



An assessment of survivors' needs and available services

October 2010



Prepared for
WOMEN'S FUND
of OMAHA

Intimate Partner Violence in Omaha: An assessment of survivors' needs and available services

Prepared for the Women's Fund of Omaha

October 2010

Prepared by Wilder Research



AMHERST H.
WILDER
FOUNDATION

ESTABLISHED 1906

Here for good.

Primary authors:

Monica Idzelis & Maggie Skrypek

Project contributor:

Thalia Cooper

Wilder Research
451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

Contents

Author’s note	1
Executive Summary	2
Next steps.....	5
Background.....	6
Study focus.....	6
Methodology.....	7
Understanding intimate partner violence	8
Introduction.....	10
Prevalence of intimate partner violence.....	10
Survivor experience	13
IPV survivor profile	13
Survivor needs	16
Services for survivors	18
Description of services.....	18
Outreach and engagement.....	21
Barriers to services.....	25
Gaps in services	26
Service coordination and program partnerships	31
Partnerships.....	31
Collaboration.....	32
Service coordination successes	32
Service coordination challenges	33
Opportunities for future coordination	35
Profile: Family Justice Center of the Midlands	36
Prevention strategies	42
Current prevention efforts.....	42
Challenges around prevention.....	44
Opportunities for future prevention work.....	45

Contents (continued)

Best practices	47
Best practices in Omaha.....	47
Programs and practices for consideration	49
Opportunities for enhancing individual practice.....	50
Funding opportunities	51
Future directions	53
Future research opportunities.....	56
Appendix.....	57
List of references.....	59
Description of participating agencies.....	62
Description of methodology	67
Review of best practices	68
Evaluation materials.....	82

Figures

1. IPV services utilized in the greater Omaha area in 2009	12
2. Sample of evidence-based domestic violence intervention and prevention programs	49

Acknowledgments

The following staff from Wilder Research contributed to the completion of this report:

Natalie Alizaga
Jackie Campeau
Marilyn Conrad
Paul Devereaux
Amanda Eggers
Jennifer Franklin
Louann Graham
Michelle Gerrard
Cheryl Holm-Hansen
Heather Johnson
Nam Nguyen
Greg Owen
Brittney Wagner
Kerry Walsh
Aaron Wasserman-Olin

We would also like to acknowledge each of the key informants interviewed for this study, and their willingness to participate in these interviews and share their insights. We would also like to acknowledge the guidance provided by the Women's Fund of Omaha and the study advisory team, comprised of Ellie Archer, Mary Heng-Braun, Dianne Lozier, Dr. Maryanne Stevens, and Barbara Weitz.

Support provided by the Lozier Foundation.

Author's note

At the time this report went to press, significant leadership changes were occurring within the Intimate Partner Violence (IPV) service provider community in Omaha. Because the data for this report were collected and analyzed prior to these changes, the report does not fully reflect the current state of leadership within the IPV provider community. However, the authors do wish to acknowledge that these changes present both challenges and opportunities with regard to the community's efforts to address IPV. While these leadership transitions may cause short-term delays in progress, they might also present a renewed opportunity for the community of service providers to come together and decide on a shared strategy for change, and work together to move forward toward common goals.

Executive Summary

The Women's Fund of Omaha, in partnership with the Lozier Foundation, contracted with Wilder Research to examine the landscape of services for Intimate Partner Violence (IPV) survivors in the Omaha community. Although prevalence rates vary, a 2005 estimate found that 22 percent of women and 11 percent of men in Nebraska have experienced partner violence at some point in their lifetime. In the greater Omaha area, on a single day in September 2010, service providers served 67 women and 33 children in need of emergency shelter, transitional housing, and other non-residential IPV-related services.

Individuals experiencing IPV can have multiple needs. Most immediately, these often include securing safety and shelter, as well as medical care for injuries, police involvement and/or obtaining an Order for Protection, basic needs such as food and clothing, and legal support. In addition, a survivor may need significant emotional support, as well as information about available services and options. Longer-term, ongoing needs can include mental health support, affordable transitional or permanent housing, substance abuse treatment, and job skills training.

To gather information about the needs of survivors and available services in Omaha, the researchers conducted interviews with 37 service providers and other local experts, focus groups with 12 survivors, and a targeted literature review. The following key themes emerged from this assessment:

A comprehensive set of services is available for survivors in Omaha, although some gaps exist

Service providers, shelters, and their community partners provide an array of services for survivors, who are often connected with these services through crisis hotlines, law enforcement incident reports, and hospitals/clinics and other community-based agencies. The primary agencies providing IPV services in Omaha typically connect survivors with an advocate, who will identify a survivor's needs and coordinate all of the necessary services. The immediate priority is to address issues of safety. Advocates often make referrals to local domestic violence-specific shelters in the area when needed, or other general shelters when space is not available. Providers will also engage in safety planning with survivors, a critical element. Survivors' basic needs are also addressed; providers frequently refer survivors to local food pantries, clothing closets, and other similar agencies as needed. Other types of support provided to survivors include legal assistance, physical and mental health support and referrals, and programming aimed at improving survivors' self-sufficiency.

While providers have the capacity to meet many survivors' needs, especially immediate needs, some services are lacking, often due to a shortage of funding and resources. Because of limited funding, providers may want to consider whether there are opportunities to partner with one another to address these key service gap areas:

- Emergency shelter and transitional housing
- Sufficient number of advocates to serve the needs of the community
- Programming for children who have witnessed domestic violence, who may be dealing with trauma or other issues
- Culturally-specific services, especially bilingual therapists and programs for African refugees
- Specialized programming for marginalized or other vulnerable populations, such as teenagers, the elderly, the gay, lesbian, bisexual, and transgender (GLBT) community, deaf and hard of hearing individuals, and male survivors
- Long-term mental health services and treatment, including funding for such services
- Emergency funds for survivors, to cover expenses like basic needs, home or car repairs, transportation, housing, storage and moving expenses, current and past bills, legal fees, and health assessments and evaluations
- Systemic gaps such as duplicative services across providers, inconsistent agency practices, and staff turnover, which can impact an agency's ability to effectively serve survivors.

Furthermore, to ensure that the individuals in need of services receive them, outreach efforts could also be expanded. This includes increasing visibility among underserved communities, enhancing marketing strategies and increasing public awareness, streamlining the crisis hotline entry point across providers, and providing training for first responders including medical personnel and law enforcement.

Service providers generally collaborate well with one another, although there are opportunities to enhance these partnerships and streamline services

Provider organizations in Omaha are familiar with one another's services and often partner in various ways to meet the needs of survivors. This includes making service referrals to one another, teaming around service provision, hosting or participating in trainings provided by a local organization, and joining forces to secure grant funding.

Successful partnerships are those in which agencies make an effort to learn about one another and develop a rapport, and clearly define the roles and responsibilities of each agency in the delivery of services. Practically, this often means making staff from one agency available to clients served through a partner agency, as in the case of advocates who visit or are located onsite at a support agency that serves survivors. However, collaboration among Omaha's providers is sometimes threatened by competition among agencies for resources and funding, often leading to "turf wars," and by a lack of clarity among support agencies and survivors around the role each agency plays in the continuum of services to survivors. The recent launching of the Family Justice Center of the Midlands, which aims to provide a "one-stop shop" for survivors and includes many community service providers as either onsite or offsite partners, also has implications for service coordination. To enhance coordination, the service provider community should consider the following:

- Engage new partners, especially those representing underserved groups
- Utilize a shared database like the Domestic Violence Information Sharing System (DVISS)
- Increase collaboration around marketing and public awareness, to avoid fragmented services and confusing messages to the public
- Renew discussions around the future of the Family Justice Center of the Midlands, including ways to increase buy-in among partners, creating opportunities to communicate and share feedback, and protocols related to referring survivors

The prevention of intimate partner violence is being addressed by the community to varying degrees, but more can be done, especially with regard to educating children

Most of the prevention efforts in the Omaha area target children and youth. Strategies include school presentations for middle schools, high schools, and colleges; school-based prevention curricula; some early childhood prevention programs; and public service announcements and other media aimed at increasing community awareness. A few service providers in the area also offer non-violence programming for perpetrators of violence. Although prevention-focused efforts have steadily increased in the community in recent years, there remain challenges to doing this type of work. These include partnering with schools, lack of funding dedicated to prevention activities, language barriers, and the perception of community resistance to discussing the issue. Despite some of the challenges around prevention work, there are several opportunities to build on the current efforts underway in the Omaha area:

- Teach young children, as early as preschool or elementary school, about healthy relationships
- Establish partnerships between schools and service providers, and consider how providers might play a role in ongoing presentations to children and in the development/implementation of school-based prevention curricula
- Implement public awareness campaigns using both traditional media outlets as well as new media, such as Facebook, Twitter, and youth-oriented websites, to reach broader audiences
- Engage men in leadership capacities, who could serve as role models for other men around maintaining healthy relationships
- Consider the language needs of the population and make prevention materials and programming available in those languages, particularly in Spanish

Next steps

Although the greater Omaha area has an extensive network of service providers and has made great strides in recent years to increase collaboration and outreach, there are opportunities to further enhance service delivery. This includes addressing current service gaps, enhancing outreach and service coordination, and further addressing prevention efforts as outlined above. In addition, the community would benefit from continued research into prevention and early intervention strategies and the needs of special populations to ensure any new services implemented are appropriate and effective. Furthermore, conducting a process and outcome evaluation of the Family Justice Center of the Midlands will provide important information about service coordination efforts and opportunities to enhance service delivery under this model.

By building on current strengths and addressing these issues, the Omaha community will ensure that survivors receive the best possible services and ultimately keep children and families safe and violence-free.

Background

The primary goal of this study was to examine the landscape of services for Intimate Partner Violence (IPV) survivors in the Omaha community. Wilder Research, a nonprofit evaluation and research organization based in Saint Paul, Minnesota, was contracted by the Women's Fund of Omaha, in partnership with the Lozier Foundation, to gather information about the needs of IPV survivors in the metropolitan Omaha area, the current state of available services for survivors, and opportunities for enhancing IPV services and programs. In particular, the study addressed:

- The needs of intimate partner violence survivors and their families
- Available services for survivors, including the capacity of providers to address survivor needs, as well as barriers to, gaps in, and duplications of service
- The identification of and outreach to survivors
- The communication and collaboration between programs and agencies, and the extent to which this influences service delivery
- Strategies for preventing intimate partner violence, and best practices in the field

Study focus

Intimate partner violence is a prevalent, complex issue involving numerous systems and individuals. Although information was gathered from stakeholders representing some of these many systems, the report is not intended as a multi-system examination of the issue of intimate partner violence. While systems such as law enforcement and schools are critical to a comprehensive community response to the issue of IPV, the purpose of this report was to examine the landscape of available services for IPV survivors in the Omaha community. Therefore, the report focuses primarily on the community of providers offering direct services, support, and advocacy to survivors.

