Working Together

Domestic Violence Advocates Co-Located at DHS Offices

POLICIES & PRACTICES RESOURCE GUIDE

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introduction

TOPICS

- Definitions of domestic violence
- How to use this resource guide
- Co-located DV advocates
- History of the program
- Co-located DV advocate services
  - Crisis intervention
  - Ongoing advocacy services
  - Meetings or interviews
  - Case staffing/consultation
- Empowerment

GOAL

The goal of co-locating Domestic Violence (DV) advocates at Oregon Department of Human Services (DHS) Self-Sufficiency and Child Welfare Offices is to support DV survivors and their children with safety planning, domestic violence education, advocacy and on-going support to encourage safety, self-sufficiency, family stability, health and well-being.

OBJECTIVES

- Define Domestic Violence and Intimate Partner Violence
- Understand how to use this resource guide and each of its sections as a separate module
- Describe the co-located DV Advocacy Program and the services that co-located DV advocates offer
- Describe empowerment

Definitions of Domestic Violence

Domestic violence (DV) includes physical, social, or emotional abuse perpetrated against another person. It often includes the use of coercion and fear tactics. The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) defines domestic violence as:

> "A pattern of **coercive** tactics that can include **physical, psychological, sexual, economic, and emotional abuse**, perpetrated by one person against an intimate partner, with the goal of establishing and maintaining power and control. Domestic violence occurs in all kinds of intimate relationships, including married couples, people who are dating, couples who live together, people with children in common, same-sex partners, people who were formerly in a relationship with the person abusing them and teen dating relationships."[1, 2]

The Oregon DHS Self-Sufficiency program uses the following statutory definition in their Temporary Assistance for Domestic Survivors (TA-DVS) program:

> "Domestic Violence" means the occurrence of one or more of the following acts between family members, intimate partners, or household members:
>
> - Attempting to cause or intentionally, knowingly or recklessly causing physical injury or emotional, mental or verbal abuse
> - Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury
> - Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427
> - Using coercive or controlling behavior
>
> "family members" and "household members" mean any of the following:
>
> - Spouse
> - Former spouse
> - Individuals related by blood, marriage (see section (42) of this rule), or adoption
> - Individuals who are cohabitating or have cohabited with each other
> - Individuals who have been involved in a sexually intimate or dating relationship
> - Unmarried parents of a child[3]

The Oregon Child Welfare definition of Domestic Violence is:

> "A pattern of coercive behavior, which can include physical, sexual, economic, and emotional abuse, which an individual uses against a past or current intimate partner to gain power and control in a relationship."

1 This definition was retrieved from https://www.ocadsv.org/resources/browse/253
2 This definition was retrieved from https://apps.state.or.us/Forms/Served/ce9200.pdf
3 This definition was retrieved from https://apps.state.or.us/cf1/caf/arm/A/461-001-0000.htm

Intimate partner violence, a type of domestic violence is differentiated as:

> "Forms of physical injury/abuse, sexual abuse or assault, intimidation, verbal abuse and emotional abuse or threats of such committed by a spouse, ex-spouse, boyfriend/girlfriend, ex-boyfriend/girlfriend, or date."[4]

The CDC similarly defines IPV as:

> "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner."[5]

The following concepts were derived from these definitions and have been integrated into most Oregon statutes, rules, definitions and practices:

- Use of coercive or controlling behavior
- Attempt to cause physical injury or emotional, mental or verbal abuse
- Intent to place another person in fear of imminent serious physical injury
- Sexual abuse of any degree, as defined in ORS 163.415, 163.425 and 163.427

Domestic violence and intimate partner violence cross all cultures, faiths, classes, and sexual orientations. Beliefs and values influence individual, community, and cultural practices around respect, safety, and abuse. The controlling tactics batterers use are often reinforced by societal and cultural stereotypes and institutions that tend to give more status and power to members of dominant groups.

For example, some cultural norms stress the importance of women staying in a relationship regardless of the consequences. It is important to understand how these social and cultural beliefs affect the perception of and reaction to domestic violence and the people seeking help to get out of domestic violence.

Research on domestic violence often uses the terms survivor and victim interchangeably. The language used throughout this resource strives to be strengths-based, so unless quoting a source directly, this document will use the term survivor.

How to Use this Resource Guide

This resource guide provides guidance and resources for fostering effective collaborations between DV organizations and DHS Child Welfare and Self-Sufficiency offices in order to support the co-located DV Advocate Program in DHS offices.

This information includes recommendations on how to:

- Form a **DV leadership team** that includes the co-located DV advocates, management from the community- based DV organization, DHS caseworkers, DV points, DHS management, and other community partners that support and guide the **co-located DV advocacy program**

4 This definition was retrieved from http://www.oregon.gov/DHS/ABUSE/DOMESTIC/Pages/definition.aspx
5 This definition was retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html

- Create a local Memorandum of Understanding (MOU) that guides the work of the **co-located DV advocacy program**
- Ensure that the **DV leadership team** meets regularly
- Affirm the value of co-locating DV advocates in DHS offices
- Distinguish the roles of **co-located DV advocates** from **DHS caseworkers**
- Understand and appropriately implement the confidentiality laws and regulations that co-located DV advocates and DHS caseworkers are bound by
- Respond appropriately to the cultural and linguistic needs of **DV survivors**
- Promote program models and best practices for **community based DV organizations** and **DHS agencies** that support **DV survivors** and their children
- Agree on practices and procedures for supporting and supervising **co-located DV advocates**
- Increase awareness of local, state and national resources available for the **DV leadership team**

Suggestions for updates, additions and/or revisions to this resource guide may be referred to Amber Harchuk at the DHS Central Office at collocated.advocates@state.or.us. This resource guide is meant to be a living document that is updated or revised as practices, policies or laws change.

Co-located DV Advocates

Co-located DV advocates are staff from a nonprofit community-based agency, who spend part of their time working in DHS offices and part of their time working at their community-based DV organization. The co-located advocates work in partnership with DHS. These co-located DV advocates provide in-depth safety planning, emotional support, domestic violence education, advocacy, referrals, available client assistance funds, program navigation, and parenting resources for victims of domestic violence, sexual assault or stalking. DV advocates also provide training and consultation on DV-specific issues to DHS staff and their partners.

The purpose of providing these services in Child Welfare and Self-Sufficiency offices is to increase the number of cases in which children can safely remain with a non-offending parent, to remove barriers to self-sufficiency and family stability for clients impacted by DV, and to foster a closer working relationship between community-based DV organizations and DHS Child Welfare and Self-Sufficiency Offices.

Co-located DV advocates strive to provide a client-centered, trauma-informed, culturally and linguistically appropriate approach to supporting DV survivors and their children. Co-locating DV advocates in DHS offices relies on a strong collaboration between community-based DV programs and DHS Child Welfare and Self-Sufficiency programs.

As outlined by law, co-located DV advocacy services are **voluntary** for DV survivors. DV survivors cannot be penalized or receive negative consequences from any of the staff at the DHS agency or the community-based DV organization if they choose not to engage with a co-located DV advocate.

History of the Program

Co-locating DV advocates in DHS Child Welfare and Self-Sufficiency offices is recognized as a best practice nationally. Oregon has been co-locating DV advocates in DHS offices for more than a decade. Oregon successfully piloted co-located DV advocates in DHS offices, utilizing state and federal funding, including two federal grants.

Early evidence found that DHS Child Welfare staff reported that their practice had changed after working with a co-located DV advocate. They also had a greater understanding of the:

- Impact of domestic violence on children
- Barriers DV survivors must overcome to leave abusive relationships
- Use of power and control tactics by batterers[6]

DHS Child Welfare staff reported women and children were positively impacted as a result of working with a co-located DV advocate. Impacts for DV survivors included:

- Increased strategies for enhancing their children's safety
- More access and likelihood to use DHS services
- Less anxiety and a greater understanding about the DHS interventions and processes
- A better understanding of the impact of DV on their children[7]

Many local Self-Sufficiency agencies developed contracts with their local community-based DV organization to try to meet the DV needs of their clients. The Self-Sufficiency agencies found the relationships with the co-located DV advocates to be very beneficial for both their caseworkers and their clients. Benefits identified from these local contracts included:

- Improved access to safety planning and intervention services for clients
- Increased utilization of DHS services by DV survivors
- A better understanding by DHS Self-Sufficiency staff of how DV impacts a client's ability to achieve self-sufficiency
- Expanded knowledge of self-sufficiency services by DV advocates
- Increased ability of DV advocates to assist DV victims to access benefits[8]

The overall goals of co-locating DV advocates at DHS Child Welfare and Self- Sufficiency offices included:

- Better access to DV support services for survivors
- Increased likelihood of child safety and family stability and preservation for survivors and their children
- Less anxiety regarding DHS involvement with DV survivors
- Greater understanding about the DHS process by DV survivors
- Greater knowledge and comfort with DHS policies and procedures by the co-located DV advocates

6 Assessing the Impact of the Rural Domestic Violence Project: Results from a Survey of DHS and Domestic Violence Agency Staff, Anna Rockhill, PSU, & Bonnie Braeutigam, DHS.
7 Ibid.
8 Ibid.

- Increased likelihood of cross referrals between co-located DV advocates and DHS caseworkers
- Increased focus on DHS tasks, such as accountability for coercive and controlling partners and/or access to DHS benefits by DHS caseworkers
- Greater level of knowledge about barriers to leaving abusive relationships and the batterers' use of power and control tactics by DHS caseworkers
- Greater knowledge and compassion by DHS caseworkers regarding the difficulties that DV survivors face in regards to parenting
- Increased level of communication between DHS caseworkers and co-located DV advocates
- Stronger respect and understanding between DHS caseworkers and co-located DV advocates
- Greater trust between DHS caseworkers and co-located DV advocates
- Stronger collaboration between DHS caseworkers and co-located DV advocates, even when they don't always agree with one another they will respect each other's points of view[9]

Other efforts established that in Child Welfare offices that had a co-located DV advocate, there was an increase in the number of children remaining in the home of the non-offending parent. (Internal file reviews by DHS for the Greenbook project in Lane County, 2004 & 2005)

In addition, the federal government awarded Pregnancy Assistance Funds (PAF) from the Office of Adolescent Health (OAH) to the Oregon Department of Justice Crime Victims' Services Division (CVSD) to pilot co-located DV advocates for **pregnant and parenting teens** in both DHS Self-Sufficiency and DHS-Child Welfare offices. The following statements are from interviews and surveys conducted as a part of the evaluation of this pilot project.

- My co-located DV advocate gave me all the support I needed to feel that I could get away from the situation safely." –*Survivor*
- "I would have had a totally different outcome. Without a co-located DV advocate, I might have lost my children." –*Survivor*
- "I was so happy (to meet my co-located DV advocate) because I realized I wasn't alone; in a maze of bureaucracy I had found a person who understood me, whose position was made just to help me." –*Survivor*
- "Co-located DV advocates have helped allow kids to stay with mom. I can't tell you how many times we've been able to close (a case) at assessment because the mom engaged in services with the advocate." –*DHS Caseworker*
- "Co-located DV advocates engage DHS caseworkers in working with families in a different way, it's more of an engagement model, (this partnership) has shown there is a fundamentally different way to do child welfare practice." –*DHS Caseworker*

In 2010, the Oregon State Legislature recognized the benefits of co-locating DV advocates at Child Welfare and Self-Sufficiency offices and provided funding for the DHS budget to contract with local community-based DV organizations to fund co-located DV advocates in DHS offices throughout the state.

