health Promotion, in partnership with the Division of Child and Adolescent Health, developed assessment strategies and tools, training curriculum, education materials and policy/procedure guidance to better enable family planning clinic staff and home visitors to identify and provide support and referral to individuals and families impacted by sexual and domestic violence. The Action Alliance built on these resources developed through Virginia's Project Connect Initiative to create the first edition of this toolkit in 2014.





Section A:

Understanding Sexual and Reproductive Coercion



Sexual Coercion Information Sheet

Sexual coercion involves any behavior intended to maintain power and control in a relationship related to sexual activity and sexual health by someone who is, was, or wishes to be involved in an intimate or dating relationship with another person.^{1,2} Sexual coercion includes a range of behaviors such as pressure, threats, sabotage and/or manipulation to coerce a person to engage in sexual activities without using physical force.

Some examples of ways that partners may engage in sexual coercion:^{3,4,5}

- Pressure to engage in unwanted sexual activities
- Threats to end a relationship if the partner does not engage in sexual activities
- Pressure to not use condoms during sex
- Threatening retaliation if notified of a positive sexually transmitted infection (STI) test result
- Disregarding “safe words” during sex
- Using insults, guilt trips, past consensual sexual activities, or extreme compliments to manipulate partner into engaging in sexual activity
 - o “If you loved me, you would”
 - o “We’ve done it before, so you can’t say ‘no’ now”
 - o “You’re not really queer if you don’t like to do this”

Screening for sexual coercion is an important part of providing access to services and options that increase safety and positive sexual health outcomes. Many coercion resources present screening in a context that assumes the victim is a cisgender (a person who is assigned a sex at birth that is congruent with their gender identity and expression) woman and the perpetrator is a cisgender man. It is important during screening that advocates do not make assumptions based on perceived sexual orientation and/or gender identity, potentially leaving out critical screening questions.

1 Adapted from: Futures Without Violence. (2015, March 3). Making the connection [Video file]. Retrieved from: https://www.youtube.com/watch?v=KRazI66kLk4&list=PLaS4Etq3IFrWgqgcKstcBwNiP_j8ZoBYK&index=5.

2 Adapted from: American College of Obstetricians and Gynecologists. (2013). Committee opinion on reproductive and sexual coercion. *Obstetrics & Gynecology*, 554, 1-5. doi: <http://10.1097/01.AOG.0000426427.79586.3b>

3 Adapted from: Futures Without Violence. (2015, March 3). Making the connection [Video file]. Retrieved from: https://www.youtube.com/watch?v=KRazI66kLk4&list=PLaS4Etq3IFrWgqgcKstcBwNiP_j8ZoBYK&index=5.

4 Adapted from: Futures Without Violence and American College of Obstetricians and Gynecologists. (2013). *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings* (third edition). Retrieved from: <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf>.

5 Adapted from: University of Michigan Sexual Assault Prevention & Awareness Center. (n.d.) Defining sexual assault. Retrieved from: <https://sapac.umich.edu/article/205>.



Screening for sexual coercion has implications beyond the needs of heterosexual cisgender women. Please review the examples below that illustrate how screening is applicable to a diversity of people:

Example: *A lesbian woman's partner makes her feel guilty when she isn't in the mood to have sex.*

When someone identifies as a lesbian, advocates should still screen for sexual coercion. Do not assume that just because someone has a current cisgender woman partner that they are not experiencing coercion; or assume that just because someone identifies as a lesbian that they have not experienced sexual coercion by a cisgender male partner previously. Sexual orientation is complex and fluid and everyone's experience with sexuality is unique.

Example: *A transgender person who does not want certain body parts to be touched while being sexually intimate, but those boundaries are violated.*

Some people who identify as transgender may identify as a woman, man, or as gender non-conforming and may need access to a variety of reproductive health services. They also may experience sexual coercion in ways that might not be congruent with assumptions about their gender identity or sexual orientation. Research has demonstrated that transgender people experience sexual violence at a greater rate than cisgender people and most often in the context of an intimate relationship.⁶ If you are unfamiliar with the medical health needs of transgender people, there are various resources available to help you. Please refer to **Section E.8 Healthy Sexuality Online Resources** to access some of those resources.

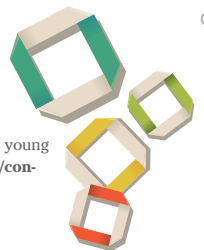
Example: *A bisexual man with a partner who is pressuring him to have sex without condoms.*

Cisgender men (of all sexual orientations) may be at risk for sexual coercion, including experiencing pressure to not use condoms during sexual encounters. The risk for sexually transmitted infections (STIs) is greater when people feel they are unable to negotiate safe condom usage in their relationships.⁷

As a result of increasing your understanding of sexual coercion, survivors will need information and services that sexual and domestic violence agencies may not currently provide or know about. Agencies must establish clear partnerships with community healthcare providers who are able to provide some of these critical services. It is strongly recommended that advocates be trained on how to implement sexual coercion screening tools and make appropriate referrals BEFORE screening actually occurs.

6 James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., and Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. Retrieved from: <https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>.

7 Teitelman, A. M., Bohinski, J. M., and Tuttle, A. M. (2010). Condom coercion, sexual relationship power, and risk for HIV and other sexually transmitted infections among young women attending urban family planning clinics. *Family Violence Prevention and Health Practice*, 1(10), 1-20. Retrieved from: <http://endabuse.org/health/ejournal/2010/06/condom-coercion-sexual-relationship-power-and-risk-for-hiv-and-other-sexually-transmitted-infections-among-young-women-attending-urban-family-planning-clinics/>.



Reproductive Coercion Information Sheet

Reproductive coercion involves behavior intended to maintain power and control in a relationship related to reproduction and sexual health by someone who is, was, or wishes to be involved in an intimate or dating relationship with another person.^{1,2} Reproductive coercion includes a range of behaviors that may involve pressure, threats, sabotage, and/or manipulation. Some examples of ways that partners may engage in reproductive coercion include:^{1,2,3}

Birth control sabotage:

- Hiding or destroying birth control pills
- Pulling out vaginal rings
- Manipulating partner to take hormones they do not want to take
- Restricting a partner's access to hormones they do want to take
- Tearing off contraceptive patches
- Breaking condoms on purpose, or taking them off during sex
- Not withdrawing (pulling out) when that was the agreed-upon method of contraception

Pregnancy pressure (physical or verbal threats when a person does not wish to be pregnant):

- "I will hurt you if you don't become pregnant"
- "I will leave you if you don't become pregnant"
- "I will 'out' you if you don't have a baby with me"

Pregnancy coercion:

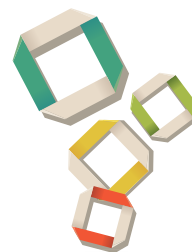
- "They told me what to do with the pregnancy"
- "I didn't have a choice"
- "I was afraid of them"
- "They said this was the only way we could be a real family"

Screening for reproductive coercion is an important part of providing access to services and options that increase safety and positive sexual and reproductive health outcomes. Many coercion resources present screening in a context that assumes the victim is a cisgender (a person who is assigned a sex at birth that is congruent with their gender identity and expression) woman and the perpetrator is a cisgender man. It is important during screening that advocates do not make assumptions based on perceived sexual orientation and/or gender identity, potentially leaving out critical screening questions.

¹ Adapted from: Futures Without Violence and American College of Obstetricians and Gynecologists. (2013). *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings* (third edition). Retrieved from: <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf>.

² Adapted from: American College of Obstetricians and Gynecologists. (2013). Committee opinion on reproductive and sexual coercion. *Obstetrics & Gynecology*, 554, 1-5. doi: <http://10.1097/01.AOG.0000426427.79586.3b>

³ Adapted from: Futures Without Violence. "Making the Connection." Youtube. 2015. https://www.youtube.com/watch?v=KRzI66kLk4&list=PLa54Etq3IFrWggcKstcBwNIP_j8ZoBYK&index=5



Screening for reproductive coercion has implications beyond the needs of heterosexual cisgender women. Please review the examples below that illustrate how screening is applicable to a diversity of people:

Example: *A cisgender woman takes birth control pills to manage irregular periods. She identifies as pansexual and her current partner is a cisgender woman.*

Some individuals use hormonal birth control methods to manage a variety of medical issues. Advocates should not make assumptions about why someone is taking birth control and whether that matches assumptions about their gender identity and sexual orientation. In the previous example, it's still critical to screen her for reproductive health needs—she may need access to a gynecologist for continued medication while in shelter.

Example: *A transgender man is partnered with a cisgender man who tampers with/or restricts hormones, which may create a period of fertility.*

Example: *A transgender woman whose partner manipulates them into taking hormones they do not want to take in order to promote or prevent a pregnancy.*

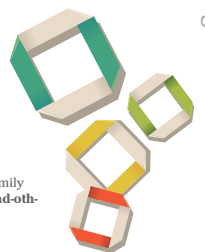
Some people who identify as transgender may identify as a woman, man, or gender non-conforming and may need access to a variety of reproductive health services. They also may experience reproductive coercion in ways that might not be congruent with assumptions about their gender identity or sexual orientation. If you are unfamiliar with the medical health needs of transgender people, there are various resources available to help you. Please refer to **Section E.8 Healthy Sexuality Online Resources** to access some of those resources.

Example: *A bisexual man who says that his partner is pressuring him to have sex without condoms.*

Cisgender men (of all sexual orientations) may be at risk for sexual coercion by being pressured to not use condoms during sexual encounters. The risk for sexually transmitted infection (STI) transmission is greater when people feel like they are unable to negotiate safe condom usage in their relationships.⁴ While pregnancy is a large part of reproductive health, it is important to remember that being exposed to and contracting an STI impacts a person's reproductive health as well. This is another reason why screening everyone, regardless of perceived gender identity or sexual orientation, is imperative. Even if a person appears to be in a relationship in which they or their partner could not get pregnant, their reproductive health could still be negatively impacted if their partner refuses to use or non-consensually removes barrier birth control.

As a result of increasing your understanding of reproductive coercion, survivors will need information and services that sexual and domestic violence agencies may not currently provide or know about. Agencies must establish clear partnerships with community healthcare providers who are able to provide some of these critical services. It is strongly recommended that advocates be trained on how to implement reproductive coercion screening tools and make appropriate referrals **BEFORE** screening actually occurs.

4 Teitelman, A. M., Bohinski, J. M., and Tuttle, A. M. (2010). Condom coercion, sexual relationship power, and risk for HIV and other sexually transmitted infections among young women attending urban family planning clinics. *Family Violence Prevention and Health Practice*, 1(10), 1-20. Retrieved from: <http://endabuse.org/health/ejournal/2010/06/condom-coercion-sexual-relationship-power-and-risk-for-hiv-and-other-sexually-transmitted-infections-among-young-women-attending-urban-family-planning-clinics/>.



Facts on Sexual and Reproductive Coercion

At the Action Alliance, we know that people who do not identify as cisgender straight women experience and are survivors of both sexual and reproductive coercion. That being said, current research does not fully express the diversity of experiences of survivors. We hope this is addressed in future research.

Sexual Coercion:

- Both men and women can be both perpetrators and victims of sexual coercion.¹
- 13 percent of women and 6 percent of men report experiencing sexual coercion at some time in their lives.²
- Perpetrators of sexual coercion most commonly reported utilizing the tactics of alcohol and drugs, emotional manipulation, or lying to control their victim.³
- In a nationally representative sample, 1 in 4 women reported lifetime coerced sex. Of these women, more than one-third were 15 years or younger at the time of the experience.⁴
- Studies show that lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals are more at risk of sexual coercion and violence than heterosexual individuals.⁵
- 41 percent of LGBTQ survey respondents reported that at least one of their experiences with sexual violence was in the context of an intimate relationship.⁶
- 75 percent of bisexual women and 46 percent of lesbian women report lifetime prevalence of sexual violence other than rape, including sexual coercion.⁷

1 Kalof, L. (2000). Vulnerability to sexual coercion among college women: A longitudinal study." *Gender Issues*, 18(4), 47-58.

2 Centers for Disease Control (CDC). (2017). National intimate partner and sexual violence survey: 2010-2012 state report. Retrieved from: <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>.

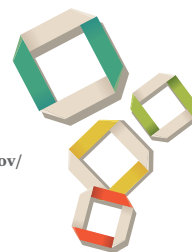
3 Kalof, L. (2000). Vulnerability to sexual coercion among college women: A longitudinal study." *Gender Issues*, 18(4), 47-58.

4 Futures Without Violence and American College of Obstetricians and Gynecologists. (2013). *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings* (third edition). Retrieved from: <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf>.

5 Virginia Education Fund and Virginia Anti-Violence Project. (2008). The state of violence in lesbian, gay, bisexual, transgender, and queer communities of Virginia. Retrieved from: http://www.communitysolutionsva.org/files/State_of_Violence-LGBTQ_Community.pdf.

6 Ibid.

7 CDC. (2013). The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf.



- 30 percent of bisexual women report sexual experiencing sexual coercion with predominantly male perpetrators.⁸
- 40 percent of gay men and 47 percent of bisexual men report lifetime prevalence of sexual violence other than rape, including sexual coercion.⁹
- 52 percent of self-identified gay men and lesbian women reported at least one incident of sexual coercion by a same-sex partner. Gay men experienced an average of 1.6 incidents per person; while lesbians experienced 1.2 incidents per person.¹⁰

Reproductive Coercion:

- Approximately 1 in 5 women have experienced pregnancy coercion and 1 in 7 have experienced active interference with contraception.¹¹
- Women disclosing physical violence are nearly three times more likely to experience a sexually transmitted infection than women who don't disclose physical abuse.¹²
- Adolescent girls in physically abusive relationships were 3.5 times for likely to become pregnant than non-abused girls.¹³
- As many as two-thirds of adolescents who become pregnant were sexually or physically abused some time in their lives.¹⁴
- Women with a history of intimate partner violence have significantly higher rates of unintended pregnancies.¹⁵
- 1 in 7 bisexual women reports having a partner who tried to get them pregnant when they did not want to.¹⁶
- Non-Hispanic Black (52.9%) and multiracial women (42.9%) are disproportionately affected by reproductive coercion compared to White women (20.6%).¹⁷

8 Centers for Disease Control (CDC). (2013). The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf.

9 Ibid.

10 Wisconsin Coalition Against Sexual Assault. (2003). Lesbian, gay, bisexual, transgender (LGBT) populations and sexual assault. Retrieved from: http://www.wcasa.org/file_open.php?id=151.

11 Futures Without Violence. (n.d.) The facts on reproductive health and partner abuse. Retrieved from: http://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Reproductive.pdf.

12 Coker, A., Smith, P., Bethea, L., King, M., and McKeown, R. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine*, 9(5), 451-457.

13 Roberts T. A., Auinger, M. S., and Klein, J.D. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health*, 36, 380-385.

14 Leiderman, S. and Cair, A. (2001). Interpersonal violence and adolescent pregnancy: Prevalence and implications for practice and policy. Retrieved from: <http://capd.traininghelpdesk.com/pubfiles/pub-2001-10-01.pdf>.

15 Pallitto, C. C., Garcia-Moreno, C., Jansen, H., Heise, L., Ellsberg, M., and Watts, C. (2012). Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO multi-country study on women's health and domestic violence. *Gynecology & Obstetrics*, 120(1), 3-9. <https://doi-org.proxy.library.vcu.edu/10.1016/j.jigo.2012.07.003>.

16 CDC. (2013). The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf.

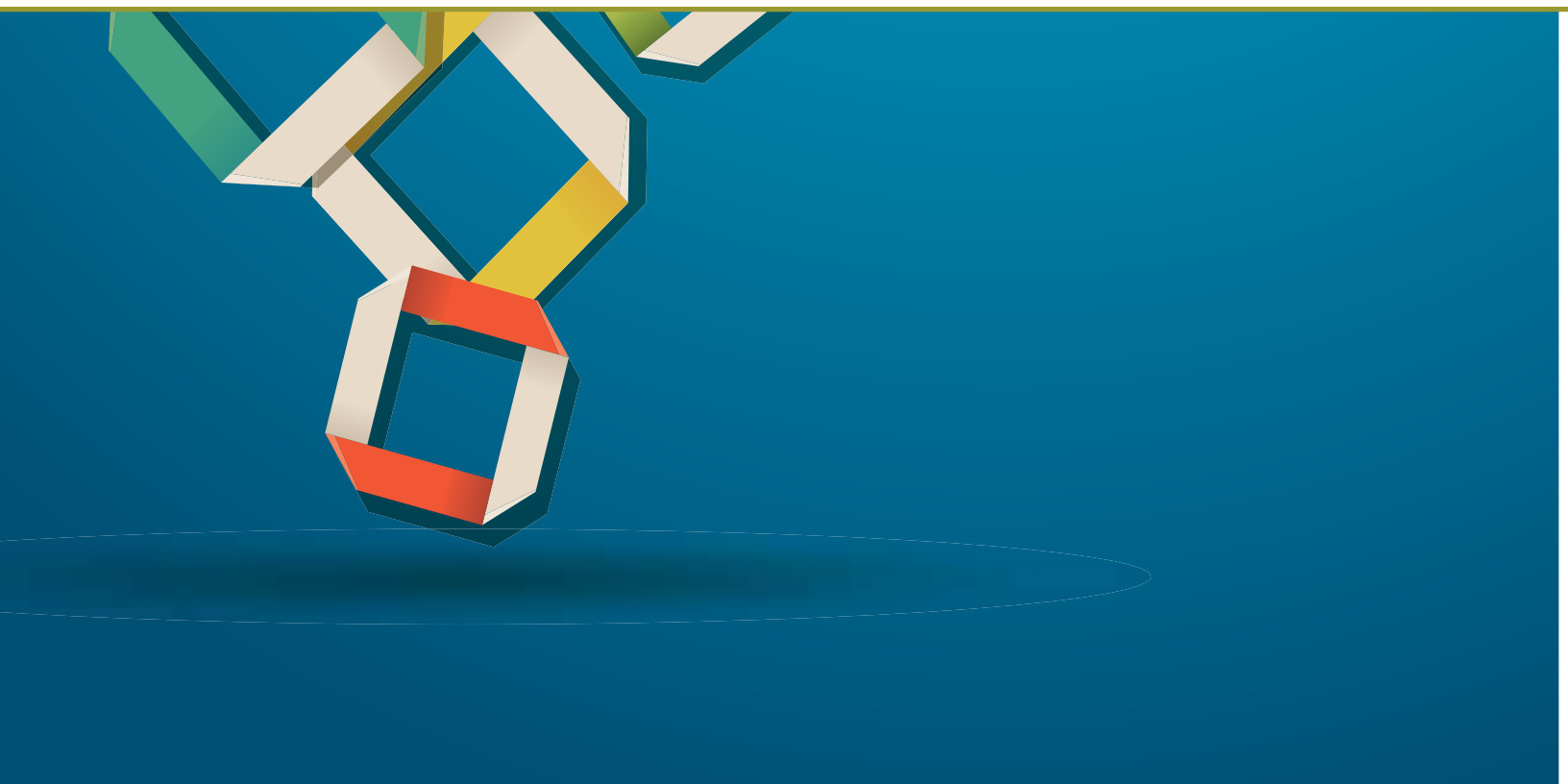
17 Grace, K.T. (2016). Caring for women experiencing reproductive coercion. *Journal of Midwifery & Women's Health*, 61(1), 112-115. <https://doi-org.proxy.library.vcu.edu/10.1111/jmwh.12369>





Section B:

Reproductive and Sexual Health Resources



Contraception Fact Sheets and Health Clinics in Virginia

Contraception Fact Sheets:

Birth Control Pill
Cervical Cap
Contraceptive Implants
Diaphragm
Emergency Contraception (EC)
External/Male Condom
Fertility Awareness Methods (FAMs)
Internal/Female Condom
Intrauterine Device (IUD)
Patch
Shot
Spermicide
Sponge
Tubal Ligation (Sterilization)
Vaginal Ring
Vasectomy (Sterilization)

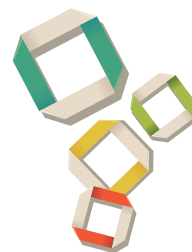
Concerned about the Cost of Emergency Contraception (EC)?

A prescription discount card is a free, downloadable card that can be presented at participating pharmacies in order to receive discounts on certain medications.

GoodRx is one of several prescription discount cards that can be used for EC. You can also search for the lowest price for EC using the **GoodRx website** or app.

Listing of Healthcare Clinics in Virginia:

Virginia Association of Free Clinics: Find a Free Clinic
Planned Parenthood Virginia Locations
Virginia Department of Health (VDH) Family Planning Clinics

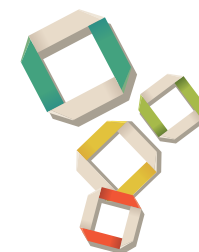


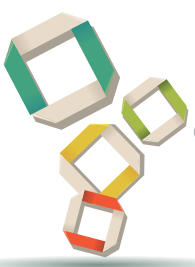
Birth Control Education

Methods that can be used without a partners' knowledge

All of these methods (except progestin-only Emergency Contraception) must be prescribed by a doctor or nurse practitioner. Progestin-only emergency contraception (EC) is available over-the-counter for people of all ages. Clients can call 1-800-230-PLAN (Planned Parenthood) to find a health care provider near them who can prescribe birth control. Talk to your client about safety planning around doctor's office reminder calls, scheduling visits, and insurance notifications if making appointments for birth control may put them at risk with a partner.

WHAT IS IT?	HOW DOES IT WORK?	HOW LONG IS IT EFFECTIVE?	HELPFUL HINTS	RISKS OF DETECTION
Implant: Nexplanon	A matchstick-sized tube of hormones (the same ones that are in birth control pills) is inserted into the inner arm. The hormones prevent ovulation.	3 years	The implant is generally invisible to the naked eye and scarring is rare.	Implant might be detected if palpated (examined by touch). Periods may stop completely. This may be a less safe option if an abusive partner closely monitors menstrual cycles.
Non-Hormonal Intrauterine Device (IUD): Paragard	The ParaGard IUD uses copper to prevent pregnancy. Sperm doesn't like copper, so the ParaGard IUD makes it almost impossible for sperm to get to an egg.	12 years	The ParaGard can be used as a form of emergency contraception if inserted within 7 days of unprotected sex.	IUDs have a string that hangs out of the cervical opening. If a person is worried that their partner will discover their IUD, they can ask a provider to cut the strings off at the cervix so that an abusive partner couldn't feel the strings or attempt to pull the IUD out. With hormonal IUDs, periods may stop completely. This may be a less safe option if a partner closely monitors menstrual cycles.
Hormonal Intrauterine Device (IUD): Skyla, Liletta, Kyleena, and Mirena	Hormonal IUDs prevent ovulation and thicken the cervical mucus, which blocks and traps sperm, making fertilization difficult.	Skyla: 3 years Liletta: 4 years Kyleena: 5 years Mirena: 6 years	Hormonal IUDs may lessen cramping around the time of your period and make the bleeding less heavy.	
Birth Control Shot: Depo-Provera	A shot is administered by a doctor that provides hormones (the same ones that are in birth control pills) to prevent ovulation.	3 months	Once administered, there is no way to stop the effects of the shot.	Periods may fluctuate (more or less bleeding). This may be a less safe option if a partner closely monitors menstrual cycles.
Emergency Contraception (EC): Plan B One-Step, Next Choice, My Way, etc.	Either a single dose or series of hormones is taken in pill-form within 5 days of unprotected sex to prevent ovulation.	Only in the 3-5 day window after unprotected sex occurs	EC can be purchased and kept on hand as a backup method of contraception.	If a person is worried that an abusive partner will tamper with their EC, they could remove from the packaging and store the medication in a hidden location.





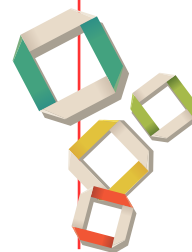
Frequently Asked Questions: Over-the-Counter Medications in Domestic Violence Programs and Sexual Assault Crisis Centers

QUESTION: Can our domestic violence program/sexual assault crisis center make over-the-counter (OTC) medications, pregnancy tests, and emergency contraception available to survivors using our program services?

ANSWER: Yes! We can remove barriers for survivors and provide access to non-prescription, OTC medications in our programs. Progestin-only emergency contraception (e.g. Plan B One-Step, Next Choice, Take Action, etc.) is available OTC without age restrictions, which means that it can be made available to survivors of all ages in your program.

THINGS TO CONSIDER

- **Offering is different from directing:** When you offer a bandage to someone who has cut themselves, the individual chooses whether or not to use what you are offering. By letting folks know that you have Tylenol, Aspirin, children's cough syrup, pregnancy tests, or emergency contraception available, you are providing information, not directing someone to use these items.
- **Dispensing is different from informing:** The term "dispensing" has legal implications in reference to controlled substances only. Informing someone that you have OTC medication available if they feel the need for it is not the same as dispensing medication. The individual is choosing to take Tylenol or give their child cough syrup; it is their choice. Domestic violence programs and sexual assault crisis centers are neither prohibited from nor directed to make OTC medications available to program participants. See Virginia Code § 54.1-2519 for "dispensing" and other related definitions.
- **Offering survivors medication enhances empowerment:** Survivor-centered, empowerment-oriented programs want to avoid controlling survivors' medications. Survivors should be in control of and have immediate and timely access to their own, and their children's, medication. If we make it difficult for survivors to access the medication that they may need, we are controlling their choices, and failing to offer a full range of options for responding to abuse. Making OTC medications available – just as you would make available a Band-Aid, Ace bandage, or ice for a wound – is a way to expand a survivor's control and choices about health and the health of their children. Increasing the ease with which a survivor can make choices about OTC medications can impact their life beyond the interaction with the program. In particular, making emergency contraception available in a timely manner can give a survivor a chance to prevent an unplanned pregnancy.



QUESTION: How do other domestic violence program/sexual assault crisis centers respond to these needs?

ANSWER: Individual programs have implemented a variety of creative approaches to meeting the medication and contraceptive needs of survivors. Some examples include:

- Provide sample sizes of Tylenol, ibuprofen, aspirin or cough medicine.
- Offer the larger-size items and ask for people to take what they need and return it immediately.
- Let all program participants know that pregnancy tests and emergency contraception are available on site, rather than waiting for someone to specifically ask.
- Give everyone an individual lock box for storage of OTC medication and prescription medication.

