



Promising Practices

Standards for Ohio's Domestic Violence Programs



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The Ohio Domestic Violence Network (ODVN) is a domestic violence coalition that mobilizes a statewide voice on domestic violence representing all 88 counties in Ohio. ODVN advances the principles that all people have the right to an oppression and violence-free life; fosters changes in economic, social, and political systems; and brings leadership, expertise, and best practices to community programs. ODVN is committed to providing high standards of service delivery to the funders and programs that it represents, thereby providing the best services possible for domestic violence survivors and their children.

The current revision of this manual was completed in July 2022. Practitioners are encouraged to use this manual in conjunction with, rather than as a substitute for, ongoing training and research reviews. Some programs refer to the Promising Practices Manual as the model used for programming in grant applications. If a program plans to utilize this manual as the model for their program, the expectation is that the best practices outlined will be utilized as a complete framework for domestic violence program service delivery.

Table of Contents

Introduction	5
Purpose of this Manual	5
ODVN Philosophy Statement	6
ODVN Diversity, Equity & Inclusion (DEI) Values:	6
Guiding Principles	6
A Note on Vocabulary	6
 Core Values of Domestic Violence Services	 7
Empowerment: The Basis of Services	7
Empowerment in Case Planning	7
Empowerment in Program Development	8
A Trauma-Informed Approach to Services	8
The Power and Control Analysis of Domestic Violence	8
The Indiscriminate Nature of Domestic Violence	9
Coordinated Community Response	9
Protecting Confidentiality	9
 Administrative Standards	 10
 Core Services	 11
Crisis Line/Hotline	11
Safety Planning	12
Advocacy	13
Survivor-Defined Advocacy	13
Individual Advocacy	13
Systems Advocacy	14
Shelter	14
Shelter Rules	15
Intake/Entry to Program	16
Case Planning/Management	17
Documentation	17
Legal Advocacy	18
Support Groups	18
Supporting Youth Residing in Shelter	19
Safety Planning with Children and Youth	21
Allying with and Supporting Parents in Shelter	22
Mandated Reporting	23
Service, Companion, and Emotional Support Animals	24
Service Animals	24
Companion/Emotional Support Animals	24

Health, Safety, and Security	.25
Medical Best Practices.	.25
Medication	.25
Medical Marijuana.	.26
COVID-19 and Its Variants	.27
Emergency Procedures.	.27
Overdose	.28
Death in the Shelter.	.28
Partner-Inflicted Brain Injury	.29
Advocate Safety.	.35
Organizational and Administrative Safety Measures	.35
Behavioral and Interpersonal Safety Measures	.40
Safety in the Community	.41
Facility Security	.42
Rights of Survivors Participating in the Program	.43
Acceptance/Re-admittance Criteria	.44
Prohibitions on Survivor Background Checks	.44
Responding to Subpoenas, Warrants and Court Orders.	.45
Subpoenas	.45
Warrants	.47
Exigent Circumstances	.48
Welfare Checks	.49
Child Protective Services (CPS) or Court Orders Regarding Children	.49
Working with Marginalized/Underserved Populations	.50
Survivors with Disabilities	.50
Survivors Experiencing Mental Health Challenges or Psychiatric Disabilities	.51
Survivors with Substance Use Issues.	.52
Survivors who are d/Deaf or Hard-of-Hearing.	.53
Survivors who are Lesbian, Gay, Bisexual, Transgender, Queer, Intersex or Asexual (LGBTQIA+)	.54
Survivors of Color.	.54
Immigrant Survivors.	.55
Older Adult Survivors	.56
Survivors of Faith.	.56
Conclusion	.57
Thanks and Appreciation:	.58
Appendix	.59

Introduction

Purpose of this Manual

Since the 1970s, the domestic violence movement has been actively working in Ohio to increase awareness of domestic violence issues and bring about social change. In response, concerned citizens have opened crisis shelters, safe homes, and nonresidential programs to meet the needs of survivors and children in crisis. As services and programs continue to develop, it is essential that standards and guidance are being developed concurrently with the most up-to-date research to ensure that survivors and their children are receiving the highest quality of support.

These standards have been developed to support service providers as they navigate the fundamental challenges of:

- increasing external monitoring,
- providing inclusive services,
- diversity, equity, and inclusion (for both survivors and program staff/leadership),
- the unique characteristics of serving survivors with their children.

These must be implemented without losing sight of creating program excellence that provides empowering services to survivors.

It is the intent of this manual to guide domestic violence programs. While these standards will apply to most situations, there will be times when a standard may be impractical, as with any broad set of recommendations. In these cases, it is recommended that programs look at the values underpinning that standard and work to implement an alternative that upholds those values. In cases where state and federal funding is being received to provide services, it is expected that agencies will work to adopt and implement best practice standards. The Ohio Domestic Violence Network exists to provide guidance, technical assistance, and support as programs work towards adopting these standards.

This manual is designed to be used by domestic violence programs directly and is not intended to be an evaluation tool used by funders. However, funders must recognize that significant resources are required for programs to reach and sustain these standards. Therefore, this manual can provide a foundation for discussions between programs and funders about resource needs and prioritization to give survivors and their families the best possible services.

ODVN Philosophy Statement

The Ohio Domestic Violence Network (ODVN) recognizes that the domestic violence movement was initiated by women who were abused and remains grounded in this history. Women and children remain particularly vulnerable to violence because of their unequal social, economic, and political status in society.

Domestic and intimate partner violence is an oppressive and dangerous use of power and control experienced in both intimate partner and family relationships. This pervasive problem gives rise to violence in families, schools, communities, and society. ODVN asserts that abusers are responsible for their abusive and harmful behavior and that communities have an obligation to hold abusers accountable. Community safety is contingent upon eradicating all forms of violence.

ODVN believes that all people have a right to a violence-free life. ODVN is committed to advocating for policies and practices that promote safety and self-determination for those who have been abused. Recognizing the link between domestic violence and other forms of oppression, ODVN remains committed to collectively working toward equity and justice.

ODVN Diversity, Equity & Inclusion (DEI) Values

Vision and Purpose

ODVN recognizes the relationship between domestic violence and oppression. Thus, it is committed to becoming an exemplary diverse, equitable, and inclusive organization by:

1. Welcoming diverse people and perspectives
2. Focusing on areas of inclusion via advocacy, training, and leadership

Values

- Fairness (Diversity, Inclusion)
Providing equitable access to advancement opportunities and grace to all individuals no matter their identities.
- Respect (Trust, Dignity)
Recognizing human characteristics in all by providing authentic affirmations and constructive feedback.
- Responsibility (Accountability, Commitment)
Committing to tasks with the energy necessary to accomplish them and owning up to shortcomings when they arise.
- Integrity (Ethics, Honesty)
Doing things as they are intended with a transparent lens.
- Awareness (Acceptance, Cultural Sensitivity)
Evaluating a person's own values and ideas while also seeking to learn and grow from others' values and ideas.

Guiding Principles

The Ohio Domestic Violence Network has adopted a set of guiding principles to direct work with survivors and their children. These principles apply to all of the advocacy work that ODVN undertakes. ODVN believes all domestic violence programs should follow these principles in their mission to provide services that are appropriate, respectful, and establish the foundation for survivors and their children to empower themselves.

ODVN promotes safety, well-being, and justice for all survivors while respecting their right to self-direction and control over their own lives.

1. ODVN is accountable to those who are or were victimized and are committed to listening to their voices and using their expertise to guide domestic violence work.
2. ODVN declares that abusers—not survivors—are accountable for their abusive behavior.
3. ODVN is committed to facilitating changes necessary to end oppression and violence within itself, and within economic, social, and political systems.
4. ODVN is committed to advancing the community's responsibility for stopping the violence.
5. ODVN is committed to providing comprehensive, survivor-centered advocacy across systems of care.

A Note on Vocabulary

ODVN primarily uses pronouns that are gender-neutral and inclusive in terms of sexual orientation in this manual to recognize and validate the reality that individuals across the gender spectrum experience domestic and intimate partner violence and that domestic and intimate partner violence is not unique to heterosexual relationships.

In addition, this manual refers to those accessing services using many terms, including "victim," "survivor," and "person experiencing domestic or intimate partner violence." Survivors who utilize services should

be referred to as program participants or survivors rather than patients or clients. People approaching domestic violence programs who have been victimized by an abusive partner deserve to be celebrated for their strength and survival strategies while also acknowledged for the intolerable situation living with an abuser creates. Often the term “survivor” feels more comfortable and respectful to individuals participating in programs and helps staff members view program participants through a lens of strength, empowerment, respect, and hope for the future.

Domestic and intimate partner violence is defined as physical, sexual, or emotional abuse, as well as sexual coercion and stalking by a current or former intimate partner. For the purposes of this manual, “domestic violence” will be used to describe both domestic and intimate partner violence.

Core Values of Domestic Violence Services

Empowerment: The Basis of Services

Empowerment is the capacity to influence the forces which affect one’s life for one’s own benefit. Programs should provide services with the goal of providing the environment and resources for survivors and their children to empower themselves. Staff needs to understand how domestic violence is rooted in social systems that reinforce the unequal status of women and children and individuals within marginalized groups in society. Advocates also need to understand and affirm the importance of a survivor’s right to self-determination and making choices for themselves and their children.

Empowerment involves educating without coercion and supporting the survivor’s right to determine a course of action free from psychological, physical, or emotional control in the domestic violence movement. Empowerment in advocacy encompasses assisting survivors in areas of decision-making, increasing their support systems, and safety planning.

Survivors should never be mandated or required to participate in or receive services to have access to, or maintain connection with, the program. All services and programming must be available on a voluntary basis. Survivors should not be required to participate in any service offered by the domestic violence program in order to access services, including shelter, or to receive case management and assistance with employment, housing, referrals, and resources. It is essential to recognize that survivors are working on leaving situations where they were not allowed to make many or most of the fundamental decisions affecting their lives. When programs link services together (e.g., survivors must participate in case management to remain in shelter) they are recreating a situation in which the survivor is not in control of their own activities. In this space, a survivor is by definition not empowered. Additionally, ***voluntary services are a requirement to receive federal Violence Against Women Act (VAWA) and Family Violence Prevention Services Act (FVPSA) funding***, which applies to virtually all domestic violence programs.

Empowerment in Case Planning

In the spirit of empowerment, all programs should recognize survivors as the primary planners of their own goals and objectives and provide information only to further their understanding of available options. Additionally, during the case planning process, advocates should identify advocacy needs and strategies with the survivor. The advocate’s role is not to select a particular goal or action plan, but to support the survivor as they weigh all their options. It is important to recognize that there may be times when the advocate does not agree with the survivor’s chosen goal or course of action. As long as the action will not actively harm the survivor or others, it is the advocate’s role to support the survivor and their decision. Supervisors of advocates should be open and available to support advocates as they work through these situations.

Empowerment in Program Development

Each program should develop decision-making structures that ensure proper distribution of authority and responsibility and empower survivors, staff, volunteers, and board members.

To accomplish these goals:

- Programs should develop a formal path for survivors to take part in program development and decision-making. Examples of these paths include serving as volunteers or committee members or by being elected to the policy-making body after they are no longer actively using program services. Programs should develop policies and procedures for the length of time between a survivor's involvement with services to serving in this type of role.
- Survivors should have input in developing and revising program guidelines/procedures (e.g., shelter rules, house meeting formats, how 'chores' are assigned). The mechanism for providing input (e.g., survey, comment forms, meeting with leadership) should be fully explained when survivors begin the program.

A Trauma-Informed Approach to Services

A trauma-informed approach is one that incorporates understanding about the pervasiveness of trauma and its impact on every aspect of its practices or programming. Trauma-informed care moves us from asking the question "What is wrong with you?" to "What happened to you?" Being a trauma-informed program allows advocates, staff, and volunteers to understand and respond appropriately with sensitivity to the behaviors, attitudes, and emotional needs of survivors of abuse and trauma.

Not all survivors will experience violence and trauma the same way and not all will cope with it in the same way. Domestic violence work with survivors needs to be individualized and flexible to provide the best possible advocacy.

To accomplish these goals:

- Programs should ensure that all staff and volunteers are trained on traumatic stress, various trauma responses, and trauma-informed approaches.
- Programs should use a trauma-informed approach in all of their services, practices, policies, and procedures.
- Programs should understand the impact that working with trauma survivors has on staff by recognizing that advocates often experience vicarious trauma and provide support and structure to care for staff needs.

ODVN offers resources, training, technical assistance, and support to programs to assist with implementation of trauma-informed approaches. See ODVN's manual [*Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs*](#) for more information.

The Power and Control Analysis of Domestic Violence

Advocates understand that domestic violence is rooted in the abuser's sense of entitlement to have power and control over their intimate partner or family member. Therefore, abusers are accountable for the violence in the relationship and **not the survivor**. To empower survivors, organizations need to reinforce this message through all the work that they do with survivors, including development of the program, drafting of policies and procedures, and the service delivery provided by staff. It is also the responsibility of the organization to convey this understanding in the work that they do with other systems on behalf of survivors and their children.

The Indiscriminate Nature of Domestic Violence

Domestic violence occurs in all economic classes, ethnicities/races, sexual orientations, gender expressions, educational strata, religions, and faiths—in all sectors of society. Survivors are not responsible for their abuse but are victimized by the abusive behavior of another person. Therefore, ODVN focuses interventions on safety and restoring well-being and does not operate from a programmatic assumption that survivors of domestic violence need to be treated or rehabilitated.

Coordinated Community Response

Survivors often call on many systems to find safety and heal from abuse. Law enforcement, courts, health care, child welfare, abuse intervention programs, shelters, places of worship, and other community systems play a key role in reducing domestic violence. Across these systems the focused goal of survivor safety and perpetrator accountability becomes shared and can only be accomplished through a strategy of coordinated knowledge, perspectives, and protocols. The communities that coordinate their efforts through risk assessment teams or other community coordinated response teams have the greatest success in responding to domestic violence and potentially reducing the number of domestic violence homicides.

ODVN is committed to helping organizations build a strong, coordinated community response to domestic violence in their communities. There are often great differences between systems and organizations involved in a community. These differences can prevent organizational leaders from coming together as a team to address domestic and intimate partner violence. ODVN staff members can assist with the establishment and development of response teams.

ODVN can assist with accomplishing the following goals of a Coordinated Community Response Team:

- Per funding requirements, programs must organize or join a domestic violence response team that meets at least quarterly with community partners. Participation in a local domestic violence task force can also fulfill this requirement.
- Outcomes of team meetings should include increased accountability to survivors and their children throughout the systems.
- Partnerships should encourage flexible, creative solutions when responding to the unique, individual needs and trauma responses experienced by survivors and their children.
- Domestic violence providers must be included whenever community response systems are being created, evaluated, or re-imagined.

Protecting Confidentiality

Confidentiality is of utmost importance when working with survivors of domestic violence and is central to survivor safety. Protecting the confidentiality of information about survivors and their children must occur beyond their primary involvement in the program but includes keeping information confidential when working on task forces and when subpoenaed to testify at court. All staff should be encouraged to take the ODVN Documentation training annually to remain current and up to date with best documentation practices. ODVN can also provide training on this topic to individual programs by request. In addition, grant administering agencies expect and require survivor confidentiality as a condition of funding (e.g., Violence Against Women Act (VAWA), Family Violence Prevention Services Act (FVPSA) and Victims of Crime Act (VOCA), etc.) all require strict guidelines for confidentiality. For more information on confidentiality requirements please see the [*Technology and Confidentiality Resources Toolkit*](#) from the National Network to End Domestic Violence (NNEDV).

Programs should take significant steps to provide every measure of confidentiality for survivors. Written policies should be made available to survivors that address Releases of Information (ROI). ROI should be **fully**

explained to the survivor, signed and time limited. ***Advocates and program staff should not ask survivors to sign blanket releases of information and no release should be filled out in anticipation of becoming necessary.*** Each release should be signed as needed and fully discussed with the survivor. Survivors have the right to terminate a release of information at any time. All policies should be based on a concern for safety, confidentiality, and professional ethics.

To accomplish these goals, programs should take the steps listed below:

- Ensure all records, electronic and written, are secure and not accessible to outsiders. Programs entering information into an external database should do so with an approved and comparable database and no personally identifying information should be included. More information about this is included in the documentation section of this manual.
- Develop clear policies and procedures regarding releases of information, responding to warrants and subpoenas, retention, and destruction of records and how to work collaboratively with local partners. (These topics are explored in the annual ODVN Confidentiality and Best Practices for Documenting Client Records training as well as additional documents found throughout this manual).
- Advocates should stay up-to-date about issues of technology safety (including devices and social networking) through regular training and discuss technology safety with program participants as part of safety planning standards. For additional technology safety resources, see NNEDV's website [here](#). For a technology tool kit for survivors, see additional resources [here](#).

The following standards were developed in an effort to help programs perform a self-assessment of where they are at the present time in relation to the administration of their program. This manual, used in conjunction with the *Trauma-Informed Approaches Manual*, will provide an outline of best practice standards and trauma-informed services designed for programs. Organizational progress can be measured by using the *Trauma-Informed Road Map* which can be found in the Appendix of this manual. The Road Map is designed to give programs a quick visualization of the areas where they may want to improve and to make sure they are engaging in “promising practices” when working with survivors of domestic violence. The expectation of self-assessment is that programs identify their specific areas for improvement. It is not the expectation that programs meet every best practice standard.

The Training Team at Ohio Domestic Violence Network is available to provide technical assistance support to programs interested in improving services and implementing changes in line with the following standards. ODVN provides individualized technical assistance and training to programs as well as general technical assistance for all programs upon request.

Administrative Standards

Sound administrative practices are essential to the integrity of every program. These standards include but are not limited to:

- Board development and management
- Fiscal management
- Resource development
- Personnel management
- Grants management

These topics are not typically the responsibility of advocates and as such are not included in this manual. They are covered in the companion *Promising Administrative Practices Manual*.

Core Services

Domestic violence programs provide services with a unique philosophy and understanding of the dynamics of abuse that have occurred in the lives of survivors and their children. As discussed previously, one of the key attributes of domestic violence programs is that they operate from a philosophy of empowerment.

ODVN's manual *Trauma-Informed Approaches: Promising Practices and Protocols for Ohio's Domestic Violence Programs* has developed trauma-informed protocols for providing several core services mentioned below (answering the crisis line, intake paperwork, exit interviews, safety planning, facilitating support groups, and providing parenting support). The manual is available for download [here](#).

Crisis Line/Hotline

In order to provide information and direct crisis intervention assistance to survivors, the program maintains, directly or via contract, a 24-hour, 7-day-a-week telephone crisis/hotline. Many agencies also provide hotline services through text and chat messaging. It is incumbent on the agency to ensure that the digital services platform that you are using does not impact security, privacy, or safety concerns. The conversation must not be stored anywhere once the conversation has concluded. If direct messaging services are available at limited times, this must be clearly explained in all outreach material. Regardless of the form of communication, each hotline contact is answered promptly by a **live person** who identifies the program by name.

The crisis line/hotline is accessible for all survivors including those who are limited English speakers or are d/Deaf or Hard-of-Hearing. Access is provided by telephone interpretation or video relay. ODVN is available to provide technical assistance to programs that need resources to meet hotline accessibility challenges.

Information and referrals are provided for all survivors to assist them with securing needed information, resources, or direct assistance. All information is freely provided to the survivor at any point in the contact and does not require that the survivor meet any criteria, such as a face-to-face meeting, having to provide demographic or identifying information about themselves or their families, or having to name or leave their partner.

All survivors are provided information on safety planning.

All survivors are treated with respect and dignity.

All survivors are advised at the end of the contact, as well as anytime during the contact, that they can always call/text back and get help from any advocate regarding their situation. Programs can keep a written/electronic record of crisis contacts so that a survivor who is calling/texting back does not have to repeat all of their information regardless of which advocate responds. Survivors are always given the option to provide identifying information or to be noted as anonymous. A survivor can also be given the option of using a pseudonym for the record. A model crisis call form can found in the Appendix section of this document.

Survivors are not the only ones to reach out via the hotline. Friends and family supporting survivors, social service professionals and law enforcement all may use the hotline for specific domestic violence expertise. Everyone should be given the same time and thoughtfulness as a survivor call. These contacts can influence whether or not a survivor is given the number of the hotline as a resource.

Social service, education, health care, and other professionals also use the hotline to gather information for survivors with whom they are working. These professionals may be helping survivors who find making

the hotline call insurmountable. Having someone the survivor already knows and trusts with them for the contact may be helpful. Advocates should partner with the professional to help the survivor feel supported and get the information they need to make empowered decisions. After the initial conversation with the professional, the advocate should ask to speak with the survivor directly to learn why they are making the contact and offer resources. If the survivor is not with the professional at the time, the advocate should let the professional know that the survivor can contact the program directly for any eligibility or enrollment conversations. In the event that an advocate, manager or director of another domestic violence shelter or program tries to establish contact regarding a survivor, the expectation is that the professional staff work together to advocate for the survivor. Program staff understand the importance of connecting with the survivor directly, but collaboration should occur between program staff in an effort to minimize undue stress and frustration for the survivor.

Agencies participating in a coordinated community response should have procedures in place detailing when law enforcement officers use the hotline. These contacts should follow a specific protocol with a script that the advocate can walk through with the law enforcement officer. After receiving the initial information from law enforcement, the advocate should always ask to speak directly with the survivor if the survivor is present. Many survivors do not want to speak with an advocate when law enforcement is present. Survivors may have mistrust of law enforcement, may fear getting into trouble themselves, may fear getting their abuser into further trouble, may fear the blame will shift to them, or the information may be sensitive and personal in nature. It is often part of the coordinated response for advocates to be given a safe phone number that is used for a follow-up contact at a later time. Whether the survivor speaks with the advocate or not, law enforcement should always make sure that the survivor has the hotline information and knows they can contact at any time.

Safety Planning

Safety planning is essential to the work advocates do with survivors. Safety planning is a process during which an advocate and a survivor work together to develop strategies to reduce a survivor's individualized risk and create strategies to increase safety. Safety planning is an ongoing activity that takes place with every survivor regardless of their situation—if meeting with them face-to-face or on the phone, if the survivor is in contact with their partner or not, and regardless of whether a person is considering leaving or staying with their partner.

Safety planning is a combined effort between the survivor and the advocate. Using principles of survivor-defined advocacy, the advocate acknowledges that the survivor is the expert about their own life and their partner. Advocates bring knowledge of different systems, how they work, what survivors can expect and community resources.

Safety planning may look different depending on the setting (e.g., hotline, shelter, legal advocate, independent housing, visitation center). It is important that advocates are fully trained on safety planning for their specific role.

The Tech Safety team of the National Network to End Domestic Violence (NNEDV) has created a number of resources to help advocates and survivors navigate the ever-changing landscape of technology. A toolkit for providing digital services can be found [here](#).

Survivors have the right to participate in technology and should have as much information as possible to make educated choices about their technologic risks. In order to provide this information and help create technology safety plans, advocates must engage regularly in training to understand survivors' risks and

options. ODVN offers an annual training related to best practices for serving survivors of technological abuse, and NNEDV's Tech Safety Toolkit for Survivors can be found [here](#).

Safety planning is a conversation that advocates have with survivors and not a piece of paper to be filled out. If the survivor is more comfortable having a tangible copy, there are many available templates.

Safety planning is flexible, fluid, and will change as the abuser increases or decreases risk. Safety planning does not stop once the survivor is in shelter. Advocates should continue to have regular conversations with survivors concerning their safety.

Because safety planning is so critical to the domestic violence work, advocates should create an open environment where survivors can share information about their abuser, discuss plans to see their abuser, or discuss any contact they have had with the abuser and what was said and how they are feeling about the interaction. It is crucial that survivors not be penalized for or judged about contact with their abuser. Survivors who are worried about repercussions may choose not to disclose this information. This information helps advocates think through safety concerns, abuser-generated risks, and life-generated risks.