Methodology

Information for this report was gathered from three primary sources, and then systematically analyzed for key themes.

Data sources

Service providers and other local experts. Researchers conducted 37 key informant interviews with select representatives from agencies and other organizations in the Omaha community serving survivors of intimate partner violence. During two visits to the Omaha area, Wilder Research conducted all in-person interviews and recorded them with the informant's permission. Due to participants' unavailability at the time of the Wilder Research visits, two interviews were conducted by telephone. Key informants were identified by the study advisory group, as well as other key informants interviewed for this study. They included representatives from coordinating agencies, domestic violence service providers, shelters, support and referral agencies, hospitals and clinics, colleges and universities, and other related systems, such as the courts and county attorney's office (see appendix for the full list of agencies and a brief description of their services). Organizations providing direct services were also asked to provide quantitative information about the number of survivors served and types of services provided.

Survivors of intimate partner violence. To gain a first-hand perspective about experiences accessing IPV services, researchers conducted two focus groups with survivors of intimate partner violence. A total of 12 survivors participated in these focus groups. Participants were referred by local service providers who felt the survivors were far enough along in their recovery to speak comfortably about their experience as an IPV service recipient without causing further trauma. Participants received gift cards as a thank you for their time.

Literature in the area of intimate partner violence. To supplement the information provided by key informants and survivors, a targeted literature review was conducted. The review focused on the following topics: a) recently published information (i.e., in the past five years) about the prevalence of and issues related to IPV, b) evidence-based programs and best practices in the area of IPV, c) the Family Justice Center model, and d) federal funding opportunities in the field.

Data analysis and reporting

For analysis, recorded interviews and focus groups were converted into electronic audio files and transcribed into text documents. Researchers then analyzed interview and focus group data using qualitative analysis software (ATLAS.ti), which involves reading all

interview and focus group narrative and coding it for themes and sub-themes. Researchers met regularly during this process to review and discuss key themes, and worked together to summarize key findings for the following report. More information about this process is available in the appendix.

Study limitations

Information was gathered from a broad range of service providers in the community with a wealth of experience and expertise in IPV. However, given the time and resources available for this study, a finite number of individuals could be consulted. Therefore, some individuals and agencies involved in the issue of intimate partner violence in the Omaha community may have been excluded from this assessment. Furthermore, only 12 survivors participated in the focus groups. The perspectives of each group (provider and survivor) were vital to understanding the needs of survivors and the availability of services, but may not be representative of all providers or survivors. In addition, a targeted literature review was conducted on select topic areas to supplement the interview and focus group data. The literature review was limited to these topic areas given the project timeline and available resources and is not intended to provide a comprehensive summary of the literature in the field of IPV.

Understanding intimate partner violence

In this report, both the terms “intimate partner violence” and “domestic violence” will be used to describe violence directed toward a current or former partner. In 1999, the Centers for Disease Control and Prevention (CDC) recommended use of the term “intimate partner violence” in an effort to distinguish it from other forms of family violence, such as child maltreatment or elder abuse. However, the term “domestic violence” is still widely used today, especially among the advocacy community and general public. Therefore, both terms will be used when referring to this type of violence. In addition, while the researchers acknowledge that both men and women can be survivors and perpetrators of IPV, the majority of individuals who experience and report IPV are women. For this reason, female pronouns are used to reference survivors.

Definitions

Definitions of intimate partner violence vary, influenced by different perspectives on the issue (e.g., grassroots movement researchers, family violence researchers, the legal system, and public health). While these variable definitions have implications for research and services, this report does not attempt to reconcile these differences or

recommend one approach above another. For the purposes of this report, domestic violence is conceptualized as the following four types of behaviors.¹

- ***Physical violence***, which involves the use of physical force to cause death, disability, injury or harm and includes behaviors such as hitting, kicking, choking, and use of a weapon.
- ***Sexual violence***, which involves forcing a partner to engage in a sexual act against his or her will and any abusive sexual contact.
- ***Threats of physical or sexual violence***, which include the use of words, gestures, or weapons to communicate an intent to cause harm, injury, or death toward a partner.
- ***Psychological/emotional violence***, or emotional abuse, which involves causing trauma to a partner through the use of threats or coercive tactics that may damage the partner's self-worth. Examples include name-calling, intimidation, isolating the individual from family and friends, stalking, and threats to loved ones or pets.

Intimate partner violence often starts as emotional abuse before escalating to physical or sexual violence. It includes violence among heterosexual and same-sex couples.

¹ This categorization of IPV is based upon the terminology used by the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Prevention.

Introduction

Omaha, located in Douglas County, is the largest city in Nebraska, with a population of more than 454,000. The Greater Omaha metropolitan area which includes eight surrounding counties (the Omaha, NE, Council Bluffs, IA metropolitan statistical area) consists of approximately 850,000 residents.² The racial composition of the city of Omaha is fairly comparable to national demographic estimates. Approximately 77 percent are White, 13 percent are Black or African American, 2 percent are Asian, less than 1 percent are American Indian or Alaskan Native, 3 percent identify as two or more races, and 5 percent comprise other races. About 11 percent are of Hispanic or Latino ethnicity. Greater Omaha tends to be slightly less racially and ethnically diverse, with Whites comprising about 85 percent of the population. In the city of Omaha, about 1 in 12 is foreign-born (compared to 1 in 8 nationally), with Hispanic/Latinos and African-born individuals (primarily Sudanese) comprising the largest proportion of immigrants and refugees. Approximately 15 percent of individuals fall below the federal poverty line (compared to 13% nationally).³

Prevalence of intimate partner violence

Prevalence reports for IPV vary widely, depending on how individual studies define violence and how that information is collected. Intimate partner violence may also be underreported in some cases, due in part to survivors' feelings of shame or guilt often associated with this type of violence.⁴ A 2005 estimate found that nationally, approximately one in four women and one in seven men reported some form of lifetime IPV victimization.⁵ Rates in Nebraska were slightly lower; 22 percent of women and 11 percent of men reported previous experience with partner violence.

2009 and 2010 Nebraska domestic violence census

Since 2006, the National Network to End Domestic Violence (NNEDV) has conducted an annual one-day, unduplicated count of adults and children seeking domestic violence services in the United States. Data are publically available for the one-day count that occurred on September 15, 2009, and included 23 identified domestic violence programs in Nebraska (three of which serve the Omaha community). Statewide, 606 individuals

² Source: U.S. Census Bureau, 2009 Population Estimates.

³ Source: U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates.

⁴ Wilt, S. & Olson, S. (1996). Prevalence of domestic violence in the United States. *Journal of the American Medical Women's Association*, (51)3, 77-82.

⁵ Estimates are based on the 2005 Behavioral Risk Factor Surveillance System (BRFSS) which included over 70,000 respondents representing 16 U.S. states (including Nebraska) and two territories.

received domestic violence services on that day, including 203 who received residential services through emergency shelters or transitional housing, and 403 who received services such as counseling, legal advocacy, and support groups for children. The most common service provided on census day was individual support or advocacy (91%), followed by transportation (74%) and emergency shelter (70%). In total, there were 232 unmet requests for services including emergency shelter, housing, transportation, child care, and legal advocacy. The vast majority of these unmet requests (89%) were related to emergency shelter and transitional housing.

The most recent one-day count occurred on September 15, 2010. At the time this report went to press, preliminary data were available from the three participating service providers serving the Omaha area (Catholic Charities, Heartland Family Services, and the YWCA). On this day, 67 women and 33 children received IPV-related services. Of these, 36 women and all 33 children received emergency or transitional housing services, and 31 women received non-residential services including individual support and advocacy, therapy, legal services, transportation, and advocacy related to immigration. During this 24-hour period, these three organizations also answered 44 hotline calls.

Omaha area service providers turned away nine women and three children who were seeking emergency shelter because there were no available beds. In addition, they were unable to serve five women seeking non-residential services due to limited staff and resources.

Omaha community provider estimates

As part of the current study, researchers asked agencies in the Omaha community to provide information about the populations served and services provided over the past year. Although data reporting methods were somewhat inconsistent across sites, this information provides a general overview of the number and characteristics of individuals utilizing IPV services in Omaha. Of the seven agencies who provided data, three were IPV direct service providers, three were homeless shelters, and one was a community support agency (information was not available for a few shelters and community-based agencies). In total, agencies reported providing IPV-related services and/or shelter to almost 30,000 individuals during 2009 (agencies were asked to provide unduplicated counts *within* their agencies, but this number may include duplicate counts *across* agencies). Figure 1 shows the types of services received, and the percent of people served who received each service.

1. IPV services utilized in the greater Omaha area in 2009

Service type	Number who received service	Proportion of all service types used
Crisis line	15,214	51%
Information/referral	9,562	32%
Victim outreach/advocacy	8,254	28%
Counseling/therapy/support groups	7,787	26%
Shelter	1,291	4%
Transitional housing	183	<1%
Other ^a	1,872	6%
Total served^b	29,939	100%

^a Service providers did not include information about types of services they counted in "other."

^b Participants received services in multiple areas, so number served does equal total number and percentages exceed 100%.

Survivor experience

During key informant interviews, service providers were asked to describe the individuals they serve and whether there were any common characteristics among survivors seeking IPV services. Service providers were clear that while they could comment on the characteristics of individuals served through their programs, they recognized that their current programming may not be targeted or accessible to all IPV survivors. In that regard, they were unsure whether the populations they are currently serving are in fact those most in need of services, or rather those for whom current services were most appropriate and accessible.

IPV survivor profile

Intimate Partner Violence is a significant social and public health concern affecting a large percentage of the overall population. According to a recent national prevalence study, IPV is most common among multiracial, non-Hispanic women, affecting 43 percent of this population, and least common among Asian women, affecting 10 percent of this population. Although IPV rates decline slightly as income and education increase, the rates of incidence are still above 20 percent for women earning over \$50,000 per year, as well as for women who hold a college degree.⁶

Consistent with the literature, Omaha area service providers agreed that intimate partner violence can and does affect women and men from all walks of life. When asked to describe the demographic characteristics of the people they serve, most providers indicated that IPV cuts across all socioeconomic backgrounds, races, and ages. However, some themes emerged with regard to the most typical or common demographic characteristics of survivors seeking services in the greater Omaha area.

Age

Service providers noted that most survivors seeking services were young women. Several providers remarked that while adults over the age of 35 may be just as likely to experience IPV, they may be less likely to attempt to leave the situation and/or seek services. Several service providers indicated that some survivors may feel that the adjustment involved in leaving the stability of the relationship is more traumatic than enduring the abuse. In addition, several providers noted a need for additional services to support teenage survivors as well as older adult survivors, as there are limited services available that target those

⁶ 2005 Behavioral Risk Factor Surveillance System (BRFSS) which included over 70,000 respondents representing 16 U.S. states (including Nebraska) and two territories.

specific groups. Given this, it may be that violence is equally prevalent among these age groups, but existing services are not targeted to meet their needs.