9 Ibid.

Co-Located DV Advocate Services

CRISIS INTERVENTION

Co-located DV advocates can offer crisis intervention services to DV survivors receiving services at DHS offices, including those with existing open cases and those with new cases. At the crisis intervention stage, DV services will focus on meeting emergency needs, such as immediate safety or medical care for injuries. If co-located DV advocate services are not immediately available, local community-based DV organizations have 24-hour crisis lines and the National DV Hotline, which are 1-800-799-SAFE (7233) or 1-800-787-3224 TTY, respectively.

ONGOING ADVOCACY SERVICES

Co-located DV advocates serve as DV specialists within DHS agencies, providing short term interventions and making referrals for more in-depth services to DV survivors. Co-located DV advocate services might include:

- Adult domestic violence assessment and safety planning
- Child domestic violence assessment and safety planning
- One-on-one emotional support
- DV advocacy and system navigation assistance within the DHS system (e.g., information about Child Welfare process, Self-Sufficiency process, meetings, and Child Welfare court hearings)
- Crime victim advocacy and system navigation assistance (e.g., information, advocacy, and accompaniment related to crime reporting, restraining orders, crime victim rights, crime victim compensation, victim impact statements, court orientation, criminal process)
- DV education regarding the dynamics and impact of DV on survivors and their support networks
- Referral for advocacy and other needed services, including emergency shelter, support groups, crisis intervention, legal representation, financial assistance, housing, medical care, etc.
- Assurance that the system hears the DV survivor and responds appropriately

"Advocates have a wealth of knowledge and experience regarding batterer- generated risks and the options and resources available to battered women. Advocates provide the opportunity for battered women to enhance their current safety plans. An advocate begins this process by understanding each battered woman's perspective on her risks and options. The advocate can then begin to add her information and resources to the woman's current safety plans. It is this sharing and integration of advocates' information with each battered woman's perspective that may enhance safety plans for battered women and their children."

Safety Planning: GHLA (8/97) – Jill Davis

MEETINGS OR INTERVIEWS

At a meeting or interview, co-located DV advocates can provide emotional support for the DV survivor and clarify expectations when necessary. The co-located DV advocate does not speak for DHS or the DV survivor.

It is best for DHS caseworkers to seek information directly from the DV survivor rather than from the co-located DV advocate.

If a DV survivor wants the co-located DV advocate to speak on her/his behalf, it is a federal requirement for the co-located DV advocate to ensure that the DV survivor is fully informed of the potential consequences of the release of confidential information. To best protect the confidentiality of a DV survivor, it is also required that the co-located DV advocate collect a written release of information (ROI) detailing the specific information that the DV survivor authorizes the co-located DV advocate to release, to whom it can be released and for how long. The ROI must comply with the Violence Against Women Act (VAWA) and Family Violence Prevention and Services Act (FVPSA) requirements specific to sharing personally identifying information. Please see the confidentiality section in this manual for a more detailed explanation.

CASE STAFFING/CONSULTATION

Co-located DV advocates can consult with all Child Welfare and Self-Sufficiency caseworkers and on-site community-based DV organization partners. DV consultation can be useful in identifying and discussing DV issues in general and in exploring how these issues may impact families. DV consultation can occur on an informal basis by speaking with the co-located DV advocate when available in the DHS office, or can be more formalized by arranging for the co-located DV advocate to attend a DHS case staffing.

DV advocates can provide technical assistance and consultation about:

- DV dynamics
- Interacting effectively with victims
- Impact of DV on parenting
- Perpetrator patterns of coercive control
- Information about protective orders
- Information about the criminal justice system response to DV
- Effects of DV on children
- Information about community resources such as shelters, legal assistance, financial assistance and other related topics as requested
- Confidential advocacy services for DHS staff that are experiencing domestic violence, affected by domestic violence, or experiencing secondary trauma

EMPOWERMENT

Empowerment is defined as an active process moving toward information and choices, autonomy, self-sufficiency, responsibility, and control of one's life. Co-located DV advocates' goals are to enable each victim to obtain the information needed:

- To make decisions, and recognize choices
- To recognize strengths, skills and competence
- To be self-sufficient and to act
- To be open and honest about experiences, needs, and feelings toward victim's self, children and support people

Co-located DV advocates cannot provide information on a specific case without a written ROI from the DV survivor.

confidentiality and releases of information

TOPICS

- Confidentiality and survivor safety
- Co-located DV advocates' confidentiality requirements
  - FVPSA and confidentiality
  - VAWA and confidentiality
  - VAWA/FVPSA and mandatory child abuse reporting
  - Oregon mandatory child abuse reporting law
  - Oregon confidentiality law
  - Certified advocate-victim privilege
  - Freedom of information act
- DHS child welfare caseworker confidentiality
- DHS self-sufficiency caseworker confidentiality
- Confidentiality and collaboration
- Release of information
- Release of information forms

GOAL

The goal of the federal and Oregon confidentiality laws is to guide co-located DV advocates and DHS caseworkers in providing needed services and ensuring safety and privacy for DV survivors and their children.

OBJECTIVES

- Define VAWA and FVPSA Confidentiality and Mandatory Child Abuse Reporting Requirements, Oregon Mandatory Abuse Reporting, Oregon Confidentiality Law and Oregon Certified Advocate-Victim Privilege
- Understand the differing confidentiality requirements that co-located DV advocates, DHS Self-Sufficiency caseworkers and DHS Child Welfare caseworkers must follow
- Identify the various confidentiality and release of information forms that co-located DV advocates and DHS caseworkers use

Confidentiality and Survivor Safety

Confidentiality is a cornerstone to successful DV advocacy. Due to the sensitive and potentially life threatening nature of DV, survivors rely on the co-located DV advocate to guard and protect their private information, whenever possible.

If a DV survivor's information is disclosed it may potentially:

- Put the safety of the DV survivor and their children at risk
- Lead to escalation of violence
- Harm the DV survivor's health
- Affect the DV survivor's employment or education
- Impact the DV survivor's relationships with family, friends and community
- Be used against the DV survivor in custody and divorce proceedings
- Be manipulated by perpetrators in criminal cases
- Undermine the DV survivor's trust in advocacy services

It is critical that all providers that support DV survivors know what confidentiality laws and regulations they must follow, as well as what confidentiality laws and regulations their colleagues and partners must follow. It is also essential for all providers to share with DV survivors what their organization's or agency's confidentiality requirements are so that DV survivors know who will be able to protect their personal information and who is required to disclose their personal information. This is key to ensuring that DV survivors can maintain their safety, autonomy and privacy.

Co-located DV advocates need to be able to speak confidentially with DV survivors in order to build trust and to provide high quality DV advocacy services. DV survivors may be reluctant to access DV services, or to share information about their circumstances, without the assurance of confidentiality. If DV survivors do not share accurate and sensitive information due to fear of disclosure, co-located DV advocates can be limited in their ability to help DV survivors plan for safety for themselves and their children.

In Oregon, some co-located DV advocates cannot guarantee that all of the information they hold about DV survivors will remain absolutely confidential. In some instances, certain information may have to be released under a court order.

Simultaneously, federal and state funders require co-located DV advocates to maintain strict confidentiality with limited exceptions (discussed below). In order to protect DV survivors' dignity and safety, all Oregon and federal DV funds that support co-located DV advocates and providers have internal policies that ensure confidentiality and/or disclose to DV survivors when they are unable to ensure confidentiality.

The co-located DV advocates that are part of organizations or agencies that provide multiple services, especially those that provide other services to DHS clients, like In-home Safety and Reunification Services (ISRS) or Strengthening, Preserving and Reunifying Families (SPRF), also must have confidentiality protocols in place to protect DV survivors from having their personal information released between programs.

Oregon DHS Child Welfare and Self-Sufficiency caseworkers have different rules and statutes that guide their confidentiality policies. In order for DHS caseworkers to most effectively protect DV survivors' safety and dignity, it is recommended that DHS clearly articulate the confidentiality and disclosure regulations to which they are bound both to the co-located DV advocates and to DV survivors. This helps to ensure that all parties are working together collaboratively in a client-centered approach.

Co-Located DV Advocates' Confidentiality

Co-located DV Advocates are held to the strictest confidentiality standards as a condition of federal grant funding allocated by the Family Violence Prevention and Services Act (FVPSA) and the Violence Against Women Act (VAWA). (For more details about VAWA and FVPSA, see below.)

All of the confidentiality provisions of VAWA and FVPSA have also been adopted by the Oregon Department of Justice and the Oregon Department of Human Services, placing the confidentiality language into all their relevant grant agreements. This language requires DV providers, including co-located DV advocates, to maintain the highest level of confidentiality possible when serving DV survivors.

*Note there are a few exceptions to the confidentiality requirements that the co-located DV advocates are bound by which are addressed in section Oregon Mandatory Child Abuse Reporting Law.

FAMILY VIOLENCE PREVENTION AND SERVICES ACT AND CONFIDENTIALITY

The Family Violence Prevention and Services Act (FVPSA), authorized as part of the Child Abuse Amendments of 1984, provides the primary federal funding that supports emergency shelter and supportive services for DV survivors and their children. A 2010 amendment of FVPSA required the same confidentiality standards as VAWA 2005.

VIOLENCE AGAINST WOMEN ACT AND CONFIDENTIALITY

The Violence Against Women Act (VAWA) was initially passed in 1994, as part of the Violent Crime Control and Law Enforcement Act. VAWA was amended in 2005, 2013 and 2017 to address and strengthen confidentiality for DV survivors.

VAWA outlines, with great specificity, the maintenance of confidentiality as a condition of grant funding. This amendment requires the protection of DV survivor confidentiality from any provider at a community-based DV organization and/or governmental agency **that receives federal funds for domestic violence, sexual assault, stalking and dating violence**. Furthermore, a program cannot require DV survivors to sign a release of information (ROI) as a condition of receiving services.

The crux of the VAWA confidentiality provision is that grantees may not disclose personally identifying information, or individual information, or reveal individual information in connection with services requested, utilized, or denied. There are only three exceptions to this law:

1. A DV survivor provides an informed, written and time-limited consent, or release of information (ROI)
2. Statutory mandate
3. Court mandate

Personally identifying information is defined in VAWA as,

> "Information that is "likely to disclose the location of a victim . . . including a victim's first and last name, a home or other physical address, contact information (including a postal address, e-mail address, telephone or fax number), social security number, or any other information, including date of birth, racial or ethnic background, or religious affiliation, that, in combination with any of the above information, would serve to identify any individual."[10]

The existence of co-located DV advocates does not change the community-based DV organization's and/or a DHS agency's responsibility to protect the confidentiality of DV survivors. A co-located DV advocate **may not** speak to a DHS caseworker about DV survivors' situation or circumstances without a written release of information (ROI) from the DV survivor. A co-located DV advocate must look at the facts of each individual case and the totality of the circumstances to determine whether any information that they disclose will reveal the DV survivor's personally identifying information.

VAWA/FVPSA AND MANDATORY CHILD ABUSE REPORTING

If a co-located DV advocate is not a mandatory child abuse reporter under Oregon law, the VAWA and FVPSA regulations and Oregon funders prohibit a report of child abuse unless the DV survivor signs an ROI based on informed consent. **VAWA, FVPSA and Oregon law, not program policy or practice, determines whether a co-located DV advocate is a mandatory child abuse reporter**. This same restriction on reporting abuse applies to elder abuse or abuse of a person with a disability if the advocate is not a mandated reporter under Oregon law and the DV survivor does not consent to an ROI.

OREGON MANDATORY CHILD ABUSE REPORTING LAW

Oregon Law defines child abuse and outlines who is required to report child abuse. These laws are defined in the Oregon Statutes ORS 419B.005 through 419B.050. ORS 419B.005 defines abuse, child, higher education, law enforcement agency and the individuals who are considered "public or private" officials required to report child abuse. Employees of the Department of Human Services are covered by the definition of "public or private officials" under ORS 419B.005 (5)(e) and, therefore, are mandatory child abuse reporters.