Advocacy

Advocacy is a core service of domestic violence programs because programs advocate for and with survivors in all systems that they encounter, both for individuals and for all survivors collectively. Advocates are sounding boards, supporters, encouragers and most importantly, nonjudgmental. Advocates are often called upon to bear witness and walk through the difficult times with the survivor and their children but cannot fix everything.

Survivor-Defined Advocacy

Advocates and survivors are partners in the work with the survivor leading the way. The decisions that are being made and the changes that result from those decisions will impact the survivor's life. Therefore, they should be the ultimate decision-maker in what happens to them. Advocates provide information and resources to survivors to help them accomplish the goals that they have set for themselves and their families.

If an advocate disagrees with a decision made by the survivor or feels that the survivor should take a different direction, they will set their feelings aside and continue helping the survivor as requested.

Individual Advocacy

When advocates work on the behalf of one individual survivor, then they are performing individual advocacy.

Individual advocacy should always be conducted in partnership and with full authority of the survivor. The advocate needs to make clear to the survivor the intention of advocacy efforts. This process includes asking the survivor for releases of information, being clear about what an advocate is planning to share, who information will be shared with, and what outcome(s) an advocate hopes to obtain on the survivor's behalf.

Releases of information should be fully explained to the survivor, signed by both the advocate and survivor, and time limited. A model release of information can be found in the Appendix section. Releases of information should be signed **only** when it is necessary to communicate with another agency. Programs should **not** ask survivors to sign a blank release, or have a survivor fill out releases of information for agencies that do not need to be contacted immediately. For example, it is likely that a release of information

to communicate with the local department of education will be needed for most survivors entering shelter with school-age children; however, this form should not be part of the intake package for families without children. The advocate should only ask a survivor to sign such a release when specific communication is needed, such as requesting transportation for the children.

Systems Advocacy

When an advocate works on the behalf of survivors inside of a particular system (legal, hospital, child welfare, Temporary Assistance for Needy Families (TANF), etc.) to make changes that will benefit all survivors that is called systems advocacy.

Systems advocacy approaches work with survivors as a collective process rather than an individual case. Therefore, the need to seek an individual survivor's permission to share information is not needed. However, to ensure confidentiality, especially in small communities, we do not share individually identifying information. In order to effectively advocate for system changes, advocates do need to be able to accurately demonstrate the challenges hindering survivors. This can be done by compressing the most common scenarios into one composite survivor story or through using survivor quotes that do not include details about the specific survivor or their abuser.

While anecdotal examples can be emotionally effective and are a useful tool to get an audience's attention, they are rarely the catalyst for systemic change, especially without a first-person testimonial. Data about domestic violence tells a compelling story that cannot be dismissed as "one person's unfortunate situation." This crucial reason is why domestic violence agencies need to be accurately collecting and analyzing data. Programs should think critically about the most consequential circumstances of systemic discrimination faced by those they serve and ensure that those stories are present in data that is currently being collected. If useful data is missing, the program should implement a way to add it to their current data collection systems. This remedy can be as simple as adding a question to a current tool already being used. Data is more persuasive when it is collected uniformly over time, so it is important to recognize gaps and move quickly to fill them. It is always possible that data will show something different than expected. When this happens, it is also beneficial and should be used to ensure advocates spend their efforts in ways that will make the most positive impact for survivors.

Shelter

Shelter can be a challenging and confusing environment for everyone. Survivors are dealing with trauma from the abuse, the uncertainty of leaving their homes, conflicting feelings, and emotions about their partner along with the physical and emotional needs of their children. Advocates should make the experience welcoming. When possible, the surroundings should be designed as a place where someone would want to take refuge.

It is important for advocates to understand that shelters exist to serve survivors. Therefore, shelters belong to survivors and not program staff. This concept may be difficult to understand from a traditional social service model but becomes obvious with an understanding of the history of the movement and the principles of empowerment.

The shelter belongs to survivors means that resources of shelters are meant to meet needs of survivors as defined by survivors and not defined by shelter staff. Survivors often leave situations during which their basic needs were arbitrarily denied or determined by their abuser. It is important that this situation not be repeated in shelter. Survivors are capable of determining their needs and the needs of their children. When following the empowerment approach, advocates trust and encourage survivors to determine how to best

meet their needs with resources available. For example, if a survivor requests diapers three days in a row and the diapers are available, they should be given to the survivor each time without question. All donations made to programs are for the intended use of the families in shelter and therefore, should be freely provided to them when requested (e.g., food, personal hygiene products, feminine products, other essential items). The best practice is to provide a supply of these products in open spaces so that survivors can freely help themselves with staff replenishing the items when they are running low.

Unfortunately, resources, especially for domestic violence services are limited. When a program must limit a resource, it is essential that these limits be clearly communicated, fairly implemented, and flexible. For example, if a program receives a limited number of winter coats, it is reasonable to limit them to one per individual. The program should communicate to all survivors that coats are available, the limit of one per individual, and a simple process to request a coat. The limit must be flexible. Coats, especially those belonging to children, can get lost or damaged within the season. If more are available the survivor should be able to request another.

Traditionally, shelter has been thought of as a 30-day maximum stay. This 30-day stay rule has allowed some programs access to emergency shelter money in their counties. Still, it is best practice not to impose time limits on a shelter stay when it is not required by a funder. Time limits do not recognize the significant challenges survivors face when meeting goals essential for exiting shelter into a safe and stable situation.

There are three especially relevant reasons that the 30-day maximum stay is inappropriate. First, many survivors leave their abusive situation without basic identifying documents (e.g., picture ID, social security card, birth certificate) that are needed to access community resources or secure employment. It often takes over 30 days to replace these documents as the first step toward gaining a sustainable income source. Secondly, in most communities, it is unreasonable to expect survivors to locate independent housing within 30 days. The process for most housing subsidy programs is longer than 30 days from application to move-in date. Survivors with new employment often have to wait for multiple pay cycles before they will be seen favorably by property owners. Thirdly, it can never be understated: survivors are making life-changing decisions while recovering from the impacts of trauma. Survivors should be encouraged to address their mental health needs. Shelter time-limits do not allow survivors access to services and create additional stress and anxiety.

Programs receiving VAWA and/or FVPSA funding cannot mandate participation in shelter programming including case management as a condition of staying in the shelter or receiving services.

Shelter Rules

In keeping with the philosophy of empowerment and support, shelter programs should routinely review the rules established for shelter life to make sure rules are not oppressive and allow survivors to exercise self-determination. The existence of some rules for shelter living creates and maintains a safe environment for all program participants. At the same time, shelters should intentionally avoid recreating the power dynamics present in abusive relationships through rules and expectations. For example, power and control dynamics are recreated when shelter staff assume the role of “parent” or “teacher” by attempting to teach, guide, or tell survivors what to do. This scenario does not support empowerment and the survivor regaining control over their own life. Shelters are advised against setting rules that are solely geared toward facilitating smooth operation of the shelter. The role of shelter rules is to provide safety for all residents.

Shelters should have as few rules as possible and only those needed for safety. This flexibility leaves room for dealing with different situations and allows for equitable solutions.

Shelter rules should be stated in a positive, empowering way to help survivors understand their role and

responsibilities while staying in the shelter. The Missouri Coalition Against Domestic and Sexual Violence led a project to reduce rules in the domestic violence shelters in their state. The project and its findings are detailed in the paper [*How the Earth Didn't Fly into the Sun*](#). It is highly recommended that programs review this project and discuss it with advocates working in shelter as a method of reviewing the shelter rules currently in place.

Below are guidelines relating to shelter rules:

- Shelters should never mandate involvement with the justice system (e.g., police, or protection orders) or any other system as a requirement to be admitted to shelter or to remain in shelter.
- ***Rules or guidelines should be in place to make it safer for survivors living in a communal environment, not for the purpose of making the shelter easier for the staff to manage.***
- Rules should be reviewed annually by staff and survivors who have used the program to ensure that there are no oppressive or unnecessary limitations. When there are issues that arise that must be addressed in between these reviews, it is strongly advised that program staff involve survivors in the process as much as possible to find a resolution that works among and between the survivors.

Intake/Entry to Program

Intake paperwork should be completed within 24-72 hours of a survivor's arrival at the shelter.

Upon entering the shelter, the staff should collect only the necessary information (name, children's names, emergency contact numbers, and information on the abuser), allowing the survivor to get settled before more extensive paperwork is done. Providing the survivors with options on when to do the necessary paperwork reinforces an environment of empowerment.

All shelters should have information about, or be able to provide access to, emergency contraception for those survivors who are concerned about unwanted pregnancy. A basic question about unwanted sex within the past 72 hours should be asked at the time of shelter entry and not postponed until full intake due to the time restrictions for emergency contraception to be effective. Making this question part of standard shelter procedure prevents the survivor from having to bring up the conversation and demonstrates the program's openness to assist with all types of concerns. Advocates should ask every survivor this question as sexually transmitted infections and injuries requiring medical attention can also result from unwanted sex. It is key that advocates use the phrase "unwanted sex" rather than rape as many survivors will not associate the situations in which they may have had unwanted sex with rape.

Intake paperwork should be completed in a private space. The survivor should be provided with an opportunity to do paperwork without the presence of any children so that details and information can be freely shared without concern for what the children or others may hear. If the survivor feels uncomfortable leaving their children, their decisions should be respected, and conversations should be conducted in a sensitive way or completed at another time.

Intake should be completed using the principles of trauma-informed care. (See *Trauma-Informed Approaches Manual* for more information). In addition, please see the *Partnering with Parent Youth Intake* in the Appendix section.

The literacy level of a survivor should never be assumed. Advocates should read and explain each form to the survivor before they are asked to sign it.

Intake forms should be translated into common languages spoken in the area. Enlarged fonts should be used for those with vision loss/visual impairments. Interpreters should be used at the intake process to

ensure that all information is clearly understood, and safety planning is facilitated. Family members or other survivors should never be used to interpret information between the survivor and staff. A professional interpreting service should be utilized and not an online internet application such as Google Translate. d/Deaf or Hard-of-Hearing survivors who communicate with sign language should be provided with interpretation and not asked to communicate by writing.

A model Intake form can be found in the Appendix section of this document.

Case Planning/Management

All case planning or management should be done using the principles of survivor-defined advocacy. Case plan goals, objectives and activities should be broken into small steps so that a survivor can have a sense of accomplishment and success. Also, due to trauma reactions, not all survivors are going to be able to remember multiple steps to complete a goal.

Advocates need to be supportive throughout the process and work with survivors to identify strategies for advocacy. Survivors who are working with a number of social service professionals may find it helpful for the advocates to partner together. For example, a survivor may be working with a shelter advocate, legal advocate, housing specialist, and a case manager from a culturally-specific organization. A joint meeting with the survivor and all of these advocates to define roles and communication could prevent confusion and help the survivor know how to best use each support.

Documentation

Because of the nature of domestic violence, advocates should be aware of the fact that abusers and their attorneys may make attempts to obtain program documentation. In the best interest of protecting the survivor and their children, documentation should be kept to a minimum.

All programs should have written policies stating who gets to document in the file, how documentation is to be completed, and how documentation is stored.

The following are minimum steps that should be taken to ensure confidentiality of documentation.

Written records:

- Survivor files are stored in a double-locked location when not in use (e.g., in a locked file cabinet in a locked case manager's office).
- All staff members who need to transport written records are provided with a lockable document case, are trained about transporting records, and confidentiality while working outside of the office.
- Computer generated records should not be sent to shared printers until the creator of the record is there to retrieve the document.

Electronic records:

- Electronic databases must be created and maintained in compliance with VAWA confidentiality guidelines.
- Access to electronic databases must be restricted to those working within the specific services program (e.g., a staff member working with survivors living in the community does not need access to the information of survivors living within the shelter).
- Survivor information should not be entered into shared databases.
- If it is necessary to enter survivor information into a shared database to access a resource, the survivor must be informed, and sign a release of information prior to entry. Additionally, no information identifying the survivor as receiving domestic violence services should be included.

All programs should have a policy on the retention and destruction of records. (Please see the *Record Retention Policy* in the Appendix section).

The file belongs to the survivor and as such they can request to see their file at any time and should not have to submit a formal request (in writing or otherwise) to see their documentation.

To understand the complexities of documentation in domestic violence programming, program staff should be encouraged to attend ODVN's annual Confidentiality and Best Practices for Documenting Client Records training.

Legal Advocacy

Legal advocates provide a valuable service to survivors. They are well informed about the way the court system functions in their county and can help a survivor navigate the system. One of the roles of a legal advocate is to be with a survivor through the legal process so that the survivor does not go through the process alone. A legal advocate is not an attorney and should not give legal advice to survivors. (Please see the *Unauthorized Practice of Law* document in the Appendix section)

Survivors may access legal advocacy services simply to gain information about legal options available to them while deciding not to engage in those options.

Legal advocates should use a holistic approach when communicating with the survivors to identify their needs and appropriate resources/referrals.

Legal advocates also do systems advocacy work to ensure law enforcement and the court systems understand the dynamics of domestic violence, how it impacts the survivor and how to best respond within the constraints of the legal system.

Legal advocates who work for the domestic violence program have a different function from advocates who work in a survivor witness or survivor assistance program. Survivor witness programs are typically county based and located within the prosecutor's office so those advocates have a different view and focus of the case. Also, these advocates may have different confidentiality standards regarding what they share with prosecutors and law enforcement. Domestic violence program legal advocates are concerned only with the best interest of survivors, not the prosecution of cases.

Support Groups

One of the main goals of domestic violence programming is to facilitate survivors' healing through decreased isolation. One of the most effective ways to do this is by helping survivors connect with others who have had similar experiences of abuse. While support groups may not be preferred by all survivors, having the opportunity to share experiences with others who understand similar circumstances can be incredibly helpful and facilitate healing.

Participating in support groups must be voluntary as required by grant funders as well as ethical principles. Domestic violence programs are not permitted to mandate survivors to participate in services, and it is important to recognize and acknowledge that not all survivors will respond favorably in a group setting.

It is paramount that group supportive services accessed by adult survivors and their children are firmly grounded in the philosophy of empowerment, with the advocate providing information and support to assist survivors in determining their own course of action.

Support groups have many goals. These goals are unique to each survivor and will often change throughout the survivor's journey of healing. Common goals include:

- Helping survivors identify and overcome barriers to safety
- Decreasing the isolation present in virtually all abusive situations
- Increasing survivors' understanding of domestic violence as an issue with personal as well as institutional aspects
- Helping survivors identify the ways in which their experiences with abuse has impacted them, their lives, and their children's lives
- Help survivors identify personal coping and survival strategies
- Recognizing and celebrating each survivor's efforts and accomplishments toward reaching their goals
- Sharing resources
- Providing hope while validating the impact of domestic violence and trauma on survivors' lives

Advocates who facilitate support groups should work to aid survivors to enable them to recognize and use their individual strengths as well as provide information about domestic violence and available resources.

Recently, many programs have started facilitating virtual support groups. Many survivors have found this to be an option that works well especially because it overcomes traditional challenges including transportation and childcare. For other survivors, virtual groups present new challenges such as locating the necessary technology and privacy concerns. Virtual groups can make providing the same emotional support that happens naturally in-person more challenging. The advocate facilitating a virtual group should have special training on ensuring confidentiality and building group rapport in virtual settings. Ideally, programs will be able to offer both virtual and in-person group options to survivors.

Supporting Youth Residing in Shelter

Creating an inclusive environment for youth and families in shelter programming is an ethical and holistic approach to survivor-defined advocacy and family-centered support. Serving youth in shelter includes a fundamental shift to a trauma-informed approach asking the question "what has happened to this child" or "what has happened to this parent" rather than asking what is wrong with this child or parent. Likewise, it includes how an agency creates programming by reflecting on what toys, books, and activities will be included. There is intentionality considering what reflects youth and adult culture. Domestic violence programs should prioritize identifying funding for and developing youth-specific programming and training for all program staff. However, if funding is limited, assigning these duties to another advocate is crucial to family-defined support and youth programming.

Trauma-informed programming means that all program staff should receive ongoing training in child development, the biology of trauma, trauma reactions, and how to appropriately engage youth and their parent in a trauma-informed, survivor-defined manner. Core to training and practice is an understanding and skill set for connecting with the family, respecting their journey, and realizing that coming to a shelter is safer but is wrapped in grief, loss, and the unknown. Shifting the philosophical mindset to one that adheres to the belief that all program staff and advocates are youth advocates enhances the engagement of parents and children and lessens program staff frustrations. This mindset demands that all program staff gain skills interacting with youth and parents from a service perspective. Serving the youth of all ages should not be an afterthought.

An abusive partner places children in the family amid violence, threats, and ever-changing rules. Youth experience domestic violence by witnessing it, hearing it, hearing about the harm inflicted, and walking into the aftermath of a violent assault. The partner/parent who causes harm models a lack of empathy for the

children and their parent who is victimized. Lundy Bancroft describes the experience of domestic violence as a “twisting of love and abuse” for children and the victimized parent. An abusive partner/parent is not cooperative or co-parenting with the other parent. They instead place children in the middle, sabotaging and creating confusion within the child’s experience. The abusive partner/parent uses “parenting” as a tactic to undermine the victimized parent and the children. Victimized parents are faced with a variety of decisions based on risk and attempts to reduce the danger perpetrated by the abusive partner while striving to protect their children from the harm inflicted.

Youth of all ages are exposed to an abusive partner/parent creating violence within their home or while they are mandated visitation. Children may also be direct targets of the violence. Domestic violence can be a traumatic event for each affected, and each child in a family will respond differently. Children of all ages exposed to violence experience chronic stress and may develop trauma reactions. They will “scan for danger” or what might happen next. The research describes them as “high alert.” Witnessing violence against a caregiver is one of the identified Adverse Childhood Experiences (ACES) benchmarks identified in a 1998 study linking childhood trauma to chronic diseases developed by adults.

As domestic violence program staff, it is crucial to recognize the emotional and behavioral signs of trauma in children and support them in the agency’s services. Likewise, it is essential to provide support and information to each survivor as a parent regarding the possible impact of trauma reactions, grief, and loss while also focusing on the strengths and resiliency of children and families.

Understanding how to support children of all ages is critical for shelter programming. Too often, youth are viewed through the lens of how they behave instead of what has happened to them. This behavioral perspective, in turn, alters how advocates/agencies view the survivor as a parent. One approach has been to provide “parenting” for survivors regarding their children. ODVN recommends a shift in strategy by intentionally designing services, interactions, and policies that honor both parents and children. It is vital to make this shift occur as it uplifts and honors the parent as equitable and sees them as caregivers of their children. For example, discuss with parents their protective ways of providing safety and nurturing their children, inquire what soothes their children and what their joys and struggles might be. This relational engagement allows the parent to be seen and honors their resilience and distress. In addition, this type of survivor-defined advocacy enables program staff to support parents in a way that reframes the trauma reactions that children may be experiencing, offering guidance, resources, and hope.

ODVN has resources to share with parents and youth that will enhance a trauma-informed approach to agency services. They include Parenting with Parent Youth Intake; Youth Intakes; Resiliency and Emotional Regulations Posters; Play, Move Imagine, I Matter, I Belong (Youth Journal), and Domestic Violence Impacts Youth (Spanish, Families of color, and Caucasian editions).

The design of youth programming should be based on understanding the complexity and the intersection of domestic violence, and children exposed to abusers, as well as trauma-informed awareness for adult and child survivors. Creating space for youth to succeed is an asset-based approach instead of excluding misbehaving children, which is a deficit-based approach.

The following are some standards that can be used to evaluate youth in agency programming:

- Every advocate, not just the child/family youth advocate, is responsible for supporting families, which includes children of all ages and developmental stages.
- All program staff acknowledge the loss of control the child has already experienced; therefore, children’s support services remain as nondirective and unintrusive as possible.
- All program staff are trained on basic child development, trauma, grief, and loss, as well as Adverse

Childhood Experiences (ACEs) and Protective and Compensatory Experiences (PACEs) for children.

- All program staff should acknowledge that while children are resilient, they need support to recover from moments of overwhelming, traumatic reactions or upset.
- All program staff are trained in the basic biology of trauma and learn how to utilize lower-brain-based interventions like belly breathing, mindfulness, tapping, and other strategies to support children with empathy, safety, and emotional regulation.
- Update all program staff job descriptions to include supporting youth and parents as essential aspects of their role and shelter service design.
- Youth and parent support become a central part of program staff supervision to provide staff development and growth in family-centered support and advocacy.
- The program has a written procedure for addressing children's educational needs utilizing the federal McKinney Vento Act through a school district liaison which affords children and their parents residing in shelter assistance and resources.
- With permission of the parent, separate youth intakes are conducted, and individual files maintained for each child served, cross-referenced with the parent in the program.
- Funding is identified and maintained to hire, develop, and retain specialized staff to support youth and parents.

Safety Planning with Children and Youth

A child or youth safety plan is similar to an adult's plan and must be tailored to be child-specific. Like adult safety plans, these plans should be developed with the abuser generated risks and life generated risks in mind. Additionally, safety plans for youth must account for the child's developmental stage, trauma triggers and responses, and cultural implications. Finally, a safety plan includes strategies with memorable cues to support physical safety, emotional safety, and safe help-seeking that can be practiced and adapted as needed. Remember to ask children about their routine daily activities and help them plan for safety in various settings.

Paramount in youth safety planning is defining what "safe" means to each child and acknowledging that safety plans may not work or might need change based on the unpredictability of abuser harm and tactics.

Some safety planning strategies to consider when working with children and youth include:

- Define with the youth their perspective of what safe means to them.
- Inquire about what has worked for the youth before and what has not worked.
- Implement safe rooms and safe places.
- Define safely leaving unsafe situations.
- Outline safe meeting places and people (e.g., neighbors).
- Suggest staying in groups or close to others; gathering other younger siblings.
- Outline how to ask for help by phone or text, including calling 9-1-1 or crisis helplines, realizing that some youth may not call the police based on their cultural experiences.
- Set code words and signals.
- Use comfort items and familiar toys when sad or worried.
- Suggest pretending to sleep or hiding.
- Outline how to vary daily schedules and travel patterns.
- Keep a safety stash of money, phone, critical items, and contact info for helpers.
- Support safe social and family connections.
- Notify schools and extra-curricular groups of safety concerns/protection orders.

The best way to support a child/youth's safety is to support the safety of the survivor parent when the abuser's behavior is a threat. To that end, it is important to consider strategies that maximize the protective parent's safety through:

- Crisis intervention and support
- Emergency housing/shelter with child/youth-friendly spaces
- Relocation assistance

Allying with and Supporting Parents in Shelter

Living with an abuser creates fractions and isolation for children and families. The parent victimized by the abuser attempts to reduce the harm their children experience. Yet, an abuser's reach can be insidious and complex, "using" the children by suing for full custody when a victimized parent seeks refugee and safety. For children, even playing becomes risky when exposed to an abuser. All have to navigate the emotional landmines of fear and hurt. Therefore, creating family-centered group work and activities to provide moments of bonding and healing can offer safe, positive experiences for families staying in shelters. Training advocates to support youth and parents with resources, emotional support, and respite are best practices.

Domestic violence impacts parenting. Most abusers undermine the authority of the survivor as a parent, either directly by telling children they do not have to listen to or follow the rules of the survivor or indirectly by being the dominant person in the family. In some cases, children are inducted into the monitoring of the survivor and do not see them as authority figures in their lives.

Deciding to enter a shelter with children can be very difficult for survivors. Likewise, adapting to shelter living can be challenging for families, parents, and children. Each must navigate through complex and confusing feelings, and often the expression and response to these feelings conflict with one another.