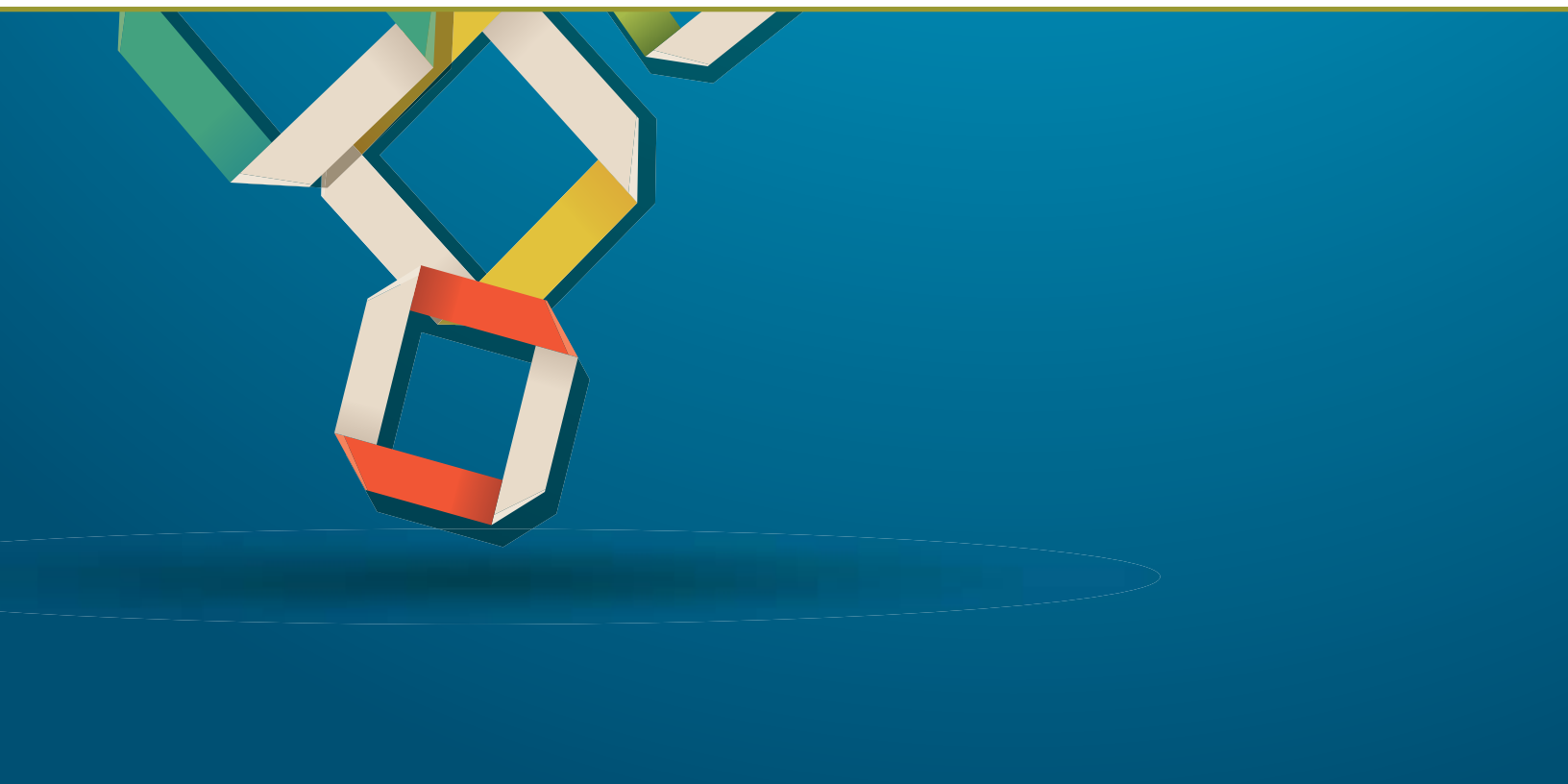
For more information and sample medication policies for shelters and/or other sexual and domestic violence programs, please see the National Center on Domestic Violence, Trauma, and Mental Health: Model Medication Policy for DV Shelters





Section C:

Implementing Reproductive Coercion Assessment



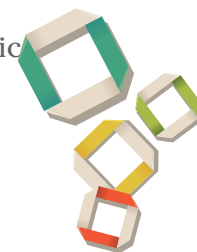
Virginia's Project Connect Coercion Screening Pilot: Lessons Learned and Recommendations

Between June 2012 and May 2013 the Virginia Sexual and Domestic Violence Action Alliance, building on the success of Project Connect and in collaboration with the Virginia Department of Health, began a pilot project to develop the capacity of four local domestic violence programs. The pilot focused on increasing screening for sexual and reproductive coercion, specifically within the context of intimate partner violence, and increasing partnerships with local healthcare providers to respond to the related healthcare needs of survivors. The four local shelter-based domestic violence programs that participated in the pilot were: Women's Resource Center of the New River Valley, Empowerhouse in Fredericksburg, The Laurel Center in Winchester, and Transitions Family Violence Services in Hampton.

Overall, the implementation of the pilot was a success. Each of the pilot sites reported they benefited from participating in the pilot. The pilot allowed them to incorporate screening for sexual and reproductive coercion into their standard intake procedures, make overall improvements to their intake process, establish community partnerships with healthcare providers, and increase access to reproductive health resources that they did not have prior to the pilot.

Lessons Learned from Virginia's Coercion Pilot:

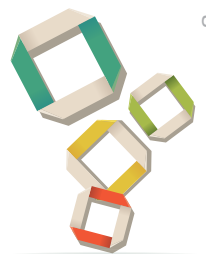
- Prior to the pilot, domestic violence program pilot sites had limited or no relationships with reproductive healthcare providers.
- Pilot programs that had baseline knowledge of sexual coercion, reproductive coercion, and reproductive health were able to modify policies and procedures and increase healthcare partnerships in a shorter amount of time, compared to those who did not have baseline knowledge. In addition, programs that were adequately staffed contributed to higher success.
- Pilot programs were more prepared when ALL domestic violence program staff (not just staff responsible for intake) participated in sexual and reproductive coercion screening training.
- During the orientation and training phase of the pilot, it was apparent that domestic violence program staff was uneasy asking questions about sexual health and experiences of coercion. In addition, overall staff knowledge of accurate sexual health information and comprehensive healthy sexuality was limited.



- When domestic violence program staff experienced positive outcomes as a result of asking survivors about reproductive health, they were more confident in implementing the screening.
- Providing regular opportunity for the pilot sites to discuss the challenges and successes experienced during the implementation increased comfort level with topic and confidence in implementation.
- After the pilot, domestic violence program sites anticipated long term changes with local health care providers and family planning providers – relationships with healthcare workers was key!
- After the pilot, Domestic Violence Program staff are talking more about a variety of health related issues that correlate to intimate partner violence.

Recommendations Based on Virginia's Coercion Pilot:

1. Assess program capacity prior to implementing screening for sexual and reproductive coercion. Comprehensive and ongoing training on reproductive health, reproductive and sexual coercion, and appropriate screening that is trauma-informed is essential.
2. Domestic Violence Program/Sexual Assault Crisis Center staff should practice/role play reproductive and sexual coercion screening to increase individual comfort level with topic.
3. Domestic Violence Program/Sexual Assault Crisis Center staff should be competent in the following topics: safety planning related to sexual and reproductive coercion, birth control/contraception (including the ability to dispel myths and misinformation regarding available options and specifically related to methods that are easily hidden from an abusive partner), sexually transmitted infections (including prevention and strategies to deal with exposure), and comprehensive healthy sexuality.
4. Domestic Violence Program/Sexual Assault Crisis Center staff should understand the health care system and have relationships with community health partners, such as family planning clinics, reproductive health care providers and community family planning/home visitation providers.
5. Domestic Violence Programs/Sexual Assault Crisis Centers should establish referral protocols with community health partners that increase the ability to quickly provide the health related service the survivor of sexual and/or intimate partner violence identifies.



Quotes from Domestic Violence Program Pilot Sites:

"Like others, women seem to respond better to health care providers providing information about health issues than an advocate."

"I learned not to worry too much about 'No' answers to the screening questions - even when we're sharing safety card information and they indicate they haven't experienced sexual coercion, we're providing education - and they may use it in the future."

"Having a nurse around (at the shelter) has opened up so many positive things and more access to health services in the community."

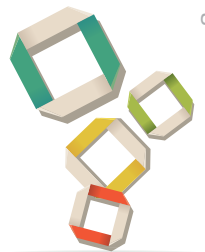
"I have found asking screening questions is very valuable. We want to incorporate this in counseling services as well, beyond residential shelter."

"The project has opened our eyes about what we can do to help clients access the health care system, beyond reproductive health."

Case Studies from Virginia's Coercion Pilot:

"Survivor is a 19 year old woman who was referred to The Laurel Center by local law enforcement. She was staying in a hotel with her partner when he became angry one night and began "torturing" her and threw her belongings out of the window. He also threatened to throw her down the stairs if she did not leave. She called the police and then was brought in to our shelter for a safe place to stay. During her intake, she did disclose that her previous partner "refused to wear condoms" and also threatened that "he would force her to have his child." She did share that at one point she was fearful of becoming pregnant when she did not want to be."

"Survivor is a 43 year old woman who found out about The Laurel Center's services online. She had left her abusive partner a few months earlier and had been living with unsupportive friends. They kicked her out of the house and she needed a place to stay. During her intake, she disclosed that she was a childhood survivor of incest. She also had been in 3 prior abusive intimate relationships. She shared that her previous partner had destroyed or tampered with her birth control and that he tried to force her to become pregnant while they were in a relationship."

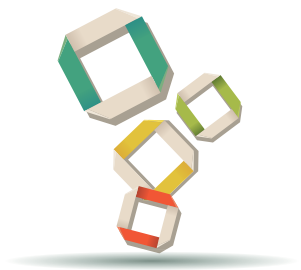


Case Studies from Virginia's Coercion Pilot:

"A young mother in her 30's came into shelter. She is the mother of a school age child and an infant. The sexual coercion assessment allowed her to open up that she had recently had a miscarriage while living with the abuser. She had not gone to the doctor to receive medical services and was very concerned about her reproductive health from the miscarriage. She was immediately linked to the nurse at shelter who referred her to the hospital for emergency care due to the seriousness of her health condition. It is the belief of our shelter coordinator that had the assessment not been performed the client would have suffered in silence. She was able to disclose her miscarriage and the sexual coercion she was experiencing and ultimately obtain medical attention."

"Survivor came to our shelter after a violent incident that ended with her being physically assaulted. She had been in a relationship for three years, and this was the first time her abuser had physically hurt her. She stated that he was controlling in all the typical ways – isolating her, insisting that he know where she is and whom she is with, not giving her access to money, choosing her friends, etc.

At some point, he started saying things like, "you should have my baby" and "you should have my kid." She saw these behaviors and dismissed them for a couple of years."





In Their Own Words: Creating a Culture of Wellness

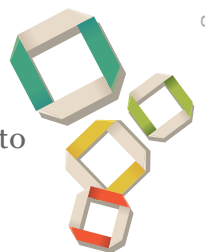
The Haven Shelter and Services in Warsaw, a Northern Neck of Virginia, has undergone a transformative process to better address the health care needs of service participants, including addressing the issue of reproductive coercion.

As part of a pilot program funded by the Office on Women's Health, The Haven was awarded a small grant that enabled us to better address the health care needs of persons who had experienced sexual and/or domestic violence. We approached the task by focusing on eating, fitness and smoking cessation. We contracted with a nurse to assist us in a whole shelter program review to assess where and how we needed to address our program and activities to be more health conscious. In assessing how we could promote good health amongst residents we quickly realized that our vision had to include promoting health and well being amongst the staff and volunteers as well – so we endeavored to make a whole culture shift to the shelter setting. Since we were working with a nurse who happened to be a nurse mid-wife, we also expanded our concept to include a focus on reproductive health.

Simultaneously we were addressing the issue of ensuring that our services were trauma-informed. This process involved a review of our policies and procedures and updating them, a review of the shelter environment, making the appropriate environmental changes, and training the staff and volunteers on trauma issues, ensuring that they maintained a consistent understanding of how trauma impacts the individuals we serve. It also included training and support in recognizing the impact of trauma on us as advocates. It was in this context that we began addressing reproductive coercion with receiving our services.

Our work involved several aspects before we began to ask women questions about reproductive coercion. First, was understanding the term. Most of the staff were familiar with the behaviors that are involved in reproductive coercion but putting a name to it helped to frame the issue. It involves forced pregnancy, pressure to become pregnant, pressure to terminate or forcing termination of a pregnancy, tampering with birth control or refusing to use birth control. Essentially reproductive coercion is attempting to control a partner through attempts to control their reproductive health. Talking about reproductive coercion also means we open up conversations about other sexual abuse and sexual coercion that program participants have experienced. Staff needed to be able to have these conversations in a trauma-informed manner and to be knowledgeable about safety planning options.

Safety planning options for reproductive coercion typically include health care providers. Staff had to be knowledgeable about what family planning health care providers were available in the community and build relationships with those providers. Staff had to be knowledgeable regarding birth control options and how to dispel myths and misinformation regarding available options. Sexual and reproductive coercion also involves a higher risk for exposure to sexually transmitted infections (STIs).



A big part of the response to these issues is connecting women with appropriate health care providers and supporting education on techniques and strategies to deal with exposure to STIs as well as prevention to exposure.

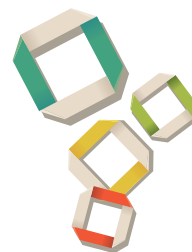
Training staff and building relationships with Family Planning Providers was a huge part of integrating information about reproductive coercion into our day to day work. Just as being able to provide program participants with accurate information and advocacy in the legal realm, we have to understand how the health care system works and forge relationships with those players in that system. Educating ourselves and building those relationships helps us to advocate on behalf of people who have experienced violence and helps them to access what they need to increase their options for safety. We find that the responses to the discussion of reproductive and sexual coercion vary greatly from those who find it difficult to engage in the conversation at all to those who are so relieved that someone is asking questions that they are able to talk and talk.

We were fortunate to be able to purchase brochures and information about birth control options, STIs, Emergency Contraception and other overall health care information in English and in Spanish to have them available for residents and staff. Much of this information is available and downloadable on line. The Office on Women's Health and Futures Without Violence both have a wealth of information on their websites to help educate both residents and staff when you are ready to begin discussions on reproductive coercion. Your local health department is also a valuable source of information on family planning information. As part of Project Connect in Virginia, all of the family planning providers in local Health Departments are required to receive training in addressing reproductive coercion and intimate partner violence. A good starting place is reaching out to your local Health Department and having a conversation on what your program has to offer and gaining understanding on what the local Health Department has to offer. If you have a Planned Parenthood Clinic in your service area, that can be another supportive organization to collaborate with.

The importance of addressing the overall health care needs in a trauma-informed manner can't be overstated. A shelter environment that supports the overall health and well being of folks provides a much more supportive context to engage in these discussions. Providing the support and opportunity for women to open up about reproductive and sexual coercion gives us a greater understanding of the complex barriers so many individuals face in escaping abusive and violent relationships. It helps break down the isolation and shame that so many women carry, having experienced behaviors that they had no name for. Building alliances and relationships with healthcare and family planning providers also helps us reach provide more effective services to individuals who may be experiencing this form of control.

When we care about women's overall health and well being, including their reproductive health, we can help women to build lives that are both healthy and safe. When we care about our own overall health and well being we can inspire others to do so as well.

For more information, contact: The Haven P.O. Box 1267 Warsaw, Virginia 22572
Phone: 804-333-1099 <http://www.havenshelter.org>



Preparing Your Program: Screening for Sexual and Reproductive Coercion at Intake

- ☐ Ensure that **all** staff, especially those responsible for intake, have received training about sexual and reproductive coercion (including best practices in screening). It is recommended that staff also receive training about healthy sexuality and contraception.¹
- ☐ Examine your intake process to ensure that it is trauma-informed.²
- ☐ Develop screening questions for both sexual and reproductive coercion that will be asked during initial contact with every survivor.³
- ☐ If you are working with survivors who are entering shelter, conduct a brief intake with minimal questions, including coercion screening questions. Follow up brief intake with a standard intake (within 24 hours) that covers more detailed and specific legal and health information.⁴
- ☐ Develop a Healthcare Information Sheet specific to your agency and service area.⁵ This should be given to every survivor upon entering shelter or at first contact with your agency.
- ☐ Develop a resource list of local family planning/reproductive health clinics and providers, including:
 - Phone number(s)
 - Location(s)
 - Transportation options (e.g. is it on the bus line? etc.)
 - Hours, services, and hours during which certain services are offered (e.g. what are the family planning clinics hours, when do they see new patients, and when do they do testing for sexually transmitted infections?)
 - Cost (e.g. are there income requirements? how much do services cost?)
 - Do they have Emergency Contraception (EC) available? If so, how much does it cost? If the facility is not a family planning clinic, do they still offer access to EC?

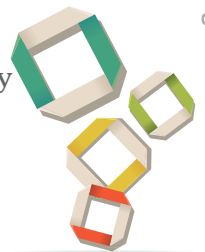
¹ For information about training opportunities provided by the Action Alliance, visit: <https://all-ancetrainingsite.wordpress.com/>.

² See Supplemental Information (Section E): Trauma-Informed Services (E.1-E.4)

³ See Sample Safety Card: Is Your Relationship Affecting Your Health? (D.7) and Sample Safety Card: Caring Relationships, Healthy You (D.8) for examples of screening questions.

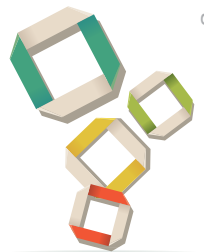
⁴ See Sample Shelter Intake Form: Brief (D.4) and Sample Shelter Intake Form: Full (D.5)

⁵ See Sample Healthcare Information Sheet (D.1)



- ☐ Develop a list of local pharmacies that carry EC. Be sure to include cost.
- ☐ Establish a formal relationship with at least one family planning partner and/or reproductive health clinic. Initial contact and relationship building may include, but are not limited to, the following cross-education opportunities:
 - Attend staff meetings to share information about your agency services.
 - Invite a clinic staff person to attend one of your staff meetings to share information on family planning services, birth control, and services offered at the clinic.
 - Make a plan for routine (monthly or bimonthly) presentations to program staff and residents on reproductive/sexual health and birth control.
- ☐ Sign a Memorandum of Agreement (MOA)/ Memorandum of Understanding (MOU) with local family planning partner(s).⁶ Ensure seamless care by developing a referral procedure between your agency and the local family planning partner(s).
- ☐ Ensure partnership sustainability by maintaining contact with your local family planning partner(s). Establish a process for annually re-evaluating the MOA/MOU.

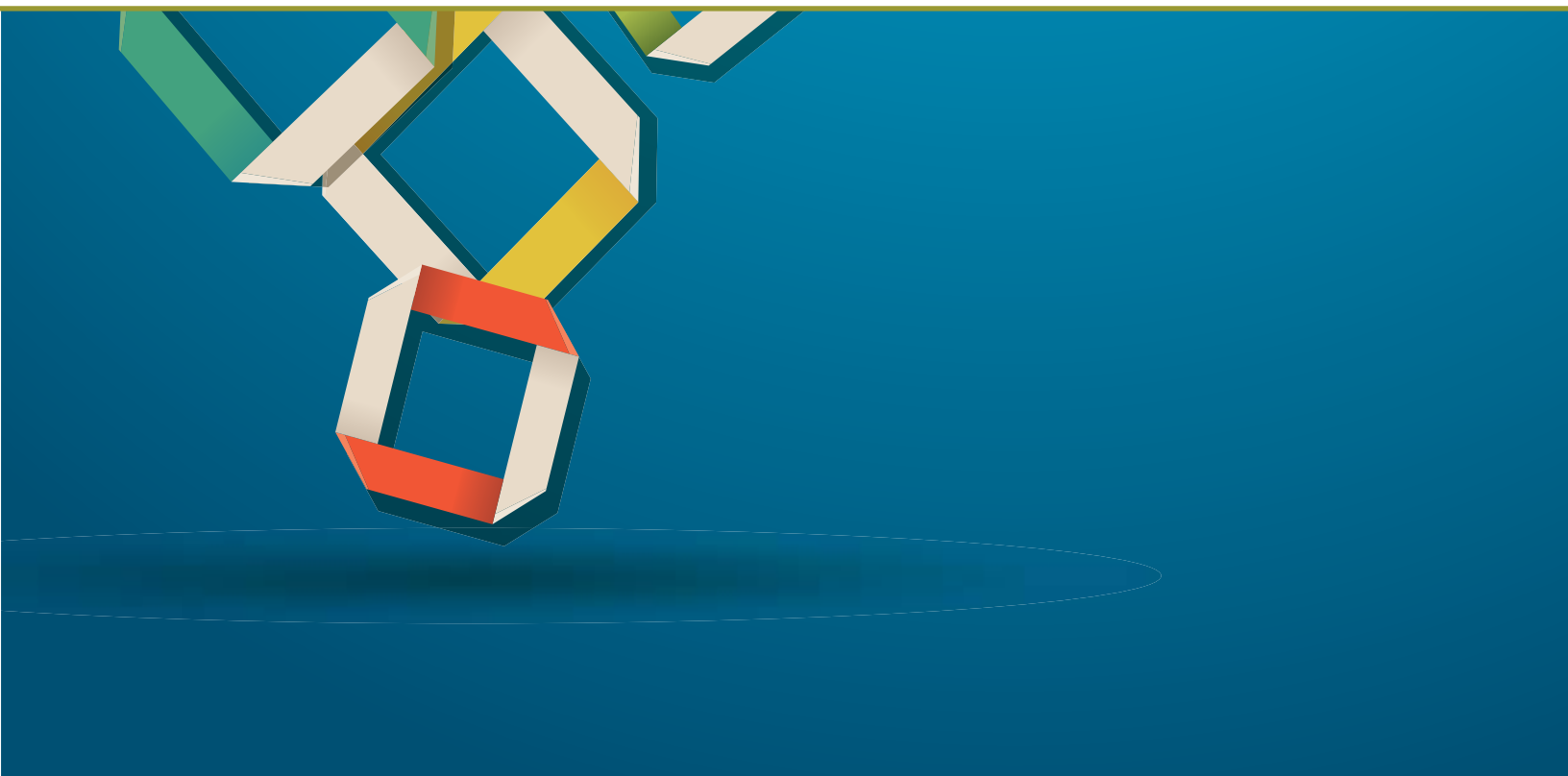
⁶ See Sample Memorandum Of Agreement Family Planning Clinics (D.6)





Section D:

Sample Forms and Policies





Health Care Information Sheet



This may not be a concern for you right now; however, we give this information sheet and this safety card to everyone who uses our services.

Many people who come to our program have experienced situations that put them at risk for unwanted or unplanned pregnancies. If you are concerned about being pregnant or if you have had unprotected sex in the past 5 days and do not wish to become pregnant, please speak with a staff member.

If you are concerned about **being pregnant** we can provide you with a pregnancy test.

If you are concerned because you have had **unprotected sex in the past 5 days**, there is a safe medication that you can take called emergency contraception (or the morning after pill).

Emergency contraception is available at the Health Department at a reduced fee or at a local pharmacy without a prescription.

Please talk to your case manager about any concerns you have about pregnancy and/or safe contraception.

Below are some resources offering reproductive health services:

INSERT DETAILS FOR LOCAL FAMILY PLANNING CLINICS, PHARMACIES, ETC. BE SURE TO INCLUDE OPERATING HOURS, SERVICES OFFERED, FEES, AND ANY OTHER IMPORTANT INFORMATION

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance

Reproductive and Sexual Coercion Toolkit
Virginia Sexual & Domestic Violence Action Alliance
www.vsdvalliance.org



Health Care Referral Form



Client Name: _____ Pronouns: _____

Date of Birth: _____

Insurance: _____

Chief Complaint: _____

Referred To: _____

Provider Address: _____

Provider Phone: _____

Appointment: _____

After staff makes appointment, please give referral form to client to take to provider.

Any follow-up needed?

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance



Health Care Screening Tool



Client Name: _____ Pronouns: _____

Date of Birth: _____ Age: _____ Last Menstrual Cycle: _____

Blood Pressure: _____ Weight: _____ Height: _____ Body Mass Index: _____

Medications: _____

Allergies: _____

Chief Complaint Today: _____

Medical History:

1. Do you have any health problems that you know of? _____

2. Do any of the following conditions run in your family?

- ☐ Diabetes (sugar problems)
- ☐ High blood pressure
- ☐ Cancer

3. Have you had any issues or problems with:

- | | |
|--|---|
| <input type="checkbox"/> Bowel movements
(constipation or diarrhea) | <input type="checkbox"/> Stomach (heartburn, nausea,
vomiting) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Urination (peeing) |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Menstruation (periods) | |

4. Have you ever been pregnant? _____

How many times pregnant? _____ How many births? _____

How many miscarriages or abortions? _____ C-section or Vaginal Births? _____

5. Do you use birth control? _____ If yes, what kind? _____

6. Last Pap smear in a doctor's office? _____

7. Mammogram? (over 40) _____

8. Have you ever been treated for depression? _____

9. Have you ever had seizures? _____

10. Have you had a flu shot this year? _____

11. Do you smoke cigarettes? _____

Comments: _____

Are there any health topics you would like more information on? _____

Referral? _____

Interviewer: _____ Date: _____

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance

Reproductive and Sexual Coercion Toolkit

Virginia Sexual & Domestic Violence Action Alliance

www.vsdvalliance.org



Shelter Intake Form: Brief



_____ Name	_____ Pronouns	_____ Cell Phone Number
_____ Intake Date/Time	_____ Staff/Interviewer	
Accommodations Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please describe: _____		

Perpetrator Information of Presenting Experience:

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender	Race: <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Latino(a)/Hispanic <input type="checkbox"/> Native American/Native Alaskan <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other/Unknown <input type="checkbox"/> White/Caucasian
Age: _____	Relationship: <input type="checkbox"/> Acquaintance <input type="checkbox"/> Caretaker (non-family) <input type="checkbox"/> Cohabiting Partner/Spouse (includes ex's) <input type="checkbox"/> Dating partner <input type="checkbox"/> Extended Family <input type="checkbox"/> Other Household Member <input type="checkbox"/> Parent <input type="checkbox"/> Stepparent/Parent's Dating Partner <input type="checkbox"/> Stranger <input type="checkbox"/> Unknown/Other
Is there a Protective Order in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a copy.	