Race and culture

Service providers noted that they see survivors from a variety of racial and cultural backgrounds, with a majority of survivors being white or Caucasian, and the next largest populations being African American and Hispanic/Latina. This distribution reflects the overall racial and ethnic composition of the Omaha area. When asked which groups were least likely to seek services, service providers mentioned Southeast Asian and American Indian populations. Statistically, American Indian women are among the most at risk for intimate partner violence, but providers speculated that they may seek services from reservations, or may be more private about violence in the home.

Providers remarked that they have made progress in reaching out and serving the growing Latina population over the past several years. However, they still remarked that some members of the Latina community may be less likely to seek services if they are undocumented, out of fear of the consequences of getting law enforcement involved.

Almost all service providers remarked on the increased number of African immigrants in the Omaha area, primarily Sudanese. Population estimates for this group are unknown, but service providers agreed that they were seeing a growing number of Sudanese women seeking IPV services and that language barriers and cultural differences make it difficult to respond to the unique needs of this community. A few service providers also mentioned language and culture differences with regard to increasing Somali and Ethiopian populations.

Other risk factors

Service providers identified a number of other characteristics that are often shared among survivors of IPV. Most women seeking services for IPV have limited financial resources or limited access to the family's finances. Two providers offered the following insights about survivors' socioeconomic status:

Domestic violence impacts women no matter their race, education, where they live, or their income. ... Working here [at shelter], the women we see coming to us are women with the least amount of support. Not so much emotional support, but sheer financial support. (Service provider)

It's surprising how prominent it is, but those with less education and less money are going to need more of the resources than someone who just needs emotional support while they are trying to leave a situation. (Service provider)

In providers' experience, most survivors coming forward for help also have past exposure to violence in the home, either as a victim of child abuse or witness to IPV among family members. Providers also noted that substance use is often associated with IPV, either by the abuser as a trigger of the violent behavior, or by the survivor as a method of coping.

Special populations

IPV affects a number of other diverse populations not included in the above description. Omaha-area service providers noted that they serve gay men and lesbian women who are survivors of IPV, as well as transgendered survivors. They also noted a slight increase in recent years in the number of heterosexual male survivors who report IPV from female partners. In addition, service providers reported serving women with disabilities, particularly individuals who are deaf or hard of hearing.

Community provider estimates

Omaha-area agencies who completed a service summary form for this study (N=7) provided some descriptive information about individuals they served in 2009. Programs were asked to provide exact numbers or percentages reflecting the demographic characteristics of individuals served during their most recent 12 month reporting cycle. Because each agency reported this information in slightly different ways for different time periods, data could not be aggregated. However, the following information provides some detail about the population of IPV survivors receiving services in Omaha.

- A majority of participants were either White or African American and between 26 and 54 years old.
- A large majority of individuals served were female (between 80-100%, depending on service provider).
- On average, about half of the individuals served had children under 18 who were living with them (between 22-83%, depending on service provider).
- Over three-quarters of individuals served had incomes below the Federal Poverty Line⁷ (between 77-100%, depending on service provider).

⁷ Based on the Federal Poverty Guidelines, a family of four is below the poverty line if their combined household income is less than \$22,050. Guidelines available at <http://aspe.hhs.gov/poverty/10poverty.shtml>

Survivor needs

It is so much easier for them to get out of the relationship when they are not married and don't have children. ... If she is a stay at home mom, how is she supposed to get a job and take care of the kids and fight for custody of the kids. Especially if they have never worked before, [survivors] think there is not a way out, and the only solution is to stay. (Service provider)

Individuals experiencing intimate partner violence may have a number of different needs at the time they seek services. In crisis, a survivor's needs are most likely focused around safety. This could include shelter, medical care for injuries, police involvement and/or obtaining an Order for Protection, food and clothing and other basic needs, and legal support. In addition, a survivor may need significant emotional support during this time, as well as basic information about available services and options. If the survivor has children, her safety needs likely extend to her children as well.⁸ A summary of short-term needs is presented below, based on information obtained through the service provider interviews and survivor focus groups.

Immediate and short-term needs

- **Safety.** Safety is a survivor's first and foremost need, and must be established for the survivor to consider addressing her other immediate needs.
- **Information and support.** In addition to information about the resources and options available to her, the survivor may simply need emotional support in the form of a mentor or advocate to listen and provide encouragement during this difficult and sometimes dangerous time.
- **Shelter.** If the survivor is fleeing her abuser, she may need help locating safe shelter. In addition, the survivor may also need access to a storage facility to store her belongings and movers to help her get out of the house or apartment, particularly because she likely will have to leave quickly and may have very little time to plan.
- **Basic needs.** A survivor often needs items such as a phone, transportation, food, clothing, and identification. These are things an abuser might have withheld in an attempt to control the survivor, or that she had to abandon in her urgency to leave the situation.
- **Medical help.** A survivor may need to see a medical professional for physical injuries, and/or evidence collection in instances of sexual assault. It is important to

⁸ Lyon, E., Lane, S., & Menard, A. (2008). Meeting survivors' needs: A multi-state study of domestic violence shelter experiences, Final report. Prepared for the National Institute of Justice.

screen for obvious outward injuries as well as less obvious injuries and/or symptoms of prolonged exposure to violence.

- **Legal assistance.** A survivor may decide to file an Order for Protection or charges against her abuser. In this case, she may need assistance filing the order as well as money for legal representation for the court hearing. Legal assistance may also be needed in the long term if the survivor needs to file for divorce or establish a custody agreement for children.
- **Employment or other income.** Although this is not essential for a survivor's immediate safety, she may have had to flee the abuser with little to no money or without access to the family's finances. If this is the case, an immediate source of income is critical.

Long-term needs

Once the survivor is out of crisis, she likely has a different set of needs to support her long-term safety and stability. Service providers and focus group participants identified the following long-term needs:

- **Mental health services.** This may include counseling and/or access to a psychiatrist who can prescribe medication if needed.
- **Housing.** Survivors of IPV may need assistance finding and securing affordable transitional or permanent housing once they are ready to move out of shelter.
- **Substance abuse treatment.** Some providers observed that survivors of IPV may also suffer from drug or alcohol addiction. They speculate that this may be related to the survivor's IPV experience if she turned to substance use as a coping strategy.
- **Job skills training.** Survivors noted that because of the abuse, they may lack the confidence or skills to maintain a steady and well-paying job.

Services for survivors

Description of services

Service providers, shelters, and other agencies work to provide a range of supports and services to survivors of IPV, ranging from safety to basic needs to life skills. In this report, the term “core service providers” refers to agencies in the greater Omaha area that specialize in domestic violence services. A number of other agencies provide ancillary services, and often make referrals to or receive referrals from the core set of providers. These agencies are referred to as “community support agencies.” A further breakdown of these agencies by category is available in the appendix. The following summarizes the main services available for survivors in the greater Omaha area.

Advocacy

If a survivor seeks out service from one of the major domestic violence agencies in the Omaha area, she will be connected with an advocate, or advocates, who will help her navigate the available service options and systems involved in addressing IPV. Advocates may be paid staff or volunteers (crisis line advocates are often trained volunteers); however, most references to advocacy services in this report are referring to paid staff. Advocacy generally includes identifying a survivor’s needs and coordinating all of the necessary services, such as those described below.

Safety and shelter

The immediate priority among all providers is to address issues of safety with survivors. Providers routinely assess the safety needs of survivors and identify options for safe housing when first working with a survivor. For those willing to go to a shelter, providers first seek out domestic violence-specific shelters (such as The Shelter, Safe Haven, or Phoenix House); if space is not available, other, general shelters are considered. Shelters not designed to handle domestic violence, either because of a lack of security or specialized services, carefully consider the needs of an individual survivor as well as the risks associated with that domestic violence situation before admitting someone to their facility.

Providers will also engage in safety planning with survivors and arrange for a protection order as necessary. Safety planning is a critical element of the advocacy services provided to a survivor. While short-term stays are sufficient for some survivors, many require more time to stabilize their situation. Providers work with these survivors to

identify transitional housing options in the community, although these have become increasingly limited.

Basic needs

As noted, many survivors seeking services, especially emergency shelter, also lack basic needs such as food, clothing, and the financial means to provide long-term for themselves and their children. As resources and funds permit, both provider agencies and shelters address these needs through case management. Providers frequently refer survivors to local food pantries, clothing closets, and other similar agencies that are equipped to address these types of needs. Because survivors often lack transportation, providers frequently subsidize cabs or provide bus passes and gas vouchers to help survivors access these resources.

Legal assistance

In addition to obtaining a protection order, survivors often require other forms of legal assistance. Advocates frequently act as a liaison to the judicial system for survivors, filing paperwork, explaining complex terminology, and accompanying survivors to court hearings. Providers often help survivors seek out legal representation to handle issues related to housing, custody, and divorce. Recent economic conditions have also forced an increased number of IPV survivors to declare bankruptcy, requiring additional legal assistance. Some providers have in-house attorneys for survivors to address many of their legal needs; in other cases, when private attorneys are not viable (which is often the case due to cost), free or sliding fee scale legal services are available through organizations like Legal Aid and the Creighton Legal Clinic.

Physical and mental health

Depending on the extent of the violence, survivors may require medical attention, available from any local clinic or hospital. When survivors seek out medical care, medical facilities will typically contact a core service provider, who will send out an advocate to provide support during the medical exam. In cases of sexual assault, at least one local hospital (Methodist) has an established SANE/SART program, which includes a Sexual Assault Response Team, comprised of a Sexual Assault Nurse Examiner, physician, a victim advocate from the YWCA, and law enforcement, who jointly respond and provide specialized care.

Regardless of the form of abuse, some form of counseling to address mental health issues is often required. This can include immediate, crisis counseling as well as long-term, ongoing therapy. Providers routinely offer or refer for counseling services and individual therapy, particularly in the short-term. They also attempt to connect survivors with

psychiatrists who can prescribe medication when needed; some providers have a psychiatrist on staff (at least on a part-time basis), but given the long waiting lists and high demand, often seek clinicians in the community, who may not provide services on a sliding fee scale.

Education, skill-building, and support

Providers, including domestic violence shelters, also offer programming aimed at building survivors' self-sufficiency skills. This includes general life skills courses as well as specific classes related to financial management, career services including resume writing and interviewing skills, nutrition, etc. This can also include helping survivors further their education, such as signing up for GED classes in the community. Several agencies also offer support groups focused on topics such as stress and relaxation, parenting, and general support. Through this type of programming, providers strive to enhance survivors' confidence and self-esteem, educating and empowering survivors to live safely and independently.