Children experience confusion and loss about the abusive parent and may have conflicting emotions about feeling safer away from the abuser while also missing them and wanting to see them. Children also experience confusion by feeling safer with the survivor parent and denying their role as a parent and disciplinarian, which is likely rooted in the abuser's tactic to undermine them. As a result, children may begin expressing regression, clinginess, frustration, aggression, sadness, depression, and anxiousness. In addition, they may develop chronic illnesses, experience nightmares, and exhibit extreme separation anxiety from the protective parent. On the other hand, some children may experience feelings of safety, and hope, with a sense of loss for what they left behind.

Parents may experience a great deal of stress, worry, trauma reactions, anxiousness, fear, mental health issues/adjustments, substance use or withdrawal, triggers, and difficulties adjusting to parenting in a shelter setting. For survivor parents, regardless of a child's age, entering a shelter is likely the first time they have been permitted to parent exclusively. Feelings of upset because of changes to living spaces and belongings left behind are losses youth and parents both may experience. Many parents described feelings of distress and overwhelm as children now live among others in the shelter setting. This environment could feel unsettling and over-stimulating if the family were isolated from others.

Best practice standards include:

- Establishing rapport and building connections with every family member in the shelter by welcoming each parent and child.
- Training all program staff and volunteers on the impact of domestic violence on children and practice resilience-based interventions and interactions.
- Commit to the practice of including youth needs within case management meetings with a lens for seeing positives and strengths of family along with needs and resources.
- If at all possible, intakes, legal paperwork, and other adult discussion are not held when children are present.
- If children are present during an intake, completion of paperwork, or other adult discussions, the

advocate offers distracting activities. They may also explain that details about what happened are going to be discussed and then checks in with the child or teen about their feelings and offers support and comfort.

- Program staff understand how children's behaviors are trauma reactions and that they need a protective adult who models empathy while the child is managing through challenging behavioral responses.
- The program has spaces that are set aside for children based on age or developmental levels, such as outdoor recreational spaces, teen rooms, or children's playrooms.
- Program staff provide information and support to survivors to use nonviolent discipline techniques such as scolding with respite, empathy, and lower-brain based regulating activities like belly breathing, movement, and tapping.

Some of the coping parenting styles that may be present in shelters require staff awareness and understanding. They may include:

- Giving up or giving in when parenting practices do not work
- Staying busy nonstop so that the children are so exhausted by bedtime that they go directly to sleep
- Keeping irregular schedules
- Bursts of yelling
- Physical discipline
- Ignoring outbursts, not "watching" children, not addressing their needs
- Often asking others in the shelter to watch children
- Asking staff to correct behaviors in children

Program staff should respond with understanding if they observe any of the patterns listed above. The core of this approach is that staff remember that the abuser has shattered a sense of emotional safety for the family members. It may take time for parents and children to feel a sense of safety while living in a shelter setting. A list of resources on domestic violence's impact on children and ways advocates can best support families is included in the Appendix.

Mandated Reporting

All programs receiving federal domestic violence funding must comply with strict confidentiality requirements. In Ohio, licensed social workers and counselors are mandated reporters. ODVN has created the Supporting Child Safety and Mandatory Reporting flowchart to guide programs' determining if a mandated reporter call is necessary. This flowchart is included in the Appendix.

Additionally, ODVN's *Parenting with Parent Youth Intake* details how program staff talk with a parent about informed consent, and includes a mandated reporting narrative. The resource details that all information shared by the parent is voluntary, and includes the necessary instruction to document "skip" if a parent discerns not to discuss or answer a question during the intake process. Writing "skip" is an action that is trauma-informed and grounded in inclusivity.

Service, Companion, and Emotional Support Animals

It is estimated today that approximately 70% of American households have at least one pet, and 98% consider their pets to be companions or members of the family. Research has documented the connection between partner abuse and animal abuse in the home. Too often, animals become a pawn in the power and control tactics of abusers leading to more trauma and injury.

On January 6, 2021, Ohio enacted HB33 requiring cross-reporting of animal abuse and domestic violence.

Mandated reporters who encounter an abused companion animal must report the situation to an animal control officer. Similarly, animal control officers and veterinarians must report to social service agencies if there is a child or senior citizen living in the home where animal abuse has taken place.

All programs that work with survivors of domestic violence/sexual assault should be trained to recognize and respond appropriately to needs of survivors with companion animals in their care as part of safety planning.

Service Animals

According to the Civil Rights Division of the U.S. Department of Justice, a service animal is defined as an animal that is “individually trained to do work or perform tasks for people with disabilities.” Domestic violence shelters are required to allow entry to service animals by the following three federal laws:

- Title III of the Americans with Disabilities Act (ADA)
- Section 5 of the Rehabilitation Act (covers all agencies receiving federal funding)
- Fair Housing Amendments Act (includes shelters and transitional housing programs)

According to the ADA, staff may only ask two questions to determine if an animal is a service animal.

1. Is the animal required because of a disability? (**Note: Do not ask details about the disability.**)
2. What work or task is the animal trained to perform?

Staff **may not** ask for documentation of the animal’s training or ask to see the animal perform the task.

Service animals must be under their handlers control the entire time they are in the facility. This access requires that the animal be allowed in all areas of the building that survivors are permitted. It also means that the survivor may not choose to leave the animal in the bedroom while they go to a meal or on an errand.

Survivors can only be asked to remove their service animal in two circumstances.

1. The handler is not maintaining direct control of the animal.
2. The animal is not housebroken.

Companion/Emotional Support Animals

While companion and emotional support animals are equally important to survivors, they do not have the same legal right to access as service animals. Each community should have a program that includes access to safe shelter, medical care, and basic needs for these animals, and all programs should have a process for accessing these resources.

Ideally, companion animals should have access to shelter at the shelter facility. If this is not possible, there should be safe 24/7 accessibility to alternative sheltering, as well as medical care and basic needs. Typical community partners might include the local Humane Society, other domestic violence providers, veterinarians, boarding and trained fostering families.

Health, Safety, and Security

Medical Best Practices

Shelters are not medical facilities and shelter staff are not medical providers, however it is important to recognize that survivors often have complex medical needs. Survivors regularly enter shelter with acute medical needs caused directly by the physical abuse they have endured. Additionally, many survivors may not have been getting routine health care. Abusers routinely prevent survivors from attending medical appointments. Other times, the survivors themselves avoid medical care as a way of reducing the possibility that someone may discover their situation. Survivors with children may be additionally concerned that medical providers who detect abuse will have to follow mandated reporting laws. Without routine health care, survivors may have developed unrecognized chronic conditions since their last visit to a doctor. Finally, it is well documented that stress and trauma manifest in the body causing weakened immune responses and other health complications.

Advocates can and should encourage survivors to engage in routine health care as well as address any presenting health concerns for themselves and their children. It is especially important to ensure that survivors have autonomy in all health care decisions including when, how, and by whom their bodies will be touched. For this reason, it is key that advocates are aware of medical providers who are trained in working with survivors of domestic violence or individuals that have experienced trauma.

It is a best practice that domestic violence shelters forge a strong partnership with a local Federally Qualified Health Center (FQHC). Shelter staff and FQHC providers should be fully trained in each other's services and referral processes. Additionally, FQHC staff should receive training specific to recognizing the signs of domestic violence and working with survivors. In the strongest partnerships, FQHC or other medical staff may even provide basic services within the shelter. ODVN can help programs locate and begin a partnership with their local FQHC.

Shelters without a formal partnership with a FQHC should maintain an updated list of local medical resources for survivors who do not have a medical provider in the area.

Medication

Shelters have a responsibility to grant survivors an atmosphere of nondiscrimination and medical privacy. FVSPA, VAWA, ADA, Fair Housing Act (FHA), and Section 504 of the Rehabilitation Act, prohibit screening program participants out of a shelter due to medical conditions. In accordance with HIPAA regulations, shelter staff **cannot** ask about survivors' medical conditions, and survivors are not required to submit proof of any medical conditions or share their prescriptions.

Shelters that control survivors' access to medication may be considered to be acting as a pharmacy. This situation can be a liability concern if staff members administering medication are not licensed medical professionals.

The National Center on Domestic Violence, Trauma and Mental Health issued a *Model Medication Policy for DV Shelters* in 2011 which details the following four guidelines for storage and dispensation of medication. It is recommended that shelters follow these guidelines in order to comply with all federal health privacy regulations.

1. Shelter staff or volunteers do not store, dispense, or monitor survivors' medications.
2. Each survivor is provided with an individual lockbox or locker to store medications and valuables.
3. Shelter staff or volunteers do not limit or monitor access to lockboxes or lockers, including holding

keys in a central office.

4. If medication requires refrigeration, accommodations are provided to ensure the greatest privacy and autonomy to the survivor.

Medical Marijuana

Domestic violence shelters are responsible for both providing unbiased, trauma-informed services to survivors and meeting the requirements of core funders. These two duties can conflict on the topic of marijuana use and possession in shelter because of the differences between state and federal laws, medical privacy, and nondiscrimination guidelines.

The United States Congress passed the Controlled Substances Act of 1970 which classified marijuana as a Schedule I substance with no currently-accepted medical use and a high potential for abuse. Other Schedule I drugs include Heroin and LSD. Despite changing state laws, this federal classification is still in place. Other federal bodies and legislation including The Food and Drug Administration (FDA) and the Americans with Disabilities Act (ADA) do not recognize or protect the use of medical marijuana, and federal funding sources such as the VOCA, FVPSA, Services Training Officers Prosecutors (STOP), and VAWA require that grantee organizations including domestic violence shelters are drug-free workplaces **for all employees**.

With House Bill 523 in 2016, Ohio became the 25th state to legalize medical marijuana, however products did not become available to qualified consumers until 2019. At the time of the 2022 revision of this manual, recreational marijuana is illegal in Ohio, and ***all forms of smoking or combusting marijuana are illegal***.

Medical marijuana cannot be officially prescribed but only recommended in Ohio. Additionally, only physicians who undergo special certification can recommend marijuana. Doctor recommendations do not exempt the user from federal prosecution even if they have a valid medical marijuana card. Ohio law also prohibits the use of medical marijuana outside of a private residence. Shelters are considered public spaces similar to bus stations and hotels. Since they are not private residences, medical marijuana use, administration, and possession on shelter property is statutorily prohibited. Information about this prohibition should be covered during the intake process.

While medical marijuana is not recognized by the ADA, restrictions of medical privacy still apply. In practical terms, this means that survivors may keep medical marijuana in their locked spaces without informing staff just as they keep any other medication.

If a survivor is found to be in possession of or using marijuana, or any other prohibited substance, in shelter or on shelter property, advocates should follow these steps:

1. Ask the survivor to dispose of, relinquish, or remove the substance from the shelter.
2. If the survivor is under the influence, ensure their safety and seek medical intervention if necessary.
3. Once the substance is no longer in their system, have a confidential, nonjudgmental conversation with the survivor about the shelter policy and concern regarding substance use.

As a part of trauma-informed care, shelter staff, administrators, and advocates should remember that substance use is often a coping mechanism for trauma. Survivors should never be denied services because of their substance use. Abstaining from illegal substances is not an intake prerequisite. All survivors regardless of substance use deserve the same access to quality services and resources. Shelter staff should ensure survivors are aware of all internal, state, and federal policies related to substance use. It is also essential to respect the privacy of all program participants and practice nondiscrimination.

COVID-19 and Its Variants

Since March 2020, all domestic violence programs, and shelters in particular, have been dealing with the evolving challenges of COVID-19. Any section on addressing medical concerns in shelter would be incomplete without some discussion of COVID-19. However, the fluid nature of the pandemic and corresponding recommended responses make it impractical to include specific best practices in a publication of this type.

Domestic violence programs should stay up-to-date with CDC recommendations and work in a coordinated fashion with their local public health agency to create and update their COVID policies and procedures. At a minimum, these policies and procedures should include:

- Program admission screening for COVID-19
- Procedures for program eligible survivors who have contracted or been exposed to COVID-19
- Regular symptom screening for COVID-19
- Procedures for staff members who have contracted or been exposed to COVID-19
- Testing availability and protocol
- Contact tracing protocol
- Communication protocol of positive cases in the facility
- Isolation/quarantine requirements and accommodations
- Mask requirements for both staff and residents
- Vaccine availability, information, and/or requirements for staff and residents
- Facility disinfecting procedures
- Social distancing accommodations
- Procedures for residents and children exposed at school or work
- Accommodations for residents and children to be able to attend school virtually or “work from home” in the shelter

ODVN maintains an up-to-date list of COVID resources for programs and resources on the [ODVN website](#).

Emergency Procedures

ODVN's *Promising Practice Guidelines for Medical Emergencies* is a comprehensive overview of policies and procedures for all types of situations that may occur in domestic violence programs. Programs are encouraged to review this guide on an annual basis to ensure that policies are being maintained and all staff are properly trained in emergency procedures.

All shelter staff should maintain up-to-date certification in CPR, first aid, and use of Naloxone to respond to medical emergencies. At a minimum, one trained staff member should be working at all times and all staff should be aware of who are trained staff. Staff members who are not currently certified should assist as instructed (e.g., clearing the area, calling 9-1-1, contacting program administration).

Protecting survivor confidentiality is essential when responding to special circumstances such as medical emergencies. A survivor's personal identifying information can still be protected even when requesting medical emergency services by following the recommendations below.

- Programs can request emergency services for survivors and only allow necessary responders into the program or area with the survivor. Programs are not required to provide personally identifying information to medical or law enforcement responders.
- Emergency operators can be provided enough information to respond, such as location of shelter and general nature of emergency, without the program revealing a survivor's personally identifying information. (e.g., a shelter resident is experiencing chest pains).

- Conscious survivors can choose what information they will or will not share with emergency responders upon arrival. Choosing not to share information is the survivor's choice and staff are not obligated and should not provide personally identifying information to emergency responders.
- If a survivor is unconscious, confidentiality between the program and survivor is not negated. Unless there is a written, informed, time limited release of information signed, a program should only report factual information leading to the emergency call without revealing personally identifying information about the survivor. (e.g., a resident came into the office complaining of dizziness and passed out). Emergency responders and medical personnel routinely assist patients who are unresponsive without being able to acquire detailed information.
- Once an emergency situation has been resolved, responders may want further details and information. A written, informed, time limited release must be signed, or a program cannot provide personally identifying information to medical personnel or law enforcement.

Medical emergencies can be trauma triggers to other residents and their children who witness or hear about the situation. Without disclosing confidential information, advocates should check-in on all residents after an emergency situation to provide any necessary support.

Overdose

In the case of a suspected overdose in shelter, 9-1-1 should be called immediately and the area should be cleared of all other residents and children. If it is suspected to be an opioid overdose and Naloxone (Narcan) is available, it should be administered immediately. Naloxone will not adversely affect someone who is not overdosing on an opioid. If nothing happens in 2-3 minutes, another dose should be administered. It may take several applications of Naloxone to be effective.

Death in the Shelter

When working in 24-hour residential services, the possibility exists that a resident may die in shelter due to health conditions, age, overdose, suicide, or natural causes. All programs should work closely with a local attorney who can provide legal assistance to develop and review policies and procedures related to shelter fatalities. The following process is considered best practice in the event of a death in shelter:

- Immediately contact 9-1-1.
- Close the area off from other residents and children.
- The senior director responsible for the shelter is contacted immediately and leads the team per program policies.
- A professional cleaning company should be hired to return the room to working order if bodily fluids are present. In the absence of a professional cleaning company, the local health department, coroner, or hospital should be contacted for proper clean-up procedures in accordance with Universal Precautions and Personal Protective Equipment protocols.
- Provide shelter residents and children the opportunity to meet with a crisis or grief counselor to process the event which may trigger past traumas for some residents and/or children.
- Provide staff the opportunity to debrief the incident and meet with a crisis and grief counselor. Ensure that staff are provided with any support that is available through an Employee Assistance Program (EAP) or other program resources.
- Executive staff should create and uphold a policy that outlines the procedures for media inquiries that may be made due to death or overdose in shelter.

In response to these types of crises and loss, ODNV has created a Crisis & Loss Response Team. The support offered by ODNV Team Members is available to all programs at no cost. Whenever possible, two team members will meet individually with the Executive Director/Director to discuss the event, the dynamics

occurring after the event, and the goals of the meeting that will take place between program staff and the ODVN team responding. The ODVN team will schedule some time to process the event with the Executive Director and program staff to promote self-care during such a stressful time. The ODVN team members will work together with staff in an effort to assist staff with their feelings of loss, helplessness and methods for moving forward. Please contact ODVN if you experience a loss in shelter or programming and would like the assistance of the ODVN Crisis & Loss Response Team. Please see the Appendix section of this document for an additional resource.

Partner-Inflicted Brain Injury

Introduction

Since the beginning of the domestic violence response movement, it has been known that people who use violence often intentionally target their victim's head, neck and face. The most iconic representation of domestic violence is the face of a battered woman with a black eye—a head injury. Understanding head injury in the context of domestic violence has the potential to transform your advocacy, your organization, and the survivors you serve.

The presence of head injury related to partner-inflicted violence should alert service providers to the possibility of brain injury. Brain injury is damage and/or trauma to the brain caused by blows to the head, decreased oxygen available to the brain, or a combination of both. For decades, brain injury has not been addressed by domestic violence survivors and/or their advocates. Poor outcomes for many survivors could be linked to this gap in understanding. Brain injury in the context of domestic violence is complicated. This document consists of three important components to help you better serve survivors of domestic violence impacted by head trauma. The first section provides you with an overview of partner-inflicted brain injury. It will assist your advocacy efforts by raising your awareness on the subject, informing you of how survivors may present or speak of potential brain injury, and increasing your empathy for those who may have endured brain injury and provide a better understanding the complications it can cause. The second section describes the CARE (Connect, Acknowledge, Respond, Evaluate) framework and provides you with promising practices and strategies for integrating CARE into your work. Finally, section three consists of CARE organizational practices, policies and procedures to address brain injury within domestic violence organizations.

Section 1 • An Overview of Partner-Inflicted Brain Injury

How the Brain Works

The brain is known as “the last frontier” in medicine for its intricate nature and depth of complexity. The brain is composed of four sections, or lobes. Each lobe is made up of neurons, nerves, and a variety of helper cells. The neurons connect with each other and through a series of electrical impulses, control our body, our thoughts, and our emotions. Our brains control voluntary decision-making as well as involuntary actions such as breathing. The lobes must work together in order for our bodies and minds to function. In addition, the brain needs oxygen in order to perform all of the tasks necessary to live.

The frontal lobe of the brain, located just behind the forehead is critically important for many “executive” functions, such as making decisions, planning, prioritizing, and controlling impulses. Just like an air traffic control system at a busy airport safely manages the arrival and departures of many airplanes on multiple runways, so the frontal lobe manages the detailed and complex executive functions essential for successful daily living.

If the ability to complete executive functions is compromised through brain injury, carrying on with daily life can become impossible. Mental/emotional health issues, substance use, maintaining employment or housing, and countless other difficulties can occur, further compounding the initial brain injury.

What is Brain Injury?

Brain injury is damage to the neurons in the brain that interferes with normal function of those neurons and their connections. The injury occurs in one of two ways: traumatic injury and acquired injury.

Traumatic brain injury (TBI) occurs after an external force is applied to the head in a way that causes the brain to collide with the skull. This collision results in damage to the brain region directly impacted (a coup injury) and possibly a contrecoup injury, an injury on the other side of the brain due to a whiplash effect. Examples of common TBIs in domestic violence include punches, blows to the head by an object, slams, and kicks to the head and neck. Sometimes these injuries can be seen on medical imaging, such as CT scans or MRIs, but these are the exception.

Acquired brain injury (ABI) results from oxygen deprivation to neurons. ABI can further be divided into hypoxic brain injury and anoxic brain injury. Hypoxic injury occurs when oxygen levels in the brain decrease to low enough levels to cause damage. Anoxic injury occurs when no oxygen is available to the brain; the consequence of prolonged hypoxic injury. Strangulation is the most lethal form of ABI and oftentimes causes no obvious signs of injury. The brain is incredibly sensitive to changes in oxygen levels. Even the slightest decrease in oxygen can cause hypoxic injury.

Someone can become unconscious within seconds, have permanent brain damage in under a minute, and die within a few minutes if oxygen to the brain is not restored.

Strangulation prevents blood and oxygen from entering the brain leading to hypoxic injury, and sometimes anoxic injury. Other causes of ABI in domestic violence include suffocation, gagging, and chokeholds.

Regardless of the type of injury the brain suffers, there are many symptoms of brain injury. These range from mild to severe depending on the type of injury. Some symptoms include memory lapses, memory problems, visual disturbances, balance issues, hearing problems, difficulty comprehending written or spoken words, trouble concentrating, and others.

The symptoms involving executive functions can be particularly challenging for survivors and advocates to identify if not aware of their possibility.

Brain Injury in the Context of Domestic Violence

Both research and practice have identified that the head, neck and face are the most common areas of a person's body that a partner and/or abuser targets with physical violence that cause TBIs. Physical violence directed towards these vulnerable regions include slaps, punches, kicks, severe shaking, and direct object impact. Potential causes of ABIs in the context of domestic violence include strangulation (choking), chokeholds, being sat on, and gagged. TBI and/or ABI can be the result of one or multiple assaults. Partner-inflicted brain injury is uniquely traumatic and devastating. Working within the context of domestic violence, it is clear that there are many mechanisms that could result in brain injury. Unfortunately, partner-inflicted brain injury is also unique in that there is almost always a clear intention to harm. There can be multiple types of traumatic blows to the head within quick succession coupled with strangulation.

The repeated nature of these damaging assaults to the head and neck also complicate the understanding of brain injury in survivors. In addition, the likely emotional connections between survivors and abusers tend to confound the story of the assault making it more difficult to identify potential brain injury.

Abusers who strangle are particularly dangerous. The Training Institute on Strangulation Prevention describes strangulation as "the last warning shot," often a last escalation of terrible violence that precedes

homicides. Victims who have been strangled are 7 times more likely to be killed by their partner. Strangulation is terrifying and traumatic. Over 70% of strangulation survivors believed they were going to die. Survivors are more likely to struggle with post-traumatic stress disorder (PTSD) as well.

After an assault, there are distinct challenges to receiving medical care for survivors. Many injuries go unidentified and untreated. Advocates and providers often approach domestic violence survivors without an awareness of possible brain injury.

This can also lead to poor outcomes for survivors. There has been much more research in some settings of brain injury, such as accidents, sports, or military service, but understanding the complex mechanisms and consequences of partner-inflicted brain injuries has long been neglected.

Unique Characteristics of Partner-Inflicted Brain Injury

- Both TBI and ABI could be present together often repeated
- Inflicted by a known and trusted person
- Caused by domestic violence, which is a stigmatized issue that is difficult to talk about and disclose
- Occurs in a private setting without bystanders or others who can assist with identification
- Safety concerns when seeking medical evaluation

Brain Injury as a Chronic Health Issue

While the injuries described previously are hallmarks of the acute presentation of potential brain injury in domestic violence survivors, there can be long-term consequences for survivors as well. Long after the initial trauma occurs survivors may experience symptoms of brain injury.

Oftentimes these symptoms can seem unrelated to past trauma making it difficult to identify and treat. Survivors who have brain injury identified soon after their assault could also suffer from long-term brain injury symptoms. It is important in practice to recognize the impacts of brain injury on survivors no matter the time frame after their assault.

Section 2 • CARE Promising Practices for Addressing Brain Injury Caused By Domestic Violence

A comprehensive, survivor-based understanding of trauma, partner-inflicted violence, and brain injury must form the foundation of domestic violence (DV) survivor advocacy.

Partner-inflicted brain injury is damage to the brain caused by partner violence directed at the head, neck and face, including blunt force trauma and strangulation. Domestic violence, psychological trauma, and brain injury are separate public health problems, but intertwined when in the context of partner-inflicted head injury. Service professionals working with domestic violence victims often lack understanding regarding domestic violence as a mechanism of brain injury.