Accompanying Child(ren) Information:

Full Name:	Age:	Gender and Pronouns:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immediate Needs:

Are you or your children in need of:

<input type="checkbox"/> food	Need Addressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
<input type="checkbox"/> clothing	Need Addressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
<input type="checkbox"/> shoes	Need Addressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____
<input type="checkbox"/> other	Need Addressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Notes: _____

Do you or your children have any current medical or health related needs? ☐ Yes ☐ No

☐ **Healthcare information provided.**

Emergency Contact Person:

Name: _____ **Phone Number:** _____

Relationship: _____

By signing below, my signature grants permission for staff to call the above emergency contact person in the case of an emergency.

Resident Signature: _____ **Date:** _____

Staff/Interviewer Signature: _____ **Date:** _____

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance



Shelter Intake Form: Full



Date: _____ Time: _____ Staff/Interviewer: _____

Participant Code: _____ Gender: _____ Pronouns: _____

Race: _____ Age: _____ Locality of Residency: _____

Do you identify as a person with a disability? ☐ Yes ☐ No

If yes, is it a result of domestic and/or sexual violence? ☐ Yes ☐ No

Are you an immigrant/refugee/asylum seeker? ☐ Yes ☐ No

Are you a person with limited English proficiency? ☐ Yes ☐ No

Are you a veteran (either active duty or retired/discharged)? ☐ Yes ☐ No

Are you eligible for Temporary Assistance to Needy Family (TANF) benefits? ☐ Yes ☐ No
☐ Don't Know

Are there concerns for your children who have been exposed to violence? ☐ Yes ☐ No

Are you currently enrolled in college? ☐ Yes ☐ No

Do you identify as Lesbian, Gay, Bisexual, or Queer? ☐ Yes ☐ No

Do you identify as deaf or hard of hearing? ☐ Yes ☐ No

Do you identify as homeless? ☐ Yes ☐ No

Have you used our services before?

How did you hear about our services? _____

Reason Shelter Requested ☐ DV ☐ SV ☐ FV ☐ Homelessness ☐ Other

Reproductive and Sexual Coercion Toolkit

Virginia Sexual & Domestic Violence Action Alliance

www.vsdvalliance.org

Presenting Incident of Violence

Was there a recent incident of violence that brought you to shelter?

☐ Yes ☐ No

Where did the presenting violence take place?

☐ Campus/University
☐ Home
☐ Other household
☐ School (pre-school – grade 12)
☐ Unknown/Other
☐ Workplace

Was the presenting incident reported to law enforcement?

☐ Yes ☐ No

Have charges been filed against perpetrator?

☐ Yes ☐ No

If yes, ☐ Misdemeanor ☐ Felony ☐ Both

Do you have concerns about custody of your children or child support?

☐ Yes ☐ No

If you do not have a protective order, are you interested in more information on how to obtain one?

☐ Yes ☐ No

Impact of Presenting Experience

What are your primary concerns right now that are a result of your most recent experience? Check all that apply.

- ☐ Ability to meet basic financial needs
- ☐ Access to affordable and safe housing
- ☐ Awareness and access to community resources (how to get more help)
- ☐ Family stability
- ☐ Impact of the violence on children
- ☐ Impact of the violence on a non-offending partner
- ☐ Impact of the violence on a non-offending parent/guardian
- ☐ Mental/emotional health and well being
- ☐ Immigration issues
- ☐ Legal issues
- ☐ Physical well-being
- ☐ Safety (fear of the abuser, feeling unsafe)
- ☐ Sexual and reproductive health and well- being
- ☐ Spiritual well-being
- ☐ Support systems/relationships (trust, relationships within communities, family and friends)

Of the concerns you have identified above, what are your three most immediate concerns?

1. _____ 2. _____ 3. _____

What have you done to help keep yourself safe in the past, in response to the violence, that has been helpful?

What have you done in the past that has not been helpful?

Asking any questions about history of violence experienced should be prefaced with an explanation and a request to continue. "I would like to ask you a couple of questions about your history with violence and whether you have had past experiences with violence, is it alright for me to proceed or would you rather not. It is up to you." Allow the person a few moments to think about what they would like to do.

History of Violence Experienced

Have you experienced sexual or domestic violence in any other relationship as an adult? ☐ Yes ☐ No

More info:

Have you experienced sexual or domestic violence as a child? ☐ Yes ☐ No

More info:

Is there anything you would like to share about any experience of violence you have experienced in the past? ☐ Yes ☐ No

More info:

I would like to move on to talk about what brought you to us. The next set of questions is about your most recent experiences with violence. Please take your time and feel free to stop if you need to take a break.

Risk Assessment and Safety Planning

If perpetrator is a former partner/spouse, is the separation recent? ☐ Yes ☐ No

Has the perpetrator ever: ☐ Yes ☐ No

Stalked you or another family member? ☐ Yes ☐ No

Used a weapon, or an object as a weapon against you or another? ☐ Yes ☐ No

Threatened to or used a firearm against you or another? ☐ Yes ☐ No

Made threats of suicide or homicide? ☐ Yes ☐ No

Blocked or obstructed your breathing? ☐ Yes ☐ No

Hurt or threatened to hurt your children? ☐ Yes ☐ No

Hurt or threatened to harm a pet or other animal you or your children care for? ☐ Yes ☐ No

Destroyed or threatened to destroy your property? ☐ Yes ☐ No

If you are dependent on the perpetrator, has the perpetrator kept you from getting help with a personal need, such as eating, bathing, toileting, or access to medications? ☐ Yes ☐ No

Are you currently pregnant or concerned about being pregnant? ☐ Yes ☐ No

Destroyed or tampered with (messed with) your birth control, refused to use birth control or prevented you from using birth control? ☐ Yes ☐ No

Forced you to become pregnant when you didn't want to or to terminate a pregnancy that you didn't want to? ☐ Yes ☐ No

Pressured or forced you to do things sexually you are not comfortable with? ☐ Yes ☐ No

As a result of the violence, have you or your children:

Sustained physical injuries requiring emergency medical attention? ☐ Yes ☐ No

Missed time from school, work or missed scheduled appointments? ☐ Yes ☐ No

Experienced a loss of income and or financial security? ☐ Yes ☐ No

Become homeless? ☐ Yes ☐ No

Had to relocate? ☐ Yes ☐ No

Considered suicide? ☐ Yes ☐ No

Become pregnant or were worried about being pregnant when you did not want to be? ☐ Yes ☐ No

Medical and Health Information

Do you or your children have any health concerns or medical issues that we should know about? ☐ Yes ☐ No

If yes, please explain.

Are you or your children on any medication that the staff should be aware of? ☐ Yes ☐ No

If yes, please explain.

Do you or your children have any concerns about any health or medical related issues that you would like to address? ☐ Yes ☐ No

If yes, please explain.

Do you have health insurance? ☐ Yes ☐ No

Do your children have health insurance? ☐ Yes ☐ No

Would you feel comfortable providing your health insurance information to the staff? *If yes, copy health insurance card/information and attach.* ☐ Yes ☐ No

If you do not have health insurance, would you like help with trying to get it? ☐ Yes ☐ No

Do you have a primary care doctor?

Name: _____ ☐ Yes ☐ No

Would you be interested in speaking with a healthcare professional while you are at the shelter? ☐ Yes ☐ No
☐ Maybe

The following questions are for individuals who express a need in obtaining housing or employment.

Housing and Employment

Are you currently employed? ☐ Yes ☐ No

If not, when and where were you last employed? _____

What is the source of your income?

☐ Child Support

☐ Other

☐ Disability/SSI Benefits

☐ Salary

What is your current income per month? _____

Do you have a prior felony conviction?

☐ Yes ☐ No

Have you ever been evicted from housing?

☐ Yes ☐ No

Do you know your credit score?

☐ Yes ☐ No

If yes, what is it? _____

Would you like help in finding out your credit score?

☐ Yes ☐ No

Do you have a car or access to transportation?

☐ Yes ☐ No

Education

Did you complete high school

☐ Yes ☐ No

If no, what grade did you complete? _____

If no, do you have a GED?

☐ Yes ☐ No

If no, are you interested in pursuing a GED at this time?

☐ Yes ☐ No

Did you complete college?

☐ Yes ☐ No

If yes, what was your degree in? _____

Are you a registered voter?

☐ Yes ☐ No

Would you like to become a registered voter?

☐ Yes ☐ No

Is there anything else you would like to tell us about your situation or what you might need from the staff?

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance

Reproductive and Sexual Coercion Toolkit

Virginia Sexual & Domestic Violence Action Alliance

www.vsdvalliance.org



Memorandum of Agreement Sample



This agreement is by and between [domestic violence program/sexual assault crisis center] and [family planning program] to enhance the response to individuals and families experiencing sexual and intimate partner violence in the [locality/region] area.

The parties listed above and whose designated agents have signed this document agree that:

- 1) The [domestic violence program/sexual assault crisis center] and [the family planning program] agree to work collaboratively on increasing reproductive and sexual coercion screening and health related referrals to enhance our response to those experiencing intimate partner violence.
- 2) The [domestic violence program/sexual assault crisis center] will provide training and ongoing technical assistance on identifying and responding to intimate partner violence for all staff of [the family planning program].
- 3) The [family planning program] will provide training and ongoing technical assistance on reproductive health and family planning to all staff of [domestic violence program/sexual assault crisis center].
- 4) The [family planning program] agrees to use model interventions identified for screening for intimate partner violence and participate in training and evaluation activities.
- 5) When intimate partner violence is identified by [the family planning program], staff will review advocacy services available in the community and provide referral to the

[domestic violence program/sexual assault crisis center] or other appropriate sexual or domestic violence services.

- 6) The [domestic violence program/sexual assault crisis center] agrees to provide each individual seeking services as a result of a referral from the [family planning program] with appropriate safety planning and support services to address sexual or intimate partner violence.
- 7) The [domestic violence program/sexual assault crisis center] agrees to provide materials to the [family planning program] in support of ongoing training and consultation efforts, as well as awareness materials to distribute to the [family planning program's] clients.
- 8) The [domestic violence program/sexual assault crisis center] agrees to develop and maintain up-to-date referral and resource materials and to make those materials available to the [family planning program].
- 9) Representatives of the [domestic violence program/sexual assault crisis center] and the [family planning program] will meet at least once annually to ensure an understanding of the scope of services provided by their respective programs, review referral policies between agencies, and revisit the terms of this agreement.

We, the undersigned, approve and agree to the terms and conditions as outlined in the Memorandum of Agreement.

Executive Director (SDVA)

Family Planning Program Representative

Date

Date

Developed by the Haven Shelter & Services, Inc. in Warsaw, Virginia and adapted by the Virginia Sexual and Domestic Violence Action Alliance

Your Past Can Affect Your Health

Some parents/caregivers hurt their kids—it happens more than we think. Maybe they:

- ✓ Called you names, didn't feed you enough, couldn't love or care for you
- ✓ Injured you when they punished you or did sexual things to you or made you do things to them

Where you live and what you saw when you were a kid can affect you too. Like if you:

- ✓ Had a caregiver who was hurt by their partner, they argued a lot, or they had mental health or addiction problems
- ✓ Faced racism, lived in unsafe places, or were bullied

Even if some of this or a lot of this happened to you—it isn't the end of the story.

Simple Steps For Healing

Science tells us when you are hurt as a kid or as an adult you are at risk for having a hard time taking care of yourself.

Let's change that.

1. The best way to make it better is to reduce the stress on your body.
 - Exercise—it calms the brain and body and helps you feel better.
2. It sounds silly, but when you get hurt, your body learns how to hold on to that stress and worry. There's a way to turn down anxiety when it's safe.
 - Deep breathing is the key to this. Check out "Tactical Breather," a free cell phone app to help you feel calm and reminds you how to slow your breathing to help you think.

Safety Planning

If you are being hurt by a partner, it is not your fault. You deserve to be safe and treated with respect.

If your safety is at risk:

- ☎ Call 911 if you are in immediate danger.
- ✚ Prepare an emergency kit in case you have to leave fast with: money, phone charger, keys, medicines, birth certificates and shot records.
- 💬 Talk to your health care provider for help using their phone to call the local or national hotlines on this card so the number you called can't be traced. Develop a safety plan using this app:
http://www.joinonelove.org/my_plan_app

Call 911 if you are in immediate danger.



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Funded in part by the U.S. Department of Health and Human Services and Administration on Children, Youth and Families (Grant #90EV0414).

The National Domestic Violence Hotline is confidential, open 24/7, and has staff who are kind and can help you with a plan to be safer.

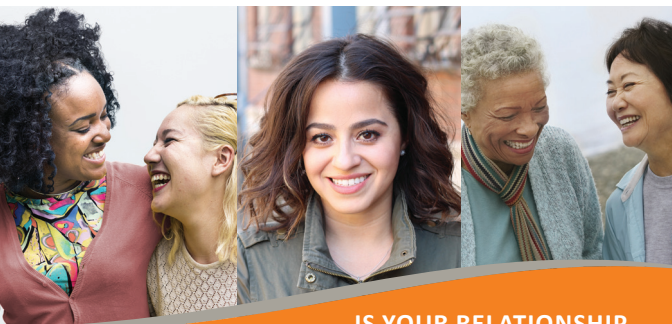
The Hotline

1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224 www.thehotline.org

Text trained counselors about anything that's on your mind:

Crisis Text Line

www.crisistextline.org
Text "START" to 741741



**IS YOUR RELATIONSHIP
AFFECTING YOUR HEALTH?**

How's It Going?

Everyone deserves to have partners listen to what they want and need. Ask yourself:

- ✓ Is my partner or the person I am seeing kind to me and respectful of my choices?
- ✓ Is my partner willing to talk openly when there are problems?
- ✓ Does my partner give me space to spend time with other people?

If you answered YES to these questions, it sounds like you have a supportive and caring partner. Studies show that being cared for by the person you are with leads to better health, a longer life, and helps your kids.

Are There Times...

My partner or the person I'm seeing:

- ✗ Shames or humiliates me, makes me feel bad about myself, or controls where I go and how I spend my money?
- ✗ Ever hurts or scares me with their words or actions?
- ✗ Makes me have sex when I don't want to?
- ✗ Keeps me from seeing my doctor or taking my medicine?

These experiences are common. 1 in 4 women is hurt by a partner in her lifetime. If something like this is happening to you or a friend, call or text the hotlines on this card.

Helping a Friend

Everyone feels helpless at times and like nothing they do is right.

Sound familiar? This can be a bigger problem if you have a partner who is unhealthy or unsafe. Connecting with friends or family who are having hard times like this is so important.

You can help by telling them they aren't alone. "Hey, I've been there too and someone gave this card to me. It has ideas on places you can go for support and things you can do to be safer and healthier."

And for you? Studies show when we help others we see the good in ourselves, too.

Partners Can Affect Health

A lot of people don't realize that having a partner hurt you with their words, injure/hurt you or make you do sexual things you don't want to can affect your health:

- ✓ Asthma, diabetes, chronic pain, high blood pressure, cancer
- ✓ Smoking, drug and alcohol abuse, unplanned pregnancies and STDs
- ✓ Trouble sleeping, depression, anxiety, inability to think or control emotions

Talking to your health provider about these connections can help them take better care of you.

Stronger You

What does it mean to be strong, resilient or come back from bad experiences?

- ✓ Knowing you aren't at fault for what was done to you.
- ✓ Figuring out how to manage stress and find healthy ways to cope.
- ✓ Finding people who are safe can help you heal.

Maybe you have a good friend to talk with. Maybe you don't yet. For some, talking to the helpful people from the hotlines listed on this card might be a great first step.



How are things feeling?

Do my partner(s):

- ✓ Support me and respect my choices?
- ✓ Support me in spending time with friends or family?

Do I:

- ✓ Feel comfortable talking about my feelings, sex, and other important things with my partner(s)?
- ✓ Support my partner(s), their independence, and their identities?

These are some elements of healthy relationships, which can contribute to good physical and mental health.

Everyone deserves to have partners who respect them and listen to what they want and need. Ask yourself:

Do I have concerns about the way

- ✓ I am being treated?
- ✓ I am treating my partner(s)?

Unhealthy relationships can have negative effects on your health.

Unhealthy: Do you or your partner...

- ✗ Use guilt or jealousy to influence what the other person does or who they see?
- ✗ Put the other person down or make them feel bad about themselves?
- ✗ Threaten to out the other's gender identity, sexual orientation, HIV status or immigration status to friends, family, or at work?
- ✗ Refuse to recognize the other person's name, pronoun, identity or preferred language?
- ✗ Control the other's money or spending freedom?
- ✗ Restrict the other's access to medicine (hormones, anti-anxiety/depression, PrEP/PEP, ART, substance replacement therapy, birth control)?
- ✗ Use the other's children to control or hurt them?
- ✗ Pressure the other person to do something sexual they don't want to do? Or fetishize or exoticize the other person's identity and/or body without consent?

Actions like these can be harmful for your emotional and physical health. Help is available.

Is your relationship affecting your health?

- ✓ Do you often feel depressed, anxious or stressed? Is your relationship making it worse?
- ✓ Are you drinking, smoking, or using drugs in order to cope with what is going on in your relationship(s)?
- ✓ Have you noticed a change in your appetite, weight, or sleeping habits?
- ✓ Do you have health issues that can be worsened by chronic stress?

The resources on the back of this card can help you make a plan to talk to your provider about how your relationship could be affecting your health.

You are not alone

Abuse and/or domestic violence occurs in all kinds of relationships.

The fact that it happens often does not make it okay.

You deserve to be in a relationship that is supportive and feels good. **Help is available.**

A plan that works for you

If you feel that there is something not right about your relationship it could be helpful to talk with a trusted friend or advocate about what you have been experiencing.

Together, you could formulate a plan about:

- ✓ How to get support for things you may be doing to help you cope, such as: binge drinking, using drugs, eating too much or too little.
- ✓ How to connect with your health provider about what to do if your partner is restricting your access to medications or health visits, and other ways that your relationship could be affecting your health.
- ✓ How to reduce harm within your relationship and/or develop a safety plan.
- ✓ How to connect with resources on the back of this card and in your community to learn about your options.

National, confidential hotlines can connect you to local resources and provide support 24/7 via phone, text, or online chat:

National Domestic Violence Hotline
1-800-799-7233 | 1-800-787-3224 (TTY)
thehotline.org

The Trevor Project
Crisis line for LGBTQ Youth
866-488-7386 | thetrevorproject.org

Developed in collaboration with the Los Angeles LGBT Center, API Institute on IPV, Casa de Esperanza, National Coalition of Anti-Violence Programs, FORGE, Kaiser Permanente of Northern California, The Network/La Red and the University of Pittsburgh

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Funded by the U.S. Department of Health and Human Services' Administration on Children, Youth and Families (Grant #90EV0414). Illustration by Vero D. Orozco

Other helpful resources:

The Northwest Network
nwnetwork.org

National Coalition of Anti-Violence Programs **ncavp.org**

FORGE for trans people and allies
forge-forward.org

The Northwest Network
of bi, trans, lesbian & gay survivors of abuse



GLMA
GLAY & LESBIAN MEDICAL ASSOCIATION

FUTURES
WITHOUT VIOLENCE

futureswithoutviolence.org

Caring Relationships, Healthy You



¿Cómo están las cosas?

¿Mi(s) pareja(s):

- ✓ Me apoya(n) y respeta(n) mis decisiones?
- ✓ Me apoya(n) en pasar tiempo con mis amistades o mi familia?

¿Yo:

- ✓ Me siento en comodidad de hablar con mi(s) pareja(s) sobre mis sentimientos, el sexo y otras cosas importantes?
- ✓ Apoyo a mi(s) pareja(s), su independencia y sus identidades?

Estos son algunos de los elementos de las relaciones saludables, las cuales pueden contribuir a una buena salud física y mental. Todas las personas merecen tener parejas que las respeten y que presten atención a lo que quieren y necesitan. Pregúntate:

¿Me preocupa la forma en que

- ✓ Me tratan?
- ✓ Yo trato a mi(s) pareja(s)?

Las relaciones no saludables pueden tener un efecto negativo en tu salud.

No saludable: ¿Tú o tu pareja...

- ✗ Usan la culpa o los celos para influenciar lo que hace la otra persona o con quién comparte?
- ✗ Humillan a la otra persona o la hacen sentir mal sobre sí misma?
- ✗ Amenazan con revelar la identidad de género, la orientación sexual, el estatus de VIH o de inmigración de la otra persona ante amistades, ante familiares o en el trabajo?
- ✗ Se rehúsan a reconocer el nombre, el pronombre, la identidad o el idioma de preferencia de la otra persona?
- ✗ Controlan el dinero o la libertad económica de la otra persona?
- ✗ Restringen el acceso de la otra persona a medicamentos (hormonas, calmantes/antidepresivos, PrEP/PEP, antiretrovirales, terapias de sustitución, anticonceptivos)?
- ✗ Usan a lxs hijxs de la otra persona para controlarla o hierla?
- ✗ Presionan a la otra persona para que haga algo sexual que no quiere hacer? ¿O hacen de la identidad y/o el cuerpo de la otra persona un fetiche o algo exótico sin su consentimiento?

Acciones como estas pueden ser dañinas para tu salud emocional y física. Hay ayuda disponible.

¿Tu relación está afectando tu salud?

- ✓ ¿Sientes depresión, ansiedad o estrés a menudo? ¿Tú relación empeora esto?
- ✓ ¿Estás bebiendo, fumando o usando drogas para poder enfrentar lo que está sucediendo en tu(s) relación(es)?
- ✓ ¿Has notado un cambio en tu apetito, tu peso o tus hábitos de sueño?
- ✓ ¿Tienes problemas de salud que pueden agravarse con el estrés crónico?

Los recursos al otro lado de esta tarjeta pueden ayudarte a hacer un plan para hablar con tu proveedor sobre cómo tu relación puede estar afectando tu salud.

No estás solx

El abuso y/o la violencia ocurren en todo tipo de relaciones.

El hecho de que ocurran con frecuencia no significa que estén justificadas. Tú te mereces una relación que te brinde apoyo y se sienta bien. **Hay ayuda disponible.**

Un plan que funcione para ti

Si sientes que algo no anda bien con tu relación, podría ser útil que hablaras con una amistad de confianza o una persona de apoyo profesional o defensora sobre lo que has estado experimentando.

Juntxs, ustedes pueden formular un plan sobre:

- ✓ **Cómo conseguir apoyo en cosas que quizás hayas estado haciendo para ayudarte a enfrentar las dificultades, como: beber en exceso, usar drogas, comer demasiado o muy poco.**
- ✓ **Cómo conectarte con tu proveedor de salud sobre qué hacer si tu pareja restringe tu acceso a medicamentos o tus visitas al médico y otras formas en que tu relación podría estar afectando tu salud.**
- ✓ **Cómo reducir el daño en tu relación y/o desarrollar un plan de seguridad.**
- ✓ **Cómo conectarte con los recursos al otro lado de esta tarjeta y en tu comunidad para aprender sobre tus opciones.**

Las líneas de ayuda nacionales y confidenciales pueden conectarte con recursos locales y proveer apoyo 24/7 por teléfono, texto o chats en internet:

Línea Nacional de Violencia Doméstica (National Domestic Violence Hotline)
1-800-799-7233 | 1-800-787-3224
(para personas sordas y mudas)
thehotline.org

El Proyecto Trevor (The Trevor Project)
Línea de crisis para jóvenes LGBTQ
866-488-7386 | thetrevorproject.org

Desarrollado en colaboración con Los Angeles LGBT Center, API Institute on IPV, Casa de Esperanza, National Coalition of Anti-Violence Programs, FORGE, Kaiser Permanente of Northern California, The Network/La Red y la Universidad de Pittsburgh. ©2016 Futures Without Violence. Todos los derechos reservados. Fundado por la Administración para los Niños, los Jóvenes y las Familias del Departamento de Salud y Servicios Humanos de Estados Unidos (Subvención #90EV0414). Ilustración de Vero D. Orozco.