Culturally-specific services

As previously noted, about 1 in 10 Omaha residents is of Hispanic/Latino ethnicity, and the services described above are provided in Spanish where possible. Agencies and shelters typically have Spanish-speaking staff who can communicate with Hispanic/Latina clients. Additionally, most of the agencies to whom these providers refer also have the capacity to serve Spanish speakers. Bilingual therapists are available in a limited capacity. Immigrants and refugees often have additional needs such as translation and English language learning, immigration visas, etc. These needs can generally be addressed by specific agencies in the community like the Latina Resource Center or the International Center at Lutheran Family Services (LFS). Providers have less capacity to serve other cultural groups, such as African immigrants, particularly the large Sudanese population. In these cases, they tend to rely on language phone lines and agencies like LFS for translation assistance.

Services for special populations

In addition to serving female survivors in opposite-sex relationships, some providers also make efforts to provide specialized services for other populations. In general, while these services exist, they are usually available in a limited capacity.

Children. As witnesses to the domestic violence, children often require special support. Some agencies provide counseling and/or groups for children in these situations, although groups often include children of varied ages. Some child therapists are also available. Shelters often utilize the services of agencies like Camp Fire USA, who come into the shelter

and provide organized activities for children and youth. Some agencies also coordinate with Project Harmony which can interview and evaluate children who witness violence.

Friends and family. The YWCA has implemented a new support group for individuals close to the survivor who have also been affected by the violence. The group provides an opportunity for them to learn ways to support the survivor.

Pets. At least one organization, the Nebraska Domestic Violence Sexual Assault Coalition has money available for pets of IPV survivors. The fund, called “Josie’s Fund” is available for Nebraska residents who are fleeing domestic violence to use for boarding or foster care for their pets.

Male survivors. Agencies serving female survivors of domestic violence also serve males, although the area’s domestic violence shelters are female only. No specialized services, such as men’s support groups, seem to be available.

GLBT. Providers also serve same-sex survivors of IPV, although little is available in the way of specialized services.

Deaf and hard of hearing. When needed, providers will make accommodations to serve the deaf and hard of hearing population. At least one agency (the YWCA) has a staff person proficient in American Sign Language (ASL).

Perpetrators. Non-violence programming for perpetrators is available through several provider agencies, including one (the YWCA) that offers groups for female batterers. Groups typically meet for 24 to 25 weeks and focus on changing behavior.

Outreach and engagement

It’s not so much the questions as the questioner. Meaning victims have very good sensory perceptions. If they sense cynicism or lack of interest, they’re not going to talk about anything sensitive. (Service provider)

Some women walk in and get counseling services and they don’t even realize they’re in a domestic violence relationship. But it comes out once they start counseling. (Service provider)

There was a lot of domestic violence everywhere, but we were seeing a lot in the Hispanic community particularly, and in the African community as well. They would come in usually for something else, whether it was prenatal care or for their children, (and say), “by the way, I have this problem. I was wondering if you could give me some information.” (Service provider)

Agencies use a variety of outreach strategies to identify survivors and promote their services. Because most providers do not gather information about what led survivors to seek services, it is difficult to pinpoint the most successful outreach strategies. Nevertheless, most providers felt that some of the most common access points were the crisis hotlines and law enforcement, followed by referrals from hospitals and clinics, and other community-based agencies.

Crisis hotlines

One of the most common points of entry into services is the domestic violence crisis hotline. All four of the core providers and domestic violence shelters in the greater Omaha area maintain a separate 24-hour telephone hotline accessible during crisis situations. Hotlines are typically staffed by trained volunteers. Some providers reported an increase in calls to their hotline in recent years. In 2009, for those tracking this information, the total number of calls received by each agency ranged from over 100 to nearly 11,000. The hotline telephone numbers are listed in the phone book, on agency websites, billboards, and brochures and flyers that are distributed in multiple locations (e.g., attorneys' offices, community-based agencies, etc.). At least one crisis line is available in Spanish.

Law enforcement

Another common way survivors come to access services is through law enforcement. In Douglas and Sarpy Counties, for example, there are specific protocols for responding to an IPV incident. In Douglas County, law enforcement will contact the YWCA via a special hotline number to report the incident and connect survivors immediately with an advocate, if they should choose to access that support. Otherwise, a YWCA card is left with survivors. In the case of an arrest or injury, law enforcement files a supplemental worksheet with the Omaha Police Department and Victim Assistance. Advocates in Victim Assistance receive the worksheets and follow up with the survivor the next day. In Sarpy County, in cases of arrest, law enforcement notifies Heartland Family Service via their 24-hour hotline, and Enhanced Outreach Advocates from Heartland go out immediately to the client's home.

The extent to which these procedures are routinely carried out is unclear. While agencies report receiving a large number of phone calls and worksheets from law enforcement, there is some evidence this may not occur in all cases. In Douglas County in 2009, there were a total of 10,502 domestic violence calls placed to 9-1-1 and 4,520 cases investigated by the Omaha Police Department (OPD), but only 1,186 referrals made by the OPD to the YWCA.⁹ Although a single survivor may place more than one call, and

⁹ The Domestic Violence Coordinating Council of Greater Omaha, 2009 annual report.

not all calls or investigations may warrant further action, the discrepancy between the number of *cases investigated* and the number of *referrals made* suggests there may be additional outreach opportunities in this area.

Hospital, clinics, and community-based referrals

In a number of cases, survivors become connected with service providers while accessing other types of services. Physical and sexual violence lead some individuals to seek medical care in an emergency room setting, health clinic, or their doctor's office. In some instances, upon being seen by medical staff, the individual readily acknowledges domestic violence as the cause of the injury. In many cases, however, this information is either elicited from screening questions that are asked in the emergency department, or is revealed during the course of conversation with medical personnel. While some individuals are admitted with specific domestic violence injuries, the majority sustain more common injuries that may not be obviously IPV-related. Based upon the information shared during the screening and using their discretion, hospital and clinic staff will make referrals to domestic violence service providers.

In addition to identification through hospitals and clinics, individuals who have experienced IPV may also be identified while seeking out various services through community-based agencies. Over time, as the individual develops a level of trust with the case manager or counselor, she may disclose a domestic violence relationship, or even come to realize that her relationship involves domestic violence. This more indirect pathway to service is especially common among certain cultural groups, such as the Hispanic/Latino and African communities, who are particularly reluctant to report IPV due to cultural norms around dealing with issues within the family, norms around violence against women, language barriers, and immigration fears.

Other access points

IPV service providers report that they do have some clients who come directly to their agency to seek services. Survivors who decide to seek support have sometimes heard about the agency from friends or family. Others are referred by leaders in their faith-based community. The core service providers also regularly make community presentations or hold other events in the community (e.g., candlelight vigils) to increase awareness of the issue among the general public, which may encourage individuals to come forward or to refer others in need. There are also relationships between select providers and the school system and colleges and universities, so school staff, counselors, and teachers also occasionally refer individuals to that provider.

Outreach opportunities

In the doctor's office, the (domestic violence) sign is about the size of that paper, saying call this 1-800 number. It needs to be something that is going to stick out like a sore thumb. It's not something that should be hidden or confidential. It's not something to hide – let it out. Tell us what's going on. (Survivor)

I think (advertise in) work places and everyday places a woman would have to go, like grocery stores, banks, doctors' offices, clothing stores, the post office. Places where they are allowed to go. (Survivor)

Current outreach strategies appear to successfully engage survivors in services, although opportunities exist for increased identification and outreach.

- **Reaching underserved communities.** Marginalized groups such as certain cultural communities, older adults, GLBT survivors, males, and the deaf community may be especially reluctant to seek services. Getting to better know these communities, and identifying champions within the community around the issue of IPV, could enhance current outreach efforts. Increasing outreach, however, also means that providers must ensure that the services available for these communities are appropriate and address any unique needs they may have.
- **Streamlining crisis hotlines.** Presently, there are four separate hotlines, maintained by four agencies providing IPV services in the greater Omaha area. This may lead to confusion on the part of survivors about who to call. There may be opportunities to streamline services across agencies to increase efficiencies and provide increased accessibility to survivors in crisis.
- **Enhancing marketing strategies.** Survivors noted wanting to see information about service in “big” and obvious ways and available in common, everyday locations like grocery stores and banks. They felt such strategies would increase the chances that a survivor would be exposed to that information, especially if her abuser is controlling her access to the outside world.
- **Increasing awareness among the public.** Stigma and shame are significant obstacles to survivors telling others about a violent relationship. Increasing the general public's awareness and understanding of IPV might lessen the stigma, and therefore increase the odds that someone will confide in a friend or family member, or seek out services directly. And if confidantes are more educated about IPV and the resources available, they may be better equipped to support a survivor who is contemplating support services. Possible strategies for increasing awareness include traditional media outlets, such as billboards and TV/radio ads, as well as new media and social networking Internet sites.

- **Training medical personnel.** Most, if not all, hospitals and clinics screen individuals with injuries seeking medical services for IPV. However, how screening questions are asked, and what follow-up occurs, may vary from one staff to the next. Continued, ongoing training of medical personnel is needed to ensure screening routinely occurs, that it is done so appropriately, and that referrals are being made to service providers.
- **Training law enforcement.** Like medical personnel, law enforcement also undergo training on IPV issues and have protocols in place about making referrals to service providers. Continued, ongoing training of law enforcement is needed to ensure officers are aware of these protocols.

Barriers to services

Transportation is a really big problem. It is a barrier to them getting a job, getting their kids to school, getting a place to live, not being on the bus line. (Service provider)

If you have any resources on your own ... it limits what we can help you with, and that's extremely unfortunate. Sometimes they need to be completely helpless in order for us to offer help. (Service provider)

My son has severe PTSD. He gets mad and says, "I'm going to kill you 'cause dad didn't do it right the first time." I am paying out of pocket for PTSD counseling and we're talking five days a week, one hour a day. ... It's expensive and there is no break. (Survivor)

As described above, there are a range of services available for survivors of IPV. However, these services are not always easily accessible or affordable.

- **Lack of transportation.** The lack of adequate transportation was the most frequently-cited barrier to services. For many survivors, the abusive partner retained the family vehicle, and they have limited means to purchase a car or even gas for a vehicle they do own. Although service providers and shelters pay for cabs and provide bus tickets and gas vouchers when possible, it is not always available, especially long-term. Services and survivors can be scattered across the Omaha area, making it difficult to work or get children to school without reliable transportation. This may be especially problematic in West Omaha, where there are fewer resources.
- **Lack of insurance.** While crisis counseling and individual therapy are generally available at no cost or on a sliding fee scale for those at a shelter or other IPV programs, they are generally not available long-term. For many survivors and their children, ongoing therapy is critical to their long-term health and well-being. Many

survivors lack insurance, or the funds to cover these costs out of pocket, making long-term mental health support unsustainable.