The designated "public or private officials" are required to report child abuse if they come in contact with either: (1) a child they have reasonable cause to believe has been abused or (2) a person who has abused a child. The obligation of a mandatory reporter is in effect 24 hours/day and 7 days/week; it is not limited to the reporter's working hours or contact made in an official capacity.

However, under ORS 419 B.005(5) (bb)(B) one exception is made to "public or private officials." It states:

> "Employee of a public or private organization providing child-related services or activities: excluding community-based, nonprofit organizations whose primary purpose is to provide confidential, direct services to victims of domestic violence, sexual assault, stalking or human trafficking."

10 This information was retrieved from http://nnedv.org/downloads/Policy/VAWA2005Summary.pdf

Therefore, in Oregon, DV advocates working for a community-based organization that provides child-related services, but whose main purpose is to provide DV direct services, **are explicitly not** mandatory child abuse reporters in Oregon.

However, VAWA allows a mandatory child abuse reporter, as defined by Oregon law, who works for a DV provider, to carry out his or her obligations under Oregon law. In other words, a co-located DV advocate who is a mandatory child abuse reporter under Oregon law, may make a report of child abuse without an ROI. However, to comply with VAWA, a co-located DV advocate required by Oregon law to report child abuse may not release more information than is required under the mandatory child abuse reporting law. Also, to protect the safety of DV survivors affected by a mandatory report, VAWA requires co-located DV advocates to make reasonable attempts to provide notice to DV survivors affected by the disclosure and take steps necessary to protect the privacy and safety of the persons affected by the mandatory report.

Co-located DV advocates may also be mandatory reporters of child abuse if they work for another type of employer that makes them "public or private officials" as defined by ORS 419B.005 (5)(e). An example of this situation would be if a co-located DV advocate works at a school or nursing home, as well as working or volunteering at a community-based organization that serves survivors of domestic violence, sexual assault, stalking, or human trafficking. In addition, if a co-located DV advocate has a license or occupation, such as a licensed clinical social worker or health care provider, which requires them to be a mandatory child abuse reporter, VAWA and FVPSA would not exempt this co-located DV advocate from being a mandatory abuse reporter.

Co-located DV advocates who are mandatory reporters are encouraged to disclose their reporting obligations and the possible implications of these obligations with DV survivors. If possible, co-located DV advocates provide survivors with the option of speaking to a co-located DV advocate who is not a mandatory reporter.

Where concerns about child abuse exist, and when otherwise safe and appropriate, a co-located DV advocate may work with DV survivors to make a voluntary child abuse report.

For more information about mandatory child abuse reporting, refer to the DHS publication "What you can do about child abuse." It is available online at http://dhsforms.hr.state.or.us/Forms/Served/DE9061.pdf.

OREGON CONFIDENTIALITY LAW

In 2015, the Oregon Legislature passed a law declaring that information maintained by sexual assault crisis centers, crisis lines, shelter homes, or safe houses relating to DV survivors is confidential (ORS 409.273(2)(b); ORS 409.292). This means that employees of these organizations must protect information about and shared by DV survivors.

Maintaining DV survivor confidentiality requires employees to:

- Avoid disclosing survivor information to people outside the organization
- Take preventive measures to avoid inadvertent disclosures of survivor information
- Challenge requests from outside parties for survivor information
- Notify DV survivors when someone requests access to their confidential information

CERTIFIED ADVOCATE-VICTIM PRIVILEGE LAW

In 2015 the Oregon Legislature passed a law, ORS 40.264, which makes the communication between a "certified advocate" from a "qualified victim's services program" and a "victim" "privileged."

"Privilege" is a legal protection that empowers a DV survivor (or victim) to decide whether their confidential communication with a co-located DV advocate will be disclosed to a third party. The privilege applies to "confidential communications" between a "certified advocate" and a "victim" (defined in the next section). It is important to recognize that the privilege is held by the "victim."

> "The DV victim has the privilege to refuse to disclose and to prevent any other person from disclosing"

When the privilege applies, this means:

> "A court cannot force a victim or their advocate to disclose the contents of confidential communications, and neither the advocate nor the survivor can be punished for refusing to disclose the information."[11]

A "victim" is:

> "a person who is seeking safety planning, counseling, support or advocacy services related to domestic violence, sexual assault or stalking at a "qualified victim's services program"

A "certified advocate" refers to any volunteer or paid person who has attended at least:

> "40 hours of training in advocacy for victims of domestic violence, sexual assault or stalking, approved by the Attorney General by rule and works for a qualified victim services program."

A "qualified victim services program" refers to:

> "A nongovernmental, nonprofit, community-based program receiving moneys administered by the Oregon Department of Human Services or the Oregon or United States Department of Justice, or a program administered by a tribal government that offers safety planning, counseling, support or advocacy services to victims of domestic violence, sexual assault or stalking" or
>
> "a sexual assault center, victim advocacy office, women's center, student affairs center, health center or other program providing safety planning, counseling, support or advocacy services to victims that is on the campus of or affiliated with a two- or four-year post-secondary institution that enrolls one or more students who receive an Oregon Opportunity Grant."[12]

11 "A Legal Guide for Oregon Advocates", retrieved at https://oregonlawhelp.org/files/CCDACC15-944D-570E-7F1F-7BBF3DEC0018/attachments/1AE3BF12-D72C-4A8D-B8C2-3DEFD466C3F0/advocate-manual-072517.pdf

12 These definitions were taken from the Oregon Revised Statutes, https://www.oregonlaws.org/ors/40.264

The communication must be "confidential":

> Confidential communication is communication not intended for further disclosure, except to: (1) persons who are present to further the interests of the DV victim (survivor) in seeking safety planning, counseling, support or advocacy services; (2) an interpreter; or (3) other persons, in the context of group counseling."

DHS Child Welfare Caseworker Confidentiality

DHS Child Welfare caseworkers are authorized to share confidential information with co-located DV advocates about any child welfare case information that:

- Promotes child well-being and safety
- Ensures the best interests of the child
- Protects children from abuse and neglect
- Provides necessary information to investigate, prevent or treat child abuse and neglect

The disclosure of any information that does not fit these criteria requires a signed form called an Authorization for Use and Disclosure of Information, DHS 2099. DHS Clients have the right to refuse to sign this form. DHS Child Welfare staff may only disclose information with a properly completed DHS 2099 and are encouraged not to use releases that are generic and lack specificity.

DHS Child Welfare caseworkers are not permitted to disclose records and reports compiled under the child abuse reporting law if the sole purpose of the disclosure is to provide services or to protect an adult DV survivor. Any disclosure of DV information and/or records must be linked to protecting the best interests of the affected child and necessary to administer child welfare services, made for the purpose of investigating, preventing, protecting or treating child abuse. DV survivor information must be tied to the child's well-being and safety.

FREEDOM OF INFORMATION ACT

Co-located DV advocates will have access to DHS email and phone systems. All DHS emails and voicemails are public records and are subject to the Freedom of Information Act (FOIA), and Oregon Regulatory Statute, ORS 410 (6) which allows the public, including the press, the right to access "writing." The term "writing" means "handwriting, typewriting, words, pictures, sound, or symbols, or combinations thereof; and all papers, maps, files, facsimiles or electronic recordings."

Thus, it is essential that no personal information about a DV survivor is put into a DHS email or voicemail, to ensure confidentiality.

DHS Self-Sufficiency Caseworker Confidentiality

By statute, DHS Self-Sufficiency caseworkers **must keep DV survivor information confidential**. DHS Self-Sufficiency caseworkers cannot share DV information, even with DHS Child Welfare caseworker, unless the DV survivor voluntarily agrees to sign an Authorization for Use and Disclosure of Information Form, DHS 2099.

A DV survivor's refusal to sign a DHS 2099 will not impact their ability to receive services from the DHS Self-Sufficiency office. For more information about confidentiality and ROIs between DHS Child Welfare Services and DHS Self-Sufficiency Programs please refer to the forms in the attachment section of this document.

Confidentiality and Collaboration

Collaboration around confidentiality can be challenging, especially when each member of the DV leadership team may have to abide by different confidentiality requirements. It is critical that each member of a DV leadership team know the general principles of federal and state laws and how they apply to each DV team member they are working with. In particular, it is critical that all DV leadership team members know VAWA and FVPSA federal requirements, the Oregon Advocate Privilege regulations and the Oregon Mandatory Child Abuse Reporting requirements. In addition, each DV team member must know how each of these laws applies to their work and their colleagues' work. In order to be able to collaborate effectively, develop common goals and achieve shared outcomes, it is critical for each member of the DV leadership team to:

- Understand and respect the different confidentiality policies, laws and rules that DHS Child Welfare, DHS Self-Sufficiency and local and state DV organizations operate under
- Respect and honor their colleagues' confidentiality policies
- Remain vigilant about maintaining and respecting the confidentiality of DV survivors' information
- Ensure both confidentiality and safety to the highest level possible, since they are integrally related
- Provide access to DV services that enhance survivor and child safety

Co-located DV advocates can carry out their responsibilities in many ways that do not require the release of personal information about DV survivors. For example, the disclosure of personal information is unnecessary when a co-located advocate working with DHS caseworkers:

- Provides general information about intimate partner violence dynamics
- Identifies gaps in services
- Describes and offers available DV services
- Provides a general perspective on survivor experiences
- Suggests ways agency partners can increase DV survivor safety

Release of Information

It is recommended that great consideration be taken before sharing DV survivors' confidential information through a signed ROI. However, there may be times when sharing confidential information may be beneficial to DV survivors. Examples of how releasing confidential information may help DV survivors include:

- Expedition of services
- Prevention of the need to repeatedly tell their story
- Continuity of services if the DV survivor is moving out of district

An informed, reasonably time-limited, written consent from DV survivors is required by signing an ROI form any time DV survivors' personal information is shared. Informed written consent, outlined in an ROI form, refers to a survivor's knowing and informed decision to allow the disclosure of confidential information.

It is important that DV survivors understand the details of informed consent. These details include:

- That the decision to disclose personal information is exclusively the choice of the DV survivor
- Possible alternatives to disclosure (e.g., is it possible for the survivor to get benefits or assistance without signing an ROI?)
- The risks and benefits of disclosing personal information

Before signing an ROI form, the DV survivor must have a clear understanding of exactly what information will be released, for what purpose, how it will be released, when it will be released, for how long it will be released, with whom it will be shared and how to revoke an ROI at any time.

An ROI must be in writing. It is essential that a VAWA Compliant Release of Information Form complies with VAWA/ FVPSA regulations is used. VAWA recommends that the ROI form include:

- A description of the information to be released (a DV survivor may choose to allow some, but not all, of her or his information to be released)
- The name of the agency designated to receive the information
- The purpose of the release
- The duration of the release
- The date the release is signed
- An explanation describing how an ROI can be revoked by a DV survivor

It is important that a DV survivor complete a **separate ROI form for each agency or individual to whom a DV survivor is authorizing an ROI**. A "blanket" release that authorizes an ROI to several different agencies or individuals at once is inappropriate. Such releases are not sufficiently precise and are inconsistent with VAWA/FVPSA regulations. The DV survivor must be informed about who has access to the information in the ROI and under what circumstances the DV survivor's information will be disclosed without the DV survivor's written and informed consent signed in an ROI.

Oral releases are also inconsistent with VAWA/FVPSA regulations.

The VAWA regulations also require ROIs to be reasonably time-limited. "Reasonably time limited" is determined in relation to the DV survivor's individual circumstances and needs. The length of time that an ROI is effective is the minimum length necessary under the circumstances and is tied to the services the DV survivor is requesting. Fifteen to thirty days is the recommended time limit and is considered best practice. It is better to tend towards the inconvenience of signing a new ROI every time information needs to be shared in order to protect the DV survivor's confidentiality and ensure safety. If an ROI is not reasonably time-limited, a DV survivor's personal information may not be released in order to protect the safety of the DV survivor.