Otros recursos útiles:

La Red del Noroeste (The Northwest Network) nwnetwork.org

Coalición Nacional de Programas contra la Violencia (National Coalition of Anti-Violence Programs) ncavp.org

FORGE para personas trans y aliadxs
forge-forward.org

The Northwest Network
of bi, trans, lesbian & gay survivors of abuse

GLMA
Health Professionals
Advancing LGBT Equality

FUTURES
WITHOUT VIOLENCE®
futureswithoutviolence.org

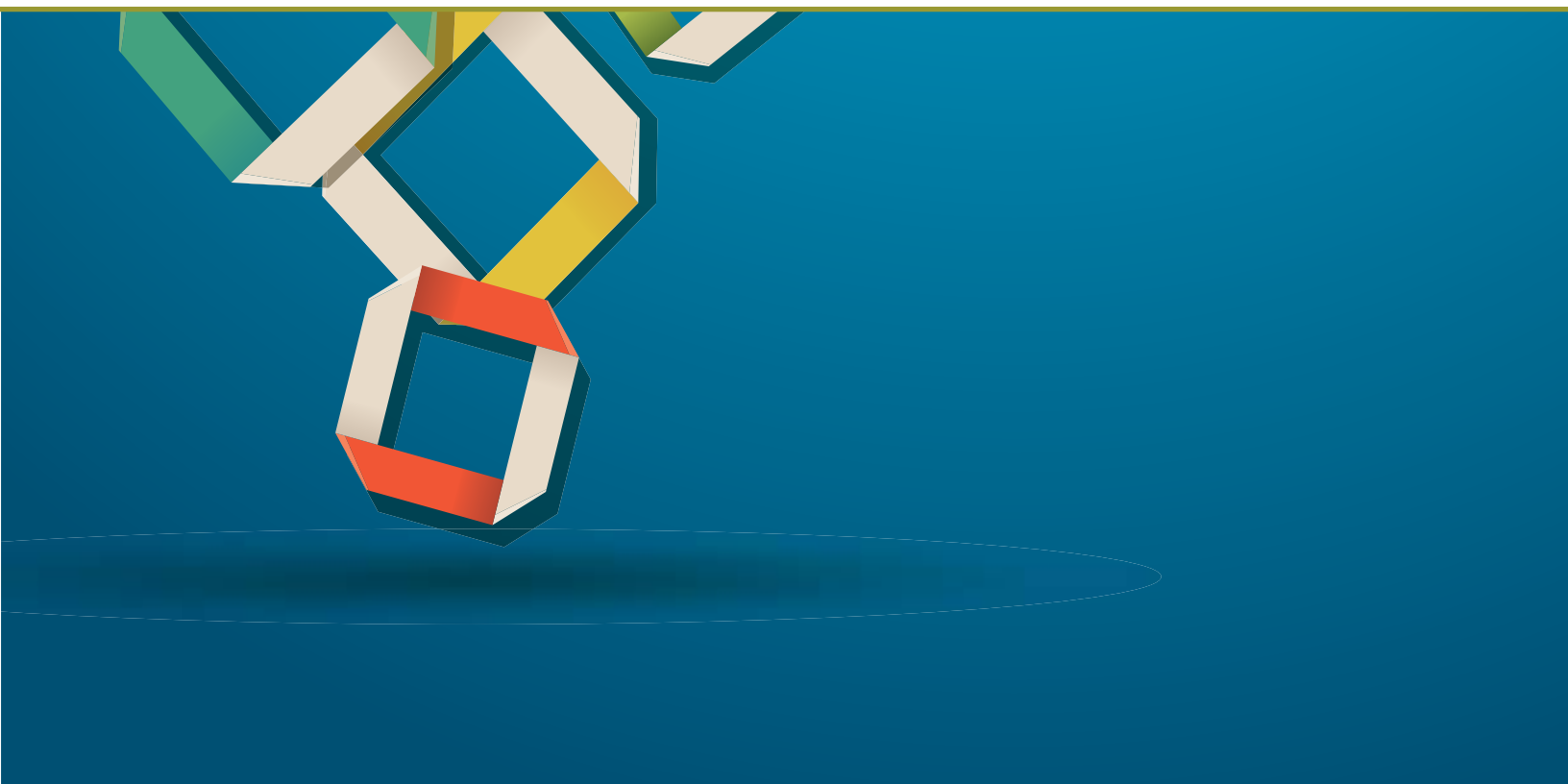
Relaciones cariñosas favorecen tu salud





Section E:

Supplemental Information



CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES

A Trauma-Informed Approach to Domestic Violence Advocacy

Adopting a trauma-informed approach* to domestic violence advocacy means attending to survivors' emotional as well as physical safety. Just as we help survivors to increase their access to economic resources, physical safety, and legal protections, using a trauma-informed approach means that we also assist survivors in strengthening their own psychological capacities to deal with the multiple complex issues that they face in accessing safety, recovering from the traumatic effects of domestic violence and other lifetime abuse, and rebuilding their lives. It also means ensuring that all survivors of domestic violence have access to advocacy services in an environment that is inclusive, welcoming, destigmatizing, and non-retraumatizing.

This document will discuss **five core components** of a trauma-informed approach to domestic violence advocacy. These include (1) providing survivors with information about the traumatic effects of abuse; (2) adapting programs and services to meet survivors' trauma- and mental health-related needs; (3) creating opportunities for survivors to discuss their responses to trauma; (4) offering resources and referrals to survivors; and (5) reflecting on our own and our programs' practice.

1. Provide survivors with information about the traumatic effects of abuse.

Many survivors of domestic violence will not be familiar with the concept of trauma. Some survivors may believe that it is a sign of strength to be able to withstand extreme difficulty without complaining. Some may view silent endurance as a religious or spiritual value. Helping survivors understand that there are natural ways that the human mind and body respond to stress and pressure can help counter the belief that these reactions are signs of weakness.

How can your programs provide survivors with destigmatizing information about the traumatic effects of abuse?

- Discuss the link between lifetime trauma, domestic violence, and mental health.
- Discuss some of the common emotional or mental health effects of domestic violence and ways that these responses can interfere with accessing safety, processing information, or remembering details.

* The notion of "trauma-informed services," which comes from the work of Maxine Harris, PhD, and Roger Fallot, PhD, at Community Connections, is designed to promote recovery and minimize the chance of revictimization. Harris, M. & Fallot, R. (2001, Spring). *New directions for mental health services, Using trauma theory to design service systems*, 89, Jossey-Bass.

- Discuss the ways that trauma can disrupt our ability to trust and to manage feelings and can affect the ways we feel about other people, ourselves, and the world.
- Discuss the things that abusers may do to make their partners feel “crazy.”
- Discuss the ways that abusers use mental health issues to control their partners.

2. Adapt programs and services to meet survivors’ trauma- and mental health-related needs.

As domestic violence programs become sensitized to the effects of trauma and the need to provide inclusive services, we can work to create programs, policies, and settings that meet survivors where they are and that are careful not to retraumatize survivors.

How can your program respond to the individual needs of survivors?

- Conduct pre-intake screenings for domestic violence only and do not “screen out” for mental health “issues” or a history of psychiatric treatment.
- Create a welcoming environment with a wide range of options for survivors and make changes when practices and policies are not well suited to individual survivors’ needs and capacities.
- Discuss ways that shelter living can be difficult for everyone and offer supportive strategies that would make it more comfortable for the individual survivor with whom you are working.
- Have a standard medication policy for everyone. It is not necessary to know what medications women are taking or why. Questions related to medication may be prohibited by law. Please see the Center’s *Model Medication Policy* for further guidance.
- Inform survivors about your medication policies and let her know you are available to discuss any particular needs she has (e.g., she has run out and needs new supply, is having problems with side effects, is not sure they’re helping, can’t afford them, etc.).
- While conducting support groups or house meetings, discuss the range of responses people have to trauma, including physical and mental health symptoms.
- Reassure and support survivors who are uncomfortable with the mental symptoms of other women in the program that these are common responses to abuse.
- Collaborate (with consent) with the mental health providers, peer support specialists, and/or systems that work with each individual survivor.
- Inform or educate the mental health providers on issues related to domestic violence, including documentation of abuse in mental health records and additional needed supports.

- Advocate with mental health providers and systems on behalf of survivors when requested and support survivors in their efforts to advocate on their own behalf.

3. Create opportunities for survivors to discuss their responses to trauma.

Once survivors are aware that most people have natural responses to extreme stress and pressure, it may be possible to help each woman to think about the specific ways that she and her children have managed, responded to, and been affected by the stress, pressure, and trauma that they have experienced.

How can your program provide opportunities for a survivor to discuss her responses to trauma?

- Ask about ways that she has changed as a result of the abuse.
- Ask if she is having any feelings or thoughts that concern her.
- Ask about the impact of domestic violence on her emotional well-being and mental health.
- Attend to the role of culture, community, and spirituality in her life.
- Talk with her about how her own emotional responses to abuse can affect how she responds to her children and offer strategies for noticing and addressing those concerns.
- Ask if her abusive partner interfered with past mental health treatment or medication.
- Ask if she has any mental health concerns she'd like to discuss, including concerns related to treatment, medications, hospitalizations, or past interactions with mental health providers or mental health systems.

4. Offer resources and referrals to survivors.

Like many of us, survivors of domestic violence may hold stereotypes about mental health treatment. Survivors may be unfamiliar with mental health services, believe they are only appropriate for people with very extreme symptoms, or think they are indulgences for weak or pampered people. You can let women know that these resources are appropriate for anyone who has been highly stressed or traumatized—that everyone deserves to feel better. Resources may include self-help tools as well as referrals to knowledgeable providers in the community or consultants who provide services at a DV program.

How can your program make resources and referrals available to a survivor?

- Discuss the process of healing from abuse and other trauma (instilling a sense of hope, that she will not feel this way forever).
- Develop culturally relevant and community-based referrals and linkages.

- Let her know that if she is interested in accessing resources and services related to healing from abuse and other trauma, you can help her to access them.
- Provide linkages to information or resources to help her advocate for herself around mental health or medication issues (or, with permission, advocate for a survivor with her mental health care provider).
- Work with her on strengthening or developing new skills for dealing with painful or disruptive feelings such as relaxation training or exercises,[†] grounding techniques, affect regulation strategies, or developing a written plan like a Wellness Recovery Action Plan (WRAP[®]).[‡]

5. Reflect on our own and our programs' practice.

Being aware of our own reactions to others and to trauma helps ensure that our interactions with survivors are focused on supporting their best interests and well-being. Reflection also helps us to make thoughtful and professional decisions with knowledge of how our personal reactions and feelings are operating.

How can your program incorporate reflection into your practice and your settings?

- Create an environment with regular opportunities to reflect on your responses to each individual survivor and how those responses may be affecting her, as well as what those responses may reflect about your own experiences.
- Reflect on the impact of the work that you do on your own life (i.e., how you experience secondary trauma) either privately or with trusted others (including supervisors, peers, therapists, family, friends, etc.).
- Work with colleagues to recognize the ways in which tensions that arise within your program (among women receiving services and among program staff) may be related to staff feelings about and reactions to trauma. Develop ways to safely and respectfully address these issues when they arise.

For more information or for technical assistance, please contact the National Center on Domestic Violence, Trauma & Mental Health at info@nationalcenterdvtraumamh.org or 312-726-7020(P) or 312-726-4110(TTY).

[†] For example, see the Capacitar Emergency Response Tool Kit (available in multiple languages) at http://www.capacitar.org/emergency_kits.html

[‡] For more information about WRAP[®], see <http://www.mentalhealthrecovery.com/aboutwrap.php>

Impact of Trauma on Interaction and Engagement: Information Sheet for Domestic Violence Advocates*

Trauma can affect a survivor's...

- Interactions
- Stress tolerance and ability to regulate emotions
- Responses to negative feedback
- Ability to screen out distractions

It could look like...

- A survivor seeming "cool" and detached
- A survivor who is highly sensitive and whose feelings are easily hurt
- A survivor is suspicious and not trusting
- A survivor does not "read" or trust warmth and caring from staff and other survivors

When someone is experiencing a trauma response, she may...

- Not be able to talk to you about what is happening
- Not notice what is happening
- Not know what will help or think that nothing will
- Need some time alone or be comforted by having you near
- Feel too upset or overwhelmed to interact with you
- Not want to say what she needs because she does not feel safe enough, she may want to protect you, or she may believe that she should not say

Connection and Reflection Skills:

We know that any survivor may have difficulty engaging with an advocate who offers to help her. It is important to develop communication skills that acknowledge a person's trauma-related barriers to communication, while also following the survivor's lead in the conversation. We can do this by using two sets of skills—our connection skills and our reflection skills. Our connection skills include our ability to engage, be available, be present, convey empathy, avoid judgment, and be open and honest about what we are offering. We sometimes think of these as "lifelines," meaning that they may not be picked up immediately but are available when the other person is ready. Our reflection skills include our self-awareness and responsibility for understanding our own needs and reactions, both of which help to sustain our connection skills.

* This handout is adapted from *Access to Advocacy: Serving Women with Psychiatric Disabilities in Domestic Violence Settings: A Curriculum for Domestic Violence Advocates*, National Center on Domestic Violence, Trauma & Mental Health, Chicago, IL (2007).

Understanding Traumatic Triggers

Traumatic triggers come in many forms. A trigger is a reminder of past traumatizing events. Many things can be a possible trigger for someone. For example, what seems like an “ordinary” request such as, “Make sure the children are ready for school on time,” can be a trigger for a survivor whose abusive partner terrorized and punished her if the children were late for school. Part of our work is in changing our frame so that we always keep in mind that survivors’ responses to seemingly neutral events and interactions with people may reflect a trauma response. Survivors may have adopted long-term patterns that reflect their efforts to adapt to a traumatizing life. We also work to hold in mind that this behavior and these patterns reflect strategies that survivors have developed to keep themselves safe—that is, they reflect strength and resiliency.

WHAT HAPPENS WHEN SOMEONE IS TRIGGERED

We can understand how it might be for a survivor of a flood, like a survivor of Hurricane Katrina, who was swept away as water rushed into her house. We can understand how she might feel frightened when someone turns on a shower without warning—just the sound of sudden water may reawaken the old experience. In a similar way, a person who has experienced terroristic abuse and control by a partner or family member may be triggered by encountering a person in authority. A survivor whose abuser made and enforced “rules” in the house may feel anxious or frightened even by the words “shelter rules.”

CAN WE ELIMINATE TRIGGERS?	EXAMPLES OF POSSIBLE TRIGGERS
Once we become aware of triggers, we might feel an impulse to “get rid of all the triggers.” Of course, we will avoid violent images or angry tones in our speech, keep video and film with aggressive content out of the common shelter areas, and try to make the environment calm. But there will always be trauma triggers that we cannot anticipate and cannot avoid. Part of trauma-informed work is supporting survivors as they develop the skills to manage trauma responses both in our shelter and elsewhere in the world.	Traumatic triggers come in many forms. A person might be triggered by a particular color of clothing (“ <i>My batterer always wore a plaid jacket home from work, and that’s when he would come after me</i> ”), by the smell of a certain food (“ <i>I was cooking taco meat when my batterer attacked me</i> ”), or even the time of year (“ <i>When it snows I remember the night I got pushed out into the snow in my nightgown</i> ”). Encountering such triggers may cause us to feel uneasy or afraid. Sometimes we know why we are feeling a certain way and other times we aren’t sure why. Recognizing when we are being triggered is an important part of building the skills to manage our trauma responses.

Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations

An Organizational Reflection Toolkit

Carole Warshaw, MD, Erin Tinnon, MSW, LSW, and Cathy Cave

April 2018

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NATIONAL Center_{on} *Domestic Violence, Trauma & Mental Health*



The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) is one of four Special Issue Resource Centers funded by the U.S. Department of Health and Human Services Administration on Children and Families, Family Violence Prevention and Services Program. NCDVTMH's mission is to develop and promote 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. Our work is survivor defined and rooted in principles of social justice.

NCDVTMH provides a comprehensive array of training, consultation and resources to support domestic violence and sexual assault advocates and their partners in the health, mental health, substance abuse, legal and child welfare fields as well as policymakers and government officials in improving agency and system responses to survivors of domestic violence and other trauma.

For more information, see WWW.NATIONALCENTERDVTRAUMAMH.ORG

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SECTION 1: PREPARING TO USE THE TOOL

Introduction

We want to thank you for embarking on this journey of transformation and hope this Toolkit provides meaningful guidance and structure.

The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) has designed this Tool for organizations serving survivors of domestic and sexual violence and their children. Its purpose is to support organizations in their efforts to become more accessible, culturally responsive, and trauma-informed (ACRTI) in their approach and services. NCDVTMH's framework for supporting the development of ACRTI services and organizations draws from a number of different perspectives - from the voices and experiences of survivors, advocates, and clinicians; from the insights of social and political movements; and from research and science, including a growing body of research on child development and neurobiology.

Initially developed as a way to bridge trauma-informed and advocacy perspectives, this approach is grounded in domestic and sexual violence advocacy; incorporates an understanding of trauma and its effects; creates accessible environments for healing; recognizes the centrality of culture; attends to the well-being of staff, organizations, and communities; and is committed to social justice and human rights. The core principles of ACRTI work - physical and emotional safety, hope and resilience, relationship and connection, and a survivor-defined approach - provide a foundation for creating services that are welcoming and inclusive, attuned to the range of people's experiences, and relevant to the people and communities we serve.

The new and revised version of our 2012 Accessible, Culturally Responsive, Domestic Violence-, and Trauma-Informed Tool includes expanded sections on accessibility, cultural responsiveness and inclusion, and on collaboration with community partners such as health, mental health, substance abuse, peer support, child welfare, and other child- and family-serving systems and agencies. It also intentionally recognizes services for children, youth, and families as an integral part of trauma-informed domestic and sexual violence advocacy. Thus, in this version, the term "survivor" is used to refer to adults, adults and their children, youth, young adults, elders, and anyone in the family system – as defined by survivors – who have experienced or witnessed violence. The term "partner," is used to refer to a current or former

spouse, someone a person is dating, a person's sexual partners, and/or someone a person has a significant emotional relationship with. In this document we alternate between using "survivor" and "participant" to describe the people engaging in our services.

Critical Concepts for Engaging in a Process of Self-Reflection and Organizational Change

In order to provide a foundation for understanding this document, we have defined some critical terms for navigating this process of self-reflection and organizational change. You can find an expanded glossary of terms at the end of this Toolkit in Appendix A, which also includes many of the terms embedded in the following definitions. We believe it will be helpful to read Appendix B prior to engaging with this material, as it covers NCDVTMH's Integrated Approach to Creating Trauma-Informed Services and Organizations. The material contained in these appendices provides the framework for using the Reflection Tool, itself.

Defining ACRTI

- ❑ The term **accessible** means that people with all kinds of abilities are able to fully access our agencies, including our information and resources; environments and spaces; and services and support with ease. A Deaf or disabled person is able to acquire the same information, engage in the same interactions, and fully participate in the same programs and services as a hearing or non-disabled person in an equally effective and equally integrated manner. People are accepted as whole versions of themselves, and are fully welcome, embraced, and accommodated. People are not reduced or understood solely through their disability and do not have to change or hide parts of themselves to be able to participate in or benefit from services. People's wishes about how they want their abilities recognized and understood are fully respected. Accessibility in this context is inclusive of people who have disabilities related to physical, sensory, cognitive, and mental health conditions, in addition to Deafness, chronic illness, and recovery from substance abuse. This concept intersects with people's multiple identities around race, class, age, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system. All of these intersecting identities are important to include when thinking about how to best serve survivors and their children; accessibility involves recognition of the barriers to meaningful involvement for all

participants. All too often, people with disabilities are left out or excluded from services because of their disability, despite experiencing higher rates of violence than non-disabled people. It is the perpetuation of discriminatory attitudes, policies, and practices, in addition to the lack of accessible environments and adequate supports that are disabling and keep people from being able to fully participate in our services. In this conceptualization of accessibility, it is critical to work toward cultivating awareness and understanding to decrease negative attitudes and stereotypes about disabled people. It also means being conscious of the assumptions we make about ability and disability, and of the images and language we use day-to-day. Finally, ensuring that all survivors have access to inclusive, anti-oppressive environments as they heal from trauma requires us to actively support the ongoing involvement of survivors with disabilities in shaping our spaces, resources, and services. (*Note: there are many ways to talk about disabled people / people with disabilities, and there is quite a bit of debate about what term is best. We have included both here knowing that for some, this will feel imperfect).

- ❑ The term **culturally responsive** means that our organizations and agencies are proactively integrating meaningful attention to the cultural identities of participants and staff, and to the ways culture can shape people's experiences of trauma and healing. Being culturally responsive also means systematically integrating awareness of culture into our services, policies, structures, and environments. It requires being interested in, learning about, and acknowledging the vast number of ways people express their cultural identities, values, connections, and experiences in order to provide services that are meaningful and relevant. It means seeking out and understanding the strengths, resources, and inherent resilience of individuals, families, and communities. Cultural responsiveness also means that organizations and individuals in agency settings affirm and are inclusive of the many aspects of human identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system. This includes having a complex understanding of the ongoing impact of historical trauma, structural oppression, and identity-based violence. It also means having mechanisms to evaluate and disrupt the impacts of those systems on the organizational culture with concrete processes to avoid replicating these experiences within our organizations. Being culturally responsive requires recognition and acceptance that microaggressive interactions will occur as a

byproduct of unequal distributions of power within our relationships, organizations, and broader social context. This, in turn, allows us to actively respond when such interactions occur, to engage in open communication about harms people experience interpersonally, and to develop strategies to prevent further harm moving forward.

- ❑ The term **trauma-informed** describes an approach that recognizes the pervasiveness and impact of trauma on survivors, staff, organizations, and communities, and ensures that this understanding is incorporated into every aspect of an organization's administration, culture, environment, and service delivery. A trauma-informed organization actively works to decrease retraumatization and support resilience, healing, and well-being. Additionally, trauma-informed organizations recognize ongoing and historical experiences of discrimination and oppression, and are committed to changing the conditions that contribute to the existence of abuse and violence in people's lives. A trauma-informed approach provides guidance on how trauma can affect people's experience of services and what we can do to reduce traumatization at every level of our organizations. In this context, our interactions with participants matter a great deal, as do our interactions with each other. When we understand trauma responses in the context of domestic and sexual violence as adaptations to surviving abusive power and control, then part of our work is to do everything we can to not replicate those dynamics and to reduce the likelihood that survivors will feel discounted and disempowered in our programs and organizations. A trauma-informed perspective supports the resilience of people and communities through the work we do and the way we work. This includes creating a physical and sensory environment that is accessible, welcoming, inclusive, and healing, and attends to potential trauma reminders; a cultural and linguistic environment that is responsive to the people and communities being served; a relational environment that is caring, respectful, empowering, and transparent, and strives to create emotional safety; and a programmatic environment that is flexible and responsive to individual and family needs. A trauma-informed approach involves providing access to a range of healing modalities and practices, and creating community partnerships to ensure survivors and their children have access to trauma, mental health, and substance use services. Trauma-informed organizations support survivors to feel more connected and empowered as they prepare for situations that are potentially retraumatizing, such as participating in a court hearing, job interview, or custody evaluation. Lastly, a trauma-informed approach fosters an awareness of what we, as service providers, bring to our interactions, including our own experiences of trauma as well as the ways we are affected when we are truly open to the experiences of other people.

With all of these definitions in mind, becoming accessible, culturally responsive, and trauma-informed (ACRTI) involves organizational commitment, making the support of staff a priority, creating environments, intake processes, programs, services, and policies that reflect ACRTI principles, investing in community partnerships, and putting mechanisms in place to ensure that the people who use our services have a meaningful role in shaping them. Becoming an ACRTI organization is a long-term, transformative process that takes a thoughtful approach, purposeful planning, and sufficient resources and time.



Becoming an ACRTI organization is a long-term, transformative process that takes a thoughtful approach, purposeful planning, and sufficient resources and time.

The Format of this Toolkit

This document provides guidance on how to use the Tool and on things to consider in preparation for engaging in this type of organizational self-assessment process. This Toolkit is presented in three sections. The first provides background information needed to utilize the ACRTI Tool, including a “Before You Get Started” section that presents guidance on assessing organizational readiness and on laying the groundwork for engaging in this process. The second section is the Tool itself, which is comprised of seven focus areas. Each focus area represents a core domain for creating accessible, culturally responsive, and trauma-informed (ACRTI) services and organizations. Together, the focus areas offer an opportunity to take a comprehensive look at the organizational policies, practices, and infrastructural supports needed to implement and sustain ACRTI work. The third section, or Appendices, contain additional information and resources to support the use of the Tool, including NCDVTMH’s Integrated Framework, which provides more detail on the core perspectives and principles that form the foundation of an ACRTI approach, a glossary of key terms and definitions, and additional links and resources.

After working through the “Before You Get Started” section, the focus areas can be completed in any order. There are worksheets at the end of the document (starting on page 60) that can be used to support reflection and planning. The focus areas are as follows:

- ☐ **Organizational Commitment and Infrastructure** — p 15
- ☐ **Staff Support and Supervision** — p 19
- ☐ **Physical, Sensory, and Relational Environment** — p 22
- ☐ **Intake Process** — p 27
- ☐ **Programs and Services** — p 31
- ☐ **Community Partnerships** — p 35
- ☐ **Feedback and Evaluation** — p 38

You will be invited to think about how to implement ACRTI principles in each focus area. You may find that you are already doing some of, or something similar to, what is suggested. You may find that some of the concepts are new to you. The ideas provided are not intended as a blueprint, but rather to be used as a starting place for conversation and reflection knowing that the work will unfold differently at each agency. You may find that you need additional resources such as specific ideas for creating emotional safety, training on social justice or Effective Supervisory Practice, or strategies for engaging your board as you are working through each focus area.

Additionally, you will find four appendices at the end of this Tool. They are as follows:

- ❑ **Appendix A: Glossary of Key Terms To Support Understanding for Accessible, Culturally Responsive, Trauma-Informed Work** — p 41
- ❑ **Appendix B: Creating Trauma-Informed Services and Organizations: An Integrated Approach** — p 51
- ❑ **Appendix C: Additional Resources for Your Process of Transformation** — p 56
- ❑ **Appendix D: Getting Concrete: Change in Real Time Worksheets to Support Organizational Change** — p 58

How to Use this Tool

This Reflection Tool is best used as part of a larger effort to build agency capacity to enhance ACRTI services for survivors. While we offer many suggestions and strategies, we encourage you to incorporate what you find useful, and add what you already know works for your organization and the communities it serves. We recognize that this may be a process that you have already started or you may be starting with this Tool. This Tool was designed with the understanding that agencies have different strengths and challenges, and that creating and sustaining an ACRTI organization is an ongoing process. Organizational change takes many shapes and forms and can happen in many different ways. It is important to start where you are!

Ideally, an organizational self-reflective process involves the entire agency, including individual staff members, agency leadership, board members, and volunteers. When leadership is committed to this process, it facilitates the ability to initiate and sustain change over time. It is vital to include people who have accessed or who are currently accessing your services as part of the change process team. As you begin this journey, take the time to consider the unique needs of your agency.

This process of reflection and change works best in a context in which staff members and other participants feel safe to learn, grow, and contribute. Design a process for approaching this work that makes room for many points of view. After deciding on a process, your agency can work through the discussions and decisions at your own pace. Take breaks as needed to seek additional input and resources, be responsive to the different needs and priorities of staff members across the organization, and reevaluate the process itself.