- **Financial constraints.** Many survivors lack the financial means to secure basic needs, especially on a long-term basis. While shelters and service providers connect survivors to community resources that address many of these needs, there are sometimes restrictions on how often a survivor can use a resource within a given time frame. As survivors struggle to get on their feet, small financial setbacks like a broken windshield can be financially devastating. The costs associated with a protection order hearing, or legal fees, can also be a significant obstacle. In other cases, individuals have minimal resources but may not need shelter, and as a result, do not qualify for needed financial assistance.
- **Feelings of isolation.** Beyond some of these more concrete barriers, the feeling of isolation among some survivors can be a significant barrier to seeking services. While many survivors can overcome feelings of shame and guilt, certain subpopulations including males, gay, lesbian, bisexual, and transgender (GLBT) individuals, and the Hispanic/Latino and African cultural communities must also overcome feelings of isolation, as there is typically less support for these issues in their respective communities. Therefore, they may be even more reluctant to come forward.
- **Culturally-specific issues.** In addition to this lack of support, language barriers can pose a significant obstacle, especially for the African community and other communities with unique language needs. Fears related to law enforcement, and immigration and deportation, can also prohibit individuals from seeking needed services.

Gaps in services

I think the biggest (gap) is shelter. We need to have more beds available. I know a lot of our clients, a lot of women, end up in just a straight homeless shelter, which is not safe for them at all. (Service provider)

The gay, lesbian, and transgender population – where do they go? And what about men, where do they go? There are not shelters for them, other than a homeless shelter. (Service provider)

We do not have enough mental health professionals that are Spanish speaking, that have credentials, that have a license. (Service provider)

I think a big gap is the lack of service to the children that are in the homes that witness domestic violence. I don't think those needs are being met at all. If we can catch them at an early age, and get them out of that violent situation, then we have a better chance of preventing future domestic violence. (Service provider)

Service providers, shelters, and their community partners provide an array of services for survivors and have the capacity to meet many of survivors' needs, especially immediate needs. Nevertheless, providers and survivors identified a number of areas where services are lacking, often due to a shortage of funding and resources.

Emergency shelter and transitional housing

One of the most prevalent gaps identified is the lack of domestic violence emergency shelter and transitional housing. Currently, the three domestic violence shelters in the greater Omaha area can serve approximately 40 women and their children at a time. Waiting lists for these shelters are common, and result in many women seeking refuge in general homeless shelters that have neither the security nor supports like counseling necessary for individuals in a situation of intimate partner violence. All but one of the shelters that provided data regarding populations served in 2009 reported that they did not have capacity to provide shelter to everyone seeking it. In 2009, Omaha area IPV shelters had to turn away at least 1,275 individuals due to capacity limits.¹⁰ Furthermore, the limited transitional housing in the area was recently reduced due to funding cuts. As a result, even fewer longer-term housing options are available for survivors.

Shortage of advocates

Several community providers felt there is a shortage of advocates to meet all the needs of survivors in the community. Due to recent cutbacks, fewer advocates are available to meet a growing need. This has resulted in advocates being unavailable to come to shelters, a reduction in advocate positions at some agencies, the elimination of the only advocate on staff in a nearby county, reduced availability of advocates to be onsite at the Probation Office, and an insufficient number of Spanish-speaking advocates in general. As a result, there is concern about advocates' capacity to respond to the many needs in the community, and to provide any services beyond immediate crisis support.

Services and programming for children

Few service options exist for children who have witnessed violence. Some children's groups and opportunities for individual therapy are available, but not enough to meet the growing need. Starting with the point of identification, there is some evidence that law enforcement may not consistently interview children or refer them for further evaluation. In agencies offering children's groups, due to limited staff and the varied ages of children in the group, little in the way of age-specific or age-appropriate programming can be

¹⁰ Service Summary Form collected spring 2010 for current study by Wilder Research. Note that form instructions indicate that a survivor and her family should be counted as one individual, regardless of the number of family members also seeking shelter. However, researchers cannot confirm whether participating agencies reported the data in this way.

provided. As a result, there is limited opportunity to identify children in need of individual therapy. As it is, there is a shortage of children's therapists to provide this type of therapy.

Services for special (underserved) populations

In addition to children, services for other underserved populations including males, the GLBT community, older adults, teenagers, and the deaf community, are lacking. Although these groups are still proportionally smaller than other groups of survivors seeking services, these populations may be growing in numbers. Service providers and shelters provide services to these groups where possible (e.g., an advocate who can sign is available), but targeted outreach to and services for these populations are generally unavailable. Furthermore, there is an insufficient level of services available for Omaha's immigrant and refugee populations. As previously noted, there are few interpreters available (especially for African languages), as well as few bilingual therapists. In some cases, the only interpreters available are male, which is particularly problematic for a female survivor given some cultural norms around gender roles. There is also a sense that not everyone in these communities who needs services is seeking out services, and that perhaps the provider community may benefit from additional education about these cultural groups and culturally competent methods of outreach and service.

Mental health services and treatment

While crisis counseling and some therapy is available through providers, there are fewer options available for long-term mental health treatment, particularly if survivors are uninsured or underinsured. Additionally, access to psychiatrists is very limited and often involves long waiting lists, which is especially problematic for individuals who would benefit from medication. In particular, there is a critical shortage of bilingual therapists. In addition to therapy, there may be a need for increased options related to treatment for substance use, particularly for women.

Emergency funds

Service providers and shelters use their own resources, and refer to other community-based agencies, to address the immediate needs of some survivors. Given the high level of need and restrictions around how frequently one can access these benefits from some agencies, there is a shortage of emergency funding for survivors. Funds are needed for expenses like basic needs (food and clothing), home or car repairs, transportation, housing, storage and moving expenses, current and past bills, legal fees, and health assessments and evaluations. A lack of funds can mean that a survivor is unable to access basic, helpful services needed for stabilization.

Systemic gaps

In addition to these specific gaps in services for survivors, other system-level gaps were identified that can also impact an agency's ability to effectively serve survivors.

Agencies have attempted to address some of these issues, but gaps persist.

- **Consistent, multi-year funding.** Providers often apply for and are awarded short-term (e.g., one-year) grants. This type of funding makes it difficult for agencies to build and establish programs. Multi-year funding would allow agencies time to implement and enhance services, and to stabilize, rather than engage in constant grant seeking and grant writing.
- **Inconsistent agency practices.** There were some reports that advocates do not use a standardized intake protocol. Although flexibility to tailor services to the individual is important, the lack of consistent procedures may result in gathering incomplete information from a survivor at a critical time or inconsistent approaches to working with her. Furthermore, some providers noted that individual agencies tend to operate under their own rubric of what is effective, resulting in potentially inconsistent approaches across agencies. This also means that not all agencies are necessarily implementing best practices consistently.
- **Staff turnover.** Staff turnover, especially at the entry level and within the shelter setting, was seen as an issue by some providers. Turnover impacts an agency's ability to provide consistent service and staff's ability to develop and establish relationships with other community partners. As one key informant described, these partnerships are essential to staff understanding what resources are available in the community and ultimately impact what is offered to a survivor.
- **Training and support for advocates.** A survivor reported a recent experience with a local advocate who accompanied a fellow survivor to court but appeared to provide little support and remained quiet throughout the hearing. Although this may have been the most appropriate approach in this situation, and an isolated incident, agencies may want to consider whether additional training for advocates around courtroom advocacy would be beneficial.
- **Overlap in services.** There were some instances of agency overlap, such as cases where two agencies are working with the same survivor and advocates from both agencies show up at the survivor's court hearing. Given the partnerships between these agencies, these incidents seem to be easily resolved (for example, one advocate will simply leave the court hearing), but suggest some opportunities for increased communication to reduce overlap. Others expressed concern about the potential

duplication of services with the opening of the Family Justice Center of the Midlands. (See the section on “Service coordination” for a discussion of this issue.)

- **Law enforcement and judicial practices.** Although the focus of this study is primarily on services for survivors and direct service providers, the role of other systems and their direct impact on survivors emerged as a common theme. Concerns arose about the extent to which law enforcement are trained to handle IPV situations, their knowledge of community resources and their role in connecting survivors to these resources, as well as the shortage of officers in the domestic violence unit to address the community need. Some also voiced concern about the inconsistent rulings by judges in domestic violence cases and their lack of knowledge and training about the issue and the landscape of services.

Service coordination and program partnerships

The benefits of service coordination and collaboration among agencies serving survivors of IPV are well supported in the literature, and providers in the Omaha area identified many examples of collaboration in their work. These examples typically fell into two types of relationships: partnerships and collaborations. In this report, “partnerships” are defined as relationships between two or three agencies or organizations. In some cases, these partnerships are bi-directional, where the exchange of resources or information goes both ways. In other instances, the relationships are one-way, like in the case of funding, training, or resource referrals. “Collaborations” involve multiple agencies or organizations, and the shared work is more broadly defined. In the IPV service arena of Omaha, individual partnerships often exist within broader collaborations.

Partnerships

Service providers identified a number of ways they partner with other organizations to better meet the needs of survivors. The types of partnerships described by service providers can be grouped into the following four categories, or some combination of these:

- **Service referrals.** Service referrals include partnerships where one organization refers a survivor to another organization for a specific service, but there is no consultation or ongoing contact between agency staff regarding the case. This is often the case when survivors come into contact with a support agency (human service organization, clinic, etc.), and that support agency refers the survivor to an IPV service agency. Law enforcement and hospitals also refer survivors to IPV service agencies. This type of relationship requires agencies to have a basic understanding of each other’s roles in the service continuum for survivors, but not necessarily ongoing contact.
- **Teaming.** In teaming partnerships, organizations work together to meet the needs of individual survivors or to answer questions about a *specific case*. This may include sharing resources or staff across programs. IPV direct service organizations provided many examples of working together in this way, including coordinating efforts to find shelter for a client, or pooling resources to purchase a bus ticket so a survivor could escape her abuser. This type of partnership requires more interaction and a closer relationship between service providers, and may also require more time and resources to maintain.
- **Training.** Another reason organizations might work together is to conduct or host a training or education program related to IPV. Several IPV direct service and

coordinating agencies noted that they have partnerships to conduct staff trainings or educational programs about IPV. Examples include training partnerships with law enforcement, colleges and universities, and hospitals.

- **Funding.** In addition to the more traditional funding relationship of grantor and grantee, some organizations have developed other types of partnerships centered on program funding. For example, two or more organizations might work together to prepare a grant application or contribute funds for a shared service. Agencies provided examples of applying for grants together to fund a shared staff person or a new program or service. The Latina Resource Center is an example of a funding partnership between Catholic Charities, the YWCA, and Heartland Family Service, with Catholic Charities serving as the lead agency and host site.

Collaboration

In this report, collaborations are groups of agencies or organizations that work together toward a broad common goal. The IPV-related collaborations in the Omaha area, identified by service providers, are the Domestic Violence Coordinating Council of Omaha (DVCC), the Coalition Against Sexual and Domestic Abuse (CASDA) of Sarpy County, and the Nebraska Domestic Violence Sexual Assault Coalition. Another collaborative effort that takes place outside these established coalitions but also involves a variety of IPV stakeholders is interdisciplinary case review meetings. Several providers noted that they are a part of teams that conduct monthly or quarterly case reviews to discuss IPV cases with a goal of improving practices.