Only the specific information authorized in an ROI form may be shared. Information revealed by the DV survivor after an ROI was signed or that was not authorized in the ROI may not be disclosed without completion of a new ROI form. While this requirement places an additional burden, this additional precaution protects a DV survivor's personal information and ensures that the DV survivor is making as informed a decision as possible about the potential consequences of disclosing the additional information.

When an exchange of information within the co-located DV advocacy program is necessary, it must be done in a manner that is consistent with each organization's and agency's regulations regarding disclosure of information.

A signed ROI cannot be a condition of providing services.

Release of Information Forms

1. DHS Request for Restriction and Use of Disclosures—Form 2099
2. VAWA Compliant Release of Information Form for DV Organizations

cultural considerations

TOPICS

- Oppression's role in domestic violence
- Culture's role in domestic violence
- Race and ethnicity
- Indian Child Welfare Act (ICWA) of 1978
- Immigrants and non-citizen survivors
- LGBTQ survivors
- Adverse childhood experiences (ACES), adolescent girls, and pregnant women
- Implicit bias

GOAL

The goal of identifying cultural and gender specific oppression in DV is to guide co-located DV advocates and DHS caseworkers in providing the most trauma informed, culturally competent support and services to DV survivors and their children.

OBJECTIVES

- Define oppression
- Understand the role that racism, sexism, classism, homophobia, transphobia, religious prejudice, and other oppressions play in DV
- Discuss the role that ICWA has on DV
- Discuss the role that immigration and non-citizen status has on DV
- Describe the role that ACEs, adolescence and pregnancy have on DV

Oppression's Role in Domestic Violence

Co-located DV Advocates and DHS caseworkers must understand the link between oppression and violence. Although disparities, such as poverty, low educational attainment, lack of housing, racism, sexism, and homophobia are not the cause of domestic violence, they can contribute to the level of personal agency and social support someone has to break free from an unsafe and unhealthy relationship. More financial, educational and social assets can provide DV survivors with the necessary resources to leave an abusive relationship. People are healthier when they feel safe, supported, and connected to other people.

Domestic violence is rooted in institutionalized oppression. DHS caseworkers and co-located DV advocates can help survivors recognize the significant role that public and private systems and institutions, such as sports, governments, businesses and churches play in propagating racism, sexism, classism, homophobia, transphobia, and/or religious discrimination. Offering culturally specific DV advocacy and resources can help facilitate a more supportive healing process.

Culture's Role in Domestic Violence

Domestic violence crosses all age groups, economic classes, faith communities, racial and ethnic groups, LGBTQ, pregnant and parenting populations. Culture can impact how someone perceives or reacts to DV, how DV survivors and perpetrators seek DV support services, and the ways that DV perpetrators abuse. It is essential that co-located DV advocates and DHS caseworkers consider the important role that culture plays when addressing DV.

DV perpetrators often use cultural or social norms to maintain their power and control over their victims. They also may justify their abuse as a cultural or religious practice if they think doing so will be effective. Similarly, stereotypes that people have about DV shape their opinions about the DV survivors they serve. This concept is referred to as implicit bias.

Race and Ethnicity

The Centers for Disease Control and Prevention (CDC) compiles IPV state and national data by race and ethnicity for men and women in their biannual intimate partner and sexual violence survey. This data asks questions about IPV during the last 12 months and lifetime experience. This data includes measures for sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health.

The CDC combined and averaged 2010-2012 data into a summative report broken down by national, state, race/ethnicity, male/female and age.[13]

For the nation, 37.1 % of women and 30.9 % of men experienced lifetime prevalence rates of IPV (including sexual, violence, physical violence and stalking). For the state of Oregon, 39.8 % of women and 36.2 % of men experienced a lifetime prevalence rates of IPV. Oregon ranked in the top quartile of states with the highest IPV prevalence rates.[14]

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13 Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

14 Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

Nationally, women who self-identified as Multiracial, American Indian/Alaska Native and Black, non-Hispanic reported the highest percentage of lifetime prevalence rates of intimate partner violence (which included sexual violence, physical violence and stalking) at 56.6%, 47.5 % and 45.1% respectively.[15]

Nationally the men who self- identified as Multiracial, American Indian/Alaska Native and Black non-Hispanic reported the highest percentage of lifetime prevalence rates of intimate partner violence at 42.3, 40.5, and 40.1 respectively.[16]

*Note that these are national numbers because Oregon-specific data within specific categories was not available due to small sample size.

Indian Child Welfare Act (ICWA) of 1978

The Indian Child Welfare Act (ICWA), passed by Congress in 1978, is a federal law that seeks to keep American Indian children with American Indian families and tribes when child abuse and/or neglect has been founded. ICWA allows a child's tribe to intervene in cases where removal and placement of Indian children in foster or adoptive homes is being considered. This law was passed in response to the alarmingly high number of Indian children that were removed from their homes, by both public and private agencies. The intent of Congress was to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and children." However, ICWA does not apply to divorce proceedings, intra-family disputes, juvenile delinquency proceedings, or cases under tribal court jurisdiction.[17]

A person may define his or her identity as Indian, but in order for ICWA to apply, the involved child must be an Indian child as defined by the law. ICWA defines an "Indian child" as "any unmarried person who is under age eighteen and is either (a) member of an Indian tribe or (b) is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe" (25 U.S.C. § 1903). Under federal law, individual tribes have the right to determine eligibility, membership, or both. Federally recognized tribes are listed at http://tribaldirectory.com.

Indian children involved in Oregon's Child Welfare system are covered by ICWA. ICWA ensures that a child's tribe and family will have an opportunity to be involved in decisions affecting services for the Indian child, including children of DV survivors. A tribe or a parent can also petition to transfer jurisdiction of a case to their own tribal court. If a co-located DV advocate and/or DHS caseworker believe that the DV survivor's and/or their child's rights are not being considered or are being ignored, they may refer to Oregon's DHS ICWA Policy information at http://www.dhs.state.or.us/policy/childwelfare/icwa/icwa.htm.

When co-located DV advocates and DHS Child Welfare caseworkers support American Indian/Alaska Natives DV survivors, it is critical that they understand and follow the regulations of ICWA. The National Indian Child Welfare Association (NICWA) provides technical assistance and training to help child welfare agencies comply with the Indian Child Welfare Act of 1978 (ICWA). For more details about this act refer to http://www.nicwa.org.

15 Ibid.
16 Ibid.
17 25 U.S.C. § 1902 retrieved from https://www.law.cornell.edu/uscode/text/25/1902

Immigrants and Non-Citizen Survivors

Immigrants and Non-Citizen Survivors often face extremely tenuous circumstances due to the unpredictability of their immigrant status and the risk of deportation. Therefore, some immigrant or non-citizen DV survivors will not disclose the DV they have experienced in order to prevent detainment or deportation.

To protect immigrants and non-citizens from feeling trapped or dependent upon their abuser, Congress created the T status and T-Visa and the U status and the U-Visa in 2000. The T-Visa was part of legislation that was developed to

> "strengthen the ability of law enforcement agencies to investigate and prosecute human trafficking, and also offer protection to victims."[18]

In the same year, Congress also passed the U-Visa, which provided support for DV survivors who would provide information to law enforcement or government.

> "The U status was intended to strengthen the ability of law enforcement agencies to investigate and prosecute cases of domestic violence, sexual assault, trafficking of aliens and other crimes, while also protecting victims of crimes who have suffered substantial mental or physical abuse due to the crime and are willing to help law enforcement authorities in the investigation or prosecution of the criminal activity."[19]

Although this legislation exists, it does not prevent immigration status from trapping many DV victims.

In an effort to strengthen the Victims of Trafficking and Violence Protection Act (VTVPA), VAWA 2013 enhanced protections for DV survivors from being deported (unless the survivor has been convicted of serious crimes). However, this legislation may be more enforced or ignored based on different regions of the country and different historical times, potentially compromising the security of DV survivors and their children. Thus, it is critical that co-located DV advocates know current laws, programs and practices in their region. For current information about immigration laws DV co-located advocacy team members may refer to https://www.ocaDV.org/resources/browse/613 or the www.nationalimmigrationproject.org/legalresources.htm#vcpv for further explanations and guidance.

To best serve cultural communities, it is optimal to have bilingual, bicultural co-located DV advocates and DHS caseworkers that reflect the populations they are serving, or at least to have access to appropriate resources or referrals. For a list of culturally specific agencies in Oregon refer to OCADSV at https://www.ocadsv.org/resources/fact-sheets.

18 This definition was retrieved from https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-human-trafficking-t-nonimmigrant-status

19 This definitions was retrieved from https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-criminal-activity-u-nonimmigrant-status/victims-criminal-activity-u-nonimmigrant-status

LGBTQ Survivors

Many DV survivors who identify as Lesbian, Gay, Bisexual, Transgender and Queer, LGBTQ, experience DV, including peer-to-peer violence, dating violence, IPV, and stalking. However, LGBTQ populations often experience disparities in accessing support services for DV. FVPSA was the first federal legislation to officially recognize LGBTQ people and relationships.

Due to discrimination and challenges to accessing support for DV services, President Obama strengthened the 2013 VAWA reauthorization bill to reduce this discrimination and ensure access to support services for LGBTQ populations in the 2013 VAWA reauthorization bill. For specific definitions for LGBTQ populations refer to https://www.ocadsv.org/resources/browse/274.

Related to the discrimination that members of the LGBTQ community experience, they often do not want to report abuse, IPV or DV for fear of being "outed" in the process and/or being treated unfairly.

Not all LGBTQ people experience the same rates of DV. According to data collected in the "National Intimate Partner and Sexual Violence Survey 2010 Findings on Victimization by Sexual Orientation,"

> "Bisexual women had significantly higher lifetime prevalence of rape and sexual violence other than rape by any perpetrator when compared to both lesbian and heterosexual women."[20]

Bisexual women also experienced severe physical violence at significantly higher rates than heterosexual or lesbian women. These experiences negatively impacted women who identified as bisexual, which was reflected in school or work absenteeism, fear for their personal safety and post-traumatic stress disorder (PTSD) symptoms. Bisexual and lesbian women also experienced much higher prevalence rates of psychological aggression, which includes expressive aggression and coercive control, than heterosexual women.[21]

For men, the "National Intimate Partner and Sexual Violence Survey 2010 Findings on Victimization by Sexual Orientation" did not have a large enough sample size for most of the DV prevalence rates to report.[22]

Gender identity also heavily influences discrimination, harassment and DV prevalence rates and how DV survivors are treated. According to the National Transgender Discrimination Survey, for respondents who identified as transgender or gender non-conforming:

> "A staggering 41% of **respondents reported attempting suicide** compared to 1.6% of the general population, with rates rising for those who were the victim of physical assault (61%) or sexual assault (64%)."[23]

Despite the discrimination that many individuals who identify as transgender experience, many of these individuals are able to remain hopeful and resilient. Although individuals who identify as transgender may experience significant bullying and harassment during middle school and high school, they continue with their education and economic advancement, even if it is a little later in life. As highlighted in the report "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey,"

20 This information was retrieved from https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf
21 Ibid.
22 Ibid.
23 This information was retrieved from https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf

> "Despite high levels of harassment, bullying and violence in school, many respondents (who identified as transgendered or gender non-conforming) were able to obtain an education by returning to school. Although fewer 18 to 24-year-olds were currently in school compared to the general population, respondents returned to school in large numbers at later ages, with 22% of those aged 25–44 currently in school (compared to 7% of the general population)."[24]

For Oregon information and resources about DV in the LGBTQ community refer to https://www.ocadsv.org/resources/browse/274

Adverse Childhood Experiences, Adolescent Girls, and Pregnant Women

The landmark Adverse Childhood Experiences (ACE) Study, a partnership between Kaiser Permanente in San Diego and the Centers for Disease Control and Prevention (CDC), found a strong association between the number of adverse experiences an individual experienced during childhood and an increased risk for negative health outcomes later in life.