Before You Get Started

Before you begin, consider whether this is the right time for your agency to take this step and what you may need to have in place before starting the process. We have learned from organizations that this process works best when all staff members have a way to be involved, especially from the beginning. Engaging in a process of reflection and change can be transformative and generate excitement, growth, and commitment to the work. It can also be challenging, bringing up different kinds of responses for each person involved and surfacing underlying tensions or difficulties. Both sets of responses are a common part of organizational change work, and it is important to make space and time to navigate what comes up. We recommend beginning the process with thoughtful conversations about the following:

1. Is your agency ready to begin a self-reflective process?

Hold an initial discussion or series of discussions on whether this is the right time to begin a reflective process at your agency. Consider these questions:

- a. What will it take to engage in this process, including time, resources, and commitments from administration, board, and staff members?
- b. Why is this work important to you? How have you arrived at the decision to undergo this process? Is this the right time? Do you have what you need to begin this process?
- c. Who needs to be involved, including people who are participating in or have participated in your services in the past? Is everyone ready to engage in the process? Who is missing from the conversation? Who is already committed to this work? Is the process itself inclusive, comprehensive, accessible, and representative of staff and program participants?
- d. What are the benefits of using this type of process? Will it allow the agency to examine its strengths while identifying opportunities to improve services?
- e. What challenges might come up during this process? Will staff time be diverted away from another project or from core work? Might staff feel overextended because of limited resources or funding? Will staff worry about giving critical or genuine feedback to leadership? Are there concerns about internal conflict?
- f. If your agency is not ready, what might be affecting readiness? What additional resources do you need to feel ready? Can you connect with other organizations that have undergone this type of process?

2. What preparation is needed prior to beginning the process?

Once you decide this is the right time for this process, what might you need to make it work well?

Consider these questions:

- a. How will you talk with everyone (staff, volunteers, board) about this process? Will you set aside time in staff meetings? Have individual conversations or facilitated discussions? Hire an outside consultant?
- b. How will you get initial information from staff about ideas, concerns, and perspectives? Will you use surveys? Discussions? One-on-one conversations?
- c. What readings or materials may be helpful to develop a shared understanding of ACRTI work?
- d. What training or technical assistance (in-person or digital) may be helpful to develop a shared understanding of ACRTI work? Do you need training on the impact of trauma on adults, children, and the parent-child relationship; on the intersections of culture, oppression, and trauma; on substance use, mental health, and disability?
- e. Are your agency's mission, vision, values, and approaches to the work rooted in social justice? If not, how can you develop a framework that is central to your work with survivors? Who can you ask to support this process in your networks and communities? Where do you need additional social justice support? Is a commitment to social justice evident in your work?
- f. Do staff members and leadership indicate a clear and committed willingness to treat all people with dignity and respect in relation to their identities, culture, ability, and range of experiences with violence?

3. What process will you use for your organization's self-reflective work?

Once you begin, you might hold a discussion or series of discussions to determine what process you will use. Consider these questions:

- a. What are the goals for this process?
- b. Who will lead the process? Will you use a workgroup? Implementation team? Outside consultants?
- c. How will you involve staff in all aspects of the process?
- d. What kind of assistance or support is needed? Do you need an outside facilitator, some technical assistance, and/or more training? How can you best support each other?

- e. How will you work to make the process safer and inclusive for everyone involved? What challenges might come up here? How will you respond? How will you determine whether a change or break from the process is needed?
- f. How will you approach the ACRTI Tool itself? In what order will you complete the sections? Is there an area to focus on first, such as the area in which your agency is the strongest, the area you need most help, or the area that feels most urgent?
- g. What logistical process will you use for working through this Tool? By sending questions to staff members and then meeting to share responses? Holding discussions at staff meetings? Having staff lead conversations? What communication mechanisms will you set up to track and share your progress and process as they proceed? Email or other productivity software?
- h. How will you evaluate your progress and process in an ongoing way? Will you check in with your goals during regular meetings? Discuss how the process is affecting individuals or groups in your organization? Engage in a formal evaluation process?

Setting clear timelines for this process can be helpful in sustaining momentum. At the same time, it is important to allow for enough time for these initial discussions to unfold and to work through challenges, tensions, and opportunities. It may be helpful to document and share ideas and learning with all staff and service participants as a way to keep everyone informed, connected, and engaged in the process. Participants might have different perspectives about what needs to change based on their position within the organization. Acknowledge how power differentials affect the work and strive to create an egalitarian process in which everyone's contributions and perspectives are recognized and valued. As is true for any change process, transparent and ongoing communication is critical.

SECTION 2: THE ACRTI TOOL

Focus Area 1: Organizational Commitment and Infrastructure

Organizational commitment can be expressed through the agency's mission, vision, values, and core beliefs. Organizational commitment is critical to making change but not enough by itself. Organizations and boards also need to allocate the resources and develop the organizational infrastructure necessary to support an organizational change process and to ensure that accessible, culturally responsive, and trauma-informed changes can be implemented and sustained.

What are some of the ways your agency might demonstrate organizational commitment and infrastructure support for ACRTI work in its mission statement, values, written policies and procedures, hiring and staffing decisions, allocation of resources, staff supervision and training, and evaluation procedures?

With an Accessibility Lens: How does the agency demonstrate and enhance accessibility through its organizational commitment and infrastructure to ensure the inclusion of people with disabilities and Deaf individuals?

With a Cultural Lens: How does the agency express organizational commitment and infrastructure in ways that affirm and are inclusive of the many aspects of all staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's organizational commitment and infrastructure align with and facilitate the implementation of trauma-informed principles and practices?



Policies that Reflect Mission, Vision, and Values

- ☐ The agency's mission statement, policies, and procedures include a written commitment to providing accessible, culturally responsive, and trauma-informed services.
- ☐ The agency's mission statement, values, and procedures include a written commitment to serving people inclusive of a person's race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, involvement, immigration or documentation status, access to education, and history with the criminal justice system – and facilitates that inclusion with its policies, procedures, and practices.
- ☐ The agency's written policies reflect incorporation for the following:
 - A recognition of the pervasiveness of trauma in the lives of people participating in services, including historical trauma and structural violence, and a commitment to reducing retraumatization and to supporting healing, resilience, and well-being.
 - An understanding of the dynamics of domestic violence, sexual assault, stalking, and other forms of violence and abuse, including racism, transphobia, ableism, and xenophobia.
 - A commitment to providing services that are culturally responsive, inclusive, and LGBTQ2SIA (Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, Intersex, Asexual) affirming.
 - Recognition of the importance of family, inclusive of how each person defines family, and a commitment to supporting survivors as individuals and as parents.
 - Clearly defined confidentiality policies.
 - A commitment to working to end abuse, violence, and oppression through community outreach, prevention, and local partnerships with others who have a similar mission.
 - A commitment to including survivors and people who have formerly participated in services as part of the board, staff, and other decision-making bodies of the organization.

Human Resources Policies and Practices

- ☐ The agency has clearly articulated and transparent policies that staff members are familiar with and can access at any time.
- ☐ The agency actively recruits, hires, and retains staff members who:
 - Reflect the diversity of the many communities being served.
 - Demonstrate a willingness to treat all people with respect and dignity, including in relation to people's experiences of disability, trauma, use of substances, and mental health challenges, as well as in relation to their cultural identities, expressions, and practices.
 - Are knowledgeable about and skilled at working with survivors of domestic violence, sexual assault, stalking, structural violence, and other kinds of trauma.
 - Have experience and interest in working with children and youth, as well as supporting survivors who are parents.

- Demonstrate a respectful, empathic, and collaborative approach to working with survivors and their children.
- Demonstrate a commitment to anti-oppression work and an awareness of power and privilege.
- ❑ The agency has a commitment to hiring staff members who have lived experience of domestic and sexual violence, who have lived experience with substance use, who have complex mental health histories, and who have disabilities.
- ❑ The agency has a commitment to hiring staff with a wide range of racial, cultural, ethnic, and gender identities.
- ❑ The agency has clear expectations and policies regarding Effective Supervision that are strengths-based and grounded in ACRTI values.
- ❑ The agency has a grievance policy that staff understand and are encouraged to access.
- ❑ The agency allocates the time and resources needed for professional growth and development of all staff.
- ❑ The agency's policies attend to the impact of secondary trauma through reflective supervision and activities that support well-being, connection, and work-life balance.
- ❑ The agency has policies that supports staff, volunteers, and board members who are currently experiencing abuse in their relationships and actively works to create an organizational culture in which individuals know they can seek support when it is needed.

Finances and Resource Allocation

- ❑ The agency allocates sufficient resources to support ACRTI practice by prioritizing reasonable staff workloads, regular Effective Supervision, and benefits that include vacation time, paid parental leave, and sick time, as well as health insurance with good mental health, substance use, vision, dental, and wellness coverage.
- ❑ Money is budgeted for staff and volunteers to attend regular trainings, and be compensated for their time. Volunteers or relief staff cover shifts so that all staff can participate in training and other learning opportunities.
- ❑ The agency engages in intentional, additional fundraising to support ACRTI work including attention to the costs involved in retrofitting the agency to be more accessible, incorporation of culturally appropriate food options above and beyond those that are already offered, and attention to quiet and private spaces for survivors, families, and staff.

Training Policies and Practices

- ❑ The agency provides training and education that supports staff and volunteers in developing the knowledge and skills to work sensitively and empathically with survivors and each other in accessible, culturally responsive, trauma-informed ways.
- ❑ Training and education take place both during new staff orientation and during ongoing in-service trainings. Trainings are rooted in social justice frameworks, such as racial justice, disability justice,

reproductive justice, environmental justice, and/or housing justice that allow staff to learn about power, privilege, and solidarity.

- ☐ Ongoing training is made available to staff to help them support survivors in more holistic ways. Examples of training topics can include: talking with survivors about the effects of trauma and what is helpful to them; supporting survivors experiencing mental health crisis including trauma-informed responses to emotional distress; supporting survivors who are actively using substances, including being trained in overdose prevention and in knowing how to talk to survivors about naloxone; talking with survivors about the effects of trauma on children and supporting them as parents; supporting survivors and their families as they define them; and training on healing and wellness practices with particular attention to supporting survivors as whole and multi-dimensional human beings.
- ☐ Staff receive regular Effective Supervision that builds on knowledge gained during trainings, supports the development of the skills needed to provide ACRTI services, and strengthens agency capacity to implement ACRTI practices.
- ☐ All training that is provided to staff is accessible, culturally responsive, and trauma-informed; offered in the languages used by staff and at many literacy levels; and in varying formats to accommodate diverse learning, visual, hearing, memory, or other sensory experiences.

Policies and Practices That Support Program Participants

- ☐ The agency's policies are in alignment with the Americans With Disabilities Act, the Fair Housing Act, the Civil Rights Act, and other Federal accessibility regulations including the 2016 final rule of the Family Violence Prevention and Services Act (FVPSA), 42 U.S.C. 10404(a)(4).
- ☐ The agency has policies to ensure that survivors who use substances and who have complex mental health needs are guaranteed access to services.
- ☐ The agency has policies regarding the safe storage of medication that ensures survivors have access to their medication at any time via the use of individual lockers, lockboxes, or refrigerated storage.
- ☐ The agency has policies that support survivors as parents, that recognize the needs of both parents and children, and that create both private and communal spaces for interaction, bonding, and play between parents and children.
- ☐ The agency has worked to minimize the number of rules participants are expected to follow. Any existing rules are transparent and non-punitive, and recognize survivors' dignity, autonomy, and ability to make decisions for themselves.
- ☐ The agency's program policies reflect a commitment to incorporating a survivor-defined and collaborative approach into its intake processes, programs, and services.

Pause and Reflect

- ☐ How does leadership actively demonstrate commitment to these principles and to becoming an ACRTI organization?
- ☐ Are you ready and able to provide internal training to your staff on how to become ACRTI? Who can you ask for support if you need help?
- ☐ What kinds of training do you provide already? What additional training can you add to help achieve your goals?
- ☐ Given where you are, what can be done to make real improvements, taking into account any obstacles?
- ☐ Are there any untapped resources that could support your efforts? Who have you asked?
- ☐ What do people participating in services have to say about these questions? What do staff members say?

Focus Area 2: Staff Support and Supervision



Investing in staff and their development is a critical part of creating an accessible, culturally responsive, and trauma-informed (ACRTI) organization. This investment involves creating an organizational culture that honors strength and resilience; attends to disparities related to power, privilege, and oppression; and respects and values staff and their work. It also means recognizing and attending to the impact of trauma on staff and organizations, including the impact of secondary trauma and ongoing oppression. An ACRTI organization provides the support staff need to be present, open, and connected in their

interactions with survivors who have many cultural and ethnic identities, and many types of abilities in respectful and collaborative ways. To these ends, Effective Supervision, training, and human resources policies are designed to support staff in building and applying the skills important for their work; in developing and deepening their self-awareness and growth; and in providing flexibility to engage in activities that sustain their well-being and connection to their work.

Effective Supervision involves a thoughtful balance of education, administration, support, and leadership skills needed to guide staff in their work. Ingredients of Effective Supervision include attending to the values and ethics inherent to ACRTI work and creating an organizational climate that conveys these values. Effective Supervisory Practice also includes a strength-based and problem-solving orientation, clear expectations and accountability, giving and receiving feedback, supervisory modeling, an intentional process for staff skill development, and reflective practice (Cave & Johnan, 2014). Together, these components can support staff to feel connected and successful in their work, provide resources to support staff in challenging situations, and cultivate self-awareness and self-care.

What kinds of ongoing training and education are provided to all staff? How does the agency provide supervision within all levels of the organization? In what ways do staff members feel respected and valued? Does the organization provide opportunities for staff to support each other through peer-to-peer or group supervision? Do policies and procedures formalize and ensure support for all staff?

With an Accessibility Lens: How does the agency demonstrate and enhance accessibility inclusive of people with disabilities and Deaf individuals through supervision and staff support?

With a Cultural Lens: How does the agency provide staff support in ways that affirm and are inclusive of the many aspects of all staff, leadership, and board members' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's policies and procedures regarding staff support align with and facilitate the implementation of trauma-informed principles and practices?

Policies and Procedures

- ☐ The agency has policies on the provision of Effective Supervision.
- ☐ The agency has policies that reflect its commitment to staff health and well-being. Policies take into account the ongoing impact of our work, including secondary trauma and oppression. The agency has an active culture of supporting and promoting self- and collective care.
- ☐ The agency has policies that delineate an ACRTI approach to addressing performance evaluations, staff development, and grievances.
- ☐ There are policies in place that ensure reasonable workloads and hours, as well as excellent benefits such as: coverage for mental health and substance abuse treatment; culturally specific and/or complementary alternative healing and well-being modalities; paid parental leave and

childcare; ample, paid personal/vacation time and sick time; and family-sustaining wages. Leadership actively model the use of these policies and express a commitment to make accommodations for all staff.

- ☐ The organization consistently builds in opportunities (in staff meetings, at organizational retreats, and in supervision) for staff, leadership, and board members to reflect on and address any biases they hold that might impact their work with survivors or with each other.

Supervision and Practice

- ☐ The organization trains supervisors and staff on Effective Supervision. The organization also provides ongoing support about supervision to staff.
- ☐ Supervision is consistent and reliable and conveys the agency's mission, vision, values, ethics, and organizational culture.
- ☐ Supervisors are attentive to power dynamics, microaggressions, and the ways that corrective feedback is offered so that it does not feel punitive.
- ☐ A process is in place to provide staff with an opportunity in supervision to reflect on their work, interactions they are having, and their own responses to the work.
- ☐ Supervision provides space for multi-directional feedback, setting of clear expectations, and a process for follow through and accountability in response to feedback. Feedback is offered with consent, in a mindful way, and uses a process that is clear to everyone.
- ☐ Staff members and supervisors have resources and strategies to respond to secondary trauma and help minimize the impact of the work, including techniques for increasing self-awareness, self-care strategies, and peer-to-peer support.
- ☐ Staff members and supervisors work to create an environment that responds to and lessens the impact of burnout. Supervisors make space for staff to discuss challenges, distress, and burnout openly.
- ☐ Staff members are supported in addressing their own responses to domestic violence, sexual assault, and stalking, including when their own experiences of trauma come up while doing their work.
- ☐ The organization makes time and space for the regular recognition of successes, strengths, and positive things people have done at meetings, check-ins, supervision, and organizational retreats.
- ☐ The organization makes opportunities for staff to participate in activities that allow for connection, fun, and creative expression.
- ☐ Work expectations are transparently articulated through job descriptions, modeling, coaching, and planning.
- ☐ The organization makes space for, acknowledges, and supports staff members as survivors themselves.
- ☐ Staff members know who they can access if a survivor shares something that leads them to need immediate support. They are fully supported to explore and understand secondary trauma as it affects them and their work.

- ☐ Staff members know who to go to for support if the issues a survivor is facing are beyond their experience and expertise. Asking for help is welcome and viewed as a learning opportunity.
- ☐ Staff members are supported in their ongoing professional growth and development to increase their skills, competence, and confidence.
- ☐ The agency has a culture in which utilizing support for health, mental health, and well-being is encouraged and valued.
- ☐ The agency ensures that all staff members have access or referrals to affordable, sliding scale, or free counseling services.
- ☐ Staff are nurtured, supported, and given the resources they need to engage in ACRTI work.

Pause and Reflect

- ☐ In what ways does your agency support staff members? What can be done to better support supervisors and staff members?
- ☐ What existing supervisory structures are in place? What do you need to actualize additional supervision goals?
- ☐ What kinds of resources or training are needed? What are some initial actions you can take?
- ☐ What do staff members say about existing supervision goals and structure?

Focus Area 3: Physical, Sensory, and Relational Environments



In an accessible, culturally responsive, and trauma-informed (ACRTI) organization, the physical, sensory, and relational environments are welcoming, inclusive, and fully accessible; minimize the potential for retraumatization; and create an atmosphere that is nurturing, supportive, and healing. There are a number of aspects to consider in creating ACRTI environments. First is making sure that your agency's physical and sensory environments are fully accessible to people with a range of physical, sensory, and cognitive abilities and disabilities, including chronic health conditions, chronic

pain, and chemical sensitivities. Examples include attention to furniture placement, door widths, and access to exits; to the height of counter, sink, and elevator buttons; thoughtfulness about ambient lighting and background noise; and policies regarding the use of fragrances and scented products in communal areas. Second, your agency's physical and sensory environments reflect a cultural connection to the people and communities it serves. Examples include obtaining input from participants and community members on the agency's artwork, décor, and written materials; culturally specific food options; and on creating spaces people can utilize in culturally meaningful ways. A third aspect involves attending to how being in the environment makes peoples feel. This means designing environments that are responsive to the range of needs people have, including their needs for engagement and connection, as well as for privacy, quiet, and time alone. The agency builds in enough flexibility in the physical and sensory environments so people can choose what works best for them.

Because the quality of our interactions is so central to an ACRTI approach, we use the term “relational environment” to refer to how people treat each other and how it feels to participate in services, as well as what the work environment feels like to staff. An ACRTI relational environment can be characterized by many things including respect, kindness, care, compassion, integrity, and transparency. In this context, transparency means that we are clear and open about our processes, intentions, plans, options, boundaries, and limitations. Transparency ensures that people have the information they need to decide if and how they want to participate in services. In an ACRTI agency, people feel that who they are as individuals and as members of their communities, along with their unique needs and experiences, are valued, acknowledged, and cared about by others.

With an Accessibility Lens: How does the agency demonstrate and enhance accessibility of the physical, sensory, and relational environments, inclusive of people with disabilities and Deaf individuals? Additionally, how does the agency demonstrate attention to the relational environment through a commitment to attitudinal accessibility among all staff?

With a Cultural Lens: How does the agency create physical, sensory, and relational environments that affirm and are inclusive of the many aspects of all staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's physical, sensory, and relational environments align with and facilitate implementation of trauma-informed principles and practices?

Indicators of Accessibility in Practice:

- ☐ The agency's physical, sensory, and relational environments are accessible for people with disabilities and Deaf individuals.
- ☐ The agency integrates principles of Universal Design in all physical, sensory, and relational environments. See the glossary for a definition of Universal Design.
- ☐ All doors open easily or have buttons to open them automatically.
- ☐ The agency makes room for a wide range of expressions of distress. People are not punished or excluded for expressing themselves in ways that might make people uncomfortable.
- ☐ The agency is attentive to, works to assess, and minimizes the barriers in its environments. The entrance into the building is physically accessible. Staff exhibit attitudinal accessibility and pay attention to how their communication style might affect accessibility. Written materials and information take into account a spectrum of sensory and learning styles.
- ☐ The agency is accessible to people of all ages, including children, youth, and older adults.
- ☐ The agency provides safe and accessible storage for participants' medications.
- ☐ Safety of children is not leveraged to exclude participants who engage in substance use or who use stigmatized medications such as opioids or benzodiazepines.
- ☐ Shared bathrooms are physically accessible and gender neutral.
- ☐ The agency is mindful of chemical sensitivities and avoids the use of scented products and cleansers. Staff and participants are able to access scent-free spaces.
- ☐ Substance use is understood both as an adaptive and understandable coping strategy, and as a widespread human behavior.
- ☐ Information and opportunities for learning are available in a number of accessible ways, such as through talking, watching videos, activities, and movement.

Indicators of Cultural Responsiveness in Practice:

- ☐ The agency is welcoming and accessible to all people. The space is warm and inviting, and people are received with kindness upon arrival.
- ☐ The agency's materials, décor, reading material, and other sensory and physical aspects of the environment reflect the diversity of the people being served, including people representing a range of ages, genders, sexualities, races, abilities, and other important identity based markers. Participants are able to recognize themselves reflected in the materials used by the agency.
- ☐ Staff members demonstrate both understanding of and respect for survivors' experiences, including diverse ways of coping and healing. The strengths and traditions that people draw on for support and for framing their experiences are honored and valued.

- ☐ Staff members are able to recognize their own cultural communication practices and tendencies that impact the relational environment such as wanting people to make eye contact or speak up, sitting close to someone when talking, the tone people use or expect, and expectations of reciprocity. Staff are willing and able to communicate respect across difference.
- ☐ Staff members demonstrate an understanding of and respect for the impact of interpersonal and structural violence on the experience of accessing services. This includes offering compassion and patience for the time it may take for survivors to develop trust for staff members.
- ☐ In providing culturally responsive services, does the agency incorporate the following practices?
 - ☐ Survivors have access to foods specific to their culture, religious beliefs, and spiritual practices.
 - ☐ Agency provides information on culturally relevant community resources for support, referrals, and assistance, including for LGBTQ2SIA (Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, Intersex, Asexual) survivors.
 - ☐ Services are available in the primary language of survivors.
 - ☐ Written material and other information about the program is available in different languages based on participant needs.
 - ☐ Staff members recognize and attend to unique experiences of culturally specific trauma such as genocide, historical and generational trauma, or the targeting of immigrants and refugees. Staff listen with openness and curiosity about the range of ways survivors understand and describe their experiences.
 - ☐ The agency incorporates understandings of the cultural values and practices of survivors into services, practices, and program evaluation.
 - ☐ The agency actively solicits feedback about whether the agency is perceived as culturally accessible and welcoming to people who have a wide range of cultural and ethnic identities. The agency takes this process seriously and uses feedback to improve cultural accessibility.

Indicators of Trauma-Informed Practice:

- ☐ Consideration is given to the impact of the physical and sensory environment on both people participating in services and staff members. Needs related to noise, chaos, and privacy are addressed. Emotional and physical safety are taken seriously for each individual with consideration for access to outdoor spaces, types of lighting available, and the number of visible exits. The space is experienced as flexible, healing, and nurturing.
- ☐ Staff members have skills, training, and investment to provide information about trauma and its impact in an empowering and thoughtful way, including asking people what is helpful to them when they are in distress. Staff members demonstrate a commitment to collaboratively partnering with people accessing services and are comfortable responding to people expressing distress in a variety of ways.
- ☐ The agency is attentive to the impact of the relational environment on both people accessing services and on staff members. Consideration is given to emotional safety with regard to respect,

trust, choice, and transparency. Staff support participants in using conflict resolution strategies to address disagreement and repair relational harm. Survivors are given plenty of time and space to share their experiences with staff.

- ☐ Staff members attend to aspects of the physical and sensory environment that may be retraumatizing to people participating in services such as a lack of privacy in bedrooms or bathrooms; lack of choice regarding quiet and communal space; lack of control over their possessions or medications; inability to move freely in the space; and locked doors or an inability to go outside.
- ☐ Staff members work with survivors to develop strategies to deal with any retraumatizing aspects of the agency's relational environment, such as: rigid shelter rules, lack of privacy, lack of autonomy, having to listen to other people's experiences, noise or silence, lack of choice, inability to use substances or medications, and inability to bring pets to shelter.
- ☐ Rules are few, flexible, non-punitive, and seen more as guidelines. The agency understands that rules might feel arbitrary and can be retraumatizing. The agency cares about and actively solicits feedback from survivors about rules. Participant rights are valued, centered, documented, and made available to all participants.
- ☐ The agency provides physical spaces that make it possible for people to care for themselves and their children. This may include a quiet, soothing place; free access to a computer; youth-centered spaces; a space for art, music, or movement; outdoor space; communal spaces to be with others; and private spaces. Staff members encourage and support people to use these spaces set aside for attending to themselves.
- ☐ Staff members are trained on trauma-informed approaches to crisis prevention and intervention, and in responding when people are experiencing emotional distress.
- ☐ The agency has materials on domestic violence, sexual assault, stalking, and trauma that are not graphically explicit.

Pause and Reflect

- ☐ What are the physical, sensory, and relational environments like at your agency? What do you need to learn in order to do a thorough assessment of your space?
- ☐ What does your agency do well to make sure that the space is welcoming, inclusive, and accessible to people of all ages and abilities, including those participating in services and individuals working in the agency? What can you do better?
- ☐ In what ways do you actively work to destigmatize commonly stigmatized experiences like substance use, mental health, and disability?
- ☐ What does your agency do well to recognize and reduce elements of your environment that might be retraumatizing? What can you do better?

Pause and Reflect

- ☐ How do you encourage transparency to enhance and cultivate emotional safety and trust?
- ☐ In what ways does the space make people feel hopeful, safe, and supported?
- ☐ Who can access your services easily? What are the barriers? What can be improved?
- ☐ What are some initial actions that you can take to move toward your goals to enhance the physical, sensory, and relational environments? What supports and resources does the agency need to implement those first actions?