Psychological trauma impacts brain function and stress response systems; brain injury is connected with these issues. The ODVN Trauma-Informed Approaches manual will help you become familiar with the trauma-informed framework of DV advocacy.

We must integrate trauma-informed principles into all work with survivors of abuse impacted by brain injury. A trauma-informed service provision approach means having a basic understanding of trauma and how it impacts survivors by understanding trauma triggers, unique vulnerabilities of survivors, and designing services that acknowledge the impact of violence in people's lives. A trauma-informed approach is sensitive and respectful; advocates seek to respond to traumatized individuals in a way to consciously avoid re-traumatization. It is critically important for trauma-informed services to strive to do no harm.

The Center for Mental Health Services (CMHS) and the National Center for Trauma-Informed Care (NCTIC) report that a trauma-informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences. This approach recognizes the complex experiences of traumatic stress as a core component of domestic violence, as well as the impact on survivors' histories.

Advocates must make every effort to develop a complete picture of a survivor's life situation—past and present—in order to provide effective service and understand behaviors, feelings, and responses. A survivor's experience with domestic violence most often includes head trauma that could cause brain injuries, and it is the domestic violence program's responsibility to intentionally address this reality using practices and approaches in this document.

Integrate a Brain Injury-Informed Approach Into Trauma-Informed Frameworks

A brain injury-informed approach highlights the significance of developing a relationship with survivors that helps the advocate understand the survivor's strengths, priorities, and values. It also includes raising awareness of the consequences of head trauma and identifying the unique impact that head injuries might have on a survivor's life.

Professionals working with survivors should receive training on intersections of domestic violence, brain injury and trauma. They should learn about partner-inflicted brain injury, signs and symptoms of partner-inflicted head trauma, and strategies to raise awareness of these injuries.

Consequently, they use the components of CARE as well as CARE tools to meet the needs of survivors with potential brain injuries accessing domestic violence services.

Use CARE (Connect, Acknowledge, Respond, Evaluate) to Raise Awareness and Address Partner-Inflicted Brain Injury

The CARE framework offers advocates specific tools and strategies for working with survivors who may have experienced head trauma or brain injury that affect their ability to access services and resources they might need. Survivors may have physical, cognitive, emotional, and/or behavioral issues resulting from the traumatic brain injury(s) or oxygen deprivation. Other components like physical or mental health challenges, substance use, other traumatic circumstances, or a combination of these may also complicate healing. In light of these realities, survivors might find it difficult to access support within DV services that truly meet their needs.

At the same time, domestic violence programs may find they are ill equipped to meet the complex needs of survivors who have suffered injuries to their head, neck, and face. However, head trauma and subsequent brain injury are part of survivor's experiences and must be addressed by advocates.

CARE contains strategies that allow domestic violence program services to address these issues. Raising awareness, education, training, accommodations, referrals, and core approaches that engage survivors are all included in the CARE framework. Advocates using CARE believe that domestic violence survivors deserve brain injury-informed services. CARE offers practical, brain injury-informed practices for survivors, staff, and other community partners.

CARE (Connect, Acknowledge, Respond, Evaluate) Strategies and Practices

CONNECT

Before addressing potential head injuries, focus on building genuine relationships and connections.

Establishing a trusting relationship is the foundation for effective advocacy. This is true even when survivors find making connections difficult, upsetting, or challenging, often as a result of their experiences involving trauma.

Sometimes called survivor-defined advocacy, services involve a person-centered approach. A person-centered approach is where the person is placed at the center of the service and treated with respect and dignity, and their perspectives, needs, and priorities are of primary importance. The focus is on the person and what they can do, want to do, and need from you and your services—not on their situation, condition or disability. It requires flexible support in order to suit the person's needs and unique circumstances.

The CARE framework offers ideas for building connections with survivors who may have difficulty relating to others. The survivor may begin to feel more connected when an advocate checks in regularly and seeks them out by offering to talk with them in their spaces. Advocates might show genuine interest in the survivor's children or other things important to them, celebrate their victories and sit with them when they experience difficulties. Asking about a survivor's children or playing with them, or eating a meal with a survivor also encourages support and creates a safe space for them to be themselves. Strong connections help people begin healing from trauma and break down the feeling of isolation that abusers create. Effective advocacy is connection.

ACKNOWLEDGE

Provide information on head injury and strangulation to all survivors. This could be through conversations between survivors and CARE-trained advocates or through the brain injury-informed CARE written materials.

In addition to providing information about partner-inflicted brain injury, ask directly about head injuries. Incorporate these questions as part of a larger discussion about the impact of head injuries if possible. Sample questions can be found on the CARE tool, CHATS.

Use the term "head injuries" to discuss possible brain injuries. Ensure that you are NOT telling a survivor they have a brain injury. Brain injury is a medical condition only diagnosed by a doctor. Tell them that like all other injuries, head injuries can heal and be managed with the proper treatment and support. There are many things that the survivor can do, and you can do together, to help them get what they need.

When talking with survivors about head trauma, share the common symptoms of brain injury. Share that many symptoms have been misunderstood by both professionals and survivors as signs and symptoms of mental health or a personal deficit or failing. Also include that symptoms have significant overlap. Many survivors have blamed themselves and many professionals have not yet developed a brain injury-informed understanding of trauma in domestic violence. Brain injury can play a significant role in a survivor's life, but can easily go unnoticed.

Using an individualized approach, work collaboratively to identify a survivor's unique experiences, strengths, and perspectives. Also explore challenges that are impacting their lives and/or ability to fully access your services. What matters to them the most, and what challenges are bothering them the most? Continue to use survivor-defined advocacy.

Effective advocacy is to acknowledge the reality of head trauma and strangulation resulting in potential brain injury.

RESPOND

Accommodations are a modification or adjustment to how you or your agency usually provides services

that take into consideration the unique needs of the person you are working with. Work together with the survivor to identify accommodations and put them into practice to improve their access to services. Sample accommodations include writing down more information than normal, checking in more frequently on a survivor, or scheduling shorter and more frequent meetings. The CHATS tool helps to identify possible accommodations and should be made available to staff to assist in this process, though a formal process such as CHATS might not always be practical and there are other different strategies that can be used.

Environmental accommodations, or changes to the environment or setting, can be enormously helpful for healing. The survivor's home, work and family as well as the shelter or service provision setting can be sources of stress that interfere with their ability to heal. While there are unique barriers to this for survivors of domestic violence, explore with the survivor how making small changes can reduce stress. Examples include identifying ways to improve sleep, adjusting lights and noise, having a quiet space or quiet time, or forming routines like returning items back to where they belong.

Identify possible referrals to medical care, behavioral health care, evaluation for additional issues, and/or other types of services that address individualized survivor needs. There are resources outside of your agency that can be beneficial to the survivor. If head trauma is part of a person's experience, incorporate medical providers and primary health care as possible referrals, particularly for physical problems such as headaches, vision issues, balance problems, or seizures.

Effective advocacy is responding to potential brain injury in an informed and empathetic way.

EVALUATE

Regularly check in with survivors for feedback on services, accommodations, referrals, case planning, or advocacy strategies. Survivor feedback not only helps them receive the necessary services and identify what is helping and what isn't, but also supports identifying strategies that may help others.

Adjust advocacy strategies, referrals, case plans, etc. to reflect changing situations. It is critical for advocates to be flexible with the healing process as circumstances change, survivors improve, and new issues emerge. Effective advocacy is evaluating how current efforts are working and how to improve healing for all survivors.

Section 3 • CARE Organizational Promising Practices, Policies and Procedures on Partner-Inflicted Brain Injury

Training and Education for Staff

1. Ensure that education on brain injury in the context of domestic violence is a priority. This could include scheduling in-services on brain injury, encouraging staff to attend conferences, webinars, and/or other training related to brain injury and DV.
2. New advocate education. Use ODVN's CARE Brain Injury and Domestic Violence online learning series to educate new advocates about CARE, available at www.odvn.org.
3. Inform all advocates and staff that ODVN's Center on Partner-Inflicted Brain Injury is available to assist with brainstorming ways to connect a survivor to community resources and discussing specific situations.

Policies and Procedures

1. Review existing policies and procedures that your agency has regarding survivors with head injuries. If your agency does not have these policies, consider what policies and procedures should be added to meet the needs of survivors with head injuries.
2. Make sure every survivor has access to CARE educational materials and information about brain injury

caused by domestic violence.

3. Develop a strategy for addressing potential head injuries with all survivors. Some examples include adding questions to hotline or intake forms, providing CARE educational materials in paperwork, and using the CHATS tool.
4. Make all paperwork and forms that survivors use as simple and straightforward as possible, using plain language. Offer to provide assistance with forms and acknowledge that brain injury can make reading, writing, and communication difficult.
5. Consider an environmental assessment of your agency. Think through what it would be like to experience your agency's services while healing from a brain injury. Begin with assessing the survivor's surroundings and the most recent events the survivor has been through.
6. Due to the widespread lack of awareness on brain injury, consider including educational opportunities on brain injury and brain health as a part of the available programming and services for survivors. This could include incorporating information on brain injury and ways to support brain health during meeting and support groups, in individual advocacy, and by providing written information.
7. Ask about recent injuries and critical health concerns at arrival to the agency. Include the following: recent violence directed at the head, neck, and face, blows to the head and strangulation or other violence that impedes breathing, as well as recent unprotected sex that could warrant emergency contraception if desired.
8. If advocates and staff learn of or observe signs of a recent head injury, ask about current symptoms. Assess for dangerous symptoms related to both head trauma and strangulation. Express concerns you might have. Offer to assist with accessing medical evaluation, care or clearance. If a survivor wants medical care, facilitate access to medical services.
9. Provide survivors with information on warning signs that indicate a need for medical attention and encourage survivors to alert an advocate if they experience any of them.
10. Check regularly on the survivor for at least 72 hours. Offer to assist with recording symptoms or encourage survivors to record symptoms on their own. Ask about dangerous symptoms during these routine check-ins.
11. If the survivor is having symptoms that necessitate immediate medical care (for example, a survivor is struggling to breathe after a strangulation), follow your agency's policies regarding medical emergencies.

Advocate Safety

Safety will always be of paramount concern to domestic violence programs. While threats to safety are innate to the field, many can be mitigated through advance planning. There are three essential areas of planning to increase safety: environmental; organizational and administrative; and behavioral and interpersonal.

Environmental planning refers to construction and management of a program's physical facility and is covered in the next section of this manual under Facility Safety.

Organizational and Administrative Safety Measures

Organizational and administrative safety measures are the policies and procedures a program puts in place to ensure a culture of safety.

Programs should have both a Safety Committee and a Safety Director if possible. The Safety Committee includes representation of staff at all levels working in all settings served by the program (e.g., shelter, community-based) along with maintenance or facility staff. The Safety Committee is responsible for reviewing policies and procedures on an annual basis. In mid- to large-capacity programs the Safety Committee should meet quarterly.

The Safety Director is the specific point-person responsible for overseeing the safety of the program. This person should be a member of the program's leadership team to ensure that they have enough authority within the program to implement and oversee implementation of all safety policies and procedures. The Safety Director is responsible for:

- Convening the Safety Committee
- Ensuring all policies and procedures are clearly communicated across the program
- Monitoring compliance with policies and procedures
- Coordinating safety trainings
- Coordinating appropriate response to critical incidents
- Ensuring that there is a formal review following every critical incident to identify ways to avoid or better respond to similar incidents in the future

At a minimum, programs should have the following policies and procedures in place.

Required Minimum Staffing Levels

The most important safety protocol a program can establish is to ensure that there are always enough advocates present to handle an unexpected or dangerous situation. Even the most well-trained, experienced advocate needs the support of a team when a crisis occurs.

When determining an appropriate minimum staffing level, programs should consider their unique traffic patterns and configuration. Some aspects to consider are listed below.

- How many roles are advocates required to play? In many shelter programs, advocates serve the dual role of answering the hotline and responding to the needs of on-site survivors. While each of these roles may be fairly quiet much of the time, what is the expectation when dual responsibilities conflict?
- What is the physical layout of the facility? Where do advocates answer the hotline? Where and how do advocates monitor the outside area of the facility? Where do on-site survivors interact with advocates? How quickly can advocates move from the office areas of the facility to the living area in the case of an emergency?
- How many survivors can the shelter accommodate and what is the average number of survivors in the shelter at any time?
- How many calls does the hotline receive? What time during the day is the highest call volume?
- What time of day do new survivors typically arrive at the shelter?
- Are there shifts/days of the week that are regularly more/less active than others?
- Are there times when fewer advocates are working directly in the shelter, but other staff members are on-site who would respond to emergencies or advocate shortages?

If at all as possible, programs should avoid advocates working alone in a building. When staff must work alone, there should be procedures in place to access an on-call administrator to talk through difficult situations or to advise of emergency situations.

Residential programs should provide 24-hour shift coverage allowing survivors the opportunity to access staff members during each shift, especially overnight shifts.

Internal Facility Communication Systems

An internal communications system is essential in order for a team to support each other effectively and respond quickly when necessary. Facility communications systems should be reliable and easy-to-use. This system may include handheld radios, an intercom system, or agency cell phones. Whenever possible, programs should not expect advocates to rely on personal cell phones for this purpose.

Off-Hours Administrative Support

A clear system of administrative support should be in place that staff can access at all times programs are in operation. This access means 24/7 coverage for most hotline and shelter programs. This responsibility should never fall on only one individual. Programs may opt to include senior advocates in the support rotation. In this case, they should not be scheduled for on-call support during a regular work shift. The exact level of administrative decisions a senior advocate is empowered to make, along with who they should reach out to for a higher-level decision, must be clearly defined.

Advocates should always know who the on-call administrator is and how to contact them. A single on-call phone that is passed between on-call administration is one way to ensure there is little confusion about how advocates reach out for off-hours support.

Often, it is the responsibility of the on-call administrator to deal with staff who call in sick or unable to work their shifts. In this case, the on-call administrator either finds coverage for the shift or works the shift themselves. It is important that the facility is never left with less than the minimal level of staff coverage identified in program policies.

Incident Reporting

It is important that unusual, threatening, and dangerous incidents are reported and reviewed in a timely manner. The purpose of internal reporting is to ensure that all necessary program staff are aware of the incident so that proper safety planning can be put in place to address the concern and prevent it from recurring in the future.

Incident reports are not written as a disciplinary tool for survivors who violate program rules and should never be included in a survivor's case file.

Each program should create written policies and procedures detailing the type of incidents that should be reported and the system of reporting. The following is a list of some but not all incidents that should be reported:

- Unauthorized individuals on the property or attempting to enter the facility
- Disclosure or suspected disclosure of a confidential program location to an abuser of a survivor actively engaged in the program
- Threats toward staff, the organization, or a specific program facility
- Heightened or specific threats toward a survivor
- Violence or threats of violence within the program

Incident report reviews should be held on a regular basis by the Safety Committee. After review, all copies of incident reports, both physical and electronic, should be destroyed. Aggregate data on incidents should be maintained as they can be useful to identify patterns and unmet needs.

Incident Post-Intervention Review

Any incidents that threaten the safety of the survivors and staff engaged in the program should be thoroughly reviewed in a timely manner in order to create a culture of on-going learning and improvement. The goal of a post-intervention review is to look at and identify the effectiveness/ineffectiveness of all staff interventions employed during an incident.

Not all incidents that require an incident report necessarily require a post-intervention review session. For example, an advocate may witness a strange car circling the shelter parking lot twice in their shift. This activity could prompt an incident report noting the make, model, and license plate information of the car

so that the situation can be shared among advocates and continue to be monitored. Since there has been no active intervention at this point, the incident does not require a review. If the situation progresses in subsequent days and advocates have to make decisions about enacting additional safety precautions in the parking lot or involving law enforcement, the situation has now risen to the level of requiring a post-intervention review. It is important to ensure that this review covers the full scope of the incident from the first time an advocate noticed the vehicle to the incident's resolution.

Post-intervention sessions are not intended to be punitive moments to point out missteps that may have occurred or identify blame for an incident. It is just as important to review incidents that are handled well as it is to review those in which an intervention was less effective. A consistent, no-blame approach, post-intervention review process creates a culture of openness and trust that enables advocates and the program to truly learn and grow.

Positive post-intervention review processes include the following aspects:

- **Select staff members are trained to facilitate post-intervention sessions.** When possible, the facilitator should not be someone who was directly involved in the incident. For this reason, it is important to have more than one trained facilitator on staff. Since post-intervention is not a clinical intervention, facilitators can be any objective, trained staff member.
- **Ensure the right people are in the room.** Typically, incidents develop over time and different advocates will have been involved in various stages and have different information about what happened.
- **Pay attention to timing.** Post-intervention sessions should happen after everyone involved is back in control of their emotions and able to think objectively about the situation but before individuals forget critical details of the situation. Check in with all individuals to see how they are doing before holding the post-intervention.
- **Collect the facts from first-person accounts.** Allow each person to tell what they experienced throughout the incident without contradiction or interruption. A good model for this is to start with the person who was first aware that something required attention. After the first person briefly (3-5 minutes) gives their factual account, the second person who was aware of the situation should speak, until everyone has spoken.
- **Recognize various points of reference and come to a consensus about how the incident progressed.** Often in the telling of the facts, people will learn information they did not have previously. Allow people to integrate this information into their first-person experiences.
- **Identify the crucial moments and any patterns.** As a group, identify where the incident escalated and/or de-escalated and what caused those changes.
- **Identify alternate actions that could have been taken.** Think about other ways the situation could have been addressed and if that would have had a positive or negative effect on the incident. For example, if law enforcement were called by the program is that something the group would choose to do again—why or why not?
- **Decide on group recommendations for policy or procedural changes if necessary.** It is up to the facilitator to take these recommendations to the Safety Director or other members of program leadership.
- **Check-in with all members and complete any agreed upon action steps.** Things may come up in a post-intervention session that can identify advocates who need additional support. The facilitator should ensure that these advocates are connected with appropriate resources (e.g., their supervisor, the EAP). Additionally, it is the responsibility of program leadership to ensure that any action steps decided on in the post-intervention are appropriately communicated and enacted.

Routine Responses

Programs should have written policies and procedures for staff to follow when specific, predictable events

occur. These policies and procedures should include events that advocates experience most often which require intervention and can be well-handled in a routine manner.

All advocates should be trained on routine response procedures at the point of hire. Refresher training sessions should be held with all advocates at least annually and more often as needed and determined by response to events.

Some events requiring routine response policies and procedures include:

- Abusers attempting to gain access to the facility
- Unexpected visitors coming to the facility and inquiring about a survivor
- Survivors returning to shelter under the influence of a substance
- Nonresidents arriving to shelter with a parenting survivor's children
- Parenting survivors leaving underage children at the shelter without permission or not returning for underage children at the expected/agreed upon time
- Outside agency representatives arrive at shelter to interview a resident
- News media arrives at shelter to interview staff due to an incident

Safety Exits

At times it may be necessary, for the safety of the program, to exit a survivor against their wishes. Programs should have clear policies and procedures detailing how advocates perform safety exits.

When a safety exit is necessary the following steps should be taken:

- Safety exits should be decided on and/or approved by senior program leadership.
- ***The possibility of exiting a survivor should never be used as a threat.***
- On-site staff members should plan together the best way to meet with the survivor to inform them of the exit.
- All on-site staff should be made aware that the exit conversation will be happening and who is leading the coordination of the exit.
- Exit conversations should be held in a private setting without the survivor's children present.
- Advocates should work with the survivor to create a safety plan, access additional housing or shelter and provide resources including transportation if necessary to help the survivor identify their next steps.
- Advocates should clearly explain to the survivor which services are being ended and which they are still able to participate in (e.g., a survivor who has to be safety exited from the shelter program can still receive legal advocacy and outreach services, support group, etc.).
- Survivors should be permitted to pack their own belongings.
- To the extent possible, timing of the exit should be flexible regarding when they can arrive at their next housing, children's schedules, etc.

Calling 9-1-1

Programs should have clear written policies and procedures on when it is appropriate or necessary to call 9-1-1. Before calling in law enforcement, EMS, or other emergency responders, advocates must take into consideration the risks of breaking confidentiality and inflicting trauma on survivors residing in the facility. The medical best practices section of this manual includes best practices for advocates to protect a survivor's confidentiality when calling 9-1-1 for a medical emergency.

Whenever emergency responders enter the facility, advocates should take steps to limit areas of the facility to which responders will have access. To protect confidentiality, all residents not involved in an emergency situation should be cleared from areas emergency responders will be entering.

All 9-1-1 agencies have emergency response protocols. It is best practice for advocates to know and understand the 9-1-1 protocols specific to their community. Communities that have a coordinated response team should be sure 9-1-1 services have representation on the team. Programs not involved in coordinated response should develop a working relationship with their local 9-1-1 response agency. Advocates and 9-1-1 call agents should be cross-trained in the operations of each agency and appropriate expectations during emergency response. Cross-training can significantly reduce the level of agency miscommunication during an emergency response intervention. If there are areas in which it is foreseeable that program confidentiality might conflict with emergency response procedures, an alternative response should be negotiated ahead of time.

Critical Incident Response

A critical incident is an extreme, unusual event which causes major distress or disruption to the program. There is no exact list of critical incidents. What is classified as a critical incident will depend on individual programs. Any incident that may result in media attention is considered a critical incident.

When the daily operation of the program is disrupted by a major event, it is important that the program administration take notice and address the incident for the emotional and physical safety of staff and survivors. ODVN has created a Crisis Response Program specifically to support programs during and after these times. Additionally, there is a *Crisis/Loss Response Checklist for Member Programs* which is included in the Appendix.

Critical incident debriefing is essential to provide emotional support to program staff. Unlike post-intervention reviews, critical incident debriefings are not times for reviewing the effectiveness of staff interventions. Key elements of critical incident debriefing may include:

- Engaging a neutral, third party to facilitate the debriefing—ODVN can facilitate these sessions through the Crisis Response Program
- Holding debriefing sessions 24-72 hours after the critical incident whenever possible
- Allowing for paid time off for those individuals or departments most closely impacted when warranted
- Developing a peer support team
- Implementing additional prevention methods moving forward

Behavioral and Interpersonal Safety Measures

It is also important that each supervisor and advocate take responsibility on an individual level for safety. Even the best policies and procedures cannot take the place of personal preparedness and a safety-minded approach to all situations. The following are things supervisors and advocates should do to personally increase program safety.

Regular Supervision Sessions

Supervisors should have regular, individual supervisory meetings with each advocate. Part of supervision should include ensuring an advocate's understanding and consistent implementation of safety measures. Advocates should share with their supervisor any safety concerns they are having and together they should identify a strategy to address and monitor these concerns.

Training

Supervisors and advocates are both responsible for identifying opportunities for safety training. Programs should have a list of required trainings and how often they need to be renewed. Safety training should be updated to be sure all advocates are trained on the most up-to-date best practices. Technology safety, specifically, is an area that is ever changing.

Know/Use the Program Team

The team approach is always the safest approach. Advocates working alone should still have access to off-site team members for immediate support. If a supervisor recognizes that an advocate has a habit of not reaching out to their team, this should be an area identified for development.

Know Survivors in the Program's Care

Knowing those in the program's care is essential to being able to recognize a safety concern as early as possible. Being aware of survivors' typical patterns, emotional baseline, and general physical health (e.g., is it typical for a survivor to have difficulty getting up after sitting for an extended period). allows advocates to recognize changes that may indicate a concern. While a survivor may be hesitant to approach an advocate with a new safety concern proactively, they may open up when an advocate says, "You seem upset, is anything going on you'd like to talk about?"