The original ACE Study, conducted between 1995 through 1997, collected health history questionnaires from adult patients at Kaiser Permanente Clinics in San Diego and retrospectively looked at the number of adverse childhood experiences (ACEs) a patient had and the increased risks for negative health behaviors, mental health conditions and chronic diseases. This ACE Study continues to guide current research and practices that connect the relationships between childhood trauma and greater health risks later in life.[25]

> "Children who experience childhood trauma, including witnessing incidents of domestic violence, are at a greater risk of having serious adult health problems including tobacco use, substance abuse, obesity, cancer, heart disease, depression and a higher risk for unintended pregnancy."[26]
>
> Adolescent girls who experience physical abuse are at least three times more likely to become pregnant than non-abused girls.[27, 28]

In addition,

> "when adolescent mothers who experience physical abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months."[29]

24 Ibid.
25 Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. The Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998; 14: 245-258.
26 Bair-Merritt MH, Feudtner C, Localio AR, Feinstein JA, Rubin D, Holmes WC. 2008. Health Care Use of Children whose Female Caregivers have Intimate Partner Violence Histories. *Archives of Pediatric and Adolescent*
27 Roberts TA, Auinger P, Klein JD. 2005. Intimate Partner Violence and the Reproductive Health of Sexually Active Girls. *Journal of Adolescent Health*. 2005; 36(5):380-385.
28 Bair-Merritt MH, Feudtner C, Localio AR, Feinstein JA, Rubin D, Holmes WC. 2008. Health Care Use of Children whose Female Caregivers have Intimate Partner Violence Histories. *Archives of Pediatric and Adolescent Medicine*. 162(2): 134-9. Available
29 Raneri LG, Wiemann CM. (2007). Social Ecological Predictors of Repeat Adolescent Pregnancy. *Perspectives on Sexual and Reproductive Health*, 39(1):39-47.

Pregnant women who experience physical abuse are also risk for:

- Depression
- Delayed prenatal care
- Premature labor
- Fetal trauma
- Low birth weight infants
- Unintended pregnancies
- Other health issues that can lead to a lifetime of health related problems for women and children
- Maternal death[30, 31]

Thus, it is important for DHS workers to be particularly attentive to possible signs of DV with adolescent or pregnant clients due to previous trauma and ACEs, since it can increase health complications during pregnancy, later in life and with their newborn child.

Implicit Bias

Implicit bias refers to the unconscious association people make between groups of people and stereotypes about those groups. Being aware of implicit bias is especially important when working in different organization/agency cultures and working with populations that are represented by people from diverse age groups, race and gender, the LGBTQ community and/or physical or mental ability.

Co-located DV advocates and DHS staff who understand cultural practices of diverse populations can offer culturally specific insights regarding DV. Thus it is critical that co-located DV advocates and DHS staff receive training in cultural competence and trauma-informed care so that the supports and services they offer best support their clients. As part of this training, it is recommended that the DV leadership team self-reflect upon their own implicit bias and what they are doing to address it. Implicit bias can be identified through online tests, including:

- http://www.understandingprejudice.org/demos/
- https://implicit.harvard.edu/implicit/demo/takeatest.html
- https://implicit.harvard.edu/implicit/research/

30 Bacchus, et al., 2004; Campbell, et al., 2004; Evanson, 2006; Taillieu & Brownridge, 2010.
31 Horon & Cheng, 2001; Nannini, Weiss, Goldstein, & Fogerty, 2002.

co-located DV program partners

TOPICS

- Domestic Violence and Sexual Assault Programs
- Oregon DHS Child Welfare
- Oregon DHS Self-Sufficiency
- Oregon Heath Authority

GOAL

The goal of Domestic Violence and Sexual Assault Programs, Child Welfare Services and Self-Sufficiency Programs is to provide support services, resources, advocacy, and education to DV survivors and their children.

OBJECTIVES

- Describe the programs that are part of the co-located DV Advocacy Program
- Describe Domestic and Sexual Assault Programs and their role
- Describe Child Welfare Services and their role
- Describe Self-Sufficiency Programs and their role

Oregon Domestic Violence and Sexual Assault Organizations

Oregon's community-based domestic violence organizations look different throughout the state. They are typically non-profit 501(c)(3) organizations that have a primary focus on providing services to survivors of domestic violence, sexual assault, stalking and/or dating violence. These organizations may receive public and private funding, as well as local donations. The infrastructure and size of the organizations vary widely depending upon the area of the state where the program is located. Most DV organizations typically offer:

- Advocacy (medical, legal, academic)
- Referrals
- Emergency/financial supports
- Crisis telephone hotlines
- Shelter (Emergency, Transitional)
- Safety planning
- 911 cell phones
- Help with basic needs
- Support groups
- Education/support for friends & family

To find out more about non-profit Domestic and Sexual Violence programs throughout Oregon, go to www.ocadsv.org.

Oregon DHS Child Welfare

The Oregon DHS Office of Child Welfare responds to child abuse reports. Trained caseworkers listen to reports of abuse, assess the safety of children, and prepare case plans to assist families.

Child Welfare caseworkers and law enforcement agencies have a shared legal responsibility for taking child abuse reports and responding to them. The Oregon Child Abuse reporting law, ORS 419B.005 to 419B.015, is designed to provide early identification and protection of children who have been abused. Child Protective Services or law enforcement intervenes when a caregiver abuses or neglects a child.

DHS Child Welfare Caseworkers perform the following duties to identify potential child abuse cases:

- Screening
- Safety Assessment

DHS Child Protective Services caseworkers are trained on the following topics:

- Symptoms of abuse
- How to screen incoming reports of abuse
- How to conduct a comprehensive assessment of the family
- How to interview victims, witnesses and alleged abusers
- When to ask law enforcement for assistance
- How to decide if abuse actually occurred

- How to determine if a child is safe or unsafe
- How to create in-home and out-of-home safety plans
- How to do a parental capacity assessment
- How to create conditions for return if a child is removed from a home
- How to create a case plan with Expected Outcomes and Action Agreements
- When to close a case

It is important that co-located DV advocates are not perceived as being part of "the system" by the DV survivor, especially when the relationship with the DHS Child Welfare System can feel adversarial to families.

Oregon DHS Self-Sufficiency

Self-Sufficiency Programs (SSP) is the division of DHS that helps low income people and their children achieve self-sufficiency by providing cash assistance, food benefits, childcare assistance, domestic violence financial assistance, refugee benefits, and job training and support programs. Domestic Violence support available through SSP includes:

> Temporary Assistance for Domestic Violence Survivors (TA-DVS): The TA-DVS program was created as a TANF-funded program intended to provide temporary financial assistance and support to families affected by domestic violence during crisis or emergent situations when other resources are not available. TA-DVS is used to help domestic violence survivors and their children address their safety concerns and stabilize their living situation, thus reducing the likelihood of the survivor returning to the abuser due to financial necessity. The most common need for TA-DVS is when the domestic violence survivor flees the abuser. The TADVS Policy Box email is: tadvs.policy@state.or.us.

Oregon Health Authority

> The Oregon Health Plan (Medicaid) provides health coverage to low-income children, adults and disabled Oregonians through a network of medical practitioners, behavioral health providers and dentists coordinated by organizations referred to as coordinated care organizations (CCOs). SSP, Aging and People with Disabilities (APD) and OHA handle eligibility for the programs. Oregon Health Plan recipients receive their care through CCOs that OHA is responsible for administering, determining benefit packages and making payments to medical providers. Although this program is not specifically for DV survivors, it can be a critical component to supporting DV survivors and their families.

building and maintaining relationships

TOPICS

- Leadership team
- Local memorandum of understanding (MOU)
  - Distinct roles & responsibilities
  - Orientation
  - Structure
  - Physical space
  - Multiple service providers
  - DHS phone lines, email, and computer access
  - Training
  - Client files and data
  - Attendence and leave policies
  - Referral process
  - Home visits
- Employee well-being and self care
- Conflict resolution
- Client grievance procedure

GOAL

The goal of building and maintaining mindful and intentional relationships for the co-located DV Advocacy program in DHS is to ensure that the collaboration enhances outcomes for DV survivors and staff.

OBJECTIVES

- Discuss what the MOU does for a co-located DV advocacy program
- Differentiate the roles and responsibilities of co-located DV advocates from DHS caseworkers
- Understand how the co-located DV advocates are oriented and incorporated into the DHS structure, physical space, operations, referral process, and home visits
- Describe employee well-being and self care
- Understand the conflict resolution process and client grievance procedure

Leadership Team

The members of the DV leadership team meet regularly to discuss and solve any problems that may arise in this collaborative relationship.

Local Memorandum of Understanding (MOU)

One of the most important tasks for the DV leadership team is to create a local MOU. A sample MOU can be found at this link: http://www.doj.state.or.us/wp-content/uploads/2017/08/mou_sample_guidelines.pdf

The DV leadership team creates an MOU that, at a minimum, addresses the following considerations:

DISTINCT ROLES AND RESPONSIBILITIES OF CO-LOCATED DV ADVOCATES AND DHS CASEWORKERS

There are important reasons that the DHS caseworker and co-located DV advocate roles differ. Co-located DV advocates play a critical role as non-coercive resources, respecting DV survivors' autonomy, and validating DV survivors' expertise regarding their needs and their lives. The co-located DV advocates play a critical role in providing safety planning for DV survivors. This increases their safety and their children's safety.

Maintaining distinct roles is necessary for preserving the empowerment-based, survivor centered, trauma-informed philosophy of advocacy. If co-located DV advocates shift their focus from supporting a DV survivor's autonomy to supporting the work of other agencies (such as DHS), an important source of support in the community is lost to DV survivors.

It is important for both co-located DV advocates and DHS caseworkers that the local MOU clearly outline the separate roles that each play. DV survivors need to know that while co-located DV advocates have offices at DHS buildings, they are not employees of DHS. Co-located DV advocates and DHS caseworkers have distinct tasks and responsibilities. It is recommended that:

- Co-located DV advocates abstain from conducting Temporary Assistance-Domestic Violence Survivors (TA-DVS) interviews or act as eligibility workers
- Co-located DV advocates avoid participation in any form of investigation with or on behalf of DHS Child Welfare caseworkers or monitor a survivor's behavior
- Co-located DV advocates refrain from speaking on behalf of DHS
- Co-located DV advocates avoid acting as safety service providers or supervising visitations
- Co-located DV advocates can sit in on DHS conversations, review these conversations with the DV survivor, and help DV survivor understand DHS expectations
- Co-located DV advocates can support a survivor in meetings with a DHS caseworker, at the survivor's request, but not routinely speak on a survivor's behalf (see confidentiality section of this manual)
- Co-located DV advocates never make decisions on behalf of DV survivors
- Co-located DV advocates create DV safety plans in partnership with non-offending parents
- DHS Child Welfare caseworkers maintain their own, independent relationship with DV survivors

- DHS Child Welfare caseworkers focus on perpetrators of DV rather than DV survivors as the source of threats to child safety
- DHS Child Welfare caseworkers create child safety plans in partnership with non-offending parents that hold DV perpetrators accountable
- DHS Child Welfare caseworkers use appropriate referrals to assist survivors who have co-occurring issues that could be a threat to child safety
- DHS caseworkers refrain from asking co-located DV advocates to reveal survivors' information

ORIENTATION

The local MOU outlines how co-located DV advocates will be oriented to DHS offices, policies and procedures. This orientation could include identifying a liaison for the co-located DV advocate to identify how the co-located DV advocate will be introduced to DHS staff.