Focus Area 4: Intake Process



Often, the first contact we have with people is during the intake process. In an accessible, culturally responsive, and trauma-informed (ACRTI) organization, the intake process is designed to welcome survivors into the program; to offer empathy, kindness, respite, and care; and to create opportunities for survivors to express the needs, priorities, concerns, and goals they have for themselves and for their children. Ideally, intake procedures should provide a sense of physical and emotional safety; acknowledge survivors' resilience and strengths; offer connection and hope; and

convey a genuinely collaborative, survivor-defined approach. Intake procedures are flexible, transparent, and meet people where they are, balancing the length and timing of the intake process with survivors' preferences and needs.

Are questions asked in accessible, culturally responsive, and trauma-informed ways? Does intake and service planning reflect an understanding that trust develops over time and that experiencing interpersonal trauma can affect a person's ability to trust others, their thought processes, or ability to thoughtfully plan for what they need from services? Do we ask survivors about their children, including

how they are doing, any worries they might have about their children, and any urgent concerns? Are our intake processes screening people out or inviting people in? Does our intake process actively exclude people? Does our intake process recognize the importance of meeting people where they are? What information do we need to maximize our ability to help people and to support their stay in our program?

With an Accessibility Lens: How does the agency's intake process demonstrate and enhance accessibility, inclusive of people with disabilities and Deaf individuals, people with complex mental health concerns, people in recovery, or people who actively use substances?

With a Cultural Lens: How does the agency create intake policies and procedures that are affirming and are inclusive of the many aspects of all staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's intake policies, processes, and procedures reflect alignment with, and facilitate implementation of trauma-informed principles and practices?

Indicators of Accessibility in Practice:

- ☐ Staff members are trained to complete intake in a number of formats, including through an interpreter, by offering TTY, video relay, or other phone options, in plain language, and across multiple sessions.
- ☐ Staff members are trained in providing services that are in compliance with federal laws and regulations such as the Americans with Disabilities Act, Fair Housing Act, confidentiality regulations, language access, and other federal anti-discrimination laws and regulations.
- ☐ Staff members make every effort to create accessible intake processes for people with disabilities and Deaf individuals. The agency offers pamphlets and handouts with design elements such as colors and shapes that are attentive to sensory disabilities. Pamphlets and materials are offered in multiple, accessible font sizes.
- ☐ The agency's intake process does not screen people out due to disability, health or mental health status, medication use, gender identity, sexuality, or use of substances. Active substance use does not exclude people from accessing services.
- ☐ Staff members are willing to read through questions with participants and take as much time as they need to complete intake. People are not turned away if they are unable or unwilling to complete intake in a short period of time.
- ☐ Staff members create intentional space during intake for participants to share what they think would be particularly helpful for staff to understand so they can get the most out of programs and services.

- ☐ The intake process allows participants to disclose (or not) any relevant experience with disability on their own terms – whether visible or invisible. Staff members do not make assumptions about participant’s abilities. People’s privacy around disclosure is respected above and beyond the requirements made by federal laws and regulations.
- ☐ Information is provided to all incoming participants about the program’s commitment to making accommodations for anyone who is accessing services. Staff members display attitudinal accessibility by being warm, welcoming, nonjudgmental, and genuinely interested in being supportive.
- ☐ Staff members offer support around medication storage and use if participants are interested. Efforts are made to destigmatize the use of medications.
- ☐ Staff members are open to the myriad ways people express emotional distress and engage participants with curiosity about how they can support survivors when they are in distress – particularly during intake. People are treated with compassion and an understanding about the ways trauma can impact communication. Staff members are willing to adapt their communication strategies according to the context, situation, or needs of the participant in the moment rather than their perception of how a person “should” be communicating.
- ☐ Staff members are able to provide information about the kinds of resources and accommodations that are available for survivors who are experiencing any mental health or substance use challenges within and outside the agency.
- ☐ Staff are supported, trained, and given opportunities in supervision to reflect on navigating challenging interactions during intake. Staff members build skills around sustaining empathy, compassion, comfort, and connection with survivors who are in distress.

Indicators of Cultural Responsiveness in Practice:

- ☐ Staff members are trained to ask questions in ways that reflect an openness and interest in learning about what is important to people about their experiences, culture, and identities.
- ☐ Optional questions about individual cultural, ethnic, racial, gender identity, sexual orientation, and primary language are included in intake and service planning. People participating in services are free to decide whether and how they want to respond. People are not excluded on the basis of previous or ongoing substance use or abuse.
- ☐ Intake structure and questions asked take into account the role of culture, religion, and spirituality in participants’ lives. The agency creates opportunities for staff and people using services to express their beliefs, values, and feedback about what is helpful.
- ☐ People participating in services are not automatically assigned to staff members from their own cultural, ethnic, racial group – unless requested. Staff members reflect the wide variety of identities held by participants. Participants are able to exercise choice and consent in determining whether or not working with someone from a shared identity group would be helpful for them.
- ☐ Assumptions are not made about people’s cultural, religious, or spiritual beliefs or practices. People are given time and space to disclose whatever makes sense for them without judgment or pressure. Staff understand and support that people might choose not to disclose any of this for a myriad of reasons.

Indicators of Trauma-Informed Practice:

- ☐ During intake staff create opportunities for survivors to discuss how they have been impacted by trauma, as well as how that might affect their experiences of services, including:
 - ☐ Staff make space for survivors to share their stories during intake but do not pressure or expect people to disclose if they are not comfortable.
 - ☐ Survivors are asked about their experiences of mental health and substance use coercion.
 - ☐ Staff provide information about how trauma and abuse affect survivors' or their children's mental health and physical health; substance use and access to recovery services and mental health treatment; and coping strategies and supports, including what helps when they or their children are feeling stressed or distressed.
- ☐ Staff members are trained and expected to talk with survivors about the kinds of things that might be challenging or cause stress in a shelter environment, such as: communal living, navigating the legal system, documentation, feeling isolated from their community and being around people who might not share important aspects of their identity, not having their pets with them, trying to stay sober or maintain recovery, parenting under scrutiny, struggling with limited financial resources, and experiencing discrimination from staff or other survivors in shelter around ableism, homophobia, transphobia, racism, xenophobia, and other forms of oppression.
- ☐ The agency works to create flexibility in its intake process that center survivors' needs, including timing and number of questions asked, space and location of intake, and a commitment to explain what questions are asked and why.
- ☐ Staff members are willing and able to engage survivors about what would be helpful regarding their parenting. Assumptions are not made that all survivors need or want parenting help.
- ☐ Before survivors disclose anything, staff members understand and are able to share the extent and limits of confidentiality and mandatory reporting requirements within the program. This includes the kinds of records that are kept, who has access to this information, and confidentiality of information disclosed by children and youth working with advocates. If computers or phone systems are provided, specifics about privacy and electronic safety measures are disclosed to all participants.
- ☐ Staff members are able to nonjudgmentally respond to people engaging in substance use (and can compassionately respond if someone is high or if they find out someone is using), to people who are in recovery, and to people taking methadone, suboxone, or utilizing other harm reduction strategies.

Pause and Reflect

- ☐ What is your agency doing well? How do you know?
- ☐ In what ways do you create a welcoming environment when people first arrive?

Pause and Reflect

- ☐ How might people participating in services experience the intake process?
- ☐ What changes might you make to intake (e.g., to the setting, length, wording, questions) in order to make this process more ACRTI? What are the initial actions?
- ☐ Who does the intake process invite in? Who does it exclude? What are the barriers in your intake process and what do you need to do to make intake more accessible?

Focus Area 5: Programs and Services



In an accessible, culturally responsive, and trauma-informed (ACRTI) organization, attention is paid not only to what services are offered but also to how services are offered. This includes formal policies and all practices. Programs and services are designed to meet survivors where they are, take into account the range of ways that survivors may have been affected by trauma, recognize strengths and resources, and provide choice and flexibility.

In what ways are the agency's programs and services accessible, culturally responsive, and trauma informed? Are programs and services flexible and designed to meet survivors where they are? Do they provide opportunities for choice and reflect respect for the needs and decisions of survivors? Do they account for the ways that trauma may impact a survivor's experiences of programs and services and ability to participate in activities? Do they recognize survivors' sources of strength and support? In what ways do they demonstrate that everyone is valued? How do they honor all manifestations of resilience?

With an Accessibility Lens: How do the agency's programs and services demonstrate and enhance accessibility, inclusive of people with disabilities and Deaf individuals?

With a Cultural Lens: How does the agency create and implement programs and services in ways that affirm and are inclusive of the many aspects of all staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual

orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's programs and services align with and facilitate implementation of trauma-informed principles and practices?

Indicators of Accessibility in Practice:

- ☐ Staff members feel comfortable and have been trained in working with survivors who are neurodivergent, people who are Deaf or hard of hearing, who have cognitive disabilities, and who are experiencing challenges related to their trauma, substance use, and/or mental health.
- ☐ Programming is offered in a variety of ways that are tailored to many learning styles including visual, kinesthetic, verbal, logical, physical, oral, solitary, social, spatial, and other relevant learning styles for participants.
- ☐ Activities are designed with all people in mind. No one is excluded from participating in activities based on their mobility or sensory abilities. When it is discovered that an activity is exclusionary, efforts are made to correct the problem immediately.
- ☐ Programs and services are regularly reviewed, with feedback from individuals and participants who are Deaf or disabled, and changes are made to reduce barriers to access.
- ☐ Programs and services are designed to ensure that participants and potential participants have affordable and accessible transportation options when traveling to and from the organization. Programs offer transportation assistance whenever possible.
- ☐ Decisions about accessibility are made with the intention of integrating everyone in the environment in equal ways, including residential sleeping areas, communal spaces, and programming. All primary entrances are accessible to everyone; participants who use mobility aids are not expected to use service elevators or come in through a back entrance. Communication and sensory needs are fully supported by staff.
- ☐ The agency is responsive to people with varying degrees of literacy and is also sensitive to providing services that account for memory challenges and diverse cognitive abilities.
- ☐ Individual privacy needs are taken seriously and all efforts are made to accommodate participants.
- ☐ Programs directly challenge ableism by intentionally developing and enhancing services over time to decrease the need for accommodations.
- ☐ Programs and services integrate an understanding of how disability and Deafness impact and inform experiences of violence, the meaning people make of their experiences, and what is necessary to heal from trauma.
- ☐ All outreach and education efforts are inclusive of disabled people and people who are Deaf.
- ☐ Ability is not a prerequisite for participating. Disability is not conceptualized as a barrier to success.

Indicators of Cultural Responsiveness in Practice:

- ☐ The agency's programs and services reflect a commitment to providing culturally responsive services for a wide variety of communities.
- ☐ The agency serves people inclusive and affirming of race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system, among other important identities.
- ☐ Staff members understand participants' identities through disclosure rather than by assumptions.
- ☐ Services are available in the first languages of the majority of people served, and use of the language line is a last resort. The agency and its staff identify opportunities to go above and beyond legal mandates for language access to effectively connect with and support survivors.
- ☐ The agency has policies and procedures for providing services for people whose first language is less common than the majority of survivors served.
- ☐ The services and supports offered are culturally sensitive and relevant for communities being served. Culturally specific programming is also available, including celebrating national holidays and events such as Black history month or Pride month.
- ☐ The agency offers identity specific support groups connected to language, gender, and sexuality.
- ☐ Participants' agency and choice over their own bodies, outward presentation, and clothing are respected at all times. Programs understand that body shaming and imposing dress codes or expectations for survivors that call for conformity or "professionalism" replicate abusive dynamics.

Indicators of Trauma-Informed Practice:

- ☐ Staff members understand what it means to work with survivors in truly collaborative and non-hierarchical ways.
- ☐ Staff members offer information about the wide range of trauma responses that people may experience. Staff talk with survivors about what would be helpful to them when they are distressed. Staff offer to work with survivors on developing strategies for anticipating and managing their trauma responses.
- ☐ Staff members talk with survivors about coercion related to mental health and substance use and incorporate strategies for addressing mental health and substance use coercion into their advocacy and safety planning.
- ☐ Staff members respond knowledgeably and empathically when a person talks about experiences of current or previous abuse, and are able to listen and offer support in a setting and structure that the survivor chooses, to the extent possible.
- ☐ When survivors choose to discuss past trauma, staff are able to respond empathically to feelings related to fear, shame, and stigma, and to offer perspective that supports survivors' awareness and understanding of trauma and coercion.

- ☐ Staff members are able to support parents in understanding the impact of domestic violence and other trauma on their children and can offer age-appropriate ways to support children's healing and resilience.
- ☐ Staff members support survivors to identify and safety plan around trauma reminders that may cause them to disconnect, or to feel frightened, overwhelmed, or off balance.
- ☐ Staff members offer support to survivors in exploring ways to create physical and emotional safety through identifying people in the survivor's life who support their physical and emotional safety; in developing clarity about personal space and boundaries; in being able to voice needs, concerns, and opinions; and in exploring how needs vary in different contexts.
- ☐ Staff members are transparent about expectations, policies, procedures, rules, and activities that might affect survivors' ability to access services. Staff members are mindful about flexibility, timing, and pacing of programming, especially if someone is feeling overwhelmed, afraid, or distressed.
- ☐ Staff members support survivors' choices and agency with regard to participation and service planning, while acknowledging that this may be overwhelming or unfamiliar for some survivors of trauma.
- ☐ Specific programming exists for parents, children, and youth.
- ☐ Specific programming exists for survivors in recovery from substance abuse.
- ☐ Specific programming exists that supports healing from trauma.
- ☐ A range of on- or offsite programming and services are offered that support healing, well-being, and recovery via gender- and culture-affirming health and mental health services, support groups, 12-step or 16-step programs, harm reduction strategies, mind-body practices, community activities, dual recovery groups, medication assisted treatment, and medication support.
- ☐ Staff members support survivors' engagement in their own personal, cultural, and spiritual healing practices and intentionally create opportunities for their respective practices. If someone cannot burn anything indoors, space is offered in alternative area; if sensory needs of multiple participants come into conflict, spaces are created to fulfill the various needs of all participants to facilitate healing; there are private, flexible, non-denominational spaces for religious engagement, spiritual practice, and prayer.

Pause and Reflect

- ☐ In what ways are your agency's programs and services already accessible, culturally relevant, and trauma-informed?
- ☐ In what ways does your agency address the intersection of mental health, substance use, domestic violence, sexual assault, and other trauma, inclusive of the effects of mental health and substance use coercion?
- ☐ In what ways does your program actively support the healing, resilience and well-being of survivors, youth, and children? What programs and services

Pause and Reflect

are you already offering? What else do you need?

- ☐ Who can access your services easily? What are the barriers to access?
- ☐ What can be improved? What are some initial actions you can take to improve?
- ☐ What resources do you already have that will support your efforts?
- ☐ What else do you need? Who can be helpful?

Focus Area 6: Community Partnerships

Cross-sector community partnerships create a more robust safety net for survivors, allowing them to connect with the services and supports they want and need. Ideally, domestic and sexual violence programs work to build partnerships with culturally specific organizations, trauma therapists, peer support services, and local health care, mental health, and substance abuse treatment providers. These collaborations can also provide opportunities for domestic and sexual violence programs and coalitions to play a critical role in influencing the development of ACRTI services and policies

across their communities and states.

How does the agency create partnerships with organizations that also reflect accessible, culturally responsive, and trauma-informed (ACRTI) principles and knowledge? How does the agency work with other systems in ways that improve services for survivors and their children? How does the agency cultivate community partnerships to ensure survivors have access to the range of services they might need?

With an Accessibility Lens: How do the agency's community partnerships demonstrate and enhance accessibility, inclusive of people with disabilities and Deaf individuals?

With a Cultural Lens: How do the agency's community partnerships honor the many aspects of all

staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's community partnerships align with and facilitate implementation of trauma-informed principles and practices?

Policies and Agreements

- ☐ The agency has written policies or agreements, such as MOUs or linkage agreements, that support people in accessing resources in other organizations.
- ☐ Community partnerships are developed with shared mission, vision, and values in mind. Partnerships are based on ACRTI principles.
- ☐ The agency seeks to form relationships with and refer to community partners that incorporate an understanding of domestic and sexual violence; provide accessible, culturally responsive, and trauma-informed services; offer trauma-specific treatment interventions, including trauma-specific mental health and substance abuse services for adults, children, and youth; and provide gender-affirming services. If these resources are not readily available in your community, consider working with partners to develop them.
- ☐ The agency seeks to form relationships and refer to agencies that provide affordable or sliding-scale treatment options; actively work with Medicaid, Medicare, child and family assistance services, and other supportive social services and benefits programs; and that are attentive to the specific transportation realities of participants.
- ☐ The agency has mechanisms to talk with survivors about following up with them if they have been referred to another agency.
- ☐ The agency has a commitment to obtaining community-based feedback from people living and working in the area.
- ☐ The agency creates intentional community partnerships with organizations that provide resources a person might need after leaving a domestic or sexual violence agency, such as housing, job training, employment opportunities, transportation, child care, health care, and other resources that are integral to survival.

Training and Practice

- ☐ The agency regularly engages in cross-training, cross-consultation, and cross-referrals with community partners about domestic and sexual violence, substance use, mental health, and an ACRTI approach.
- ☐ Staff members are knowledgeable about the services available through other agencies in the

community, including:

- Culturally specific and culturally relevant services, including LGBTQ2SIA (Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, Intersex, Asexual) specific resources.
 - Options for mindfulness-based healing practices (yoga, tai chi, relaxation and grounding techniques, other mind-body techniques, traditional healing modalities).
 - Community mental health and substance use services, including access to support groups, Medication Assisted Treatment, detox, and residential services.
 - Trauma-Specific and Trauma-Informed treatment.
 - Services for children and parenting resources.
 - Peer support services and resources.
 - Health care providers, hospitals, and inpatient treatment centers.
 - Resources related to transitional housing, permanent housing, or independent living.
 - Options for employment and education, including vocational support.
 - Disability support services.
 - Services to access benefits including food stamps, Medicaid, social security, WIC, and unemployment benefits.
 - Support for survivors navigating immigration, asylum, and documentation.
 - Opportunities for survivors to become leaders in their communities.
- ❑ Staff members are knowledgeable about confidentiality policies of their own and of partner agencies. When making referrals staff talk with survivors about any risks and obtain informed consent before sharing information with another organization.
 - ❑ The agency ensures that information about outside agencies and resources is readily available and accessible to all participants.
 - ❑ The agency intentionally develops relationships with peer support organizations in addition to other mental health and substance abuse treatment services.

Pause and Reflect

- ❑ What partnerships do you already have with other agencies in the community? What is the quality of each of these partnerships?
- ❑ In what ways do your partnerships improve services for survivors?
- ❑ How do you create partnerships or networks of services that are accessible, culturally responsive, trauma-informed, and reflect an understanding of domestic and sexual violence?

Pause and Reflect

- ☐ How do staff members connect people with other resources in the community?
- ☐ What can you do better? What are the initial actions you can take? What support do you need to make these actions a reality?

Focus Area 7: Feedback and Evaluation



Obtaining regular feedback and input about our services and organizations from both staff and people utilizing our services is an important part of accessible, culturally responsive, and trauma-informed (ACRTI) work. It helps us to strengthen what is working, to try new and creative ideas, and to change what is not working well. Evaluation can create opportunities to pause and reflect on our progress in becoming an ACRTI organization.

Does the agency have mechanisms in place for obtaining and integrating regular input and feedback from the people who are utilizing services, from staff and volunteers tasked with delivering services, and from the broader community? Is attention to accessibility, culture, trauma, domestic violence, sexual assault, and stalking included in agency's quality improvement strategies?

With an Accessibility Lens: How do the agency's feedback and evaluation processes demonstrate and enhance accessibility, inclusive of people with disabilities and Deaf individuals?

With a Cultural Lens: How do the agency's feedback and evaluation processes consider and are inclusive of the many aspects of all staff, leadership, board members', and participants' identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system?

With a Trauma-Informed Lens: How do the agency's community partnerships reflect alignment with, and facilitate implementation of trauma-informed principles and practices?

Gathering and Implementation:

- ☐ The agency has a procedure for soliciting regular input and feedback from people who have accessed their services, including children and youth.
- ☐ Policies and procedures are in place for including people who use services in an advisory capacity to the agency.
- ☐ Feedback systems and evaluation methods are available in many languages, formats, and contexts, including verbal, written, video relay, TTY, digital that enable people of all abilities to participate in assessment and effecting change.
- ☐ People who access or have accessed services are able to provide feedback anonymously and confidentially.
- ☐ Exit interviews or equivalent methods for soliciting feedback when people leave the agency are available in the languages used by participants.
- ☐ The agency obtains confidential and anonymous feedback from staff members about whether they feel safe and valued at the agency.
- ☐ Focus groups are utilized to solicit feedback in a format that might feel safer for some participants. Group evaluation strategies provide opportunities for participants to listen and add to the contributions of other participants.
- ☐ The agency creates opportunities for participants to provide feedback about the usefulness, responsiveness, and relevance of services in a cultural context.
- ☐ The agency systematically incorporates feedback from participants into its ongoing improvement processes and does so in a timely manner.
- ☐ All evaluations are read and considered in making decisions about making organizational changes.
- ☐ Evaluation is both quantitative and qualitative, providing a variety of question styles, including scaling questions (e.g., on a scale from 1-5...), questions by comparison (e.g., is this more or less than...), feeling assessment (e.g., how did you feel when...), and opportunities for people to provide their own specific feedback to questions not asked.

Key Evaluation Topics and Themes:

The agency solicits **input and feedback** from people who participated in services on the following:

- ☐ Whether they felt treated with dignity, respect, and autonomy.
- ☐ Whether they felt visible or invisible.
- ☐ Whether they felt heard or not heard.
- ☐ Whether services were culturally relevant.

- ☐ Whether the physical, sensory, and relational environments felt welcoming and inclusive.
- ☐ Whether they felt informed about staff expectations and whether those expectations were fair.
- ☐ Whether they were able to influence rules that felt punitive or controlling.
- ☐ Whether they had access to information about domestic violence, sexual assault, and trauma.
- ☐ Whether they found staff to be nonjudgmental.
- ☐ Whether they felt understood and taken seriously when grievances were raised.
- ☐ Whether they experienced relationships with staff as hierarchical or as collaborative partnerships.
- ☐ How they were supported as parents (if relevant).
- ☐ Whether any service interactions or experiences were retraumatizing, frightening, or overwhelming.
- ☐ Whether services provided useful information and skills that enhanced physical and emotional safety, healing, recovery, and well-being.
- ☐ Whether they felt encouraged and enabled to be whole versions of themselves, particularly as it relates to identity, disability, mental health, and substance use.
- ☐ Whether the agency has adequate policies and procedures for obtaining regular input from people participating in services with regard to the accessibility, inclusiveness, cultural responsiveness, and physical and emotional safety, as defined by survivors.
- ☐ Whether they have any additional comments or suggestions for improvement.

Pause and Reflect

- ☐ What mechanisms does your agency have in place for obtaining and integrating regular input and feedback from the people who are participating in services? From staff? How are you implementing the changes suggested?
- ☐ How well do those mechanisms address whether or not the organization has created accessible, culturally responsive, and trauma-informed services?
- ☐ How are you doing? What are you learning? What can you do better?
- ☐ How are you addressing adverse or concerned feedback in a timely manner?
- ☐ If your agency does not have an evaluation or feedback process, what are some initial actions we can take to set one up? Who can you ask for support?

SECTION 3: KEY RESOURCES AND WORKSHEETS

Appendix A:

Glossary of Key Terms to Support Understanding for Accessible, Culturally Responsive, Trauma-Informed Work

★ **Accessible:** means that people with all kinds of abilities are able to fully access our agencies, including our information and resources; environments and spaces; and services and support with ease. A Deaf or disabled person is able to acquire the same information, engage in the same interactions, and fully participate in the same programs and services as a hearing or non-disabled person in an equally effective and equally integrated manner. People are accepted as whole versions of themselves, and are fully welcome, embraced, and accommodated. People are not reduced or understood solely through their disability and do not have to change or hide parts of themselves to be able to participate in or benefit from services. People's wishes about how they want their abilities recognized and understood are fully respected. Accessibility in this context is inclusive of people who have disabilities related to physical, sensory, cognitive, and mental health conditions, in addition to Deafness, chronic illness, and recovery from substance abuse. This concept intersects with people's multiple identities around race, class, age, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system. All of these intersecting identities are important to include when thinking about how to best serve survivors and their children; accessibility involves recognition of the barriers to meaningful involvement for all participants. All too often, people with disabilities are left out or excluded from services because of their disability, despite experiencing higher rates of violence than non-disabled people. It is the perpetuation of discriminatory attitudes, policies, and practices, in addition to the lack of accessible environments and adequate supports that are disabling and keep people from being able to fully participate in our services. In this conceptualization of accessibility, it is critical to work toward cultivating awareness and understanding to decrease negative attitudes and stereotypes about disabled

people. It also means being conscious of the assumptions we make about ability and disability, and of the images and language we use day-to-day. Finally, ensuring that all survivors have access to inclusive, anti-oppressive environments as they heal from trauma requires us to actively support the ongoing involvement of survivors with disabilities in shaping our spaces, resources, and services. (*Note: there are many ways to talk about disabled people / people with disabilities, and there is quite a bit of debate about what term is best. We have included both here knowing that for some, this will feel imperfect)..

★ **Coercion**: use of force or manipulation to control an intimate partner's thoughts, actions, and behaviors through violence, intimidation, threats, degradation, isolation, and/or surveillance. In the context of intimate partner violence, coercion can involve financial, psychological, physical, sexual, emotional, and other kinds of abuse to undermine and control an intimate partner. There are two specific forms of coercion that we discuss in this Toolkit – mental health and substance use coercion.

★ **Mental Health Coercion**: abusive tactics targeted towards a partner's mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include gaslighting, preventing a survivor's from accessing treatment, controlling or manipulating a survivor's medication, using a survivor's mental health to undermine and discredit them with sources of protection and support, leveraging a survivor's mental health to manipulate police or influence child custody decisions, engaging mental health stigma to make a survivor think no one will believe them, among many other tactics.