Take all Threats Seriously

Never dismiss a threat without reporting and documenting the event. Even if an advocate does not expect a specific threat to materialize, it must be reported and documented. Each safety threat may come to fruition or be the part of a larger pattern that will not be recognized without consistent reporting.

Know When to Disengage

Rational detachment enables advocates to recognize that specific situations are not aimed at them personally. This skill is essential to de-escalating an unsafe situation. If unable to remain calm and objective in a specific situation, it is best for the advocate to pass the situation to a team member as soon as someone is available. Sometimes an advocate's presence may escalate a situation for reasons beyond their control (e.g., the advocate looks or sounds like a survivor's mother or abuser). In these cases, it is also best for the advocate to remove themselves and allow other team members to take over the intervention.

Self-Care

The importance of self-care can never be overemphasized when it comes to personal safety. When an advocate is not able to relax, renew, and take time for themselves, they are not able to care for others. Advocates should take advantage of time off and should be encouraged to not sign up for more overtime or other new responsibilities than is emotionally healthy. Advocates should find external support through family, friends, and/or a professional counselor to help prevent vicarious trauma and compassion fatigue. Advocates should be encouraged to speak to a supervisor and explore Employee Assistance Program (EAP) for resources and further support.

Safety in the Community

Community work is fundamental to most domestic violence programs. Advocates working in the community face additional safety concerns that require advance planning. The following precautions should be taken by all programs and advocates working in the community.

Trust Instincts

Advocates should not go into a situation alone that feels unsafe and should be encouraged to call a supervisor or on-call administrator for guidance.

Communication

Advocates working in the community should travel with an agency cell phone. Supervisors or on-call administrators should know the expected locations of advocates when they are off-site. Advocates should check-in when they change locations. If an advocate does not check-in as expected, the supervisor should reach out.

Select a Public Meeting Space

It is not recommended that advocates meet with survivors in their homes. Choose a public meeting space that will not jeopardize the survivor's safety. Libraries, parks, coffee shops and other public buildings are all meeting places that often can provide the necessary privacy to converse with a survivor. Advocates also often accompany survivors on errands, to appointments, and to court. All of these are public areas and safer than home visits.

Team Up

If a community appointment feels unsafe for a single advocate, it may be appropriate and safer for advocates to pair up. For example, home visits as a team are safer than alone. One advocate may help with childcare while the other talks with the survivor, allowing the survivor to feel more open without having to worry about what their children may hear.

Know the Safety Plan

Review the survivor's safety plan with them before any meeting. Understand the risks and the plans if something should become unsafe. If the abuser is expected to be present (e.g., court, child transfer), use alternate entrances and minimize interaction as much as possible.

Weapons

While survivors may feel they need a weapon for their safety, they should not have them while in the program facility or meeting with program staff. If a survivor has a weapon, the program should have written policies and procedures in place regarding securing, storing and returning the property to the survivor as they come and go daily or when they are ready to leave shelter. Staff members who may carry weapons for safety or have a conceal and carry permit should not have those items with them during their working hours or while transporting survivors.

Facility Security

Many domestic violence programs operate a shelter as part of their services. Even if the program does not provide shelter, there are a number of standards that apply to the operation and maintenance of the program's physical space.

Each program should develop, maintain, and update written policies and procedures that should include but not be limited to:

- Level of confidentiality of the address
- Admission to the facility
- Response to unexpected visitors, trespassers, and intruders
- Response to threats of attacks against the building, staff, or survivors including bomb threats and suspicious packages
- Universal precautions for the handling and cleanup of bodily fluids
- Universal precautions for addressing communicable diseases and bed bugs
- Emergency drill and evacuation procedures for fires or natural disasters

Shelter programs must ensure that a secure, comfortable, and safe living environment is provided to all survivors. The environment should include but not be limited to:

- Proper heat, ventilation, and cleanliness throughout the facility
- Secured locking windows and doors, monitored against intrusion
- Separate living and sleeping areas
- Access to adequate, weather appropriate clothing that is kept in a clean and sanitary area

- Safe, clean, and adequate inside and outside play spaces for children
- Access to unmonitored communication on telephone or other communication device for those who are d/Deaf or Hard-of-Hearing*
- Access to unmonitored living and personal space such as bedroom and bathroom
- Meal service that meets USDA standards for nutrition, if applicable, or access for individual food preparation
- Internet access, if applicable, with privacy and parental controls in place
- Information on how to disable location applications on cell phones and cars and other technology safety information available to all survivors and staff

**Federal Telecommunications Relay Services funds provide these services for free through Sorenson Video Relay Services (SVRS).*

Programs should select the specific facility safety features that will be the most effective and least restrictive for each building they operate. If an agency is constructing a new facility or undergoing extensive renovation, they should seek to work as much as possible with architects, engineers, and general contractors with demonstrated prior experience integrating safety features. Safety features range from very simple to highly complex and should be evaluated for both effectiveness and feasibility. Safety features that are difficult for staff to use consistently or correctly should be avoided. The list below is a sample of safety features that can be considered by domestic violence service providers:

- Emergency alert buttons that contact the local police department when activated
- Two-step locked entryway doors
- No exterior signage other than the street number
- Maintaining separate, updated list of authorized residents, staff members, and disclosed abusers of current residents and cross-checking all contractors and visitors against the abuser list
- Video doorbells that enable staff to see individuals requesting entry
- Using an alternate address for all USPS mail and general deliveries when possible
- Fire doors that can be automatically shut to cordon off living and non-living spaces
- Outdoor spaces are not visible from outside the property (e.g., enclosed courtyards, privacy screens)
- External security cameras monitored by program staff
- Privacy walls preventing those entering the building to be seen from outside the property
- Separate visitor and resident entrances
- External and internal motion sensor lights
- Windows in living areas starting at 6 feet and higher
- Privacy shades on all windows
- Bullet proof glass on windows

Rights of Survivors Participating in the Program

While providing services, it is important to remember that program staff advocate for and with survivors. Survivors are not to be viewed as “others” to be helped through advocacy efforts. Rather, survivors are important participants in a joint effort to end abuse and violence many adults and children experience in society. Therefore, as equals and partners in these efforts, survivors have basic rights while participating in domestic violence programs.

The program has written policies on domestic violence survivor rights that include, but are not limited to the following:

- Programs do not discriminate in the provision of services on the basis of age, race, creed, sexual orientation, gender identity, gender expression, ethnicity, national origin, marital status, socio-economic status, STD/HIV status, employment status in a sex industry, immigration status, physical or

cognitive ability, and religious/spiritual beliefs or membership.

- Identical services are provided to survivors of any gender identity. Segregated services based on gender identity or gender expression are not appropriate. Transgender women, transgender men, CIS-gender men, and non-binary individuals all must receive the same accommodations as CIS-gender women.
- A copy of the written statement of Survivor Rights is posted in clear view in all facilities.
- Children under 18 years of age should be allowed to remain in the shelter with their parent or guardian regardless of the gender of the child, parent, or guardian. A service is not really accessible to parents if it means choosing between safety and their child.
- The program has a written policy to respond to subpoenas, court orders, and other legal processes which includes provisions for the automatic filing of motions to quash any request for survivor information not authorized in writing by the survivor and allowing the release of material not authorized by the survivor only upon the Order of a Judge.

Acceptance/Re-admittance Criteria

The denial of services to a survivor may contribute to severe injury or death and should not occur. *A program's primary responsibility is to provide safety to any survivor who needs it.*

Refusal to provide or re-admit to services should be discussed with the leadership team and based on their final decision. If a survivor is not going to be accepted or re-admitted or will have services discontinued, an appropriate and specific referral plan should be created. This plan should be based on the community resources and services available.

Survivors who have been denied services or have had services discontinued should be re-assessed each time they ask to re-enter the program. This assessment might mean that an agreement with them needs to be in place as part of the re-admittance process.

Decisions about discontinuing or denying service should not be based on survivors' personalities, mental health status, substance abuse history, or their decision to return to the abuser. Domestic violence programs must be careful about using restrictive criteria in determining acceptance or re-admittance of a survivor.

Prohibitions on Survivor Background Checks

Background checks to determine program or service eligibility of any kind are prohibited, according to two important domestic violence funding sources. Programs engaging in background checks as a condition of services, or once a survivor is engaged with services, may risk losing their FVPSA and/or VAWA funding. Background checks include, but are not limited to criminal, civil, public record searches (Courtview, Public Access, etc.), and social media.

Survivor autonomy, safety, privacy, and confidentiality are foundational to the domestic violence movement. Survivor-centered, trauma-informed programs commit to providing and protecting the safety, privacy, and confidentiality of every survivor seeking services. FVPSA and VAWA rules and regulations prohibit the use of any information obtained through any type of background check to determine whether or how to provide

services. This information negatively impacts service delivery among staff and creates mistrust of survivors when discovered.

As a condition of receiving a STOP Violence Against Women Act (VAWA) award, grantees are required to submit a signed statement acknowledging that activities including conducting criminal record checks will

¹ https://www.ocjs.ohio.gov/STOP_VAWAstatement.doc

not be carried out that compromise survivor safety and recovery¹.

FVPSA regulations also address this issue:

*Programs cannot impose conditions for admission to shelter by applying inappropriate screening mechanisms, such as **criminal background checks**, sobriety requirements, requirements to obtain specific legal remedies, or mental health or substance use disorder screenings.*

Programs must implement the best practice standard of prohibiting background checks of any kind by all staff in order to comply with FVPSA and/or VAWA funding requirements. This includes the prohibition of any condition being applied to receive services as well as prohibiting any inappropriate screening or background check once a survivor has entered shelter or program services. A written policy prohibiting survivor background checks can be found in the Appendix section of this document.

Responding to Subpoenas, Warrants and Court Orders

Navigating the intersection between survivors' confidentiality requirements with requests from law enforcement and the courts can be complicated. For this reason, it is imperative that programs have attorneys who can guide them in both writing policies and procedures and in responding to specific requests. ODVN's one-page chart *Response Guidance for Warrants, Subpoenas, Missing Person Requests, Exigent Circumstances and Child Protective Services* was designed to help programs understand when confidentiality should be upheld and when it must be violated. This chart is included in the Appendix. While some basic information is provided here, ODVN has developed a model policy that addresses these circumstances.

Building and maintaining a positive working relationship with a program's local law enforcement agencies is a key step in handling warrants and subpoenas with minimal conflict. When programs are clear about their duty to protect the confidentiality of survivors, a protocol can be developed in advance that does not violate either agency's responsibilities.

Subpoenas

A subpoena is a legal document ordering someone to appear in a court of law or to produce specific documents.

Not all subpoenas are court mandates, so a program may not be required to respond. Please consult with the program attorney to determine if the subpoena requires action.

When a process server or police officer appears on site to serve a subpoena:

- The program is under no obligation to accept service of a subpoena, including Civil Protection Orders.
- Programs should not accept a subpoena on behalf of a resident unless the resident has given permission.
- If a process server or police officer comes to the door asking for a survivor who is in shelter to attempt to serve a subpoena, it is imperative that you do not let them come into the facility. Ask them to wait a moment outside and then consult with the survivor to see if they are willing to accept the subpoena.
- The resident does not have to go to the door to accept the subpoena, but the program should encourage a response within a specified time frame (24 hours).
- Consider posting signage at each entrance of the facility to indicate that subpoenas are not accepted at the location. (Since any attorney might try to serve a subpoena, it may be hard to proactively communicate about subpoenas.)

- In order to maintain community relationships, determine a workable solution on how to resolve the service of subpoenas (e.g., inform community partners that within 24 hours they will hear from the person or an attorney).
- Do not confirm or deny anyone's presence in shelter. It is important to avoid indicating that the person will respond at a later time.

When the program has received a subpoena requiring testimony or records from the program, the following steps should be taken:

1. The staff member receiving it will immediately provide it to a designated member of the program administration.
2. The following information will be determined immediately:
 - a. What kind of subpoena has been issued, e.g., for testimony only, or a subpoena ducas tecum (for testimony and for the records/files)?
 - b. Which staff member is the subject of the subpoena, e.g., a staff member with direct knowledge of the case or the keeper of the records?
 - c. Is that employee licensed and can or should assert privilege?
 - d. What factors can be considered to protect the agency and confidentiality?
 - e. Who is issuing the subpoena and is the source an adversary to the survivor's interests or an advocate for them?
3. If the subpoena has been issued by a party with adversary interests to the survivor, the Executive Director or their designee will immediately contact agency legal counsel and the attorney who is representing the interests of the survivor.
4. If the subpoena has been issued by a party who is an attorney advocate for the interests of the survivor, the administrator or their designee will contact the survivor and ascertain their wishes. If the survivor states they wish for the agency to speak with the attorney, a written waiver of confidentiality is required to permit the agency to speak with the attorney. Once the written release has been secured, then the administrator or their designee shall contact the attorney to discuss the information (only that which is the subject of the subpoena) and determine if that information will have a helpful or potentially detrimental impact on the survivor.

Often the appropriate response to a subpoena is for the program attorney to file a motion to quash. A motion to quash relates to the compliance of a subpoena. It is a specific type of request asking the court to render a decision as to whether or not a subpoena should be complied with or modified. A motion to quash should be filed before the hearing or trial.

Programs should file a motion to quash all subpoenas when *any* of the following is true:

- The party seeking the information has an adversarial relationship to the survivor in the case.
- It cannot be determined if the party seeking the information will use it in a manner that supports the best interests of the survivor.
- The survivor who was served by the agency does not give their permission for the information released, whether or not the information has a potentially helpful or detrimental impact to the case.

A sample motion to quash can be found in the Appendix section.

Warrants

There are two types of warrants—a search warrant and an arrest warrant.

²Wex Law Dictionary

Search Warrant

A search warrant is a warrant issued by the competent authority authorizing a police officer to search a specified place for evidence even without the occupant's consent².

Arrest Warrant

An arrest warrant is a document issued by a judge or magistrate that authorizes the police to take someone accused of a crime into custody. An arrest warrant is issued by the competent authority upon a showing of probable cause, which means a warrant may be issued if a reasonable person would believe the information at hand is sufficient to suggest criminal activities. Arrest warrants serve the purpose of protecting people from unlawful arrests under the Fourth Amendment. The warrant also gives an actual notice to the person or persons being arrested about the charges pressed. An arrest warrant is preferred but not required to make a lawful arrest³.

All programs should draft a policy and procedure for responses to search warrants. Executive Directors/ Directors should be notified immediately and should support staff members throughout the process. Program attorneys should be consulted throughout the process if possible. Procedures may include, but are not limited to, some of the following:

1. The staff person responding to the presence of an officer with a search warrant should first ask to see it.
 - The staff person should confirm it is signed and dated.
 - The staff person should review the warrant to see the search items or areas specified.
 - Once this information has been reviewed, identified, and confirmed, the staff member should allow the officer(s) entrance to the facility.
2. Staff members can, and should, limit the officer(s) to only the identified areas specified in the search warrant.
 - Officers are entitled to view and examine anything that is out in the open, so it is important to limit them to only the specified areas as much as possible.
3. Prior to permitting the officer(s) entrance to the facility, all residents should be sequestered to their private rooms or one general area of the shelter that is private and not part of the area to be searched.
 - Residents should be informed that law enforcement will be entering the facility before allowing the officer(s) to enter.
4. A search warrant must clearly identify the property to be searched, the name of the person to whom the warrant is about and must be properly signed and dated by the Court.
5. A valid search warrant does not conflict with confidentiality requirements with VOCA, VAWA and FVPSA.
6. For search warrants regarding a specific resident, staff members should ask officer(s) if they can take a moment to speak with the resident to see if they are willing to come to the officer(s) voluntarily.
 - If the officer(s) are agreeable, have them continue waiting outside while you address the matter directly with the resident.
 - If the officer(s) deny this request, there is not much that can be done. Staff members are required to allow officer(s) entrance to the facility, but all prior guidelines should be followed to protect the privacy of other residents.
7. Programs should create a procedure and process with their law enforcement departments prior to having these issues arise.

²Wex Law Dictionary

8. *Search warrants are required to specifically address property, items, areas, and people to be searched. (Examples may include drugs, stolen materials, physical evidence.) Staff members should not permit officers to search the entire shelter, or any area not specified in the warrant. They may not ask to speak to other residents who are not identified in the warrant. The search cannot go beyond what is identified in the warrant.*

All programs also should draft a policy and procedure for responses to arrest warrants. The following are important to take into consideration when drafting policies:

- Arrest warrants do not give law enforcement the right to search. If law enforcement arrives at the facility and states they believe a person is residing in shelter and reveals they have an arrest warrant and would like to come in to search, there is no obligation to allow them in or to conduct a search. Once a program becomes aware of a warrant, the program must inform the survivor and cannot hide them. Rather than allowing the officers to come into the facility, the best practice is to have the officer(s) wait outside and bring the resident to the officer(s) at the door.
- Once a program becomes aware of an arrest warrant, there is an obligation to cooperate. Programs cannot continue to house survivors with an active warrant once the program becomes aware of it and the existence of a warrant is discovered. Best practice responses include providing as much assistance to the survivor as possible to address the warrant. This support may include holding space for a reasonable amount of time for the survivor to return, linking the survivor with legal assistance, and assisting with fines or fees if possible. The ODVN Relocation & Safety Assistance program may be able to assist with fines and fees.
- If a resident is not on site when officer(s) produce the warrant, try to make arrangements with them to allow the resident to turn themselves in within 24 hours.
- All residents should be provided with the program's policies related to warrants and subpoenas. In addition, they should sign a form that describes the program's policies and procedures related to warrants and subpoenas to ensure all residents understand why the program must cooperate with law enforcement.
- It is also important that staff and residents understand the 3 areas where the confidentiality restrictions of VAWA, VOCA, & FVPSA do not apply:
 - Court or statutory mandate
 - A licensed staff person required to make an abuse or neglect report (elder or child abuse)
 - Signed, time limited release of information
- If a survivor is making active threats to kill someone or harm themselves with an active plan of suicide or an overdose in progress, contact the program attorney to determine if the confidentiality restrictions of VAWA, VOCA, or FVPSA apply.

Exigent Circumstances

If police are able to make a case that "Exigent Circumstances" exist, they may be permitted to enter the facility without a warrant.

Circumstances that would cause a reasonable person to believe that entry (or other relevant prompt action) was necessary to prevent physical harm to the officers or other persons, the destruction of relevant evidence, the escape of the suspect, or some other consequence improperly frustrating legitimate law enforcement efforts. Exigent circumstances are exceptions to the general requirement of a warrant under the Fourth Amendment searches and seizures.

Police officers may not seize a person in his home in the absence of a warrant, consent, or exigent circumstances.

Examples that do not meet the threshold of exigent circumstances:

- Suicidal resident
- Someone using drugs or overdosing
- Law Enforcement or Child Protective Services stating they need to do a welfare check

In these circumstances, residents do not give up their right to Fourth Amendment protections.

Examples that may meet the threshold of exigent circumstances:

- Child Protective Services investigating child abuse or neglect
- Child Protective Services investigating parents using drugs with children present
- Report to police that someone is holding a gun to someone's head inside a home

Welfare Checks

If the police show up at the facility and want to do a welfare check on a resident in shelter, staff should do the following:

- As often as possible, make arrangements with law enforcement departments (or Child Protective Services) ahead of time to have the resident respond to officer(s)/CPS worker(s) within a specified timeframe (not to exceed 24 hours).
- Ask the officer(s) to wait while staff sequester other residents and families.
- Speak to the resident and explain what is happening, what a welfare check is, and what the officer(s) are there to determine.
- Ask the resident if they are willing to go outside and meet with the officer or meet in a private location inside the facility away from other residents and families—AND—if the survivor is working with an attorney, have the survivor contact them immediately (or as soon as possible) for direction and legal advice.

Missing person requests do not meet the same level of urgency as welfare checks. In this case, consider having the resident contact law enforcement within 24 hours of request and let law enforcement know that if they do not hear anything from the shelter or resident in that time period, that the person is not in shelter.

Child Protective Services (CPS) or Court Orders Regarding Children

Child Protective Services should not be permitted entry into a facility without an order to remove children. If they are working with a resident in shelter, the program should work with CPS in order to resolve the issue. CPS workers should not be meeting with residents in shelter in order to preserve the confidentiality of other residents and families.

If there is a subpoena regarding child custody, the best thing for the parent is to respond. Advocates should work with the parent to encourage answering the subpoena and appearing in court.

- Shelters cannot harbor people who do not have custody of their children.
- If a parent is required to turn over their children, staff should help the parent through the process. ***Programs should not help the family to relocate to another shelter in an effort to evade turning the children over.***
- If a parent should lose custody of their children while in shelter, the children cannot continue to stay in shelter with that parent.
- If CPS/law enforcement show up at the shelter with a court order for the children, the program is not required to protect confidentiality and must produce the children.

The full best practice guidance for responding to warrants and subpoenas can be found in the Appendix section of this document.

Working with Marginalized/Underserved Populations

In the area of domestic violence, different groups of survivors may have different needs and face different challenges.

All programs should develop appropriate practices and policies for responding to differing cultures, ethnic backgrounds, sexual orientations, and gender identities, which consider different cultural norms. The appropriate policies and practices should be determined by the population in question. As much as possible, programs serving the general population should seek to partner with culturally-specific agencies to help increase their capacity to serve specific cultures appropriately.

One crucial practice is the orientation of new staff to understanding and respecting diverse communities. Programs need to be firm in their commitment to diversity, equity, and inclusion. New staff and volunteers must be oriented to the program's practices related to issues of diversity, equity, and inclusion. Staff and volunteers should be encouraged to engage in self-reflection and to look at difficult, challenging, and sometimes painful experiences when dealing with difference as opportunities to learn and grow. ODVN has many opportunities for additional training on cultural diversity, as well as several caucuses and task forces relating to advocacy with marginalized populations listed below.

Programs should ensure diverse representation among Board, staff, and volunteers through the development and implementation of a cultural diversity plan including specific benchmarks. Outreach programs developed to engage under-represented or underserved populations should include input from the communities the program wants to reach.

Becoming culturally competent is a lifelong journey both for individual advocates as well as for programs. Part of providing trauma-informed services is to respond in a way that is supportive and understanding of the individual survivor. Cultural competency inherently requires the advocate to understand the ways in which they have inherited social and institutional privileges as well as the ways in which they have experienced oppression. Advocates who have examined their own privilege and developed knowledge about cultural norms of diverse communities are more effective when working with survivors from diverse populations.

To support advocates in their journey of becoming culturally competent, the following policies and procedures should be put in place:

- Provide experiential cultural diversity and competency training in addition to knowledge- and skill-building training about specific populations
- Provide ongoing trainings about different cultures and how they are impacted by domestic violence
- Encourage staff to attend and actively participate in ODVN caucuses or taskforces related to specific communities. A list of these opportunities can be found [here](#)
- Commit to diversity and inclusion for staffing as well as the survivors served

The following is a sampling of information about selected communities that are under-resourced in current culture.

Survivors with Disabilities

Programs should be responsive to survivors who may have physical, sensory, or cognitive impairments. While the experience of domestic violence may be similar for persons with and without impairments, persons with disabilities are more vulnerable to experiencing victimization and face more barriers to seeking services with domestic violence programs. It is estimated that almost 20% of the U.S. population has a

disability that affects their activities of daily living.

While this manual is unable to address the variety of disabilities and barriers disabled survivors may face, some standards that domestic violence programs may want to follow to increase accessibility for survivors with disabilities are included.

For a more complete self-evaluation of shelter accessibility, please refer to [Increasing Agency Accessibility for People with Disabilities: Domestic Violence Agency Self-Assessment Guide](#) published in 2004 by the Washington Coalition Against Domestic Violence.

At a minimum, programs should meet the accessibility standards below for survivors with disabilities.