STRUCTURE

Co-located DV advocates are employees of a community-based DV organization. They are hired and supervised by a manager from their organization. They are governed by the personnel policies of their organization, including requesting time off and following time-keeping procedures. They must abide by the rules and regulations of their organization. Co-located DV advocates are expected to attend required staff meetings and one-on-one meetings with their DV organization supervisor to debrief cases, problem solve and minimize secondary and/or vicarious trauma.

Co-located DV advocates are located at DHS offices and have daily responsibilities to colleagues, including the development and maintenance of strong collaborative relationship with DHS caseworkers, supervisors and line managers. The local MOU outlines how the co-located DV advocate and DV organization supervisor will:

- Coordinate with DHS offices on schedules regarding when the co-located DV advocates staff are working in the DHS office and when the co-located DV advocates are working off-site
- Comply with DHS policies and procedures regarding the use of DHS resources and ethical conduct when interacting with DHS clients
- Consider DV coverage at DHS offices when taking time off for vacation and illness

The services that co-located DV advocates offer in DHS offices include, but are not limited to:

- Short-term crisis intervention for referred DHS clients who voluntarily participate in accessing emergency shelters, safety planning, follow-up services, assistance with restraining orders, peer support, information on referrals to community resources and other community helpers
- Collaboration with DHS caseworkers to identify DV-related cases and perform an initial assessment and evaluation, as appropriate, for each DHS client referral
- Direct DV services to DHS clients
- Referrals to community DV resources
- Advocacy, support, referral and resources as requested by DHS clients with law enforcement, civil, criminal and juvenile courts
- Problem solving and collaboration with DHS staff

- Participation in DHS case planning
- Navigation through DHS procedures for survivors
- Provide DV training to DHS staff

The local MOU designates a DHS liaison for the co-located DV advocate to consult with for problem-solving and questions about DHS's responsibilities, procedures and policies. The local MOU also outlines how DHS supervisors will communicate directly and respectfully with the co-located DV advocates if a personnel issue arises.

PHYSICAL SPACE

The co-located DV advocates work at DHS offices, as well as at their own DV organization. The local MOU outlines how the DHS agency will provide private meeting space for the co-located DV advocates to talk with DV survivors so that confidentiality can be preserved.

The MOU also outlines how desk space will be allocated in the DHS offices and makes every effort to ensure that advocates are located in a place that is accessible to DHS caseworkers and convenient for DV survivors.

MULTIPLE SERVICE PROVIDERS

If there are multiple providers at a DHS office, it can be confusing for DHS caseworkers and clients. Thus the local MOU outlines strategies for distinguishing and clarifying the roles, confidentiality requirements, and expertise of each provider in the DHS office. The local MOU could also contain strategies for cross-training and coordinating services between multiple providers.

DHS PHONE LINES, EMAIL AND COMPUTER ACCESS

DHS provides the co-located DV advocates with state-funded DHS phone lines, email addresses and computer access. These resources allow co-located DV advocates to stay up-to-date on DHS practices, trainings, events, etc. It also allows advocates to use the same technological operating systems as DHS staff, including the Outlook email and calendar system.

The local MOU makes it clear to all parties that all DHS emails and voicemails are public records and are subject to the Freedom of Information Act (FOIA), and Oregon Regulatory Statute, ORS 410 (6) which allows the public, including the press, the right to access "writing." The term "writing" means "handwriting, typewriting, words, pictures, sound, or symbols, or combinations thereof; and all papers, maps, files, facsimiles or electronic recordings." **Thus, it is essential that no confidential client information is put into email or voicemail to ensure confidentiality for DV survivors**.

The local MOU also outlines how co-located DV advocates use the DHS communication systems, specifying expectations for how often advocates will log into their accounts, update and check their calendars, etc. It would also be useful to specify whether DHS staff will be able to schedule appointments for the advocate using the Outlook calendar sharing options.

TRAINING

The local MOU outlines whether the co-located DV advocates can participate in DHS training opportunities and how they sign up for them.

It also lays out expectations for DV training of DHS staff to be given or arranged for by the co-located DV advocate, and the procedures for planning and arranging for such trainings.

CLIENT FILES AND DATA

The MOU spells out how client files and data must be stored. Co-located DV advocates must keep all files or other records secure. The local MOU outlines how this will be accomplished. Ideally, advocates will keep all written information in a locked briefcase for transport to and storage at the DV agency.

DHS outlines what information the co-located DV advocate will have access to and how that will be accomplished.

ATTENDANCE AND LEAVE POLICIES

Since the co-located DV advocates and the DHS caseworkers work for different organizations, attendance and leave policies may vary. Thus, the co-located DV advocates need to follow the holiday, attendance and leave policies of their agency. Procedures for this are outlined in the local MOU. For example, if DHS has a holiday that is not observed by the community-based DV organization, the co-located DV advocate could report to their organization for a normal workday instead of the DHS office.

In cases of vacation or leave for the co-located DV advocate, the local MOU outlines who needs to be notified at DHS, how that notification will be made, and what the back-up or coverage expectations will be.

REFERRAL PROCESS

Each local community creates their own referral process to meet local needs. Developing standardized referral processes is critical to ensuring high quality, consistent care. These processes would be carefully described in the local MOU.

In Child Welfare, DV survivors may be identified and referred to the co-located DV advocate during the screening or initial case assignment process, or may be identified and referred by a Child Welfare caseworker. In Self-Sufficiency, DV survivors generally self-disclose on the application or are identified during screening, at the eligibility intake or during JOBS program interactions. In addition, DV survivors may be referred to co-located DV advocates from:

- Child Welfare protective services supervisors, permanency supervisors, or family meeting facilitators
- Self-Sufficiency screeners, eligibility case workers, case managers or other branch staff
- DV organization partners or contractors

Since the co-located DV advocate will be unable to confirm that they have been able to connect with a DV survivor unless the survivor voluntarily signs an ROI, it is recommended that the MOU outline how every effort will be made to provide the DV survivor with a range of information about

services, including the local DV agency's hotline number. This can include brochures, posters, tear-offs in restrooms, etc.

The MOU also describes how referrals are managed and prioritized, and how referrals from DHS staff are encouraged. Further, the MOU lays out a strategy for addressing caseloads that are too light or too heavy.

HOME VISITS

Not all co-located DV advocates will accompany DHS caseworkers on home visits. If the local MOU includes this as an option, it is recommended that it include the following standards when developing the practice:

- The DV survivor will be informed about the separate identities and roles of the partners
- The DV survivor will be able to decline DV advocacy services without any consequences
- If the DV survivor wishes to speak to the co-located DV advocate, she/he will be able to do so in a confidential setting
- The co-located DV advocate will not be involved in any investigative activities, such as room-by-room house inspections

Employee Well-Being and Self Care

The work of co-located DV advocates is challenging. State organizations can feel unwelcoming or alien to a nonprofit employee, there may be lack of trust among DV partner organizations, and they may struggle to truly work collaboratively. Inherently this work brings a high level of vicarious trauma. Furthermore, staff may have their own trauma history. Thus, it is critical that the DHS and the partner agency create strategies that minimize trauma for their staff.

Strategies for the local MOU that help to prevent burnout and ensure a healthy workforce include flexible scheduling; reflective supervision; personal connection; opportunities to expand intellectual and emotional intelligence; positive acknowledgement; mindfulness practices, such as meditation, yoga or tai chi; continual skill building; respectful environments; continuing education; and workforce development.

Conflict Resolution

There may be occasions when co-located DV advocates and DHS staff encounter conflicts regarding jointly shared cases that they cannot solve themselves. Both agencies are encouraged to consult with their respective supervisors as they attempt to resolve issues with one another. The partner organizations could commit to using the processes outlined below or their own conflict resolution process for resolving the conflicts or differences that may arise.

If the partner agency has developed their own conflict resolution process refer to this process. If a program has not developed a conflict resolution process, a standard practice for most conflicts could be as follows:

Problem solving process for Child Welfare or Self-Sufficiency caseworker:

1. Talk with co-located DV advocate. If unable to resolve:
2. Consult with designated DV point of the co-located DV advocacy program. If still unable to resolve:
3. Consult with DHS line manager or supervisor

Problem solving process for co-located DV advocate:

1. Talk with DHS staff or manager. If unable to resolve:
2. Consult with designated DV point of the co-located DV advocacy program. If still unable to resolve:
3. Consult the Domestic Violence Program Supervisor

DHS funded co-located DV advocates can also contact Amber Harchuk, at 503-947-2630 or amber.r.harchuk@state.or.us.

Client Grievance Procedure

If a client of DHS has a complaint about the services they have received, that their privacy rights have not been protected or that they feel that they have been discriminated against; DHS form #0171 contains the procedures for filing a grievance.

Each Domestic Violence agency has their own client grievance procedure that can be provided to the client upon start of services. Examples of additional Client Grievance Procedures are provided in the attachments.

It is recommended that both the DHS agency and the local community based DV organization complaint forms be included in the local MOU.

child welfare program models

TOPICS

- Oregon Safety Model
- Strengthening, Preserving and Reunifying Families Model
- Safe and Together Model

GOAL

The goal of the child welfare program models is to provide examples of best practices to support DV advocates and DHS caseworkers in their jobs.

OBJECTIVES

Describe each of the following models

- Oregon Safety Model
- Strengthening, Preserving and Reunifying Families Model
- Safe and Together Model

The Oregon Safety Model (OSM)

The Oregon Safety Model provides guiding principles, practices and policies to keep children safe. This model identifies the following actions as key concepts essential for child and family safety:

- Recognizing present and impending danger
- Distinguishing the difference between present danger and impending danger
- Implementing proactive action
- Identifying safety threats, safety threshold and child vulnerability
- Outlining conditions necessary to ensure safety
- Ensuring protective capacity
- Completing protective capacity assessments
- Confirming safe environments
- Maintaining an ongoing safety plan

The Oregon Safety Model is currently the framework that guides most child welfare practices across the state. More details about the Oregon Safety Model and accompanying tools to support this model can be found at http://www.dhs.state.or.us/caf/safety_model/index.html

Strengthening, Preserving and Reunifying Families (SPRF)

The Oregon Regulatory Statute (ORS) 418.580 outlines the Strengthening, Preserving and Reunifying Families Program, including implementation, contracts, allowable services, rules, training, funding, and annual reporting. The programs that may be implemented under this program must be client-focused, culturally competent, and evidence-informed. Programs included under this statute include:

- Mental Health and/or Drug and Alcohol Services as intervention services for allegations or founded reports of child abuse and neglect
- Residential treatment for a child's caregiver to participate in 24 hour supervised mental health or addiction services
- Supervised housing where children and caregiver can live together while the caregiver is receiving any SPRF program services and mental health or addiction services
- Intensive in-home services
- Facilitated visits
- Case managers to provide supervision, identify needed services, support positive parenting and develop life skills to ensure sufficiency
- Access to short term, emergency, drug-free supportive housing
- Family finding services
- Appointment of a Court Appointed Special Advocate (CASA) for the children if available and appropriate

SPRF programs work collaboratively in state-county partnerships between DHS agencies and county social services providers; collect outcome measures; offer workforce development and training; and demonstrate fiscal prudence as outlined in ORS 418.585. Extensive details about the SPRF statute can be found at https://www.oregonlaws.org/ors/418.580.