★ **Substance Use Coercion**: abusive tactics targeted towards a partner's substance use as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include forcing a survivor to use substances or to use more than they want, using a survivor's substance use to undermine and discredit them with sources of protection and support, leveraging a survivor's substance use to manipulate police or influence child custody decisions, deliberately sabotaging a survivor's recovery efforts or access to treatment, engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal, among many other tactics.

★ **Culture**: an integrated pattern of behavior or shared beliefs, values, traditions, arts, history, folklore, and institutions of a group of people. This also includes shared experiences, thoughts, communication and actions. What unifies people can be related race, ethnicity, nationality, language,

religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender identity and/or expression, age, disability, or any other cohesive group identity. Cultural identity refers to the way individuals understand themselves and are viewed by others, and includes the ways individuals self-identify, collectively identity, the sense of belonging to a specific group, and relational identity, which includes interactions between groups. Culture shapes the experiences we have and the meaning we make of those experiences. Individuals often identify with and belong to many different identity groups at once (Adapted from Singh, 1998; Cross, Bazron, Dennis, & Isaacs, 1989).

★ **Culturally Responsive:** means that our organizations and agencies are proactively integrating meaningful attention to the cultural identities of participants and staff, and to the ways culture can shape people’s experiences of trauma and healing. Being culturally responsive also means systematically integrating awareness of culture into our services, policies, structures, and environments. It requires being interested in, learning about, and acknowledging the vast number of ways people express their cultural identities, values, connections, and experiences in order to provide services that are meaningful and relevant. It means seeking out and understanding the strengths, resources, and inherent resilience of individuals, families, and communities. Cultural responsiveness also means that organizations and individuals in agency settings affirm and are inclusive of the many aspects of human identities, including identity related to race, class, age, disability, language, sexual orientation, gender, gender expression, culture, ethnicity, religion, spirituality, mental health, employment, housing stability, family and important relationships, recovery, use of substances, military involvement, immigration or documentation status, access to education, and history with the criminal justice system. This includes having a complex understanding of the ongoing impact of historical trauma, structural oppression, and identity-based violence. It also means having mechanisms to evaluate and disrupt the impacts of those systems on the organizational culture with concrete processes to avoid replicating these experiences within our organizations. Being culturally responsive requires recognition and acceptance that microaggressive interactions will occur as a byproduct of unequal distributions of power within our relationships, organizations, and broader social context. This, in turn, allows us to actively respond when such interactions occur, to engage in open communication about harms people experience interpersonally, and to develop strategies to prevent further harm moving forward.

★ **Domestic Violence:** this term describes intentional, patterned, ongoing, systematic behaviors and actions used to control, manipulate, and maintain power over someone in any kind of intimate relationship. This can manifest as physical, emotional, sexual, economic, and psychological abuse. It can specifically include gaslighting, sexual assault, and coercion related to mental health, substance use, or parenting; outing around sexuality, gender, disability, or documentation status; emotional manipulation of children; and constant threats to a person's physical and emotional safety.

★ **Effective Supervisory Practice:** involves the consistent offering of a variety of approaches and ingredients within day-to-day supervisory interactions to provide the balance of education, administration, support, and leadership needed to guide staff in their work. Ingredients of Effective Supervision include attending to the values and ethics inherent to ACRTI work and creating an organizational climate that conveys these values. Effective Supervisory Practice also includes a strength-based and problem-solving orientation, clear expectations and accountability, giving and receiving feedback, supervisory modeling, an intentional process for staff skill development, and reflective practice (Cave & Johnan, 2014). Together, these components offer opportunities for new learning and can support staff in feeling connected and effective in their work; in handling challenging situations; and in cultivating self-awareness and self-care. The models and processes used are transparent and expectations are clearly defined, taught to staff and implemented consistently. These ingredients are incorporated on a regular basis and one component is not prioritized over another based on a supervisor's level of comfort. For example, the use of reflection, while essential, is not a replacement for modeling competence, setting clear expectations, or communicating about accountability. Each ingredient is a piece of the whole (Cave & Johnan, 2015). ***See also *Reflective Supervision*.**

★ **Gaslighting:** can be understood as intentionally or unintentionally controlling and manipulating someone to make them question their memory, experience, or sanity. This often happens slowly, repeatedly, and over time, to make it more difficult for a survivor to recognize that they are being emotionally manipulated or to be able to trust themselves. Some tactics of gaslighting used by abusers include telling outright lies, manipulating the truth, attacking a survivor's character, denying they said or did something, telling the survivor no one will believe them, and telling a survivor that everyone else is a liar. There are many ways that gaslighting can happen, these are just a few examples.

★ **Microaggression:** Microaggressions are brief and commonplace daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the targeted person or group (Sue, et al., 2007, p. 273). Microaggressions can also be insults related to gender identity and expression, sexual identity, class background, ability, immigration status, religious or spiritual affiliation or any other identity marker. Experiencing microaggressions can result in lack of physical and/or emotional safety and further marginalization of individuals and groups. These experiences impact the accessibility and cultural responsiveness of our services and organizations.

★ **Neurodivergent:** or ND means having a brain that functions in ways that significantly diverge from what is otherwise thought of as regular or common. The terms “neurodivergent” and “neurodiversity” were coined by Kassiane Sibley, a multiply neurodivergent neurodiversity activist. Neurodivergence can result from many things and present in multiple forms – genetic forms such as autism, epilepsy, or dyslexia, and experiential forms such as trauma, long-term meditation and trance-based activities, or heavy use of psychedelic drugs. This term is not positive or negative, but instead informed by the person’s experience of being neurodivergent.

★ **Neurotypical:** or NT is a term used to describe a person who does not have autistic or other neurologically atypical patterns of thought, communication, or behavior. This is a common term in autistic communities as a label for people who are not on the autism spectrum but is not the opposite of autistic. Neurotypical is the opposite of Neurodivergent. This is not a derogatory term or one that has a negative connotation.

★ **Oppression:** is the systematic subjugation of one group for the social, economic, and political benefit of a more powerful group. Oppression can manifest through many forms of violence, including racism, classism, ableism, sexism, heterosexism, and other isms. Only the dominant group can be oppressive because only the dominant group can leverage power against less powerful groups. Structural oppression occurs when history, culture, ideology, public policies, institutional practices, and personal behaviors and beliefs interact to maintain a hierarchy – based on race, class, ability, gender, sexuality, and/or other group identities – that create the privileges associated with the dominant group and the disadvantages associated with the oppressed, targeted, or marginalized group to endure and adapt over time (adapted from the Dismantling Racism Works Book, 2018 ; Open Source Leadership).

★ ***Reflective Supervision***: is an ingredient or component of **Effective Supervisory Practice**

that expands on the idea that supervision is a context for learning and professional development. The term Reflective Practice was coined by Donald Schon, who described it as "the capacity to reflect on action so as to engage in a process of continuous learning." The three key elements – *reflection* (zooming out from the work to examine thoughts, feelings, actions and reactions that are evoked in us), *collaboration* (between supervisor and supervisee, and between staff and participants, characterized by mutuality, joint exploration and integration of new learning), and *regularity* (predictable, regularly occurring with enough frequency to create a sense of safety and trust within the relationship) – are consistently woven into a stable supervisory relationship to explore the experiences, thoughts, reactions, and feelings that are directly connected to doing the work and to build trust.

The process is intended to engage staff in exploration and learning in an environment characterized by safety, calmness, and support that is parallel to the approach staff need to use in their work with others. Following exploration and perspective checking, the supervisor and supervisee work as a team to understand and identify next steps. Although often used in early childhood work with families, reflective practice can be useful in supervision in many human service arenas as a collaborative way to navigate challenges. This process can be used for co-reflection among colleagues, group supervision, and in individual supervision. **See also *Effective Supervisory Practice*.**

★ ***Resilience***: our inherent capacity to make adaptations in the face of adversity, trauma,

tragedy, threats, or significant sources of stress. In talking about resilience, it is important to keep in mind that it is not a trait that a person does or does not have and that people can be resilient whether or not they are experiencing ongoing health, mental health, or substance use-related challenges. Research on resilience and experience working with survivors indicate that there are multiple intersecting factors that contribute to resilience, including psychological, cultural, and social factors. These include having a supportive community, feeling valued, having a sense of belonging and being able to engage with others, as well as having access to basic necessities such as food, housing, education, employment and transportation. For children, the most important contributor to resilience is having at least one meaningful relationship with a supportive parent, coach, teacher, caregiver, or other adult (adapted from The Harvard Center on the Developing Child, 2017; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014).

★ **Retraumatization**: occurs when any situation, interaction, or environmental factor replicates events or dynamics of prior traumas and evokes feelings and reactions associated with the original traumatic experience.

★ **Sexual Violence**: is an overarching term to describe any sexual contact, manipulation, coercion, or behavior that occurs without explicit, freely given consent of the survivor. There are a myriad of reasons that someone might not be willing or able to give consent, including fear, intimidation, a person's age or disability, or being under the influence of medications, alcohol, or other drugs. Sexual violence can be experienced by anyone at any age. This term is often used to encompass sexual harm that occurs in the context of any relationship with an intimate partner, with a stranger, with a friend or coworker, or within a family or community system. Sexual violence in the context of an intimate partnership is often part of a larger pattern of violence and control (adapted from RAINN, 2017; National Sexual Violence Resource Center, 2010).

★ **Solidarity**: involves showing up for and advocating for people's needs while taking direction from them about what feels the most helpful. Solidarity is different from allyship in that it centers the voices, perspectives, and needs of the groups most affected and how they want to see change happen, and it expects accountability from people, systems, and institutions who abuse their power. Solidarity means showing up with people to change the conditions that create injustice and finding ways to do so without centering the perspectives of those with the most privilege. Solidarity demands that people do their own work to learn about privilege, marginalization, and oppression.

★ **Survivor**: we define survivor to mean adults, adults and their children, youth, young adults, elders, and anyone in the family system – as defined by survivors – who have experienced or witnessed violence. This can include violence experienced in ongoing ways in intimate relationships, family systems, state systems such as the police or prison, and in communities. It can also include traumatic events such as sexual assault, transportation accidents, loss of loved ones, terminal or serious health diagnoses, or other threats to someone's life or their physical or emotional safety.

★ **Trauma-Informed**: The term trauma-informed describes an approach that recognizes the pervasiveness and impact of trauma on survivors, staff, organizations, and communities, and ensures that this understanding is incorporated into every aspect of an organization's administration, culture,

environment, and service delivery. A trauma-informed organization actively works to decrease retraumatization and support resilience, healing, and well-being. Additionally, trauma-informed organizations recognize ongoing and historical experiences of discrimination and oppression, and are committed to changing the conditions that contribute to the existence of abuse and violence in people's lives. A trauma-informed approach provides guidance on how trauma can affect people's experience of services and what we can do to reduce traumatization at every level of our organizations. In this context, our interactions with participants matter a great deal, as do our interactions with each other. When we understand trauma responses in the context of domestic and sexual violence as adaptations to surviving abusive power and control, then part of our work is to do everything we can to not replicate those dynamics and to reduce the likelihood that survivors will feel discounted and disempowered in our programs and organizations. A trauma-informed perspective supports the resilience of people and communities through the work we do and the way we work. This includes creating a physical and sensory environment that is accessible, welcoming, inclusive, and healing, and attends to potential trauma reminders; a cultural and linguistic environment that is responsive to the people and communities being served; a relational environment that is caring, respectful, empowering, and transparent, and strives to create emotional safety; and a programmatic environment that is flexible and responsive to individual and family needs. A trauma-informed approach involves providing access to a range of healing modalities and practices, and creating community partnerships to ensure survivors and their children have access to trauma, mental health, and substance use services. Trauma-informed organizations support survivors to feel more connected and empowered as they prepare for situations that are potentially retraumatizing, such as participating in a court hearing, job interview, or custody evaluation. Lastly, a trauma-informed approach fosters an awareness of what we, as service providers, bring to our interactions, including our own experiences of trauma as well as the ways we are affected when we are truly open to the experiences of other people.

★ **Trauma:** Historically, the concept of trauma has focused on individual trauma - childhood abuse and neglect, adult or adolescent sexual assault, and abuse by an intimate partner as well as the individual effects of combat trauma and military sexual assault. Yet, many people experience collective forms of trauma, as well - trauma that affects people as part of a particular community, culture, or group and - experiences that continue to affect individuals and communities across generations, including the ongoing legacies of trauma resulting from structural violence, slavery, and colonization; the trauma of

war, poverty, displacement, and persecution; the trauma of transphobic, homophobic, and gender-based violence; as well as the insidious, microaggressive trauma of objectification, dehumanization, and marginalization that many people experience on a daily basis.

★ ***Individual Trauma:*** The unique individual experience of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s mental, physical, social, emotional, or spiritual well-being. When a person experiences trauma, their coping capacity and ability to integrate their emotional experience is overwhelmed, causing significant distress. (NCDVTMH, 2017; SAMHSA, 2014).

★ ***Collective, Historical, and Ongoing Trauma:*** **Collective Trauma** refers to cultural, insidious, political, and economic trauma that impacts individuals and communities, involving shared injuries to the group’s social, cultural, and physical support structures. More specifically, **Historical Trauma** refers to the ongoing and cumulative emotional, psychological, and spiritual wounding over the lifespan and across generations, suffered by a group of people because of historical events that were destructive to the physical, mental, emotional, and spiritual life way. **Ongoing Structural Violence and Interpersonal Discrimination** refers to racist or other discriminatory beliefs and ideology used as justification for discriminatory structures, social inequities, mass incarceration, exposure to social stressors, intrusion, and economic disparities that are socially and systematically supported by culture, laws, institutions, and policies (Root, 1997; Fabri, 2003; Michaels, 2010; Goosby, 2013; Sotero, 2006; Saul, 2014; Packard, 2014; Braveheart, 1995).

★ ***Trauma Reminder (commonly known as triggers):*** is something that evokes a memory of past traumatizing events, including the thoughts, feelings, and sensations associated with those experiences. They can take the form of smells, emotions, bodily sensations, images, situations, a tone of voice, a certain type of interaction, or a particular time of day or year. Trauma reminders may cause someone to feel frightened, overwhelmed, off balance, edgy, checked out, or feel like their mind and body are reliving the traumatic experience itself.

★ ***Universal Design:*** is a concept used in design and architecture to ensure that buildings, products, and environments are developed to be accessed, understood, and used to their greatest extent regardless of age, size, ability, or disability. This concept, which is also named in the Americans with Disabilities Act (ADA), asks that design is used to reduce the need for adaptation, modification, or assistive devices to independently understand, navigate, or use a environment. Grown out of resistance to institutional and structural ableism, Universal Design asks us to shift our understanding, design, and construction of environments to be inclusive of all people. Examples of this can include flat entrances, wider doors and hallways, accessible cabinets, ergonomic chairs, accessible print and website materials, and acoustics that support a range of hearing needs. Some people refer to this approach as “human-centered design.”

Appendix B:

Creating Trauma-Informed Services and Organizations: An Integrated Approach

Introduction

The National Center on Domestic Violence, Trauma & Mental Health's (NCDVTMH) approach to creating accessible, culturally responsive, and trauma-informed domestic and sexual violence services and organizations draws from a number of different places and perspectives - from the voices and experiences of survivors, advocates, and clinicians; from the insights of social and political movements; and from research and science, including a growing body of research on child development and neurobiology.

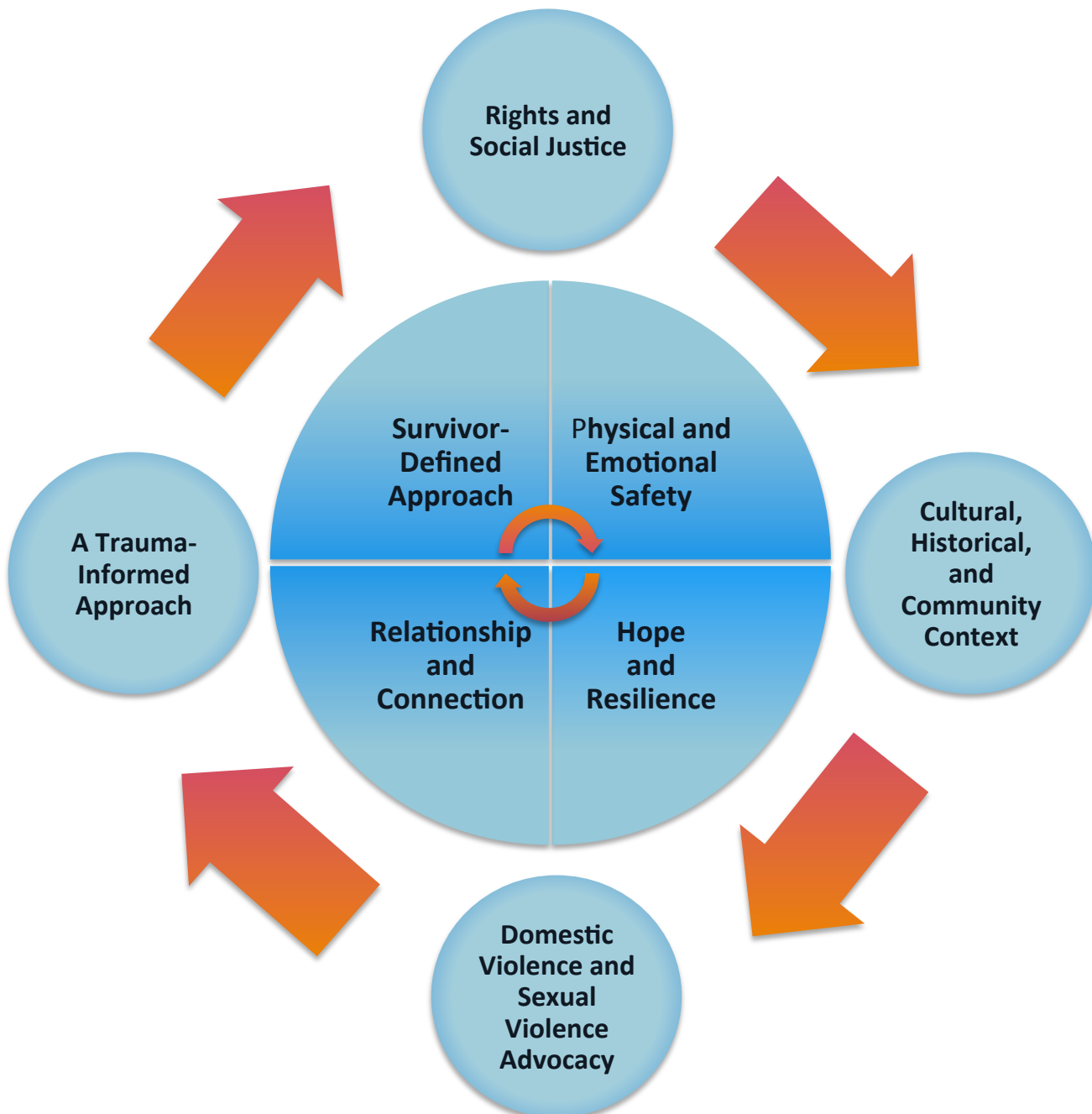
Initially developed as a way to bridge trauma-informed and advocacy perspectives, this more integrated approach has evolved into a framework for holding many of the key elements that are critical to doing our work - work that is grounded in domestic and sexual violence advocacy perspectives, that incorporates an understanding of trauma and its effects, that creates accessible environments for healing, that recognizes the centrality of culture, and that is committed to social justice and human rights.

More specifically, this framework provides a foundation for doing work that is inclusive and accessible, attuned to the range of people's experiences, and relevant to the people and communities we serve. It also provides a foundation for working in ways that are grounded in dignity, respect, and justice; that honor people's strengths and creativity; that foster resilience and healing; that attend to the well-being of staff, organizations, and communities; and that support activism and social change.

It provides additional scaffolding for holding the depth, nuance, sensitivity, attunement, self-awareness, and accountability that is so important to our interactions with others and the broader political awareness needed to understand our own and others' experiences in context. It also provides the inspiration, analysis, and tools to advocate for change within our organizations, in the systems that impact the lives of survivors, and in the attitudes and policies that contribute to abuse and violence in our world and restrict people's options. Given this, we use the term "survivor" to mean adults, adults and their children, youth, young adults, elders, and anyone in the family system – as defined by survivors – who have experienced or witnessed violence.

The following perspectives and principles help provide a foundation for accessible, culturally responsive, and trauma-informed work. They also offer a framework to draw on when our work becomes challenging and to support us in creating services and organizations that truly reflect our intentions and values. We hope that you can take strategies from this document to help you live and practice these values in your work.

Key Perspectives and Core Principles for Engaging in Accessible, Culturally Responsive, and Trauma-Informed Work



Key Perspectives

NCDVTMH's framework is informed by several key perspectives, which, when woven together, provide a more integrated approach for working with survivors and their children. Each perspective offers an important dimension that helps inform how we conceptualize and how we do our work. All contribute to our ability to ensure our programs are welcoming, inclusive, and accessible.

Domestic Violence and Sexual Violence Advocacy

This perspective highlights the importance of attending to not only the traumatic effects of domestic and sexual violence but also the ongoing realities of coercion and control by an abusive partner, and by the systems where survivors seek help. A domestic and sexual violence perspective also brings an analysis of gender-based violence, including transphobic, biphobic, and homophobic violence, to our work and emphasizes the importance of holding individuals and systems accountable for their abuse of power.

Cultural, Historical, and Community Context

This perspective focuses our attention on the historical and social context of people's lives including their ongoing experiences of oppression, discrimination, and microaggression. It helps us recognize the richness and complexity of people's identities, beliefs, and experiences, and the traditions, values, and relationships that serve as sources of meaning and strength. It also places the creation of services that are inclusive, culturally responsive, and linguistically accessible at the forefront of our work.

Human Rights and Social Justice

Incorporating human rights and social justice perspectives ensures that awareness of the conditions that create and uphold abuse, violence, oppression, and discrimination in our lives, our communities, and our society remains central to all that we do. It strengthens our ability to recognize social injustice, to critically analyze the conditions that produce it, and to work toward social change. It also helps us to be more attuned to any stigma or discrimination experienced by survivors and staff in our own programs and to actively take this on.

A Trauma-Informed Approach

A trauma-informed perspective brings an understanding of the pervasiveness of trauma and its impact on survivors, our organizations, our communities, and ourselves, and what we can do to help mitigate

those effects. It normalizes human responses to trauma and reminds us that the quality of our interactions is critical to the process of healing from abuse and trauma. A trauma-informed approach provides guidance on how trauma can affect people's experience of services and what we can do to reduce further traumatization at every level of our organizations. When we understand trauma responses as adaptations to being under siege, then part of our work is to do everything we can to reduce the likelihood that survivors will feel discounted and disempowered in our programs and systems. A trauma-informed perspective also informs the creation of services and environments that support the resilience and well-being of people and communities through the work we do and the way we work. A trauma-informed perspective acknowledges the need to support staff and to create opportunities for reflection and growth.

Core Principles

The following core principles or values provide a foundation for doing accessible, culturally responsive, and trauma-informed work. They are all part of creating a relational environment that can help to counteract people's experiences of trauma and dehumanization - one that is deeply respectful and that honors and supports each person's experience, resilience, agency, and humanity. Central to this integrated approach is recognizing the importance of the quality of our interactions and the relationships we create. Each of the following principles represents a somewhat different aspect of this overarching approach. These principles include recognizing and honoring the importance of:

Physical and Emotional Safety:

A key aspect of accessible, culturally responsive, and trauma-informed work involves attending to both physical and emotional safety, with particular attention to culture and accessibility, while honoring each person's understanding of what safety means for them, and a commitment to ongoing self-reflection and evaluation of whether systems, policies, and procedures are facilitating feelings of safety among participants and staff.

Relationship and Connection:

Relationships are central to healing, growth, and change, including our relationships to the people, places, practices, and things that help us to cope, grow, and thrive. As harm often occurs in relationship, the quality of our relationships and interactions has the potential to facilitate healing from experiences of abuse and discrimination, and create a sense of connection and belonging.

When trust has been betrayed, being honest, clear, transparent, and consistent and relating in ways that are genuinely respectful, collaborative, and non-hierarchical are essential to creating safety and building trust.

Hope and Resilience:

Believing in the human capacity to survive and heal, and recognizing the strengths, resources, and tools that survivors already possess, are central to holding hope and resilience. Being a steady source of hope, and acknowledging, naming, and reflecting people's profound resilience are critical parts of supporting survivors while they heal from trauma. It also means that we embody a genuine sense of openness in our relationships and our work.

A Survivor-Defined Approach:

Recognizing and honoring each person's right to define and determine what works for them, and guaranteeing choice and control over their experiences are critical components of a survivor-defined approach. This means taking cues and guidance from survivors, including adults, children, and youth, about our programs and services. This approach ensures the meaningful involvement of survivors who use or have used our services in our planning processes, in evaluation and oversight, and in volunteer, staff, and leadership roles within our programs. Engaging in survivor-defined work also means that we are working to acknowledge and jointly confront the power imbalances in our interactions, while working to change the conditions that facilitate violence in our relationships and communities.

Appendix C:

Additional Resources for Your Process of Transformation

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Additional Materials from National Center on Domestic Violence, Trauma & Mental Health:

WWW.NATIONALCENTERONDVTRAUMAMH.ORG

Note: Look out for the upcoming webinar and implementation guide for this toolkit.