- Program facilities are fully accessible with clearly marked entrances, bedroom, bathrooms, and communal spaces.
- Program staff is fully aware of resources and/or community agencies for people with disabilities.
- Facility has ample parking space for people with disabilities.

For more information on working with individuals with disabilities, contact ODVN for information about serving survivors with disabilities and best practices for providing meaningful access. A template for creating Meaningful Access policies can be found in the Appendix section of this document.

Survivors Experiencing Mental Health Challenges or Psychiatric Disabilities

Program participants often approach programs during crisis when a traumatic event has recently occurred. A trauma-informed approach recognizes that many behaviors and responses expressed by trauma survivors are directly linked to their traumatic experiences. Many common responses to trauma (such as depression, avoidance, anxiety, hyperarousal, cognition and memory problems, challenges with emotional regulation and self-soothing, mood swings, and sleep problems) are symptoms found in diagnostic manuals. Many survivors who have been diagnosed with a mental health disorder may not have been asked about their relationships or trauma histories and were diagnosed due to symptoms that could easily be trauma reactions. The connection between psychiatric disability, substance use, and trauma is strong, so it is very important to view domestic violence work through a trauma-informed lens.

Everyone deserves high quality services, regardless of mental health condition. Individuals with a psychiatric disability or a mental health diagnosis are vulnerable to abuse and domestic violence. Their needs for safety are no less significant than those who are not experiencing these challenges. In fact, a survivor with mental health challenges that impact their ability to perceive, understand, or act on signals of danger might be at increased risk.

Symptoms of numbing, depression, anxiety, paranoia, and substance use are often the result of living through emotional, physical, and sexual abuse. These problems can be consequences of the abuse, not a cause of it. In addition, some survivors experience Post Traumatic Stress Disorder (PTSD)—a logical, predictable set of symptoms connected with serious trauma.

Programs that are licensed to diagnose mental health disorders are encouraged to become familiar with the role trauma plays in the lives of survivors and be familiar with emerging approaches and treatments that assist in healing from traumatic experiences. Clinicians should be familiar with trauma-related disorders and to watch for inaccurate diagnosis of a mental disorder which often occurs due to the failure to identify traumatic experiences and the impact of trauma.

As part of best practices, programs should have the following guidelines as it relates to survivors with mental health issues:

- Program provides training for all staff on trauma and on distinguishing trauma reactions from traditional mental health symptoms.
- Program avoids the use of any diagnostic language in survivor records except when required by funders. These records should be kept separate from the survivor's shelter file.
- Programs share information about trauma with survivors, so that their reactions and responses can be normalized, and instead of feeling "crazy," survivors can be validated rather than further stigmatized.
- Program staff and volunteers acknowledge that survivors may have a psychiatric disability and also experience abuse. Advocates do not automatically assume survivors with mental health challenges are not reliable in their account of victimization.
- Survivors are never required to present proof of medical conditions, a list of their prescriptions, or to be medication compliant in order to receive program services.

Survivors with Substance Use Issues

Domestic violence programs have a responsibility to serve all survivors, regardless of race, disability, gender, or economic status. In addition, FVPSA and VAWA regulations prohibit discrimination against survivors with disabilities of any kind, including those survivors who may be actively using substances.

Substance use is often a function of trauma, and every effort should be made to ensure survivors using substances receive the same services as other survivors. Exiting a survivor or refusing services because of substance use or addiction discourages survivors from seeking services in the future and puts them in danger of re-victimization and homelessness. For this reason, FVPSA and VAWA prohibit denying services and/or providing services on the condition the survivor receives substance use treatment.

- Survivors **cannot** be exited from shelter or denied participation in services (such as support groups) because they did not perform a specific action (e.g., refusing to seek an assessment or return to a treatment group).
- Survivors **should not** be exited from shelter for substance use/abuse. Agencies should make every effort to address the survivor's substance use from a trauma-informed perspective.
- Program staff should offer intervention and harm reduction strategies to survivors as part of their safety planning.

Best practices for assisting survivors actively using substances include:

- Build relationships with local substance use treatment providers so that the agency may connect the survivors with resources if they wish
- Create an agency protocol for the disposal of drugs, medication, and drug paraphernalia
- Train staff in overdose prevention including the use of Narcan and Naloxone
- Utilize a trauma-informed lens at all times and remain nonjudgmental
- Ask about struggles with substance use and assess prospective needs of survivors
- Have honest and respectful conversations with the survivor about how their substance use can potentially put them at increased risk of violence/harm
- Discuss the substance use and ways to decrease risk to the survivor as part of the safety plan
- Consider implementing on-site recovery meetings
- Consider partnering with local service providers that offer peer support specialists

Programs are also encouraged to seek technical assistance, training and program support from ODNV's Substance Use and Mental Health Program Director.

Survivors who are d/Deaf or Hard-of-Hearing

Programs need to be responsive to the needs of survivors who are d/Deaf or Hard-of-Hearing in their community. All domestic violence agencies should acquire telecommunication devices for the d/Deaf or Hard-of-Hearing. Video conferencing devices such as Sorensen are available to programs free of charge if they are not already in place. These allow d/Deaf or Hard-of-Hearing survivors and hearing advocates to communicate on help-lines for crisis counseling, referrals, admittance to shelters, and connections to other agency programs.

Other forms of communication that d/Deaf or Hard-of-Hearing survivors may use include telephone or video relay, text messaging, or email. Text messages and emails may not be a secure way to communicate with a survivor. Communication can be hacked, or if a keystroke program has been put on their computer, the abuser would have access to read everything the survivor has shared. For more information, refer to the NNEDV Digital Services Toolkit, found [here](#).

Programs should seek out specialized training about the d/Deaf or Hard-of-Hearing community. There are significant cultural norms which, when not observed, discredit a domestic violence agency seeking to help d/Deaf or Hard-of-Hearing survivors. Here are three key informational points it is important for programs to understand.

- Being d/Deaf or Hard-of-Hearing is not viewed as a disability by many d/Deaf or Hard-of-Hearing persons who live in the d/Deaf or Hard-of-Hearing community. References to being hearing “impaired” are also offensive, as they make the hearing world the point of reference.
- d/Deaf or Hard-of-Hearing people communicate through a variety of languages and means, including American Sign Language (ASL), Pigeon Signed English (PSE), lip reading, and others. It is important to understand what language and means of communication the survivor uses. The ability to read lips is rare and often inaccurate and should never be the main means of communication.
- The d/Deaf or Hard-of-Hearing community is just that: a community. Because of oppression from hearing people, like any marginalized, small community, there may be mistrust of hearing people. When programs can acknowledge this mistrust and take every action possible to facilitate communication (on hotlines, at community events via translators, in brochures, etc.), trust can be rebuilt.

In addition, programs can take the following steps to ensure that d/Deaf or Hard-of-Hearing survivors’ needs will be met.

- On-call, certified interpreters trained in domestic violence issues should be used to facilitate communication between d/Deaf or Hard-of-Hearing, and hearing people to aid communication with staff, outside agencies or individuals, or in support groups. This is a requirement of the Americans with Disabilities Act (ADA); programs should check these regulations to get detailed information about the level of their responsibility to provide interpreters.
- Brochures explaining services can be developed and distributed within the d/Deaf or Hard-of-Hearing community and to social service agencies. It is important to note that American Sign Language (ASL) is a separate language. It will not be adequate to write a brochure in spoken English style. Programs should have certified ASL translators review any written materials targeted for d/Deaf or Hard-of-Hearing survivors.

For more information on working with individuals who are d/Deaf or Hard-of-Hearing, contact ODVN for information and policies on providing Meaningful Access to all survivors.

Survivors who are Lesbian, Gay, Bisexual, Transgender, Queer, Intersex or Asexual (LGBTQIA+)

No community is exempt from domestic violence, and the LGBTQIA+ community is no exception. However, due to social stigmatization, LGBTQIA+ survivors may face greater isolation and be more hesitant to contact domestic violence agencies. In addition to the kinds of abuse other survivors encounter, LGBTQIA+ survivors may fear being “outed” by their abusers, thereby jeopardizing their jobs, family support network, housing, and child custody. In most communities, it remains legal to fire or evict people based upon their sexual orientation and/or gender identity, and there are many prominent cases of loss of child custody based solely upon sexual orientation. These realities create additional barriers for LGBTQIA+ domestic violence survivors.

To begin removing barriers to LGBTQIA+ survivors receiving services, programs need to explicitly state that abuse exists in same sex and transgender marriages and relationships. The commitment to serve the LGBTQIA+ community must then be reflected in their mission and philosophy statements.

The commitment to welcome LGBTQIA+ survivors is rooted so firmly in the philosophy of the domestic violence movement that there can be no debate. Programs are committed to respond to the needs of *any* person who is being abused.

In same sex relationships, the abuser is not always the person who is bigger in size or appears more dominant. The survivor is the person who is living in fear and changing their behavior because of this fear. Often the person who is abused will take the blame or say that they have the problem with violence.

The following are standards for domestic violence programs to follow when serving LGBTQIA+ survivors:

- LGBTQIA+ survivors are directly told they are welcome in the shelter and will receive support services from staff to address any homophobia, transphobia, or gender discrimination they encounter.
- The program provides for special safety needs of those abused by individuals of the same gender identity. For example, lesbians are not necessarily safe under “no male” policies and additional screening may be necessary to ensure that lesbian perpetrators do not enter the shelter/safe home.
- Language used in hotline calls/texts and intake interviews is neutral so as not to assume the gender of survivor or abuser. Individuals are allowed to self-identify and share their preferred gender pronouns.
- Statements prohibiting discrimination in agency policies include discrimination based upon sexual orientation and gender identity.

For more information on working with individuals who are members of the LGBTQIA+ community, contact ODNV about the LGBTQIA+ Task Force, which provides opportunities for meeting, training, networking, and a better understanding of how to best serve survivors from this community.

Survivors of Color

While survivors of color come from diverse, rich, and distinct cultures and communities, all are included here as a group for the purpose of helping programs acknowledge and address racism and oppression, and common experiences among Black, Indigenous People of Color (BIPOC) survivors.

The most pressing is for domestic violence programs to understand the severity of racism and oppression in the United States, how survivors of color are affected, and to address this as a barrier to safety planning. One powerful tool is the provision of culturally-specific programming. This programming gives survivors the opportunity to know that service providers understand the issues, and in the cases of culturally-specific support groups, gives survivors the chance to process difficult situations with other survivors facing similar barriers.

The domestic violence movement has become increasingly focused on court outreach and related services. What sometimes fails to be acknowledged, as a field, is that the criminal justice system is largely operated by white males and begins with law enforcement contact. These two facts have significant ramifications for survivors of color. Regarding the police, some survivors of color associate the arrival of police in their neighborhoods with an increase in danger for themselves and their loved ones. While police reform is slowly occurring, many survivors have prior negative experiences with the justice and medical systems, which may make them less likely to call the police or others for help. Similarly, for women of color, it may be difficult to turn their abuser into a justice system largely operated by white males whose track record around racism and violence against Black, and indigenous males of color presents additional risk factors.

Some best practice standards to follow when working with people of color include:

- The program trains staff about racism, unconscious bias and oppression and the role they play in keeping survivors of color from getting and staying safe.
- The shelter environment includes diverse posters, magazines, reference materials, and resources which include a variety of people of color.
- The program ensures that staff is knowledgeable about available resources within local communities of color, seeks referrals from agencies serving such communities, and encourages survivors to seek assistance from these outside resources as appropriate.
- The program is a safe place for people of color to work as staff or volunteers.

ODVN facilitates the Women of Color Caucus, which provides advocates and managers of color opportunities for meeting, training, and networking. Contact ODNV for more information. ODNV is committed to developing leadership in women, community education, and efforts that will influence policy and systems to respond more effectively to improving the lives of BIPOC communities.

Immigrant Survivors

It is important that programs acknowledge that immigrant survivors are a diverse group. Some may have lived in the United States for two weeks, while others may have lived here twenty years. Their reasons for coming to the United States vary. Immigrants may be visiting family or seeking better economic conditions, or they may be refugees fleeing persecution.

If a survivor is in this country without documentation, a conditional resident, or here on a visa, their abuser may use the threat of deportation as a means of control. The abuser may threaten to harm the survivor's family in their country of origin. In leaving, the survivor may be leaving the only community they know. They may fear poverty, losing their children, or living in an unfamiliar culture knowing little or no English.

Programs need to commit to explore and dismantle the stereotypes staff and volunteers may have about immigrants. There also needs to be focused outreach efforts to access agencies that serve immigrant communities. These agencies can help programs find interpreters and peer support for survivors involved with the domestic violence shelter/program.

In multicultural communities, programs should have multilingual staff and volunteers. At the very least, interpreters trained in domestic violence dynamics should be made available (using the survivor's children or other relatives as interpreters may place them in danger). Programs may use a variety of language/interpreter lines, which offers confidential interpreters for many languages in an effort to make hotline services available to survivors who do not speak English fluently. To be in compliance with federal funders, programs need to have a written Limited English Plan (LEP) in place for how they will access interpreters. (See the Meaningful Access policy in the Appendix.)

Some best practice standards for working with immigrant survivors include the following:

- Staff and volunteers are trained to understand differences in immigration status, special visas that are available, and which attorneys in their area understand domestic violence dynamics and will be best able to help the survivor.
- Staff and volunteers are trained to be careful about recording information about a survivor's status that may compromise them in any subsequent immigration proceedings and to NEVER call the United States Customs and Immigration Services (USCIS) to verify their status.
- Programs in multi-national communities have informational brochures with several languages, which explain the dynamics of domestic violence, legal options, and how to access safety.
- Interpreters are oriented to domestic violence dynamics, and family members are not used for interpretation services.

Older Adult Survivors

Older survivors, those who are 50 years and older, entering domestic violence programs have similarities to other survivors but do have some specific needs that programs need to address.

Programs should develop resources and procedures, which address the needs of older survivors.

Some best practice standards for working with older survivors include the following:

- If the survivor receives minor medical care at home, the program/shelter allows this service to continue within the shelter. The program may screen potential in-home service providers, and these providers are required to sign a confidentiality agreement.
- Staff is knowledgeable about legal issues affecting older people such as elder abuse reporting laws, powers of attorney, guardianships, Medicare appeals, and housing rights.
- The program works in coordination with the local aging agency, adult protective services, and other organizations for seniors.
- The program works to provide separate space away from children for older survivors. Many older survivors are not accustomed to living daily with children so a separate space can help to provide some relief and quiet space to process their trauma and heal.

Survivors of Faith

Religious faith is an important strength for some survivors of domestic violence. In keeping with the principles of empowerment, programs need to respect the varying religious values and beliefs of the survivors they serve and see faith beliefs as a strength to be utilized when service planning.

Some best practice standards for working with survivors of faith include:

- Interventions should be strength-based, with religious faith viewed as a strength and resource for the survivor.
- Program accommodates survivor's religious rituals, (for example, quiet space is made available for prayer time).
- Program staff and volunteers are aware of supportive clergy in the local community.



Conclusion

Domestic violence programs across the state of Ohio work tirelessly to ensure that every individual who experiences domestic violence has safe and supportive options. ODVN recognizes how difficult this work is and the desire of every program to provide the best services to survivors. ODVN hopes that programs use this Promising Practices Manual as a framework to do just that. ODVN is always available to provide support and technical assistance to programs in this process. Together, ODVN and its member programs will continue to build safer, more supportive, more comprehensive options that reach more survivors.

We know that managing a domestic violence program requires oversight in many areas that are ever changing. The Promising Practices Manual will be a living document that will be updated on an ongoing basis. New sections important to domestic violence program management will be added and/or revised and new emerging promising practices will be added. We appreciate that there are many moving parts to domestic violence program management and thank you for your commitment and dedication to serving survivors in the most trauma-informed and survivor-centered manner.

Thanks and Appreciation

The revision of the primary Promising Practices Manual, as well as the new Promising Administrative Practices Manual, would not have been possible without the assistance of so many experienced, dedicated and committed advocates in the domestic violence movement. Their commitment to best practice procedures, trauma-informed and survivor-centered services, and exceptional domestic violence program management is inspiring and exemplary. It is with tremendous thanks and deep gratitude that ODVN thanks the following people for their contributions:

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Appendix

The following documents can be found online at www.odvn.org/directorsacademy/.

The documents with an asterisk (*) can be found in this document on the following pages.

A. The Trauma-Informed Roadmap for Ohio's Domestic Violence Programs

B. Crisis Call Information (Model Form)*60
C. Limited Release of Information (Template).63
D. Partnering with Parent and Youth Intake	
E. ODVN Residential Intake Model Form*64
F. ODVN Non-Residential Intake Model Form*67
G. NNEDV Record Retention	
H. Unauthorized Practice of Law	
I. Reporting Flow Chart	
J. Model Medication Policy for DV Shelters	
K. Best Practice for Medical Emergency Protocols*70
L. Coping with Sudden Loss	
M. Head Injury Accommodations	
N. Agency Checklist	
O. STOP VAWA Statement of Acknowledgement*83
P. Survivor Background Checks*84
Q. Response Guidance for Warrants*85
R. Sample Motion to Quash	
S. Responding to Subpoenas and Warrants*86
T. Model Policy Responding to Warrants and Subpoenas	

Appendix B: Crisis Call Information (Model Form)

Using this Crisis Call Form will assist staff in collecting basic information from callers. A name should not be required, but it might be helpful to ask what the survivor wants to be called while talking with you. Callers should not be required to report or provide any information that they don't wish to share and not sharing information should not prohibit their consideration for being admitted to the shelter or program services.

A crisis call is conversational and does not need to follow the order of the questions on the form. Callers should not be left with the impression that you are gathering information in order to complete a form or check a box. Having a conversational tone often comes when a staff member gets more experienced with answering crisis calls. This can take some time! On the model form, there is some suggested language with various questions in italics to assist advocates in collecting information.

The "Internal Use" section of the form is filled out after the call is done. This section is for communication between staff or for grant reporting. The Crisis Call Form template is specific to agencies providing shelter. If your organization does not provide shelter, please modify the form to remove those questions.

Residential Crisis Call Form

Sample introduction: *(If your program doesn't already have a standard method of answering calls)*

"Hello, _____, *(insert agency name)*. How may I help you?" or, "_____ *(insert agency name)* hotline, how may I help you?"

"My name is _____ *(staff first name)*, what is your name?" _____ *(if caller is reluctant or does not want to provide their name, you may ask, "is there a name you would like me to use during the call?")*

"Are you safe right now?" [] Yes [] No—"If you are not safe right now, how may I best assist you?"

If survivor wants you to call the police, obtain an address prior to hanging up so you can call the police, arrange transportation to a safe place, etc.)

Address if provided: _____

If needed: "Can I provide an interpreter for you?" [] Yes [] No

If yes, what language: _____

(Please refer to your agency's Meaningful Access policy and/or your Language Line instructions to secure interpretation services)

"What we talk about today is confidential, and I will not share what you tell me, unless you want me to."
(If you are a mandated reporter as required by a professional license and Ohio Law, disclose you are mandated reporter and what types of information you are required to report and the limits to confidentiality. If caller is more comfortable speaking to a staff member who is not a mandated reporter, please try to accommodate if possible.)

Caller informed about program/staff confidentiality? ☐ Yes ☐ No

"How can I help you? What happened for you to call today? What has been going on?"

(Reason for seeking assistance).

☐ Domestic Violence ☐ Sexual Violence ☐ Stalking ☐ Teen Dating Violence ☐ Trafficking
☐ Other _____

"Is shelter requested?" ☐ Yes ☐ No—(Share information regarding space availability)

(If no, skip the boxed questions below and ask what types of services, resources or referrals would be most helpful)

"Do you have children or dependents that will be coming with you?" ☐ Yes ☐ No

"What are their ages?" _____

"Do you have a service animal you will be bringing to the shelter?" ☐ Yes ☐ No

"Do you have pets you need to bring to the shelter or do you need assistance in locating a safe place for them?" ☐ Yes ☐ No

"What types of pets do you have?" _____

"We are able to provide you shelter. Are you safe and able to talk about a few things before coming into our shelter?"

"I would like to let you know about our agency and what to expect when you arrive." (Share a little about your shelter—looks, layout, etc.—items that your program can provide, what they should try to bring with them, what the community living is like, etc.)

"Our goal is to provide a safe option for any individual experiencing violence. We have a diverse group of individuals living here, including individuals with children of all ages; people of various ethnic, cultural and religious backgrounds and abilities; people who may speak different languages; and individuals of varied gender identity and sexual orientation.

"Do you have any questions about that?"

"Do you feel our program services would be a good fit for you?" ☐ Yes ☐ No

"If our shelter services aren't a good fit for you, are there other areas that we might be able to assist you with or other safety concerns you would like to talk about?" ☐ Yes ☐ No

If so, please summarize here: _____

"Would you like to talk about creating a safety plan for you and/or your children?" [] Yes [] No

"Was safety planning conducted with caller?" [] Yes [] No

"What can I help you with?" (If coming into shelter, when and how will they arrive. List all services requested.)

Referrals and Resources provided:

FOR INTERNAL USE

Name of Staff Taking Call: _____ Date: _____

Time Spent on Call: _____

Shelter Request Approved? [] Yes Arrival Time: _____
[] No If denied, reason: _____

Number of Individuals Denied: ____ Women ____ Men ____ Children ____ Unspecified Gender

Other Notes: _____

Appendix C: Limited Release of Information Form (Template)

READ FIRST

[Program] must keep information about you private. The only time your personal information should be shared is when you want us to for specific services or if we are compelled by law or court order.

- You never have to agree to share your information. We will still help you and provide our services.
- If you do want [Program/Agency Name] to share some information about you, use this form to give instructions about what you do and don't want shared, and with whom you want it shared.
- Before you sign this, someone at [Program/Agency Name] will discuss your goals/needs, your choices for how to meet those, and the pros and cons of having us share the information for you.
- You can change your mind about what you want shared at any time, and we will update this form to reflect your decision.

These are my instructions for [Program/Agency Name] to share my information:

I want this information about me shared:	<i>(Be as specific as possible. A few examples include: my name, dates I got help, documents about me)</i>
I want the information shared with this person or agency:	
I want the information shared:	<input type="checkbox"/> In Person <input type="checkbox"/> By Phone <input type="checkbox"/> By Fax <input type="checkbox"/> By Mail <input type="checkbox"/> By E-Mail <input type="checkbox"/> By Text <input type="checkbox"/> Other: _____
Sharing this information helps me because:	
I know that once the information is shared by [Program/Agency Name]: _____ (initials) <ul style="list-style-type: none">• Others will know that I have worked with [Program/Agency Name],• Others might try to get more information about me from [Program/Agency Name], and• The person/agency receiving my information might share it without asking me first.	

I want [Program/Agency Name] to stop sharing the information above on _____ (date).

I know that I can change my mind and tell [Program/Agency Name] to stop sharing sooner than the date above _____ (initials).

Signed: _____	Non-abusive parent/guardian signature (if required): Signed: _____
Printed Name: _____	Printed Name: _____
Date: _____	Date: _____

Extending the Release

To help meet my goals, I want [Program/Agency Name] to keep sharing the information above for longer.

I want them to stop sharing on _____ (new date).

Signed: _____	Date: _____
Non-abusive parent/guardian signature (if required) Signed: _____	Date: _____

Appendix E: ODVN Residential Intake Model Form

The Intake Form captures initial information from the survivor about the abuse that has occurred to them and their children. While it is important that some documentation for the survivor file and some program paperwork is very limited for record keeping purposes, staff members/case managers do want to document details of current and past abuse for the survivor and children with as much detail as possible including documenting any injuries. It is important to remember that whenever survivor information is being collected for reporting purposes, that personally identifying information is not included and that aggregate data only is provided and reported.

Start by welcoming the survivor and informing them of the purpose of collecting intake information and of their right to provide only as much information as they feel comfortable. Survivors have the right not to answer questions and/or decline case management services. When doing any type of program paperwork, intake or case management appointment, it is important to share with the survivor that they can take a break when needed.