Safe and Together Model

David Mandell and Associates, LLC, developed the Safe and Together Model as one of many tools to support the safety and well-being of children that have experienced domestic violence. This Model is based on the following principles:

- Keeping children safe and together with a non-offending parent
- Partnering with non-offending parent as the default position
- Intervening with perpetrator to reduce risk and harm to the child

David Mandell and Associates, LLC has created education materials, online courses and training and consultation about the Safe and Together Model, as well as other Domestic Violence tools. Details about Safe and Together Model, and the many resources that David Mandell and Associates, LLC support can be found at http://endingviolence.com.

DHS promotes the practice of this model in their:

- DHS new child welfare worker core training
- As part of the Oregon Safety Model
- Child welfare best practices for DV cases

guiding frameworks

TOPICS

- Collaboration
- Collective impact
- Domestic violence informed care
- Trauma-informed care

GOAL

The goal of the guiding frameworks is to develop mutually beneficial and well-defined relationships to achieve a common goal, support well-being and base the work on trauma-informed principles.

OBJECTIVES

- Describe
  - Collaboration
  - Collective Impact
  - Domestic Violence Informed Care
  - Trauma-Informed Care
- Discuss the role of these frameworks in supporting DV survivors

WHAT IS COLLABORATION?

Collaboration requires a group of people with diverse skills, experience and knowledge to commit to working towards a shared vision. Collaboration can:

- Open lines of communication between participants
- Improve relationships
- Increase trust, knowledge, and resources
- Break down barriers between individuals

Collaboration builds on the individual strengths and institutional resources of the participants and results in outcomes that cannot be achieved alone. In recognition of this, partner organizations acknowledge that each has different roles and guidelines in responding to child abuse/neglect and domestic violence. All parties agree to respect these roles and the specific confidentiality guidelines, policies and procedures of the individual agencies, and commit to fostering an environment of cooperation, respect and trust.

The Levels of Collaboration Scale defines collaboration as networking, cooperation, coordination, coalition and collaboration. A copy of the levels of collaboration scale can be found in the attachments.[32]

The benefits of collaboration extend beyond this project and can extend to other multi-disciplinary efforts.

Collective Impact

The Collective Impact Model is based on collaborative relationships where partners can develop a common agenda, identify shared measurements or metrics that they can work on together, implement mutually reinforcing activities, and continuously communicate with one another. However, building strong working relationships takes time and trust. All partners will need to overcome old patterns of working independently and in silos to new patterns of working together towards shared outcomes.[33]

The Domestic Violence Informed Care Framework

This framework outlines a Social and Emotional Well-Being Promotion Framework, also referred to as the as the Well-Being Framework, as an ideal structure to guide the goals and practices of domestic violence programs. This framework focuses on the development of intrapersonal and interpersonal factors of well-being in order to minimize risk factors for domestic violence and maximize protective factors for resiliency.

Intrapersonal well-being is defined as how a person feels internally. It is based on self-efficacy and hopefulness. Self-efficacy is the belief in one's self in achieving a goal, and hopefulness is the belief that tomorrow will bring better times. Interpersonal well-being is defined as the

32 This information was retrieved from http://www.signetwork.org/content_page_assets/content_page_68/MeasuringCollaborationAmongGrantPartnersArticle.pdf

33 Kania, J., Kramer, M. (Winter 2011) Stanford Social Innovation Review. *Collective Impact*. Retrieved from http://ssir.org/articles/entry/collective_impact

external relationships a person has and the environments that an individual lives in. Examples of interpersonal components include:

- social connectedness and positive relationships with others
- safety
- physical, emotional and spiritual health
- adequate resources
- social, political and economic equity

DV programs that build both intrapersonal and interpersonal strengths can

> "help survivors and their children thrive; and recognize the importance of community, social, and societal context in influencing individual social and emotional well-being."[34]

Co-located DV advocacy programs that are built on intrapersonal and interpersonal factors and contain the following program activities can improve the overall social and emotional well-being of DV survivors. Activities that support the Well-Being Framework include:

1. Connection to information
2. Development of a safety plan
3. Opportunity for skill building
4. Encouragement
5. Supportive counseling
6. Access to community resources
7. Social support and community connections
8. Opportunities to contribute to community and systems change[35]

Trauma-Informed Care

DV survivors and their children have experienced trauma and need to be supported by a system that incorporates trauma informed care principles into their procedures, practices and policies. A fundamental element of implementing a trauma informed care framework is the understanding of the impact of historical trauma and oppression. To address this, DV programs are encouraged to incorporate cultural and linguistic specific practices into all aspects of the co-located DV advocacy program.

The basis for incorporating a trauma informed care model include the following elements:

- **Creating a safe space**, physically, emotionally, that is transparent, predictable and has clear and consistent boundaries
- **Valuing the individual** through relationship, compassion, respect, acceptance, non-judgment and collaboration
- **Restoring power** by promoting choice, empowerment, strengths and skill building

34 Retrieved (August, 2017), from: http://www.dvevidenceproject.org/wp-content/uploads/DVEvidence-Services-ConceptualFramework-2016.pdf
35 Ibid.

The increased awareness of the high prevalence rates of trauma led the Substance Abuse Mental Health Service Agency (SAMHSA) to develop a trauma informed framework based on a public health approach. SAMHSA brought together trauma survivors who had been recipients of care in multiple service systems; practitioners from diverse backgrounds with experience in trauma treatment; researchers whose work focused on trauma; and policymakers in the field of behavioral health to develop a trauma informed care framework with a common language and philosophy about trauma.[36]

This framework is based on four components:

- **Realization** is the understanding of the impact that trauma has on individuals, children, groups, organizations, and communities
- **Recognition** is the ability to identify the signs and symptoms of trauma
- **Responsiveness** is the ability to respond to trauma with the shared principles of a trauma-informed approach
- **Resisting Re-traumatization** requires that individuals or organizations do not act, have practices or policies that continue to cause trauma

In addition, there are some basic principles that most trauma specialists agree are standard principles of Trauma-Informed Care System. These principles include a common understanding and awareness about the role of trauma and its impact on individuals and communities; safety and a sense of security for everyone involved; trustworthiness; peer support and relationship-based care: collaboration and mutuality; empowerment through a governance that includes consumer voice and choice; respect for culture, history, gender choices and diversity; healing, post traumatic growth and resiliency opportunities; and aligned and integrated care.[37, 38, 39]

The Trauma-Informed Framework that SAMSHA developed has ten implementation strategies for organizations that want to develop practice and systemic changes. These strategies include:

1. Governance and Leadership- the leaders and governance of an organization need to be invested in making trauma informed organizational change
2. Policy- the organization has written policies that support trauma informed principles that are part of the organization's culture and practices
3. Physical Environment- the physical space has to feel safe and secure
4. Engagement and Involvement- trauma survivors and people in recovery need to have a voice in the development of the system and have a menu of choices to support their healing
5. Cross sector collaboration- this collaboration must be based on a shared vision and understanding of trauma, healing, post traumatic growth and resiliency
6. Screening, assessment and treatment services- the screening and support services for people who have experienced trauma must be evidence based and/or evidence informed to ensure the highest quality of care

36 Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration. (July 2014). Retrieved at http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

37 Ibid.

38 Gordon R. Hodas. Responding to Childhood Trauma the Promise and Practice of Trauma Informed Care. (February 2006). Retrieved at http://www.childrescuebill.org/VictimsOfAbuse/RespondingHodas.pdf

39 Richard G. Tedeschi & Cara L. Blevins (2015) "From Mindfulness to Meaning: Implications for the Theory of Posttraumatic Growth", Psychological Inquiry, 26:4, 373-376, DOI: 10.1080/1047840X.2015.1075354. Retrieved at https://ptgi.uncc.edu/wp-content/uploads/sites/9/2015/01/From-Mindfulness-to-Meaning-Implications-for-the-Theory-of-Posttraumatic-Growth.pdf

7. Training and workforce development- training and practices are in place to support people who are working with people who have experienced trauma, especially complex trauma
8. Progress monitoring and quality assurance- a tool to ensure ongoing assessment to ensure that best practices are being implemented
9. Financing- structures that are robust enough to ensure that the strategies of the framework, and the principles of trauma informed care can be implemented to full fidelity
10. Evaluation- measures and design that intentionally measures the effectiveness of the trauma informed system

For Oregon information about trauma informed care training and resources refer to https://traumainformedoregon.org/.

resources

- State and national contact list
- Local contact list
- Oregon domestic violence documents
- National domestic violence documents
- State websites
- Regional and national websites
- Glossary
- Acronym list
- Attachments

State and National Contact List

It is recommended that the local MOU include a list of local contacts for both the Co-located advocate and DHS staff. An example follows with recommendations for positions that could be included, particularly within DHS:

DEPARTMENT OF HUMAN SERVICES (DHS)			
NAME	PROGRAM	EMAIL	PHONE
Amber Harchuk	TA-DVS Policy/ Co-located Advocates	Amber.r.harchuk@state.or.us	503-947-2630
Cheryl O'Neill	Child Welfare	cheryl.l.oneill@dhsoha.state.or.us	503-945-6686

OREGON DOMESTIC AND SEXUAL VIOLENCE RESOURCES CONTACTS		
PROGRAM	WEBSITE	PHONE
Oregon Coalition Against Domestic and Sexual Violence (OCADV)	www.ocadsv.org	503-230-1951
Oregon Sexual Assault Task Force	www.oregonsatf.org	503-990-6541

NATIONAL DOMESTIC AND SEXUAL VIOLENCE RESOURCES CONTACTS		
PROGRAM	WEBSITE	PHONE
National Network to End Domestic Violence (NNEDV)	www.nnedv.org	202-543-5566
National Sexual Violence Resource Center (NSVRC)	www.nsvrc.org	717-909-0710

Local Contact List

DEPARTMENT OF HUMAN SERVICES				
COUNTY	BRANCH	SSP/CW	NAME	PHONE

LOCAL DOMESTIC VIOLENCE SERVICE PROVIDER			
Website:			
Crisis line:			
DVSA AGENCY CONTACT	POSITION	PHONE	CELL

Oregon Domestic Violence Documents

1. A Legal Guide for Oregon Advocates: http://oregonlawhelp.org/files/CCDACC15-944D-570E-7F1F-7BBF3DEC0018/attachments/1AE3BF12-D72C-4A8D-B8C2-3DEFD466C3F0/dv-advocate-manual.pdf
2. Child Abuse and Neglect: What You Can Do About Child Abuse: https://apps.state.or.us/Forms/Served/de9061.pdf
3. Child Welfare, Child Welfare, Client Rights, Policies and Oregon Administrative Rules: http://www.dhs.state.or.us/policy/childwelfare/manual_1/division_10.pdf
4. Child Welfare, Child Welfare Practices for Cases that have Domestic Violence: https://apps.state.or.us/Forms/Served/ce9200.pdf
5. Oregon Coalition Against Domestic and Sexual Violence Legal Manual: https://www.ocadsv.org/sites/default/files/resource_pub/ocaDV_legalmanual2015.pdf
6. Parenting: http://www.dhs.state.or.us/caf/documents/Parenting_in_the_Context_of_Coercive_Control.pdf
7. Portland State Evaluation Report One: http://www.doj.state.or.us/victims/pdf/ipvp_psu_evaluation_findings_report_1.pdf
8. Portland State Evaluation Report Two: http://www.doj.state.or.us/victims/pdf/ipvp_psu_evaluation_findings_report_2.pdf
9. Portland State Evaluation Report Three: http://www.doj.state.or.us/victims/pdf/ipvp_psu_evaluation_findings_report_3.pdf
10. Portland State Evaluation Report Four: http://www.doj.state.or.us/victims/pdf/ipvp_psu_evaluation_findings_report_4.pdf