Service coordination successes

We have an advocate in the probation office part time and she has a ton of contact [with survivors]. Our probation officer that deals with all of our domestic violence cases is just swamped. ... Now they can contact [advocate]. The advocate can get back to the victim right away versus the attorney's office. That eased a lot of anxiety for victims. That was a tremendous help to both departments but also the victim. (Service provider)

That's the component where it helps to be part of [coalition] because we have a representative from [hospital]. That's the key to getting in. If we have someone with a vested interest, then it's a lot easier to make the sell. (Service provider)

On-site advocates

Several support agencies noted the value of having a YWCA advocate visit their organization or provide services on site. Having advocates available in places where

survivors are visiting for other reasons grants survivors' easier access to IPV services. In the case of IPV, where a survivor's abuser may have control over when she can leave and where she can go, it is especially critical to have services available and accessible from multiple locations. Currently, the YWCA houses advocates at Project Harmony, the Latina Resource Center, and the Order for Protection office at the Douglas County Courthouse. Similarly, Heartland Family Service houses an advocate at the Sarpy County Probation Office. Several organizations also remarked that they previously had advocates housed on site and hope to bring them back if funding becomes available.

Clear roles and responsibilities

In many of the partnerships described by service providers, one of the key elements for success was all parties having a clear understanding of the relationship and the role in service provision. One example of a successful partnership where roles and responsibilities are clearly defined is the SANE/SART program, which is a program to respond to the immediate physical and psychosocial needs of survivors of sexual assault. The program is a partnership between Methodist hospital, the YWCA, and law enforcement. The program follows a national model where each party's role is clearly defined, and all partners appear to work well together.

Building rapport

Coalitions like the Domestic Violence Coordinating Council (DVCC), Coalition Against Sexual and Domestic Abuse (CASDA), and the Nebraska Domestic Violence and Sexual Assault Coalition allow for sharing of information, policies, best practices, and training information between service providers and other partner organizations. One of the most important benefits of these coalitions, however, is that they allow individual providers to get to know one another and establish trust and rapport. This leads to more effective working relationships outside the coalition, and ultimately better service for survivors.

Service coordination challenges

Sometimes I think someone's own agenda can get in the way of serving the greater community. ... Yes, you need to protect the agency you work for, but at the same time there needs to be a sense of working together. (Service provider)

We don't do a lot of collaborating because of the territory issue. "Who's victim is she?" ... It's nobody's fault. It's a matter of being short-funded. So it's a matter of wanting to serve the victim the best we can while also making sure we can count her in our statistics. (Service provider)

I think [there is a] need for coordination between organizations... .over the years multiple agencies began to provide a variety of services, some high level shelter care to outreach and advocacy. Because there are so many agencies doing these services, there is not a point place to go to. I think there is a lot of confusion – there’s a lot of competition between the agencies. As a result, I think victims find it harder to navigate and know, “Who do I turn to, who can I go to?” It’s just not clear. (Service provider)

Territorialism

By far, the most common challenge mentioned by service providers was “turf wars,” with “turf” referring to both geographic area and services. Although these territory issues are different, the root cause for both is an underlying fear of resource scarcity and competition for funding. With regard to geography, providers noted the challenges of collaborating across county lines when many of the services available to clients are county-dependent. They remarked that it is somewhat impractical for advocates to work across county lines because the law enforcement response and judicial process for IPV are different, and advocates from within each county are most familiar with their own county’s practices and procedures. This becomes an issue if a survivor lives in one county and experiences an IPV incident in another county, or if she receives emergency services in one county, but lives in another. Although advocacy organizations reported positive working relationships with one another, they noted that it can be challenging to determine what organization will provide ongoing services for a survivor in cases that cross county lines.

“Turf wars” also exist within the IPV community over which service areas are most needed and/or effective, and which strategies for providing these services should be employed. Similar to physical turf wars, the underlying cause of these disagreements is competition for a limited number of dollars available to fund IPV services. Each provider is endorsing their model or approach because they think it is the most effective way to meet the needs of survivors, but also in order to keep their doors open and their programs staffed.

Lack of role clarity

One interview respondent representing a support agency indicated that there is a lack of clarity regarding roles within the IPV service continuum. Currently, there are several direct-service IPV agencies that serve as the first point of contact for a survivor. However, once a survivor enters the service delivery “system,” it may not be clear to her how all the service providers work together to meet her needs. IPV service providers seem to have a clear understanding of their own role in the service continuum and the

ways in which they interact with one another. However, agencies providing supportive services and survivors may be confused about which agencies provide what services.

Opportunities for future coordination

I think we need more services and collaboration with the faith-based community. I think that is very important, especially in certain cultures and certain areas of the city, it's huge. I think we need a lot more collaboration with partners that we never really thought about having around the table, like Indian services, Child Protective Services, churches, medical personnel, HHS. I think now it is time to really think outside the box in order to make services more creative. You have to in order to reach out to underserved populations. (Service provider)

We can always have several different groups who have the same goal but maybe aren't totally working together. And resources are always limited. So anytime we can pool our resources toward that same goal we are trying to achieve, I think it is beneficial for everyone. (Service provider)

Engage new partners

Although providers identified a number of important partnerships, there may be other community organizations or groups whose voices are underrepresented within current collaborations. Several providers identified partnerships with clergy and representatives from other faith communities, but there were few examples of individuals from this sector being involved in any formal way. In addition, there was a noticeable lack of representation from culturally-specific service providers representing African American and Native populations. These perspectives would also add value to the conversation about ways to best serve IPV survivors, and may result in broader reach to these underserved populations.

Utilize the Domestic Violence Information Sharing System

According to one service provider, government entities and IPV service providers in Douglas County have access to a shared database called the Domestic Violence Information Sharing System (DVISS). The database is still new, but was several years in development. Due to time and resource limitations of this study, researchers were unable to obtain more information on this shared database, but it may be an opportunity to enhance current collaboration efforts and increase efficiencies in service delivery.

Increase collaboration for marketing and public awareness

Another challenge noted by several IPV service providers was related to public awareness efforts. In the past, individual organizations conducted similar but separate annual public awareness activities such as candle light vigils, which service providers

agreed sent a confusing and fragmented message to the public. This year, IPV service providers and coordinating agencies are partnering to host individual community vigils on one designated day. This coordinated effort will help unify their mission and message, while still allowing for a sense of ownership within each community.

Profile: Family Justice Center of the Midlands

What is a Family Justice Center?

In the 1990s, a national effort began to encourage IPV service providers and criminal justice agencies to work more closely on behalf of survivors to address problems of reporting and access to services. The goal of this effort was to improve communication between agencies responding to IPV and to improve effectiveness of the communities' response to survivors. This model of coordinating services later evolved into the Family Justice Center (FJC) model. Family Justice Centers bring together government and non-government services (social services, criminal justice, community agencies, medical professionals, legal services, etc.) at one central location to provide a "one-stop shop" for survivors of domestic violence. In 2003, a federal demonstration project called the President's Family Justice Center Initiative was established by the Office on Violence Against Women to fund 15 communities to create new Family Justice Centers, and three existing FJCs to provide support and technical assistance to the new sites. The purpose of the FJC is not to establish new services, but to integrate existing services under one roof.

Long term goals of the Family Justice Center model

- Reduction in IPV and IPV-related crimes
- Increase in offender accountability
- Decrease in the number of children who witness IPV or commit violent acts
- Increase in community awareness of the issue, due to marketing and outreach to the broader community

At the time this demonstration project began, there was little data to support the effectiveness of this model. However, program developers and experts in the field believed there could be several benefits of the Family Justice Center model, including less fragmented services, less duplication of services, and easier access to services; organizational culture change leading to overall service enhancement; and an increase in the number of survivors seeking services. They also identified a number of concerns and potential pitfalls of the model, including: limited utilization by immigrant populations and communities of color, as they may prefer seeking services through less formal

channels; reluctance to visit an FJC among survivors who do not want government services to be involved; the over-management of survivors, where they lose decision-making autonomy; and overall concerns that the goals of the FJC could be driven by the priorities and interests of the lead organization rather than goals of the broader community.¹¹

Best practices

In 2007, the U.S. Department of Justice Office of Violence Against Women published the following set of best practices for Family Justice Centers. These best practices were derived from the work of the President's Family Justice Center Initiative, and subsequent evaluations, focus groups, and feedback surveys.

- Co-located, multi-disciplinary services for victims of family violence and their children increases safety and support.
- Pro-arrest/mandatory arrest policies in Family Justice Center community increases accountability for offenders.
- Policies incidental to arrest/enforcement reduce re-victimization of victims.
- Victim safety and advocacy must be highest priority in the Family Justice Center service delivery model.
- Victim confidentiality must be a priority.
- Offenders must be prohibited from on-site services at the center.
- Community history of domestic violence specialization increases the success of the collaboration in the Family Justice Center model.
- Strong support from local elected officials and other local and state government policy makers increase the effectiveness and sustainability of the Family Justice Center.
- Strategic planning is critical to short-term and long-term success in the Family Justice Center service delivery model.
- Strong and diverse community support increases resources for victims and their children.

¹¹ Townsend, M., Hunt, D. & Rhodes, W. (2005). Evaluability Assessment of the President's Family Justice Center Initiative. Prepared for the U.S. Department of Justice.

Outcomes

To date, there is very limited information about the outcomes of the Family Justice Center model. Most of the published materials on this topic are process evaluations (assessments of implementation) and evaluability studies. Several Family Justice Centers have submitted evaluation data to the National Family Justice Center Alliance indicating that their communities have seen a reduction in domestic violence-related homicides, an increase in prosecution rates of offenders, and lower rates of recantation and recidivism since their community opened a Family Justice Center.¹² However, there has been no coordinated effort to collect this information. Although supporters of the Family Justice Center model agree that comprehensive evaluation data would be useful, they also acknowledge that such an effort would be extremely difficult given the fact that the implementation of the family justice center model varies widely by community.

Origins of the Family Justice Center of the Midlands

In 2006, the Omaha Domestic Violence Coordinating Council (DVCC) convened a multi-disciplinary team of people working in the area of IPV to engage in a strategic planning process to identify needs and gaps in IPV services in the Omaha area. Several of the people involved in the strategic planning process were aware of the President's Family Justice Center Initiative, and proposed the idea of Omaha creating a Family Justice Center. In response to this community interest, the DVCC invited staff from the San Diego Family Justice Center to Omaha to help assess community interest and readiness for a Family Justice Center in Omaha. At that time, approximately 50 community professionals and service providers working in the area of IPV participated in the DVCC strategic planning process, and they agreed to move forward to develop a Family Justice Center. The DVCC established several planning committees to move this effort forward. It was determined that the DVCC would be the host organization because, according to the DVCC director, they are a "neutral convener."