The form can be kept as a part of the survivor's file. When they leave the program, please preserve and retain the paperwork and file according to your program's record retention policy. Please note that survivors have the right to view their file at any time.

Residential Intake Form

Information is confidential (*explain the limits to confidentiality*)

Sample introduction after welcoming the survivor:

I'd like to ask you some questions to help me understand a little more about you and your children. Some information is used in reports to funders and provides only numbers and cannot be traced back to you or your children. You have the right not to answer any of these questions. You also have the right to share with me information that you think I should know, and you can ask me not to write it down. If you need a break just let me know and these questions can be finished at another time.

Survivor ID Number (*assigned by the program, if applicable*) _____

Name _____ **Date of Birth** _____

Age _____ **Gender** _____ **Personal Pronouns** _____

Race/Ethnicity _____

Immediate Needs (*Are there immediate concerns that I can help you with? Are there any accommodations or assistance you need and would like to share with me?*)

Do you have any needs that you would like to share that will make it easier for you to feel comfortable and confident in understanding the information we provide you? (*Do you need an interpreter, large print*

copies of things in writing, assistance with completing written documents, someone reading printed material to you, or do you need me to face you when speaking so you can see my lips, etc.) [] Yes [] No

If yes, describe _____

Interpreter needs _____

Primary reason for assistance *(What has been happening that made you want to seek shelter for you and/or your children?)*

- [] Domestic Violence [] Sexual Violence [] Stalking [] Teen Dating Violence [] Trafficking
[] Other _____

Safety Planning *(Do you have concerns about your safety that you would like me to help you with?)*

Periodically we have maintenance providers—plumbers, copy machine repair, electricians, etc.—who come to our shelter. Please let us know if you have any concerns with allowing these service providers to come into our shelter or if the person who abused you works in these types of jobs. [] Yes [] No

Other victimization if disclosed *(Are there any other experiences you might have had in the past, or recently, that you would like to talk about with me or another staff person?)*

- | | |
|-----------------------------------|--------------------------------------|
| [] Domestic Violence | [] Sexual Violence |
| [] Stalking | [] Teen Dating Violence |
| [] Trafficking (Labor, Sex) | [] Child Abuse |
| [] Elder Abuse | [] Adult Sexually Abused as a Child |
| [] Violation of Protection Order | [] Family/Friend of Homicide Victim |
| [] Other _____ | |

Abuser's Information *(Can you share some information with me about the person who is harming you?)*

Name _____

Relationship *(Can you share with me how you know them?)*

- [] Current/Former Spouse [] Current/Former Dating Partner [] Other Family/Household Member
[] Acquaintance [] Stranger [] Trafficker
[] Unknown

Children *(If services related to children are not requested, this can be skipped)*

Name _____ **Pronouns** _____ **DOB/Age** _____

Ethnicity _____ **Abuser's Relationship** _____

Name _____ **Pronouns** _____ **DOB/Age** _____

Ethnicity _____ **Abuser's Relationship** _____

Name _____ Pronouns _____ DOB/Age _____
Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____
Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____
Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____
Ethnicity _____ Abuser's Relationship _____

Dietary Needs *(Do you or your children have any dietary/food needs that you would like us to be aware of?)*

Environmental Needs *(Are there cleaners or soaps you or your children are allergic to? Any other environmental concerns you would like to share with us?)*

Service Animal or Emotional Support Animal

Name _____	Last Visit to Vet (if known) _____
Name _____	Last Visit to Vet (if known) _____
Name _____	Last Visit to Vet (if known) _____

Pets

Name _____	Last Visit to Vet (if known) _____
Name _____	Last Visit to Vet (if known) _____
Name _____	Last Visit to Vet (if known) _____

FOR INTERNAL USE

Name(s) of advocate(s) working with survivor _____

Room Assignment _____ Entry Date _____ Exit Date _____

Appendix F: ODVN Non-Residential Intake Model Form

The Intake Form captures initial information from the survivor about the abuse that has occurred to themselves and their children. While it is important that some documentation for the survivor file and some program paperwork is very limited for record keeping purposes, staff members/case managers do want to document details of current and past abuse for the survivor and children with as much detail as possible including documenting any injuries. It is important to remember that whenever survivor information is being collected for reporting purposes, that personally identifying information is not included and that aggregate data only is provided and reported.

Start by welcoming the survivor and informing them of the purpose of collecting intake information and of their right to provide only as much information as they feel comfortable. Survivor's have the right not to answer questions and/or decline case management services. When doing any type of program paperwork, intake or case management appointment, it is important to share with the survivor that they can take a break when needed.

The form can be kept as a part of the survivor's file. When they leave the program, please preserve and retain the paperwork and file according to your program's record retention policy. Please note that survivors have the right to view their file at any time.

Residential Intake Form

Information is confidential (*explain the limits to confidentiality*)

Sample introduction after welcoming the survivor:

I'd like to ask you some questions to help me understand a little more about you and your children. Some information is used in reports to funders and provides only numbers and cannot be traced back to you or your children. You have the right not to answer any of these questions. You also have the right to share with me information that you think I should know, and you can ask me not to write it down. If you need a break just let me know and these questions can be finished at another time.

Survivor ID Number (*assigned by the program, if applicable*) _____

Name _____ **Date of Birth** _____

Age _____ **Gender** _____ **Personal Pronouns** _____

Race/Ethnicity _____

Immediate Needs (*Are there immediate concerns that I can help you with? Are there any accommodations or assistance you need and would like to share with me?*)

Do you have any needs that you would like to share that will make it easier for you to feel comfortable and confident in understanding the information we provide you? (*Do you need an interpreter, large print*

copies of things in writing, assistance with completing written documents, someone reading printed material to you, or do you need me to face you when speaking so you can see my lips, etc.) ☐ Yes ☐ No

If yes, describe _____

Interpreter needs _____

Primary reason for assistance *(What has been happening that made you want to seek shelter for you and/or your children?)*

- ☐ Domestic Violence ☐ Sexual Violence ☐ Stalking ☐ Teen Dating Violence ☐ Trafficking
☐ Other _____

Safety Planning *(Do you have concerns about your safety that you would like me to help you with?)*

Periodically we have maintenance providers—plumbers, copy machine repair, electricians, etc.—who come to our shelter. Please let us know if you have any concerns with allowing these service providers to come into our shelter or if the person who abused you works in these types of jobs. ☐ Yes ☐ No

Other victimization if disclosed *(Are there any other experiences you might have had in the past, or recently, that you would like to talk about with me or another staff person?)*

- | | |
|--|---|
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sexual Violence |
| <input type="checkbox"/> Stalking | <input type="checkbox"/> Teen Dating Violence |
| <input type="checkbox"/> Trafficking (Labor, Sex) | <input type="checkbox"/> Child Abuse |
| <input type="checkbox"/> Elder Abuse | <input type="checkbox"/> Adult Sexually Abused as a Child |
| <input type="checkbox"/> Violation of Protection Order | <input type="checkbox"/> Family/Friend of Homicide Victim |
| <input type="checkbox"/> Other _____ | |

Abuser's Information *(Can you share some information with me about the person who is harming you?)*

Name _____

Relationship *(Can you share with me how you know them?)*

- ☐ Current/Former Spouse ☐ Current/Former Dating Partner ☐ Other Family/Household Member
☐ Acquaintance ☐ Stranger ☐ Trafficker
☐ Unknown

Children *(If services related to children are not requested, this can be skipped)*

Name _____ **Pronouns** _____ **DOB/Age** _____

Ethnicity _____ **Abuser's Relationship** _____

Name _____ **Pronouns** _____ **DOB/Age** _____

Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____

Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____

Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____

Ethnicity _____ Abuser's Relationship _____

Name _____ Pronouns _____ DOB/Age _____

Ethnicity _____ Abuser's Relationship _____

FOR INTERNAL USE

Name(s) of advocate(s) working with survivor _____

Entry Date _____ Exit Date _____

Appendix K: Best Practices for Medical Emergency Protocols

The following information is a collection of best practice standards for medical emergencies for domestic violence programs as outlined by the Ohio Domestic Violence Network (ODVN).

ODVN supports that every program should follow universal precautions, provide staff with accessible personal protective equipment (PPE), and adhere to the following recommendations for potential drug clean-up. Annual staff training on these best practices and protocols is recommended. Many hospitals, Red Cross organizations, and 4-H Extension Offices provide presentations to outside agencies and programs on Universal Precautions and proper use of PPE equipment.

What are Universal Precautions, Blood Borne Pathogens and Personal Protective Equipment?

Universal precautions are an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV (Hepatitis B virus), and other blood-borne pathogens.

Blood Borne Pathogens are disease-causing viruses, bacteria and other microorganisms carried in the bloodstream such as HIV, HBV (Hepatitis B virus), and HCV (Hepatitis C virus). Transmission of blood-borne pathogens occurs when there is direct contact with blood or other potentially infected material. To assist in the prevention of contact with blood and other potentially infected material, all blood should be treated as if it is infectious.

Methods that reduce the chance of exposure:

- Universal precautions
- Hand washing—is the single most important technique for preventing the spread of infectious disease
- Sharps containers

Personal Protective Equipment (PPE) is defined as specialized clothing or equipment worn by an employee for protection against infectious materials.

Local health department guidance for hepatitis A investigations in jails, halfway houses, drug treatment centers, and homeless shelters

From January 1, 2018, to September 17, 2018, the Ohio Department of Health (ODH) has received over 390 reports of hepatitis A virus (HAV) infections associated with person-to-person outbreak transmission. Of the reports for which risk factors are known, more than 62% of the infected persons report drug use (injection and non-injection), and about 8% report homelessness.

Transmission

Infection is acquired by ingestion of the virus; the mode of transmission is via the fecal-oral route. Hepatitis A is spread primarily by close person-to-person contact or through contaminated food. Person-to-person transmission of HAV between persons who report drug use and/or homelessness could result from contaminated needles and other injection paraphernalia, specific sexual contact, and practices, or generally poor sanitary conditions. Infected persons shed virus in their stool from approximately two weeks before the onset of symptoms through the 10th day after onset. If a case of hepatitis A is identified in jail, halfway house, drug treatment center, or a homeless shelter, local health departments should conduct a contact investigation, offer post-exposure prophylaxis (PEP) as necessary, and provide education about infection control to personnel at the facility in order to prevent transmission.

Conducting A Contact Investigation

1. Determine the infectious period. In order to determine the infectious period for the index HAV case, calculate the date two weeks before the onset of symptoms through the 10th day after onset. If jaundice is present, use the date of jaundice onset. If it is not present, use the date of onset of the earliest symptom.
2. Identify contacts by conducting a thorough interview with the index case. Key information during the two to six-week incubation period includes the identification of the following:
 - Close contact with a person with confirmed or suspected hepatitis A
 - Injection or non-injection illicit drug use
 - Men who have sex with men
 - Current or recent incarceration
 - Experiencing homelessness
 - Travel to an area currently experiencing a hepatitis A outbreak
3. Provide close contact notification and administer appropriate post-exposure prophylaxis (PEP) to close contacts within two weeks of exposure. This may include household contacts, sexual partners, injection or non-injection illicit drug-sharing contacts, as well as persons who share living quarters with the case in the facility.

Infection Control Measures for Local Health Departments

Provide PEP to close contacts identified in the contact investigation. Hepatitis A vaccine administration recommendations and guidelines are published by the Advisory Committee on Immunization Practices (ACIP):

- [Prevention of Hepatitis A Through Active or Passive Immunization](#)
- [Update: Prevention of Hepatitis A After Exposure to Hepatitis A Virus and in International Travelers](#)

Consistent with these recommendations and guidance, in the current multistate hepatitis A virus outbreak, the following actions may be considered:

- Use of TWINRIX® for pre- and post-exposure prophylaxis
- Use of pediatric vs. adult formulations of hepatitis A vaccine
- Use of one dose of hepatitis A vaccination

Visit <https://www.cdc.gov/hepatitis/outbreaks/InterimOutbreakGuidance-HAV-VaccineAdmin.htm> for additional details on using vaccines during outbreaks. NOTE: The efficacy of IG or vaccine when administered >2 weeks after exposure has not been established.

Infection Control Measures for Facilities

Ensure appropriate control measures are implemented for HAV-infected patients:

- Follow standard precautions for the care of the infected case, including use of personal protective equipment (PPE); keeping wounds covered at all times in congregate settings; washing hands regularly after being in contact with blood, other bodily fluids, or possible contaminated objects or surfaces; following safe injection practices; and disposing of contaminated objects properly and timely.
- Infected persons should adhere to strict hand hygiene for the first two weeks of symptoms and up to one week after the onset of jaundice. They should not prepare or handle food for other people during this time. Strict hand hygiene includes routine hand washing with soap and warm water especially before preparing, handling, or eating any food; after going to the bathroom; after changing a diaper; and after caring for someone with diarrhea.
- Clean and disinfect surfaces or objects that may have been contaminated with HAV using appropriate sanitization techniques.

Sanitation

Sanitation is a valuable hepatitis A prevention strategy and includes both personal hygiene and a clean environment. Practicing good hand hygiene—including thoroughly washing hands after using the bathroom, changing diapers, and before preparing or eating food—plays an important role in preventing the spread of HAV. Jails, halfway houses, drug treatment centers, and homeless shelters can support personal hygiene by increasing the availability of soap, water, and paper towels and encouraging their use.

Know the Difference Between Cleaning, Disinfecting, and Sanitizing

Cleaning removes germs, dirt, and impurities from surfaces or objects. Cleaning works by using soap (or detergent) and water to physically remove germs from surfaces. This process does not necessarily kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

Disinfecting kills germs on surfaces or objects. Disinfecting works by using chemicals to kill germs on surfaces or objects. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection.

Sanitizing lowers the number of germs on surfaces or objects to a safe level, as judged by public health standards or requirements. This process works by either cleaning or disinfecting surfaces or objects to lower the risk of spreading infection.

Routine Cleaning and Disinfecting

It is important to match your cleaning and disinfecting activities to the types of germs you want to remove or kill. While there are no specific ODH or CDC environmental sanitation recommendations for HAV, it is at least as difficult to inactivate as norovirus. Therefore, guidelines for environmental control of norovirus can be used as a proxy for HAV. See [EPA's List of Registered Antimicrobial Products Effective Against Norovirus](#).

Clean and Disinfect Surfaces and Objects that are Touched Often

Follow your facility's standard procedures for routine cleaning and disinfecting. Typically, this means daily sanitizing surfaces and objects that are touched often, such as desks, countertops, doorknobs, computer keyboards, hands-on learning items, faucet handles, phones, and toys. Some facilities may also require daily disinfecting of these items. Standard procedures often call for disinfecting specific areas of the facility, like bathrooms.

Immediately Clean Surfaces and Objects that are Visibly Soiled

If surfaces or objects are soiled with body fluids or blood, use gloves, and other standard precautions to avoid contacting the fluid. Remove the spill, and then clean and disinfect the surface.

Clean and Disinfect Correctly

Always follow label directions on cleaning products and disinfectants. Wash surfaces with a general household cleaner to remove germs. Rinse with water and follow with an EPA-registered product. Read the label to make sure it states that EPA has approved the product for effectiveness against norovirus, which is a proxy for HAV.

If a surface is not visibly dirty, you can clean it with an EPA-registered product that both cleans (removes germs) and disinfects (kills germs) instead. Be sure to read the label directions carefully, as there may be a separate procedure for using the product as a cleaner or as a disinfectant. Disinfection usually requires the product to remain on the surface for a certain amount of time (e.g., letting it stand for 3 to 5 minutes).

Use disinfecting wipes on electronic items that are touched often, such as phones and computers. Pay close attention to the directions for using disinfecting wipes. It may be necessary to use more than one wipe to keep the surface wet for the stated length of contact time. Gloves may also be required. Make sure that the electronics can withstand the use of liquids for cleaning and disinfecting.

CDC has a [Shelter Assessment Tool](#) to assist shelters in rapid assessment of shelter conditions. In addition to homeless shelters, it can also be used for jails, drug treatment centers, and halfway houses. It covers 14 general areas of environmental health, ranging from basic food safety and water quality to sanitation. The tool can be modified to meet local needs and has been used to assess tent cities.

Recommendations for Personal Protective Equipment (PPE)

The following items are considered essential to make available for all staff working in domestic violence programs:

Gloves

- Nitrile gloves to protect hands when coming into contact with any blood, fluids, or unknown substances. Nitrile gloves are recommended as they provide additional protection. Certain drugs (such as opioids & fentanyl) can be absorbed through latex gloves. An example of these types of gloves can be found [here](#).

Eye Protection

- Safety glasses or goggles should be made available to all staff as part of routine PPE. An example of safety goggles can be found [here](#).

Facial Mask

- A disposable mask (recommended N-95) to prevent any potential inhalation of a substance that can become airborne. The N-95 style mask can mold and form to the face. An example of this type of mask can be found [here](#).

The following items are optional:

Gown

- Disposable gowns are optional to provide as PPE. For blood, other potentially infectious materials, and drug clean-up, you may want to consider providing staff with disposable gowns. An example of this type of disposable gown can be found [here](#).
- Long sleeves

Additional information on personal protective equipment from OSHA can be found [here](#).

Additional information on blood-borne pathogens from OSHA can be found [here](#).

Recommendations for Vomit and Diarrhea Clean-Up

First Steps

- Segregate the area. It is recommended that all surfaces within a 25-foot radius of the vomit or diarrhea accident be segregated and properly cleaned and disinfected.
- Block entry to the contaminated area.
- Wash equipment within a 25-foot radius.

Clean Up

- Remove vomit or diarrhea right away
 - Wear disposable gloves during cleaning. To help prevent the spread of disease, it is recommended that a disposable mask and/or cover gown (apron) be worn when cleaning liquid matter.
 - Wipe up vomit or diarrhea with paper towels—place the paper towels over the waste then carefully remove the towels and their contents—do not vacuum the material!
 - Work from the clean areas to the most contaminated areas to minimize the spread of infectious material.
 - Use kitty litter, baking soda, or other absorbent material on carpets and upholstery to absorb liquid.
 - Dispose of paper towels/cleaning clothes and waste in a plastic trash bag or biohazard bag.
 - Use soapy water to wash surfaces that contacted the vomit or diarrhea and all nearby surfaces, such as door knobs and toilet handles.
 - Rinse thoroughly with plain water and wipe dry with paper towels.
 - Clean and disinfect any non-disposable tools (mop heads) used.
 - Place disposable protective clothing, rags, and towels in a sealed garbage bag. Seal and place in the disposal area.
 - Remove all clothing or fabrics that may be contaminated. Machine wash and dry with detergent and hot water on the longest cycle and high heat setting.

Disinfect Surfaces by Applying a Chlorine Bleach Solution

Steam cleaning may be preferable for carpets and upholstery. Chlorine bleach could permanently stain these. Mixing directions are based on EPA-registered bleach product directions to be effective against norovirus.

- Prepare a chlorine bleach solution (CDC & EPA recommendations):
 - $\frac{3}{4}$ cup of concentrated bleach + 1 gallon water (concentration ~3500ppm) OR
 - 1 cup of regular strength bleach + 1-gallon water
- Use a spray bottle and saturate the area and surfaces (25-foot radius).
- Apply the disinfectant or bleach solution and allow it to remain wet in the affected area for at least 10 minutes. Allow to air dry. Dispose of any remaining disinfection solution once the accident has been cleaned up.
- Rinse all surfaces intended for food or mouth contact with plain water before use.

Wash Your Hands Thoroughly with Soap and Water

- Hand sanitizers may not be effective against norovirus

In The Case of Any Emergency

- In the case of any emergency ***dial 9-1-1 or designate someone to dial 9-1-1***
- If your program/staff members are CPR certified and the emergency calls for CPR, please administer accordingly and in line with your program protocol

In The Case of Suspected Opioid Overdose:

If a staff member identifies or suspects that a person might be experiencing an Opioid overdose, please follow the following steps to provide assistance:

- ***Dial 9-1-1 or designate someone to dial 9-1-1***
- Check for vital signs
- Lower the victim to the floor
- Activate any internal procedures for medical emergencies if such procedures are established by your program or organization

- Administer Naloxone as directed through training and as described below

EMS Arrival

- All personnel authorized to administer naloxone must summon emergency services (9-1-1) as soon as possible in any suspected overdose situation.
- EMS must be called if naloxone is administered, even if the client wakes up and appears coherent.
- The person who found the client unresponsive and administered the naloxone shall give an accounting of events verbally to EMS once they EMS is on-scene*
 - ****It is imperative that while providing information that confidentiality protections as outlined by VAWA, VOCA, and FVPSA funding be strictly adhered to***

Administration of Naloxone

(Naloxone should only be administered if you have been trained on how to safely and effectively utilize it)

- Use EXTREME CAUTION when touching potential overdose victims because of the danger of being exposed to drug residue on the victim's body, bodily fluids, or drug paraphernalia;
- Responders should wear personal protective gear (glasses, gloves, face mask) at all times if possible when caring for potential overdose victims;
- Remove the naloxone nasal spray from the box and peel back the tab with the circle on the dispenser;
- Hold the naloxone nasal spray with your thumb on the bottom of the plunger, and your first and middle fingers on either side of the nozzle;
 - Do **NOT** prime the applicator;
- Gently tilt the person's head back and provide support under the neck with your hand;
- Insert the tip of the nozzle into one nostril until your fingers are on either side of the nozzle, against the bottom of the person's nose;
- Press the plunger firmly to administer the dose of naloxone nasal spray;
- Remove the naloxone nasal spray from the nostril after giving the dose;
- Observe the victim closely. Continue basic life support if necessary. If the victim responds to the naloxone with breathing or arousal, move the person onto his or her side (recovery position);
- If the person does not respond to the naloxone with breathing or arousal, repeat the dose every 2- 3 minutes
- After administering naloxone, initiate CPR if the victim is not breathing or has no pulse;
- Await EMS arrival; and
- Notify the immediate supervisor of the event as soon as possible.

Potential Client Response After Receiving Naloxone

- Clients who receive naloxone typically become responsive; they may become combative and agitated. Reassure the client and explain the care rendered.
- Protect all clients, staff (including you), and victim(s) from harm. Move an arm's length away from victims who are thrashing about, but stay with the victim until EMS arrives.
- If the client wakes up and refuses care by EMS, do your best to convince the client to remain where he/she is until EMS arrives and can assess the client.

Signs and Symptoms of Opiate Overdose

- Unresponsiveness to verbal stimuli or sternal rub;
- Pinpoint pupils
- Slow, shallow, or no breathing;
- Turning pale, blue, or gray (especially lips and fingernails);
- Snoring/gurgling/choking sounds;

- Body very limp; and
- Evidence of drug use/and or drug paraphernalia around or on the client (i.e. track marks, syringe)

Naloxone administration is indicated when a person is exhibiting signs and symptoms of an opiate overdose. This reversal drug is used for the following OPIATES:

- Buprenorphine (Subutex or Suboxone)
- Codeine
- Demerol
- Dilaudid
- Fentanyl
- Heroin
- Hydrocodone (OxyContin, Percocet, Percodan)
- Morphine
- Oxycodone
- Tramadol
- Vicodin

Naloxone Precautions

- In the event of a potentially fatal drug overdose, Naloxone may be given to a pregnant woman
- Naloxone may be transmitted to infants via breast milk in nursing mothers

Potential Adverse Reactions to Naloxone

- Administration of naloxone may precipitate opioid withdrawal symptoms in the person experiencing the overdose.
- Withdrawal symptoms may include fever, high blood pressure, fast heart rate, agitation, restlessness, diarrhea, nausea, vomiting, muscle pain, sweating, abdominal cramping, yawning, and sneezing.
- These symptoms may appear within minutes of naloxone administration and subside hours later.
- The severity and duration of the withdrawal syndrome are related to the dose of naloxone and the degree of opioid dependence.
- Adverse effects of administering naloxone beyond opioid withdrawal are extremely rare.
- If a person is experiencing a potentially fatal drug overdose, administer the naloxone even if it may precipitate withdrawal symptoms.