National Domestic Violence Documents

1. Battered Women's Protective Strategies: http://vawnet.org/sites/default/files/materials/files/2016-09/AR_BWProtStrat.pdf
2. Helping Children Thrive: Supporting Woman Abuse Survivors as Mothers: https://vawnet.org/material/helping-children-thrive-supporting-woman-abuse-survivors-mothers-resource-support
3. Invisible Majority: The Disparities Facing Bisexual People and How to Remedy Them: http://www.lgbtmap.org/file/invisible-majority.pdf
4. Supporting Battered Mothers Protects Children: Reducing the Effects of Domestic Violence on Children https://www.dhs.state.or.us/caf/documents/Supporting_Battered_Mothers_Protects_Children.pdf

State Websites

1. Child Welfare: Child Abuse and Neglect: http://www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE/Pages/index.aspx
2. Child Welfare: Practices for Cases with Domestic Violence: https://apps.state.or.us/Forms/Served/ce9200.pdf
3. Child Welfare Tools: http://www.dhs.state.or.us/caf/cw_stafftools.htm
4. LGBTQ Communities: https://www.ocadsv.org/resources/browse/274
5. Oregon Coalition Against Domestic and Sexual Violence: www.ocadsv.org
6. Oregon Department of Human Services: http://www.oregon.gov/DHS/Pages/index.aspx

7. Oregon Department of Human Services Domestic Violence Programs: http://www.oregon.gov/DHS/ABUSE/DOMESTIC/Pages/resources.aspx
8. Oregon Law Center: http://www.oregonlawcenter.org
9. Oregon Law Help: www.oregonlawhelp.org
10. Oregon Self-Sufficiency Tools Page: http://www.dhs.state.or.us/caf/dv/tools.htm#presentations

Regional and National Websites

1. American Bar Association: https://www.americanbar.org/aba.html
2. CDC-Coping with Stress: https://www.cdc.gov/features/copingwithstress/index.html
3. David Mandel's online training: http://endingviolence.com/
4. Futures without Violence: https://www.futureswithoutviolence.org/
5. Legal Momentum: https://www.legalmomentum.org/
6. National Child Traumatic Stress Network: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
7. National Immigration Project: https://nationalimmigrationproject.org/index.html
8. National Indian Child Welfare Association: www.nicwa.org
9. National LGBTQ Institute on IPV: http://lgbtqipv.org/collaborate/
10. National Network to End Domestic Violence (NNEDV): http://nnedv.org/
11. National Resource Center on Domestic Violence: http://www.nrcdv.org/
12. National Sexual Violence Resource Center: http://www.nsvrc.org/
13. Northwest Immigrant Rights Project: https://www.nwirp.org/our-work/direct-legal-services/survivors-of-violence/
14. Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse: http://www.nwnetwork.org/
15. Prevention Institute, Preventing Violence: https://www.preventioninstitute.org/focus-areas/preventing-violence
16. Resource Center on Domestic Violence: Child Protection and Custody: https://rcdvcpc.org/
17. Safe and Together: http://endingviolence.com/our-programs/safe-together/safe-together-overview/
18. US Department of Justice—Office on Violence Against Women: https://www.justice.gov/ovw
19. VAWnet: http://vawnet.org/
20. Women's Law: http://www.womenslaw.org/

Glossary

Advocate Privilege is an Oregon law that makes the communication between a certified advocate and the victim, or the victim's family or providers, confidential and information can only be disclosed if the victim consents.

Child Welfare Services is often the name of an agency or division that strives to keep children healthy and safe. In Oregon this division is referred to as Children and Youth.

Domestic Violence and Sexual Assault Agencies are organizations that have a primary focus on providing services to survivors of domestic violence, sexual assault, stalking and/or dating violence.

Indian Child Welfare Act (ICWA) is a federal law that seeks to keep American Indian children that have experienced abuse or neglect with American Indian children and tribes.

Mandatory Child Abuse Reporter is a person who is required to report child abuse outlined by Oregon law.

Oregon Safety Model is the framework to keep children safe that guides most child welfare practices across the state.

Self-Sufficiency are assistance and benefit programs that support individuals and families with basic needs, such as food, clothing, shelter, child care, refugee supports, disability services, employment training and health care.

Strengthening, Preserving and Reunifying Families are services in Oregon that focus on preventing foster care placements, preserving the safety, health and integrity of families; and promoting the quickest reunification possible.

Safe and Together Model is a model developed by David Mandel Associates, LLC, that offers domestic violence tools and interventions. It is a strengths based approach to domestic violence that is perpetrator based, child centered and survivor strengths focused.

T-Visa is a nonimmigrant status the United States Government developed to strengthen the ability of law enforcement agencies to investigate and prosecute human trafficking, and also offer protection to victims

U-Visa is a nonimmigrant status which provides support for DV survivors who provide information to law enforcement or government about human trafficking.

VAWA, the Violence Against Women Act initially passed in 1994, as part of the Violent Crime Control and Law Enforcement Act was the first comprehensive federal legislative package designed to end violence against women.

DHS Web Based Resources and Tools

For all current forms and publications, go to the DHS form server: https://aix-xweb1p.state.or.us/es_xweb/FORMS/?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany and use the DHS form number to find the most updated form.

1. DHS –Release of Information: Form #2099
2. DHS Child Welfare for Cases with Domestic Violence: Form #9200
3. Safety Strategies (Child Welfare)
4. DHS Client Complaint or Report of Discrimination: Form #0170
5. DHS Safety Assessment: Form #7802

Attachments and Links

1. Authorization for Use and Disclosure of Information (DH 2099)
2. VAWA Compliant Release of Information Form: (ROI)
3. NNEDV VAWA 2005 Policy Fact Sheet
4. The Safety Packet is available at: https://apps.state.or.us/Forms/Served/de8660.pdf
5. Additional information about safety concerns and child support is at: http://www oregonchildsupport.gov/resources/safety_2.shtml
6. Filing a Complaint (Grievance) with Oregon DHS
7. DHS Administrative Hearings
8. NCTSN: Domestic Violence and Children
9. Frequently Asked Questions Related to Children Witnessing Domestic Violence
10. Department of Justice Guideline for Memorandum of Understanding
11. Domestic Violence and the Mandatory Reporting Act for State Supplemental Program Workers – Confidentiality and Sharing of Information in the Domestic Violence and DHS Collaboration (pp. 68-70)
12. Domestic Violence and the Mandatory Reporting Act for State Supplemental Program Workers
13. Domestic Violence 101 Outline
14. Levels of Collaboration Scale

Domestic Violence 101

Domestic Violence is a pattern of controlling and coercive behaviors including physical, emotional, sexual, verbal, psychological, spiritual, and economic abuse. Domestic violence is present in all cultures, ages, socio-economic classes, and communities of faith.

DHS recognizes the importance of training all staff on the dynamics of domestic violence. Whenever possible, DHS staff are to be trained by their local domestic violence service provider. In addition to training, domestic and sexual violence advocacy programs are the primary resources for shelter, developing safety plans, support groups, etc. DHS staff are encouraged to seek collaborative partnerships in order to address the needs of victims and survivors in their communities. To cover all the subjects identified it is estimated that the training will take at least 3-4 hours. The following basic components are recommended for any DHS sponsored training on domestic violence:

1. Types of Abuse/Continuum of Abuse

- Emotional
- Physical
- Sexual
- Verbal
- Psychological
- Spiritual
- Economic Escalation of abuse over time
- Financial Abuse

2. Warning Signs of Abusive Behavior:

- Manipulative Charm
- Isolation
- Jealousy
- Emotional Abuse
- Control
- Unstable financially and culturally (often seen in the immigrant and refugee families)

3. Addressing Myths

- Children who witness domestic violence grow up and become abusers or victim
- Alcohol and/or drugs cause domestic violence
- Domestic Violence is an “anger control” issue
- Stress/Poverty/Culture causes domestic violence
- Low self-esteem leads to becoming a perpetrator/victim of domestic violence
- Women “choose” abusers/go from one abuser to another
- The victim is responsible for the actions of the abuser

4. Dynamics of Domestic Violence

- Domestic violence is a choice
- Domestic violence is about power and control
- Domestic violence crosses all ages, socio-economic levels, cultures, religions, etc.

5. Barriers to Leaving an Abuser

- Fear/Danger
- Lack of Options/Poverty
- Pressure from family, friends, faith community
- Oppression
- Language
- Cultural / societal pressures (often seeing in the refugee and immigrant families)
- Transportation
- System (paperwork, regulations, time lines, and etc.)
- Children (often seeing the in immigrant and refugee families that victims do not want to leave their abuser or come back to their abuser)
- Illiterate / uneducated

6. Ways to Support Survivors/Services Available/Coordination with other Service Providers (Law Enforcement, District Attorney's Office, Medical Service Providers, etc.)

7. Partnering with Domestic and Sexual Violence Advocacy Programs

Levels of Collaboration Scale

Collaboration is generally treated as meaning the cooperative way that two or more entities work together towards a shared goal. The School Program Evaluation and Research Team developed the Levels of Collaboration scale, based on the work of other collaboration researchers (Hogue, 1993; Borden & Perkins, 1998, 1999) to measure progress over the five stages of collaboration. The five stages are described as:

1. **Networking-Aware of organization**
   - Loosely defined roles
   - Little communication
   - All decisions are made independently
2. **Cooperation-Provide information to each other**
   - Somewhat defined roles
   - Formal communication
   - All decisions are made independently
3. **Coordination-Share information and resources**
   - Defined roles
   - Frequent communication
   - Some shared decision making
4. **Coalition-Share ideas**
   - Share resources
   - Frequent and prioritized communication
   - All members have a vote in decision making
5. **Collaboration-Members belong to one system**
   - Frequent communication is characterized by mutual trust
   - Consensus is reached on all decisions

It is also possible that some partner groups have no interaction with other groups, especially at baseline, and this possibility is reflected in the instrumentation by allowing respondents to choose "0" to indicate no collaboration whatsoever.

Given the definitions of each level, during administration of the scale, respondents are asked to what extent they collaborate with each other grant partner. Answer options are on a 0 to 5 scale with 0 indicating "no interaction at all" and 5 indicating the collaboration level using Hogue's taxonomy.

Data collected with the *Levels of Collaboration* scale can be reported quantitatively utilizing different formats and different summations depending on the interests of evaluators, grant directors and stakeholders. Collaboration can be reported as the mean level of perceived collaboration across all respondents for all partners, summarized in other meaningful ways, or provided as raw data in a table. Because, by definition, collaboration only exists when two or more parties interact with each other, situations where two partners report different levels of collaboration with each other represent areas for exploration and discussion between those partners. As the scale assesses perceptions of collaboration, different perceptions by two collaborating partners may both be valid responses.

Levels of Collaboration Scale

From Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation*, 27, 3, 383-392.

Name _____

Date _____

This form is designed for those who work in one of the organizations or programs that are partners in the _____. Please review these descriptions of different levels of collaboration.

- On the response section at the bottom of the page, please circle the name of the organization or group with which you are associated.
- Using the scale provided, please indicate the extent to which you **currently** interact with each other partner. (Skip your own row.)

FIVE LEVELS OF COLLABORATION AND THEIR CHARACTERISTICS

PARTNER	1: NETWORKING	2: COOPERATION	3: COORDINATION	4: COALITION	5: COLLABORATION
	– Aware of organization – Loosely defined roles – Little communication – All decisions are made independently	– Provide information to each other – Somewhat defined roles – Formal communication – All decisions are made independently	– Share information and resources – Defined roles – Frequent communication – Some shared decision making	– Share ideas – Share resources – Frequent and prioritized communication – All members have a vote in decision making	– Members belong to one system – Frequent communication is characterized by mutual trust – Consensus is reached on all decisions
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	1	2	3	4	5
	1	2	3	4	5