After four years of planning, the Family Justice Center of the Midlands (FJCM) opened in Spring 2010. At the time interviews were conducted for this report, the FJCM did not have partner agencies onsite in the office and were not yet serving clients. However, they had confirmed that the following partners would have staff located at the Center.

On-site agency partners

- Domestic Violence Coordinating Council
- Douglas County Attorney's Office

¹² M. Mack, Director of Technical Assistance for the Family Justice Center Alliance, personal communication, September 8, 2010.

- Douglas County Sheriff Chaplains
- Douglas County Victim Assistance Unit
- Legal Aid of Nebraska
- Nebraska State Probation/District 4
- Omaha Police Department – Domestic Violence Squad
- YWCA Omaha

The Family Justice Center of the Midlands also has a number of off-site partners with whom they work collaboratively. These agencies do not currently have plans to house staff at the Family Justice Center, but may in the future. These partners are the Eastern Nebraska Community Action Program, Heartland Family Services, Immanuel Senior Living/Lifeline, OneWorld Community Health Centers, and the University of Nebraska – Omaha School of Social Work.

Community perceptions: Benefits

It will help us have more of a personal relationship with some of the [other providers], just getting to know them a little bit better than just making a phone call, which I think, in turn, will provide better service to our victims, when you actually know the people you are working with. At this point, a lot of what the Family Justice Center provides is kind of what's out there, but the ultimate goal is to get everybody in one place. (Service provider)

This is where the FJC comes in. It's the lack of communication between agencies. It is very frustrating and nothing or very little gets accomplished. The police need to speak to the advocates. For them to be able to communicate with the courts or the judges and lawyers, for everyone to know exactly what is going on and take care of it accordingly. From what I experienced [without a FJC], that never happened. (Survivor)

- **Co-location.** The most obvious advantage and primary benefit of the Family Justice Center model is the co-location of program services. This approach is supported in the literature and also addresses a number of concerns raised by service providers and survivors. Co-location of services is more efficient and should better accommodate survivors with limited time and resources to travel to different agencies. It also prevents them from having to re-tell their traumatic story over and over again. However, as noted in the previous section of this report related to service coordination, many service providers also noted the benefit of having on-site

advocates located at various support organizations, which is an alternate approach to the co-location offered through the FJC model.

- **Increased rapport among providers.** Many providers remarked that an added benefit of co-location is that it allows for partner agencies to get better acquainted with each other and learn firsthand how different components of the community response to IPV fit together. While most providers noted that they have a fairly good grasp of this now, many agreed that they would probably learn more by working side by side with one another, and that this would likely result in better services for survivors.
- **Building on existing expertise.** Planning partners of the FJCM were clear that the model is not creating a new service, but rather building on the existing knowledge and expertise of current service providers. They believe the FJCM model maximizes the knowledge of community providers by bringing everyone together in one location.

Community perceptions: Challenges

They are still struggling to get the partners in that should have been there. There wasn't good engagement to get people at the table and now they are almost being forced to the table. So when you have partners that are forced to the table and putting up resistance, you have partners that are not really fully vested in this. So I think some of that goes back to how it was created, and who is leading it, and why they are the leader. I don't have confidence that it is going to really take off because they really weren't inclusive in how they developed and created this. It was just, "This groups gonna' do it, and you're going to be there." It's still very, very political. (Service provider)

Some women are ready to come in and sit down and go over everything and get it told and get it set, but many times, women just want to reveal things in pieces. They're not ready to face the whole story. Sometimes that's part of the resistance to [FJC model]. (Service provider)

The DVCC is doing a good job on doing the Family Justice Center. One of the things I'm really trying to work on with them though is to be culturally diverse. To be able to handle anyone that comes in respectfully if it's a different language. ... The staff needs to be just as diverse as the clientele. That is something they need to work on. (Service provider)

We know it's a national model. We're still trying to figure out what the benefits are versus what's currently in place where you have an advocate to walk you through things. We understand the intention is that everybody is co-located – you can visit all these systems at once. It seems like prior [to the FJC] these things were happening because an advocate would walk you through that. (Service provider)

- **Perception that FJCM is a duplication of services.** Some providers are confused about the need for the Family Justice Center and believe it is a duplication of service;

those involved with planning, however, report that the FJCM itself is not a direct service agency, but rather a center for housing *existing* direct service agencies. One of the barriers that will need to be overcome in order for the FJCM to be successful is reconciling this issue between providers and the FJCM planning team.

- **Jurisdiction concerns.** Sarpy County service providers are partners and have been involved in the planning of the Family Justice Center of the Midlands. However, because the location for the Center is in downtown Omaha and most of the services offered there are for a different county system (Douglas), most Sarpy County service providers believe it is unlikely that anyone from their county will seek services through the FJCM.
- **Accessibility.** FJCM planners selected an office building in downtown Omaha to house the Family Justice Center of the Midlands. This location was selected because it is conveniently located near several of the government partners, is on a bus line, and has ample parking. However, many service providers are critical of this location and say it is not easily accessible, there are costs to park, it may be intimidating as it is in a large office building, and it will not be convenient for people in West Omaha or Sarpy County. The Center also maintains regular business hours, so it will not be accessible to survivors after hours.
- **Role confusion.** For the most part, community providers were fairly consistent in their understanding of the current processes and players related to IPV service delivery in Omaha (although some mentioned confusion in this area). The community will need to come together to decide whether the recommended procedures change as a result of the new FJCM, and if so, how. For example, should referring agencies now send survivors to the FJCM instead of referring them to an advocate at the YWCA or Heartland Family Service? Or should they be referring survivors to both agencies? What is the new protocol, and how will this message be delivered?

Prevention strategies

The Omaha-area providers working in the field of domestic violence are not only dedicated to serving current survivors of IPV, but are also engaged in activities aimed at preventing IPV and ending the cycle of violence, especially recently. It should be noted that Wilder Research was unable to speak directly with the area school systems about prevention programming, and thus, the prevention activities described here are based upon information provided by service providers. For that reason, some current prevention activities may not be reflected here.

Current prevention efforts

Education for children and youth

Most of the prevention efforts in the Omaha area target children and youth. A variety of educational programs and strategies are being used in a range of settings.

- **School presentations.** Some providers are currently working within the Omaha public school system to educate children and youth from elementary school through high school about healthy and safe relationships. In the city of Omaha, this primarily involves giving presentations to younger children (elementary school) about ways to stay safe when there is violence at home, and presentations to older children and youth (middle and high schools) about how to prevent dating violence and sexual assaults.
- **School-based curricula.** Select middle schools in the Council Bluffs area are using curricula around violence prevention with their students. Seventh- and eighth-graders in these middle schools are participating in a 10-week course based on the “Flirting or Hurting?” and evidence-based “Safe Dates” curricula, which address issues of peer sexual harassment and teen dating violence. It is uncertain whether Omaha Public Schools are currently using any curricula related to violence prevention, although the passage of the Lindsay Anne Burke Act in 2009 now requires school districts (as of July 1, 2010) to address teen dating violence through the education and training of staff and through the incorporation of dating violence education into the school program.
- **HALO curriculum.** Heartland Family Services has developed the Healthy Alternatives for Little Ones (HALO) curriculum. Targeting 3- to 6-year-olds, HALO addresses topics like social/emotional development, making healthy choices, and communication, and can be implemented in childcare centers, preschools, and Head Starts. The curriculum is reportedly not being used in Sarpy County, and it is unclear to what extent the program is being used in the greater Omaha area.

- **Kid Squad.** An early childhood prevention program, “Kid Squad” expanded their services into multiple centers throughout Douglas and Sarpy Counties as part of the Nurturing Healthy Behavior in Early Childhood pilot project. This early childhood consultation program provides therapeutic consultation, training, and support to child care providers serving preschool-age children with behavior issues. Staff from partnering agencies work with child care providers to develop staff skills, implement effective classroom strategies, and solve problems related to challenging behavioral problems.
- **R.E.S.P.E.C.T.².** The Relationship Empowerment for Students, Parents, Educators, & Community through Theatre initiative (R.E.S.P.E.C.T.²) is another current initiative in the Omaha area aimed at teaching children and youth how to build healthy and respectful relationships. The organization uses plays, role-playing, and improvisational theatre to examine relationship dynamics, and tailors the material to the age-level of students, from elementary up to college-age. The Omaha school system is reportedly implementing this program, although to what extent is unclear.

Education for young adults

Efforts are also underway to educate college students as well as campus staff about IPV issues and how to prevent them. One example of these efforts is a recent collaboration between the YWCA and the University of Nebraska at Omaha (UNO) aimed at training campus security, resident hall advisors, student health and counseling department staff, coaches, academic advisors, and other points of entry for students about IPV (there are plans to expand the training to other student groups). The campus has also hosted presentations, speakers, and other multimedia events about IPV with the goal of increasing awareness across campus. Campus staff have begun to take advantage of social media outlets like Facebook to promote these activities, which has proved successful.

Community-wide education and awareness

There have been some broad-based community efforts related to violence prevention, such as billboards and media messages in the form of radio and TV ads, and public service announcements (PSAs). However, some providers report that messaging is relatively limited, sporadic, and not marketed throughout the entire Omaha area. During the year, different service providers will sponsor community events like candlelight vigils. Some providers reported that these primarily draw other service providers and individuals working in the field.

Both the Iowa Coalition Against Domestic Violence and the Nebraska Domestic Violence and Sexual Assault Coalition were recipients of grants from the Centers for Disease Control in 2009 that enable them to participate in specialized training programs on primary prevention, and learn how to incorporate primary prevention strategies into

existing violence prevention efforts and plan for new efforts. A statewide prevention campaign in Nebraska is reportedly in development, while Iowa plans to continue their efforts around two campaigns: Men Can Stop Rape and Coaching Men into Boys. This grant also supported the recent hiring of a Prevention Coordinator for the Nebraska Domestic Violence Sexual Assault Coalition, increasing their focus on prevention activities statewide. The Coalition is now sponsoring various events aimed at increasing local programs' knowledge and capacity around prevention. This includes sponsoring a community day focused on best practices in prevention, hosting monthly prevention webinars for local programs, and sharing information learned at national trainings with agencies across the state.

Programming for batterers

A few service providers in the area offer non-violence programming for perpetrators of violence. There are multiple groups for men, aimed at educating men about non-violence and teaching them skills to prevent future abuse. Depending on the agency, groups typically last 24 or 25 weeks and charge a fee. Some non-violence groups for women perpetrators are also available at one service provider.