Trauma-informed resources for advocates:

☐ Resources for Advocates – Trauma-Informed Domestic Violence Advocacy

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/TRAININGTA/RESOURCES-FOR-ADVOCATES-TRAUMA-INFORMED-DV-ADVOCACY/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/TRAININGTA/RESOURCES-FOR-ADVOCATES-TRAUMA-INFORMED-DV-ADVOCACY/)

Mental Health and Substance Use Coercion information:

☐ Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/COERCION-RELATED-TO-MENTAL-HEALTH-AND-SUBSTANCE-USE-IN-THE-CONTEXT-OF-INTIMATE-PARTNER-VIOLENCE-A-TOOLKIT/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/COERCION-RELATED-TO-MENTAL-HEALTH-AND-SUBSTANCE-USE-IN-THE-CONTEXT-OF-INTIMATE-PARTNER-VIOLENCE-A-TOOLKIT/)

☐ Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/MENTAL-HEALTH-AND-SUBSTANCE-USE-COERCION-SURVEYS-REPORT/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/MENTAL-HEALTH-AND-SUBSTANCE-USE-COERCION-SURVEYS-REPORT/)

- ❑ **Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline**

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/MENTAL-HEALTH-AND-SUBSTANCE-USE-COERCION-SURVEYS-REPORT/](http://www.nationalcenterdvtraumamh.org/publications-products/mental-health-and-substance-use-coercion-surveys-report/)

- ❑ **Mental Health and Substance Use Coercion: Results of Two National Surveys and Implications for Practice – Webinar**

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/TRAININGTA/WEBINARS-SEMINARS/2015-WEBINARS-ON-INDEPENDENT-TOPICS/](http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/2015-webinars-on-independent-topics/)

- ❑ **Model Medication Policy for Domestic Violence Shelters**

[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/MODEL-MEDICATION-POLICY/](http://www.nationalcenterdvtraumamh.org/publications-products/model-medication-policy/)

Additional Resource:

- ❑ **Building Dignity: Design Strategy for Domestic Violence Shelter**

[HTTP://BUILDINGDIGNITY.WSCADV.ORG/](http://buildingdignity.wscadv.org/)



GETTING CONCRETE : CHANGE IN REAL TIME

Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations



Focus Area 1: Organizational Commitment and Infrastructure

Vision: If our organizational commitment and infrastructure reflected an ACRTI approach, it would look like...

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?

**GETTING CONCRETE : CHANGE IN REAL TIME***Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations***Focus Area 2: Staff Support and Supervision**

Vision: If our staff support and supervision reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?



GETTING CONCRETE : CHANGE IN REAL TIME

Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations



Focus Area 3: Physical, Sensory, and Relational Environments

Vision: If our physical, sensory, and relational environments reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?

**GETTING CONCRETE : CHANGE IN REAL TIME***Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations***Focus Area 4: Intake Process**

Vision: If our intake process reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?

**GETTING CONCRETE : CHANGE IN REAL TIME***Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations***Focus Area 5: Programs and Services**

Vision: If our programs and services reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?

**GETTING CONCRETE : CHANGE IN REAL TIME***Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations***Focus Area 6: Community Partnerships**

Vision: If our community partnerships reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?

**GETTING CONCRETE : CHANGE IN REAL TIME***Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations***Focus Area 7: Feedback and Evaluation**

Vision: If our feedback and evaluation processes reflected an ACRTI approach, it would look like:

What are we doing well?

What are our challenges?

Based on our challenges, what would we like to change (initial actions)?

What is our timeframe (including when we will check back in on our goals and visions)?

How will we know when there has been change or progress?

Resources (what we have already and what we still need)?



What is Reproductive Justice?

SisterSong defines Reproductive Justice as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.

The Herstory of Reproductive Justice (RJ)

Indigenous women, women of color, and trans* people have always fought for Reproductive Justice, but the term was invented in 1994. After attending the International Conference on Population and Development in Cairo, where the entire world agreed that the individual right to plan your own family must be central to global development, a group of black women gathered in Chicago. They recognized that the women's rights movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women and trans* people. We needed to lead our own national movement to uplift the needs of the most marginalized women, families, and communities.

These women named themselves Women of African Descent for Reproductive Justice, and RJ was born. Rooted in the internationally-accepted human rights framework created by the United Nations, Reproductive Justice combines reproductive rights and social justice. The progenitors of RJ launched the movement by publishing a historic full-page statement with 800+ signatures in The Washington Post and Roll Call. Just three years later, in 1997, SisterSong was formed to create a national, multi-ethnic RJ movement.

We believe that Reproductive Justice is...

- A human right. RJ is based on the United Nations' internationally-accepted Universal Declaration of Human Rights, a comprehensive body of law that details the rights of individuals and the responsibilities of government to protect those rights.
- About access, not choice. Mainstream movements have focused on keeping abortion legal as an individual choice. That is necessary, but not enough. Even when abortion is legal, many women of color cannot afford it, or cannot travel hundreds of miles to the nearest clinic. There is no choice where there is no access.
- Not just about abortion. Abortion access is critical, and women of color and other marginalized women also often have difficulty accessing: contraception, comprehensive sex education, STI prevention and care, alternative birth options, adequate prenatal and pregnancy care, domestic violence assistance, adequate wages to support our families, safe homes, and so much more.
- To achieve Reproductive Justice, we must...
- Analyze power systems. Reproductive politics in the US is based on gendered, sexualized, and racialized acts of dominance that occur on a daily basis. RJ works to understand and eradicate these nuanced dynamics.
- Address intersecting oppressions. Audre Lorde said, "There is no such thing as a single-issue struggle because we do not live single-issue lives." Marginalized women face multiple oppressions and we can only win freedom by addressing how they impact one another.
- Center the most marginalized. Our society will not be free until the most vulnerable people are able to access the resources and full human rights to live self-determined lives without fear, discrimination, or retaliation.
- Join together across issues and identities. All oppressions impact our reproductive lives; RJ is simply human rights seen through the lens of the nuanced ways oppression impacts self-determined family creation. The intersectionality of RJ is both an opportunity and a call to come together as one movement with the power to win freedom for all oppressed people.

If You Really Care About Intimate Partner Violence,¹ You Should Care About Reproductive Justice

What is Reproductive Justice?

The Reproductive Justice (RJ) movement places reproductive health and rights within a social justice framework.² The movement supports the right of individuals to have the children they want, raise the children they have, and plan their families through safe, legal access to abortion and contraception. In order to make these rights a reality, the movement recognizes that Reproductive Justice will only be achieved when all people have the resources, as well as the economic, social, and political power to make healthy decisions about their bodies, sexuality, and reproduction.³

A society that respects the sexual and procreative rights of each individual will be a society with less violence against women, and that provides greater support to those who experience violence within their relationships. By advancing RJ, you are working toward the elimination of violence against women.

How Can Advancing Reproductive Justice Reduce Violence Against Women?

Addressing the racial and socioeconomic inequities that deny some women Reproductive Justice will also reduce instances of violence and help victims escape their abusive relationship.

Intimate Partner Violence (IPV), including sexual, physical, emotional and economic abuse, affects the lives of women across all races and income levels.⁴ Nonetheless, women of different racial and socioeconomic backgrounds experience different rates of violence. Historic inequities in access to education and economic opportunity result in socioeconomic disparities. Poverty, stress, unemployment and substance use are all predictors of IPV.⁵ IPV may contribute to higher rates of unintended pregnancy and escalate during pregnancy.⁶ One study found that a woman's odds of experiencing IPV rose by 10% with each pregnancy.⁷

American Indian and Alaskan females have higher rates of nonfatal IPV as compared to either Black or White females,⁸ but Black women account for 22% of all intimate partner homicide victims.⁹ There are also both linguistic and cultural barriers to seeking help for many women, who may fear authorities even more than their batterer,¹⁰ or may have trouble accessing culturally appropriate services in the language they are most comfortable speaking.¹¹

The social and economic costs of IPV include isolation from friends and family, inability to work, loss of wages, lack of participation in regular activities, and limited ability to care for themselves and their children. These outcomes perpetuate a lack of control and autonomy for victims, contributing to their further subjugation to their abusers.

Further, while it is difficult for any woman experiencing violence to end her relationship, the need to provide for a child makes escaping far more difficult for some mothers. Children who are exposed to violence also face long term effects, and are more likely to have violent relationships themselves.¹²

Controlling a woman's sexual and reproductive life is often a component of abuse, so restrictions on access to family planning and abortion keep women both physically and financially vulnerable.

An abuser may try to get a woman pregnant in order to keep her economically dependent and physically vulnerable. Health professionals report seeing cases of young men who use various techniques to control women's reproductive lives, including demanding unprotected sex, lying about "pulling out," hiding or destroying birth control, and preventing abortion.¹³

Governmental restrictions on family planning and abortion services only further abusers efforts to control their victims. Because a woman experiencing IPV has greater difficulties negotiating contraception with her abusive partner, it is especially important that she has access to methods that are not dependent on a partner's cooperation, or that can be used without her partner's knowledge.¹⁴

The Hyde Amendment, which bans federal funding of abortion except in cases of rape, incest, or life endangerment, may force a woman to carry her pregnancy to term¹⁵ and maintain contact with her abuser, despite her desire to limit his involvement in her life. In *Planned Parenthood v. Casey*, the Supreme Court acknowledged that restricting a woman's access to abortion by requiring her to notify her husband of her decision can result in her being abused. The Supreme Court explains that requiring a woman to notify her husband of a pregnancy "is frequently a flashpoint for battering and violence," including physical and psychological abuse.¹⁶

When women are not provided the basic resources to raise their children, including those related to health services, they may be left economically dependent on their abusers.

Reproductive justice demands that we work to improve economic conditions for women who want to parent. A woman may stay with an abuser if he is the only means of financial support for her child. Policies that improve economic conditions for women and their families help women escape violent relationships.

Some states attempt to discourage child bearing by women receiving public assistance by denying them additional assistance for the birth of another child.¹⁷ These are known as child exclusion policies, or "family caps." Such policies hinder reproductive justice by discouraging childbearing or encouraging women to terminate pregnancies they would otherwise carry to term. Women may also feel forced to stay in abusive relationships for fear of not being able to feed their children. Likewise, policies that increase women's ability to care for their children, such as strong child support enforcement,¹⁸ and subsidized child care,¹⁹ increase low-income women's ability to escape violent relationships.

An abuser may also force a woman to stay by threatening to seek sole custody of her child. Judges, unaware of the dynamics of abuse, may actually penalize a woman who is in an abusive

relationship by removing her children from her, instead of invoking the power of the state to protect her from abuse.²⁰

How You Can Combat Intimate Partner Violence and Support Reproductive Justice

- Advocate for access to comprehensive reproductive health care. Because abusers often isolate their victims, contact with a health care provider can present a rare opportunity for a woman who is being abused to get help. All providers should screen for IPV and be able to direct patients to resources for those experiencing violence.²¹
- Oppose restrictions on access to family planning services and abortion, which are especially burdensome to women who are experiencing violence and do not want to become pregnant or continue their pregnancies.
- Support laws that expand access to contraceptives²², including emergency contraception, so women are not dependent on their partners' cooperation in preventing unintended pregnancies.
- Support laws and policies that improve economic conditions for low-income women, so women have the financial ability to leave abusive relationships.

¹ While men may also experience partner violence, and violence may occur between same-sex partners or among family members such as siblings or between parent and child, this fact sheet addresses the type of violence most closely related to limitations on Reproductive Justice, that between a male perpetrator and a female victim. Eighty-five percent of IPV victims are women. Bureau of Justice Statistics Crime Data Brief, *Intimate Partner Violence, 1993-2001* (February 2003), cited in Nat'l Coalition Against Domestic Violence, *Domestic Violence Facts* (2007), [http://www.ncadv.org/files/DomesticViolenceFactSheet\(National\).pdf](http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf).

² SisterSong, *What is Reproductive Justice?*, http://www.sistersong.net/reproductive_justice.html (last visited Oct. 19, 2009).

³ Asian Communities for Reproductive Justice, *Mission and Vision*, <http://www.reproductivejustice.org/mission-vision.html> (last visited Oct. 19, 2009).

⁴ Nat'l Coalition Against Domestic Violence, *supra* note 1.

⁵ University of Minn. Inst. on Domestic Violence in the African American Community, *Fact Sheet: Intimate Partner Violence (IPV) in the African American Community*, http://www.dvinstitute.org/media/publications/FactSheet.IDVAAC_AAPCFV-Community%20Insights.pdf (last visited Oct. 19, 2009).

⁶ L. Roth et al., *Predictors of Intimate Partner Violence Among Women Requesting Medical Abortion*, 78 CONTRACEPTION 190 (2008).

⁷ Rebekah E. Gee et al., *Power Over Parity: Intimate Partner Violence and Issues of Fertility Control*, 201 AM. J. OF OBSTETRICS AND GYNECOLOGY 148.e1 (2009), available at <http://www.ajog.org/article/PIIS0002937809004426/abstract>.

⁸ Bureau of Justice Statistics, *Intimate Partner Violence in the U.S.: Victim Characteristics* (2007), available at <http://www.ojp.usdoj.gov/bjs/intimate/victims.htm>.

⁹ Black women are only 8% of the U.S. population. University of Minnesota Institute on Domestic Violence in the African American Community, *supra* note 5.

¹⁰ Sakhi for South Asian Women, *The Need for Sakhi's Services*, <http://www.sakhi.org/about/needsakhisvcs.php> (last visited Oct. 19, 2009).

¹¹ Alianza- National Latino Alliance for the Elimination of Domestic Violence, *Public Policy* (Mar. 3, 2009), <http://www.dvalianza.org/home.htm>.

¹² Nat'l Coalition Against Domestic Violence, *supra* note 1.

¹³ Elizabeth Miller, et al., *Adolescent Intimate Partner Violence and Contraceptive Nonuse among Adolescent Females Utilizing Teen Clinics*, 42 J. OF ADOLESCENT HEALTH 8 (Feb. 2008).

¹⁴ Rebekah E. Gee et al., *supra* note 7. Such methods might include hormonal shots, implants, the IUD or oral contraceptives, though there is a risk that pills could be discovered. For information on contraceptive options, please visit <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm>.

¹⁵ Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review* (Guttmacher Institute 2009), available at <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf>.

¹⁶ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 889 (1992).

¹⁷ Jodie Levin-Epstein, *Lifting the Lid Off the Family Cap: States Revising Problematic Policy for Welfare Mothers*, Childbearing and Reprod. Health Series (Ctr. for Law and Soc. Policy, Washington, DC), Dec. 2003, available at http://www.clasp.org/publications/family_cap_brf.pdf. The states most likely to implement the family cap are states with higher percentages of African-Americans and Latinos receiving assistance. *Id.* at 2. For information on state family cap policies, see Office of Family Assistance, Admin. for Children and Families, Dep't of Health and Human Services, *TANF Eighth Annual Report to Congress*, available at <http://www.acf.hhs.gov/programs/ofa/data-reports/annualreport8/chapter12/chap12.htm#15> (last visited Oct. 20, 2009).

¹⁸ Vicki Turetsky, Ctr. for Law and Soc. Policy, *Child Support: Ripple Effects Throughout the Community* (2008), available at http://clasp.org/publications/child_support_ripple_effects_formatted.pdf.

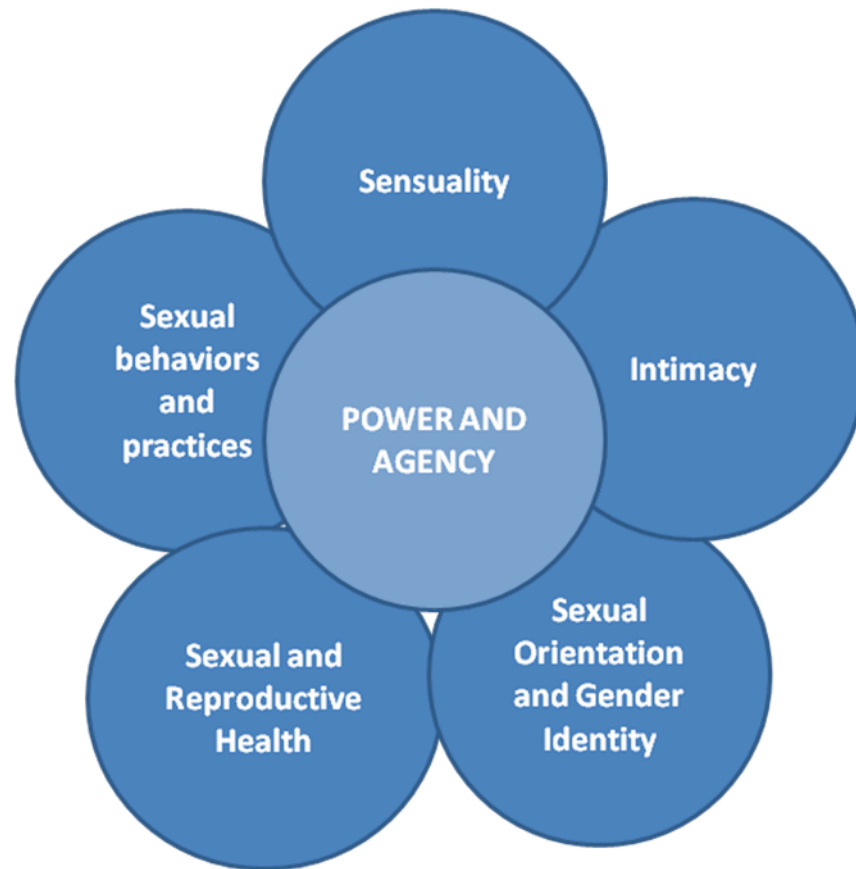
¹⁹ To find out how you can advocate for increased funding for child care, please visit the National Women's Law Center's Child Care page at <http://www.nwlc.org/display.cfm?section=childcare>.

²⁰ Daniel G. Saunders, *Child Custody and Visitation Decisions in Domestic Violence Cases: Legal Trends, Risk Factors, and Safety Concerns* (National Resource Center on Domestic Violence 2007).

²¹ The American College of Obstetricians and Gynecologists recommends that all patients be screened for all forms of violence. American College of Obstetricians and Gynecologists, *Screening Tools-- Domestic Violence*, http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585 (last visited Oct. 20, 2009).

²² For information on how you can increase access to contraceptives, please visit the National Women's Law Center's Medicaid Family Planning Project at <http://www.nwlc.org/details.cfm?id=3483§ion=ReproductiveChoices> and the National Women's Law Center's Contraceptive Coverage Project at <http://www.nwlc.org/details.cfm?id=2184§ion=ReproductiveChoices>.

Circles of Sexuality and Definitions



Sensuality

Awareness and feeling with one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give ourselves and others.

Intimacy

The ability and need to be close to another human being and accept closeness in return. Aspects of intimacy can include sharing, caring, emotional risk-taking, and vulnerability.

Sexual orientation and gender identity

A person's understanding of who he or she is sexually, including:

- Gender identity: a person's internal sense of being a man or a woman, which may or may not correspond with the sex assigned at birth.
- Gender expression: how one's characteristics and behaviors conform to or transgress gender norms and roles of femininity and masculinity.

- Sexual orientation: whether a person's primary attraction is to the opposite sex (heterosexuality), the same-sex (homosexuality), or both sexes (bisexuality).

Sexual health and reproduction

One's capacity to reproduce and the behaviors and attitudes that support sexual health and enjoyment. This includes factual information about sexual anatomy, sexual intercourse and different sex acts, reproduction, contraception, STI prevention, and self-care, among others.

Sexual behaviors and practices

Who does what with which body parts, items, and/or partners.

Sexual power and agency

Power within sexual relations. This includes:

- Power within, derived from a sense of self-worth and understanding of one's preferences and values, which enable a person to realize sexual well-being and health.
- Power to influence, consent, and/or decline.
- Power with others to negotiate and decide.
- Power over others; using sex to manipulate, control, or harm other people.

Healthy Sexuality Online Resources

Comprehensive healthy sexuality education is a key part of sexual violence prevention.

Online Resources about Healthy Sexuality:

The **American Social Health Association** is dedicated to improving the health of individuals, families, and communities with an emphasis on sexual health and a focus on preventing sexually transmitted infections/diseases.

Healthy sexuality for sexual violence prevention: A report on promising curriculum-based approaches, published in 2011, provides a summary of the top curriculum-based healthy sexuality programs. Included are detailed descriptions of 4 outstanding curricula with target audiences from ages 5-21, two of which are offered in Spanish.

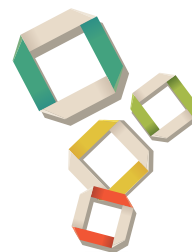
Scarleteen is an independent, grassroots sexuality and relationships education and support organization and website. Scarleteen provides comprehensive sexuality, health and relationship articles, guides, factsheets and in-depth advice answers, extensive external resource lists for each topical section of the site and a collective blog, along with interactive services, referrals, outreach, and mentoring and leadership opportunities for teens and young adults.

Sexuality Information and Education Council of the United States provides resources in the areas of both policy/advocacy and information/education. Excellent data and fact sheets supporting comprehensive sexuality education.

Online Resources about Trans Healthcare:

The National LGBT Health Care Education Center is a program of the Fenway Institute. This collection of webinars, publications, and trainings aims to educate health care providers and staff at health care organizations to better provide quality, inclusive, and welcoming care to transgender people.

Planned Parenthood provides introductory information on trans health care, including specific barriers trans and gender nonconforming people face when trying to access health care. Additional pages include information on trans and gender nonconforming identities, transphobia, and how to support someone who is trans.



Publications:

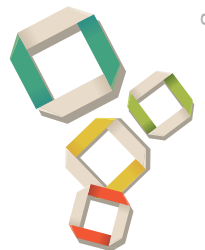
The **2014 National Sexual Assault Awareness Month (SAAM) campaign** focused on healthy sexuality and young people. This campaign provides tools on healthy adolescent sexuality and engaging youth. Learn how you can play a role in promoting a healthy foundation for relationships, development, and sexual violence prevention. SAAM 2014 engages adults in supporting positive youth development, and encourages young people to be activists for change. Many resources also are available in **Spanish**.

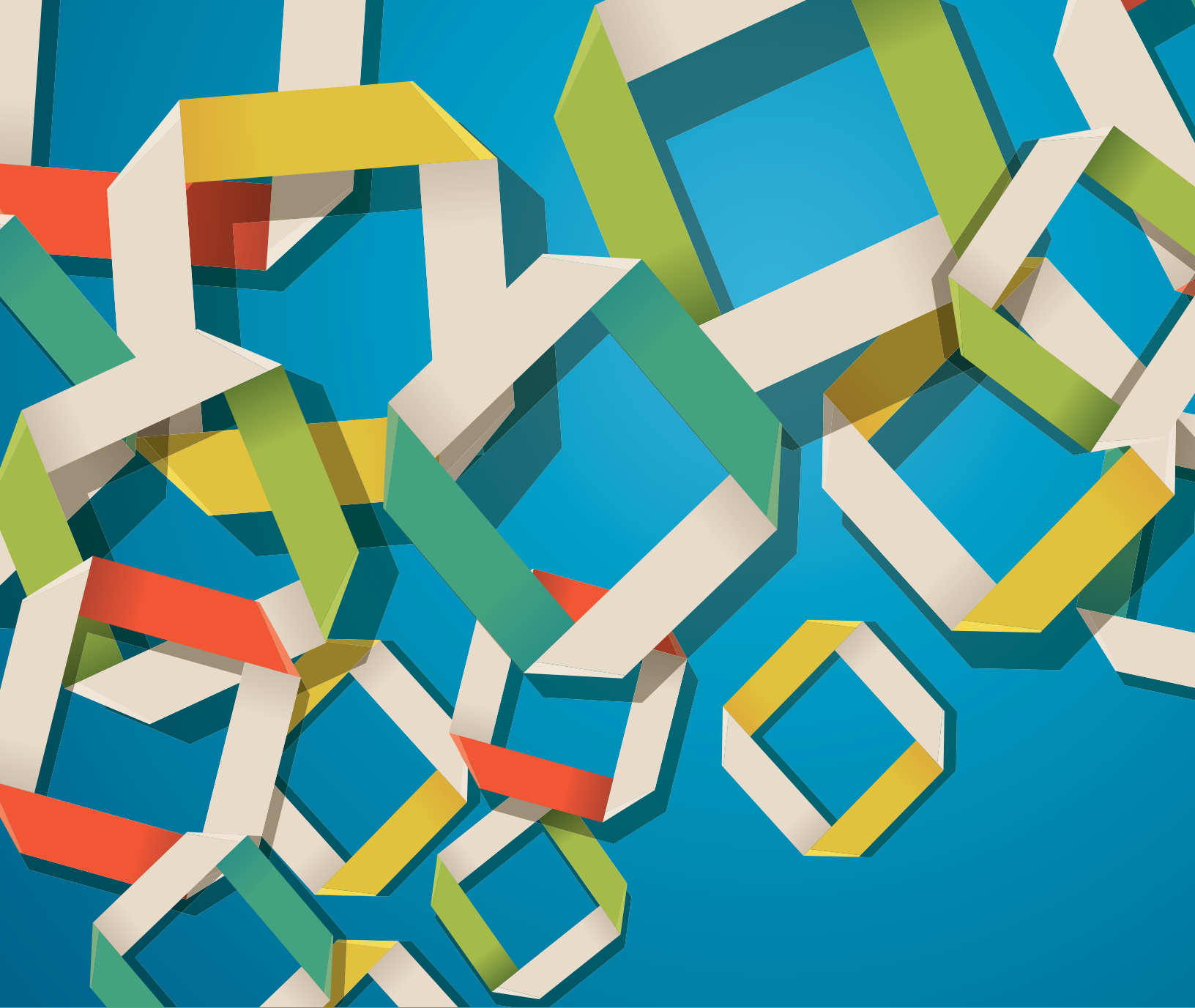
Relationship Status, an online booklet by the Vermont Network Against Domestic and Sexual Violence uses comic book illustrations and activities to discuss healthy relationships and sexuality for teens.

S.E.X.: The All-You-Need-To-Know Sexuality Guide to Get You Through Your Teens and Twenties is the popular, in-depth, progressive and inclusive teen and young adult sexuality and relationships guide by Scarleteen founder Heather Corinna (2007 & 2016, DaCapo Press/Perseus Books). S.E.X. covers consent, safe sex, emotional health and more.

Sexuality & Social Change: Making the Connection, Strategies for Action and Investment covers the intersection of sexuality with major social issues, including women's and children's health; youth development; population growth; gender discrimination; gender-based violence; and women's empowerment.

WholeSome Bodies: Broadening the Conversation About Sexuality and Sexual Violence Prevention, a curriculum by the Vermont Network Against Domestic and Sexual Violence, focuses on integrating sexuality into our wholeness as an approach to sexual violence prevention.





Reproductive and Sexual Coercion
A Toolkit for Sexual & Domestic Violence Advocates
Second Edition (2018)



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