Naloxone Information

- 3 micrograms are a lethal dose of carfentanil
- Opiate overdose affects the part of the brain that controls breathing
- Naloxone must be kept at room temperature 59-77 degrees. Exposure to extreme temperatures can ruin the integrity of the medication. Keep out of direct sunlight, do not store in vehicles
- Naloxone has an 18-24-month shelf life and expires at the end of the dated month on the package
- Naloxone only works on opiates, not other drugs. Naloxone is not harmful if opiates are NOT present.
- Signs of Opiate Withdrawal:
 - Muscle aches
 - Excessive sweating
 - Anxiety
 - Agitation
 - Insomnia
 - Tearing eyes
 - Runny nose

- Rapid pulse
- Seizures
- Combative behaviors
- Signs of overdose:
 - Slow & shallow breathing or not breathing
 - Tiny pinpoint pupil—3 mm in diameter
 - Cool, sticky skin, pale
 - Lips, nails blue in color
 - Sounds of choking, loud snoring, or gurgling
 - No response to name, shaking
 - Weak, no pulse—do a sternal rub
- Safety is primary—be aware of surroundings:
 - Bodily substances—use gloves, mask
 - Protect against Hepatitis B & C, HIV
 - Blood, vomit, saliva, urine, and feces may be present—use universal precautions
 - There may be powder on the body—carry gloves, use a barrier mask
- Re: Needles:
 - NEVER try to recap a needle
 - Let EMS dispose of it properly
 - Prevent needle sticking, put in a sharps container
- Physical safety: you may be—
 - Alone in shelter
 - On the ground (if the victim is on the floor or fallen)
 - In close quarters (in a small bathroom, bedroom, closet)
 - Have a loss of tactical advantage if on the ground or in close quarters
 - Reactions of people coming out of Naloxone revival vary—reactions are unpredictable, and people DO NOT react the same
 - Staff should have intense situational awareness at all times
 - Be sure to position oneself closer to the door
- Call 911
 - Brain damage starts within 4 minutes—chances of survival decrease after that time frame
 - Call for emergency medical services immediately
 - ****Do not wait for EMS to arrive before giving Narcan**** Dispatchers can help through the process by helping to provide calm, and walking staff through the process as they would with CPR
 - If nothing happens within 2-3 minutes of administering Naloxone, try again, it may take several attempts
 - Naloxone can wear off in 30-90 minutes—be aware and get emergency assistance as quickly as possible
- Signs of Improvement:
 - Normal or returned breathing
 - Circulation
 - Pulse present and normal
 - Consciousness and alertness
 - Skin tone improving—nails, lips, lose bluish color
 - Lay the person in the recovery position:
 - Lying on side
 - Mouth facing down
 - Head resting on the arm
 - Leg outstretched

- If Naloxone Doesn't Work: (Naloxone lasts 30-90 minutes, extra doses may be required)
 - Seek professional medical assistance—call 911 immediately
 - Consider rescue breathing/CPR
 - Rescue breathing:
 - No normal breathing but the pulse is present
 - 2 full breaths (use a barrier device such as a pocket mask)
 - tilt head back
 - pinch nose
 - look at the chest to see if it's rising
 - 1 breath every 5-6 seconds
 - check pulse every 2 minutes
 - Ensure 911 has been called
 - If no pulse, begin CPR (if you have been trained)
- CPR—Begin CPR (if you have been trained) if the victim has no pulse
 - 30 compressions: 2 breaths
 - Option to do hands-only CPR if barrier device is not available
 - Rate of 100-120 compressions per minute
 - Use an AED if available and if you've been trained
- ***Regardless of response time to a program or facility, staff and programs should be trained in the administration of Naloxone. Emergency personnel may be engaged elsewhere and may take longer to respond. After 4 minutes, the chances of survival decrease.***

Ohio Laws Regarding Naloxone

Ohio Revised Code 4729.44

Dispensing of Naloxone: the law allows you to enter a pharmacy and get naloxone without a prescription. The pharmacist does not need you to give them a prescription for Naloxone.

Ohio Revised Code 2925.61

Lawful Administration of Naloxone: the law protects you from criminal liability if you give Naloxone in good faith to someone who you believe is experiencing an opiate overdose. You will not be held criminally accountable for administering Naloxone to someone experiencing an opiate overdose but there is no protection for civil liability.

Ohio Revised Code 2925.11

911 Good Samaritan: the law helps to protect the person who calls 911 and the person who is overdosing. Often people are afraid to dial 911 for help because they fear having the police arrive, thinking they will get in trouble. This law helps alleviate those concerns. As long as the victim seeks a referral for treatment within 30 days of the incident, they will not be held accountable for minor drug or paraphernalia possession.

*****Please be advised that in some jurisdictions there have been prosecutions for felony-murder in drug overdose cases in spite of the Good Samaritan laws. Please know the practices in your county and work closely with local attorneys (Prosecutors and Defense) to know how these cases are processed in your area.***

Narcan Now App

(Narcan is the brand name for Naloxone)

- Free up-to-date product and safety information for Narcan nasal spray
- Usage guide
- Pharmacy Locator
- Training videos

Becoming a Naloxone Service Entity

Programs already trained on Naloxone and those who have it on site should strongly consider implementing the service entity protocol. It is a liability protection for the agency and is an easy process to complete. For those programs not trained, becoming a service entity after training is highly recommended.

Pursuant to section 4729.514 of the Ohio Revised Code, agencies that become a service entity through this protocol are not liable for, or subject to, any of the following injury, death, or loss to a person or property that allegedly arises from the use of Naloxone.

A link to further explain the purpose of the service entity protocol can be found [here](#).

A link to the service entity protocol template can be found [here](#).

The following information is taken from the Centers for Disease Control and Prevention: The National Institute for Occupational Safety & Health (NIOSH). Detailed information can be found [here](#).

Fentanyl: Preventing Occupational Exposure to Emergency Responders

- Potential exposure routes of greatest concern include inhalation, mucous membrane contact, ingesting, and needle stick.
- These exposures can result in a variety of symptoms that can include rapid onset of life-threatening respiratory depression. ***Skin contact is also a potential exposure route but is NOT likely to lead to overdose unless large volumes of highly concentrated powder are encountered over an extended period of time.***
- Brief skin contact with fentanyl and its analogs is not expected to lead to toxic effects if any visible contamination is promptly removed.

Please click [here](#) for more detailed information on Fentanyl from the Office of Homeland Security. Learn the myths and facts to become fully informed.

Standard Safe Operating Procedures

Standard safe work practices must be followed when fentanyl or its analogs are known or suspected to be present. Responders should follow established work practices as well as these recommendations when fentanyl or its analogs are known or suspected to be present:

- Do not eat, drink, smoke, or use the bathroom while working in an area with known or suspected fentanyl.
- Do not touch the eyes, mouth, or nose after touching any surface potentially contaminated with fentanyl.
- Never handle fentanyl or its analogs without the appropriate personal protective equipment (PPE)
- Avoid performing tasks or operations that may aerosolize fentanyl due to increased exposure risks. Activities that aerosolize fentanyl require higher levels of PPE and should be conducted by appropriately trained personnel and in accordance with agency policies and procedures.
- Wash hands with soap and water immediately after a potential exposure and after leaving a scene where fentanyl is known or suspected to be present to avoid potential exposure and to avoid cross-contamination. ***Do not use hand sanitizers or bleach solutions to clean contaminated skin.***

A resource for Managing Pharmaceutical Hazardous Waste can be found [here](#).

Recommendations for Drug Clean-Up

If drug clean-up is required after a suspected overdose, or found in a shelter, please adhere to the following process for safely cleaning the affected area:

- Close off the area from other shelter residents and children
- Contact supervisor to report the incident and follow instructions per program policy
- Before any clean-up begins, staff members should apply the following Personal Protective Equipment (PPE):
 - Nitrile gloves
 - Safety glasses
 - N-95 facial mask
 - Disposable gown
- Close vents, turn off ceiling fans, and close any windows to limit drafts that may potentially cause substances to become airborne.
- Clean any affected areas where the substance may have had contact with soap and water. Do not use any other chemicals unless instructed to do so to avoid any potentially hazardous reactions. Do not use hand sanitizers or bleach solutions to clean surface areas or wash hands.
- Bag any client property that may have been affected.
- Clean room or area completely
- Dispose of any material per program policy
- As you develop your policy, work closely with local EMS, fire, and police departments
- Document incident and clean up per program policy and protocol

Recommendations for Drug Disposal

It is not recommended that you dispose of any drugs or unknown substances found in the shelter without contacting proper authorities for further instruction. Many communities have anonymous drug disposal programs, turn-in or drop-off programs, or a “no questions asked” policy if local law enforcement responds to requests for disposal.

It is important to keep in mind the confidentiality of residents when requesting assistance in the shelter for drug disposal. Recommendations for safely disposing of drugs include the following:

- Find out in advance what types of drug turn-in, drop off or disposal programs exist in your community and make sure that staff are well informed of the steps to take to dispose of the drugs while maintaining the confidentiality of residents and children
- If no programs exist in your community for drug turn-in or disposal, please form an agreement or MOU with local law enforcement that would permit the shelter program to report drugs that need to be disposed of in the shelter without compromising the confidentiality of all shelter residents and children and without any negative consequences to survivors who may possess the drugs.
- It is recommended that these policies are drafted before they are needed.

Possible Drug Disposal Options

- In some communities, drug disposal bags may be provided free of charge by ADAMH boards. Check with your local board to see if these are available.
- Deterra Bags can dissolve up to 45 pills or 6 ounces of liquid or 6 patches. *Deterra Bags are intended for disposal of prescription and controlled medications and are not intended for other drug disposal uses.
- Other methods of drug disposal for medications include mixing medications with substances such as dirt, kitty litter, or used coffee grounds. Place the mixture in a sealed plastic bag and dispose of it in the trash.

Because each community differs with available programming regarding drug disposal options, it is not possible to designate a universal process for drug disposal. However, we do ask that you consider the above recommendations, work with local programs in your area and implement your own policies. Make sure staff are well informed and trained on all procedures.

Recommendations for Reporting a Death in Shelter

When working in 24-hour residential services, the possibility exists that a resident may die in the shelter due to health conditions, age, overdose, suicide, or natural causes. In the event of a death in the shelter, please adhere to the following process for reporting:

- Contact 9-1-1 immediately or designate someone to dial 9-1-1
- Close the area off from other residents and children
- Contact your supervisor immediately and follow instructions per program policies
- If the emergency responders do not provide protocols or recommendations on clean-up of the area, please consider contacting a professional cleaning company to return the room to working order if bodily fluids are present
- If your program is not able to hire a professional cleaning company, please contact your local health department, coroner, or hospital for proper clean-up procedures and adhere to the Universal Precautions and PPE protocols listed throughout this document
- Provide shelter residents and children the opportunity to meet with a crisis or grief counselor to process the crisis which may trigger past traumas for some residents and/or children
- Executive staff should create a policy that outlines the procedures for media inquiries that may be made due to a resulting death or overdose in the shelter.

The suggestions and/or recommendations contained in the document are meant to be guiding practices for the development of policies and procedures. All programs should work closely with a local attorney that provides legal assistance for your program to develop and review policies and procedures related to this subject matter.

Responding to Rare or Emergency Situations

Considering Confidentiality in Domestic Violence & Sexual Assault Programs

We know that a wide variety of emergencies occur for domestic violence, sexual assault, and stalking programs that are often unanticipated. Given that emergencies can arise at any time, programs need to develop policies around these issues to provide safety for survivors and protect their confidentiality. Medical and other emergencies can present particularly difficult issues with confidentiality for survivors and programs.

Important Points to Remember About Confidentiality

- Programs and agencies have legal obligations to protect a survivor's personally identifiable information. Survivors have the right to choose what, when, and how their information will be shared and with whom. Programs have a responsibility to safeguard any survivor information they collect and hold.
- Releases of information should be time-limited, informed, written, and signed. Only the information specified in the release by the survivor should be shared.
- When mandated to disclose or release information about a survivor by state, territorial, tribal law, or court order, only minimum & necessary information may be shared to meet the statutory or court mandate. Programs and agencies must take all possible steps to notify the survivor of disclosure.
- If programs are unsure how the law applies to particular circumstances, consult a local attorney or expert is recommended. Some circumstances may require localized legal advice.

Responding to Medical and Emergency Situations

Protecting survivor confidentiality is essential when responding to special circumstances such as medical emergencies. A survivor's personally identifying information can still be protected even when requesting medical emergency services by following some of the recommendations below:

- Programs can request emergency services for survivors and only allow necessary responders into the program or area with the survivor. Programs are not required to provide personally identifying information to medical or law enforcement responders.
- Emergency operators can be provided enough information to respond, such as the location of shelter and general nature of the emergency, without the program revealing a survivor's personally identifying information. (Ex. A woman is experiencing chest pains, or an abuser is attempting to enter the shelter putting a resident at risk)
- Conscious survivors can choose what information they will or won't share with emergency responders upon arrival. Choosing not to share information is the survivor's choice and it is not a right or obligation to fill in the blanks for emergency responders.
- If a survivor is unconscious, confidentiality between the program and survivor is not negated. Unless there is a written, informed, time-limited release of information signed, a program should only report factual information leading to the emergency call without revealing personally identifying information about the survivor. (Ex. A resident came into the office complaining of dizziness and passed out) Emergency responders and medical personnel routinely assist unresponsive patients without being able to acquire detailed information.
- If an abuser attempts to enter the property or program, police can be informed without revealing the survivor's personally identifying information. Programs do not need to disclose whether or not the survivor was ever served by the program.
- Once an emergency has been resolved, responders may want further details and information. A written, informed, time-limited release must be signed or a program cannot provide personally-identifying information to medical personnel or law enforcement.

Appendix O: STOP VAWA Statement of Acknowledgement

As a condition to receive your STOP Violence Against Women Act (VAWA) award, **the Implementing Agency** is required to submit a signed statement acknowledging that activities will not be carried out that compromise victim safety and recovery:

The following activities have been found to jeopardize victim safety, deter or prevent physical or emotional healing for victims, or allow offenders to escape responsibility for their actions and cannot be supported with STOP Violence Against Women Formula Grant Program funding:

- Procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children;
- Offering perpetrators the option of entering pre-trial diversion programs;
- Requiring mediation or counseling for couples as a systemic response to domestic violence or sexual assault, or in situations in which child sexual abuse is alleged;
- Requiring victims to report sexual assault, stalking, or domestic violence crimes to law enforcement or forcing victims to participate in criminal proceedings;
- Relying on court-mandated batterer intervention programs that do not use the coercive power of the criminal justice system to hold batterers accountable for their behavior;
- Supporting policies that deny individuals access to services based on their relationship to the perpetrator;
- Supporting policies or engaging in practices that impose restrictive conditions to be met by the victim in order to receive services (e.g., attending counseling, seeking an order of protection);
- Sharing confidential victim information with outside organizations and/or individuals without the documented consent of the victim;
- Placing of batterers in anger management programs; or,
- Procedures that would penalize or impose sanctions on victims of domestic violence or sexual assault for failure to testify against the abuser and/or the perpetrator.

In addition, applicants should be cognizant of victim confidentiality. In accordance with 42 U.S.C. § 13925(b) (2), applicants receiving OVW funding, and their subgrantees, must protect the confidentiality and privacy of persons receiving OVW-funded services to support victims' safety. OVW grantees and their subgrantees are prohibited from disclosing personally identifying information collected in connection with services requested, utilized, or denied through the grantee and their subgrantee's programs, to any third party or third party database without informed, written, reasonably time-limited, consent of the person, unless compelled by statutory or court mandate. In this case, grantees and subgrantees must make reasonable attempts to provide notice to victims affected by the disclosure of information. They must also take necessary steps to protect the privacy and safety of the persons affected by the release of the information. Regarding unemancipated minors or persons with disabilities lacking capacity to consent, a parent or guardian may consent to the disclosure; however, if the parent or guardian is the abuser of the minor, the person with disabilities, or the minor's other parent, he or she is prohibited from giving consent to the disclosure.

Project Director, Implementing Agency

Date

Project Title

Date

Appendix P: Survivor Background Checks

Prohibition Regarding Survivor Background Checks A Promising Practices Approach to Service Delivery

Background checks to determine program or service eligibility of any kind are strictly prohibited, according to two important domestic violence funding sources. Programs engaging in background checks as a condition of services, or once a survivor is engaged with services, may risk losing their FVPSA and/or VAWA funding. Background checks include, but are not limited to: criminal, civil, public record searches (Courtview, Public Access, etc) and social media.

Survivor autonomy, safety, privacy and confidentiality are foundational to the domestic violence movement. Survivor-centered, trauma-informed programs commit to providing and protecting the safety, privacy and confidentiality of every survivor seeking services. FVPSA and VAWA rules and regulations prohibit the use of any information obtained through any type of background check to determine whether or how to provide services. This information negatively impacts service delivery among staff and creates mistrust of survivors when discovered.

As a condition of receiving a STOP Violence Against Women Act (VAWA) award, grantees are required to submit a signed statement acknowledging that activities including conducting criminal record checks will not be carried out that compromise victim safety and recovery¹.

FVPSA regulations also address this issue²:

*Programs cannot impose conditions for admission to shelter by applying inappropriate screening mechanisms, such as **criminal background checks**, sobriety requirements, requirements to obtain specific legal remedies, or mental health or substance use disorder screenings.*

In conclusion, programs must implement the promising practice of prohibiting background checks of any kind by all staff in order to comply with FVPSA and/or VAWA funding requirements. This includes the prohibition of any condition being applied to receive services as well as prohibiting any inappropriate screening or background check once a survivor has entered shelter or program services.

¹ https://www.ocjs.ohio.gov/STOP_VAWAstatement.doc

² 45 CFR § 1370.10(b)(10)

Appendix Q: Response Guidance for Warrants

Response Guidance for Warrants, Subpoenas, Missing Person Requests, Exigent Circumstances and Child Protective Services

Situation	Must We Violate Confidentiality?	What Law Governs This?	What Other Steps Should We Take?
Police at door about missing person report	No	VAWA, VOCA, HPPA, licensure statutes	We can suggest that if we know where the survivor is, we will ask them to call the officer.
Police at door with active arrest warrant	Yes	Obstruction of official business, ORC 2921.31	We can suggest that if we know where a survivor is, we will have the survivor turn themselves in. Contact Program Director to inform and seek guidance.
Police at door with search warrant	Yes	Obstruction of official business, ORC 2921.31	Before entering, see if law enforcement will allow you to contact your program director so that they can communicate with the officer before executing the warrant. If not, contact Program Director immediately.
Police at door about what they consider an “exigent emergency” or “exigent circumstance”	Probably yes, but maybe not always	Obstruction of official business, ORC 2921.31	Get the police to define the emergency and only provide entry if there is a real emergency. Contact Program Director for guidance.
Police at door about a report by a shelter resident of a crime	No	VAWA, VOCA, HPPA, licensure statutes	Encourage report to be made at police station. If police are called to shelter without staff knowledge, encourage the report be given outside.
CPS at door to investigate an emergency safety issue about a child	Yes		If we can address the safety issue, see if CPS agrees we can do so. If not, have families report to their rooms and allow CPS worker to only interact with family involved in emergency
CPS at door to visit a family to start or continue an investigation	No	VAWA, VOCA, HPPA, licensure statutes	Ask that arrangements be made to meet at a safe location for the family offsite.

Appendix S: Responding to Subpoenas and Warrants

I. Review record-keeping procedures

These procedures should be differentiated for:

- People
- Warrants (search, arrest, and/or bench warrants)
- Staff vs Residents

Ask yourself these questions:

- Is the information kept in the records factual?
- Have you done everything you can to comply with the confidentiality requirements of VAWA, VOCA, and FVPSA?
- Do other state and federal laws apply to you?
- What do other laws require?
- Which staff have confidentiality privileges by statute?

After you have answered these questions:

- Determine how and where files are kept
- Determine who has access to the files
- Determine your record retention policy
- Determine when & how you will release information.
- Revise record-keeping policy & review all relevant forms
- Train staff/volunteers/interns on updated policies and forms
- Inform program participants about the newly revised policies

II. Designate a custodian of records who shall:

- Maintain control over the records
- If necessary, bring the records to court
- Ensure conformity in procedures
- Keep track of number and types of subpoenas served
- Follow the agency procedures when responding to a subpoena
- Include in your procedures that:
 - If there is an administrative office separate from the shelter, the custodian should be at the administrative office
- Only the custodian or person named on document can accept subpoenas and warrants

III. Develop a relationship with an attorney who:

- Advises the program on its potential liability
- Is committed to the policy of the program & understands domestic violence issues
- Is aware of the program's legal obligations under federal and state confidentiality laws
- Is willing to file a Motion to Quash on behalf of the organization

IV. Inform and train staff, volunteers, interns and board members about all policies and procedures.

- Clearly communicate policies, procedures, practices and expectations
- Tell staff that only authorized persons can accept subpoenas and ensure that everyone knows who that identified person is
- Ensure that staff who may be the first point of contact for a subpoena are well trained and know the protocol for follow up after being contacted

V. Proceed on a case-by-case basis for each subpoena

- Never reveal information to anyone who is serving the subpoena
- Do not answer any questions from the process server

VI. Examine and develop procedures

- Review existing record-keeping procedures
- Require all volunteers, board members, student interns and staff workers to sign confidentiality agreements with the program
- Consider changing record-keeping procedures so that no confidential information is kept in the program participant files
- Assess the impact that the disclosure of records will have in court
- Be sure to follow confidentiality requirements of VOCA, VAWA and FVPSA as well as appropriate releases of information
- Have the attorney (both one working for the agency and the program participant's attorney, if applicable) explain to the program participant the effect of records release
- Ensure that workers or volunteers who receive a subpoena contact the Program Director immediately
- Remember that a subpoena, even one signed by a judge, does not require the automatic release of files or other information. Follow the established agency process when responding to a subpoena.

VII. Take the appropriate legal actions

1. The attorney working with the agency should:
 - File a motion to quash the subpoena when it is determined that the records or testimony sought should not or cannot be released
 - Object to procedural defects with documents—e.g., incomplete, overly broad, unclear, improperly served
 - Insist that the information sought is privileged or confidential
 - Learn why the records are sought and for what purpose
 - Present testimony information on the critical importance of confidentiality and safety to victims
 - Use litigation to educate the judge on purpose of the program and why confidentiality is so essential
2. If the motion to quash is unsuccessful:
 - Ask the Judge for an in camera review
 - File a motion for a protective order for the records
 - Argue for partial protection for the records or scope of questions
 - If both motions are unsuccessful, appeal with other organizations joining by amicus curiae.

VIII. If someone must testify:

- Consult an attorney immediately
- Prepare for questions most likely to be asked
- Listen carefully to the language of the questions
- Pause before answering—to allow for an objection by your attorney
- Limit your answer to what was asked
- Bring copies of policies and records to court
- Tell the truth
- Do not volunteer information
- Do not show anger

This material was adapted from the model confidentiality policy drafted by the Pennsylvania Coalition Against Domestic Violence (Barbara J. Hart, Staff Counsel) in December 1992, contained in the Appendix of "Confidentiality for Domestic Violence Service Providers In Arizona Under Federal and State Law," Arizona Coalition Against Domestic Violence, June 2001, p. 38-40 and contained in the Appendix of "Model Protocol on Record Keeping when working with Battered Women, Washington State Coalition Against Domestic Violence, 2007.