Challenges around prevention

When I was assaulted, my son had just started 5th grade the day after I was put in the hospital. He went to talk to the school counselor, and they said, "Don't worry, it will be okay." And he said, "No, it's not okay." Where can he go? He can't get in his car and drive to the Y. School staff need to be educated about this. (Survivor)

Prevention is difficult because a lot of funding sources will not do prevention. Prevention is something that should be top priority when it comes to funding and unfortunately, it is not. (Service provider)

Although prevention-focused efforts have steadily increased in the community in recent years, providers identified some challenges around doing prevention work. For example, although at least one agency has established a partnership with the school system in Omaha to carry out prevention activities, several providers noted difficulty in getting access to schools to do programming around prevention. Because of schools' increased focus on academics and test scores, there is a perception that schools do not have time to incorporate non-academic programs and curricula. At least one provider noted the lack of funding available for prevention activities, and the tendency of grants to focus on intervention and "victims." Providers working with Spanish-speaking clients described the lack of non-violence programming and groups available for Spanish-speakers. One service provider noted that media campaigns and education activities tend to target South

and North Omaha, because they are perceived as “at-risk” communities, and consequently overlook the needs of West Omaha. Another provider felt that the broader community is resistant to prevention efforts like awareness campaigns and community presentations because of their discomfort with this disturbing issue.

Opportunities for future prevention work

(Prevention) needs to start earlier...it doesn't have to be about dating violence per se, but making it more about, “This is what a healthy relationship looks like. This is what you're entitled to as a human being.” (Service provider)

One-time presentations are good, but if you really want to look at changing an attitude, a belief, knowledge – it's a long-term process. (Service provider)

Start in second or third grade, and teach these children things like respect and effective communication and negotiation. I think that's where it has to start because by the time they get to be 20 or 25, it's such an ingrained belief system and behavior pattern that it's very difficult to make effective changes in the batterer. If you can prevent it through education, it's going to be cheaper in the long run. (Service provider)

It's like how smoking is no longer fashionable. I think men have to realize that it's not acceptable behavior. Most of the focus has been on the victim, which is important, but to solve this problem, it's going to have to really focus on the perpetrators. I think the best time is when they're young. (Service provider)

Despite some of the challenges around prevention work, there are several opportunities to build on the current efforts underway in the Omaha area. Providers overwhelmingly agreed that prevention efforts must start with children at a young age – as early as preschool, or most certainly elementary school. While some programming may be happening with young children, it does not appear to be widespread. Service providers should consider ways of partnering with schools, preschools, and child care centers to support the implementation of age-appropriate curricula and programs focused on social-emotional development and healthy interaction. Many providers also recommended that these prevention efforts continue through elementary, middle, and high school, so that both girls and boys are exposed to ongoing, consistent messages about healthy relationships. As youth age, topics can evolve from discussions around bullying to teen dating violence and sexual assault. The stipulations of the Lindsay Ann Burke Act suggest that school districts not already doing so will begin training staff on dating violence and implementing dating violence programming into the curriculum. These requirements afford schools the opportunity to more comprehensively address this issue at all grade levels, and to consider research-based curricula that will be most effective in preventing dating violence. At the same time, it also offers providers an opportunity to

connect with schools around what these programs should entail. (See the section on Best Practices for more information about evidence-based and evidence-informed options.)

In addition to school programs and curricula, providers suggested a range of other prevention strategies related to working with youth, including mentoring and identifying youth who can serve as leaders or “ambassadors” in their schools around this issue.

Service providers and survivors alike felt that more could be done in the way of community education and public awareness, although limited funding for these efforts should be acknowledged. Where funds are available, public awareness campaigns should utilize traditional media outlets like radio and television as well as new media, such as Facebook, Twitter, and youth-oriented websites, to reach broader audiences. Several providers felt that community-wide prevention efforts also needed to engage men in leadership capacities, who could serve as role models for other men around healthy relationships.

Any prevention efforts, whether they target youth, batterers, or the broader community, must also consider the language needs of the population. Currently, few materials or programs are available in Spanish, the primary non-English language in the community. Materials should not only be made available in other languages, but the prevention programs and outreach strategies used with these communities should also be culturally appropriate. Furthermore, primary prevention efforts should consider the relative value of targeting certain regions, schools, or populations at the risk of excluding areas within the community that might also benefit from prevention efforts, such as Western Omaha, where resources are less accessible and community members may feel more isolated.

Best practices

Efforts to address issues of intimate partner violence are strengthened when they are guided by research and incorporate best practices in the field. Service providers in the greater Omaha area identified several programs and strategies currently being implemented that are research-based (i.e., supported by research studies and/or evaluation), and, in some cases, qualify as an established “best practice.” Best practices, as the term is used here, refer to programs or strategies that have a body of evidence supporting the effectiveness of the work and have met other, specific criteria; as a result, they are deemed to be a “best practice” or “evidence-based” by an outside authority. The following summarizes a sample of these approaches currently being used in the Omaha area, including treatment and services for survivors, batterer interventions, and prevention strategies:¹³

Best practices in Omaha

Treatment approaches and services for survivors

SANE/SART. A Sexual Assault Response Team (SART), typically comprised of the Sexual Assault Nurse Examiner (SANE), a physician, a victim advocate, and law enforcement, provide specialized care to victims of sexual assault. Methodist Hospital operates the Heidi Wilke SANE/SART Survivor Program.

The Sanctuary Model. The Sanctuary Model helps organizations develop a trauma-sensitive culture with the aim of improving services to clients. Heartland Family Service is implementing the model across its programs.

Seeking Safety. Seeking Safety is a form of therapy aimed at helping people attain safety from trauma/PTSD and substance abuse. This evidence-based approach is used at Heartland Family Service.

Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a psychotherapy treatment that involves accessing and processing traumatic memories with the goal of bringing them to an adaptive resolution. It is deemed an efficacious treatment for PTSD and is offered at the YWCA.

¹³ Only agencies who identified providing a specific “best practice” (verified as a best practice in the literature by the researchers) are listed here. Other agencies in the Omaha area may also be providing the same best practice, or another evidence-based practice not listed here, but that information was not provided to Wilder Research.

Dialectical Behavior Therapy (DBT). DBT is an evidence-based treatment that helps those having difficulty managing emotions to modify their ways of thinking and behaving. DBT is used at Heartland Family Service.

Youth prevention strategies

R.E.S.P.E.C.T.². The Relationship Empowerment for Students, Parents, Educators, & Community through Theatre initiative is based in Omaha and uses plays, role-playing, and improvisational theatre to examine relationship dynamics with elementary-age children to young adults. The program travels to schools in the greater Omaha area as requested.

HALO. The HALO curriculum for 3- to 6-year-olds addresses topics like social/emotional development and communication, and was developed by Heartland Family Service. It is not known whether the program is currently being implemented in the Omaha area.

Kid Squad. The program provides therapeutic consultation, training, and support to child care providers serving preschool-age children with behavior issues. The program is reportedly being implemented in some child care centers in the greater Omaha area.

Non-violence (batterer) programs

The Duluth Model. Also known as the Domestic Abuse Intervention Program (DAIP), the Duluth Model is an education program for offenders. This evidence-informed program guides non-violence programming at the YWCA.

Other activities and initiatives

Family Justice Center model. The Family Justice Center model consists of the co-location of coordinated, multi-disciplinary services for survivors of family violence. The evidence-informed model was recently implemented in Omaha under the direction of the Domestic Violence Coordinating Council, as described in the profile.

Nebraska Domestic Violence Sexual Assault Coalition. The Coalition regularly convenes grantees across the state in discussions of best practices, offers trainings and webinars on best practices in developing interest areas, and conducts a peer review process in which programs evaluate one another's work against national standards.

Programs and practices for consideration

Beyond the best practices being implemented in the Omaha area, there exists a broad array of other domestic violence prevention and intervention programs and practices deemed to be “model programs” or “evidence-based.” Limited space prohibits a thorough review of each program here, but the following figure depicts a selection of some of the more rigorously evaluated approaches to addressing IPV. They include examples of treatment approaches for working with survivors and perpetrators, as well as several best practices in the area of prevention, that have been found to be successful in a range of communities (Figure 2). To the best knowledge of the researchers, these programs are not currently being used in the Omaha area, but may be worthy of consideration. More information about these programs, and other strategies, is available in the appendix.

2. Sample of evidence-based domestic violence intervention and prevention programs

Program/approach	Type of programming	Evidence-level rating
Child-Parent Psychotherapy (CPP)	Intervention for trauma-exposed children aged 0-5	Supported by Research Evidence, CEBC
Project SUPPORT	Intervention for mothers and children (4-9) in shelters	Supported by Research Evidence, CEBC
The Community Advocacy Project	Intervention for survivors (home and community-based)	Supported by Research Evidence, CEBC
The Kids' Club and Moms Empowerment	Intervention for mothers, preventative intervention for children exposed to violence	Promising Research Evidence, CEBC
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Intervention for youth (group and individual programming)	SAMHSA NREPP program
Trauma Recovery and Empowerment Model (TREM)	Intervention for women (group-based)	SAMHSA NREPP program
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Intervention for children and youth	SAMHSA NREPP program; Well Supported by Research Evidence, CEBC
Safe Dates	Teen dating violence prevention curriculum	SAMHSA NREPP program
Incredible Years	Early childhood social adjustment curriculum (violence prevention)	SAMHSA NREPP program; Blueprints; Well Supported by Research Evidence, CEBC
Olweus Bullying Prevention Program (BPP)	Bullying prevention program for children and youth	Blueprints
AMEND	Intervention for men (batterers group)	Promising Research Evidence, CEBC

Note. *The CEBC refers to the California Evidence-Based Clearinghouse for Child Welfare, NREPP refers to SAMHSA's National Registry of Evidence-Based Programs and Practices, and Blueprints refers to Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado. All three organizations systematically review and rate the effectiveness of programs.*

Opportunities for enhancing individual practice

Beyond integrating these types of evidence-based programs into service delivery and community-based efforts, there are other opportunities for service providers to enhance the work that they do. Both the Nebraska Domestic Violence Sexual Assault Coalition and the Iowa Coalition Against Domestic Violence offer trainings on an array of IPV-related topics. The Nebraska Coalition also hosts monthly webinars on best practices in the field. Resources are also available through VAWnet, the National Online Resource Center on Violence Against Women. The center includes information on “program management and staff development” targeting those working directly in the field. It offers resources to support the work of local, state, and national domestic violence program staff regarding non-profit management, personnel supervision and staff development, coalition-building, program development, and program evaluation. More information is available at: <http://new.vawnet.org>.

Funding opportunities

Service providers readily acknowledged some gaps in service and opportunities to enhance those services. Many of these gaps are the result of inadequate funds. The following summarizes funding opportunities available in the area of intimate partner violence, including both government agencies and foundations.

Government funds

Federal funding is available largely through two primary offices within the U.S. Department of Justice – the Office of Violence Against Women (OVW) and the Office for Victims of Crime (OVC) – as well as the U.S. Department of Health and Human Services, Family and Youth Services Bureau. Federal funding to the state of Nebraska is administered through the Nebraska Crime Commission and the Nebraska Domestic Violence Sexual Assault Coalition.

VAWA. OVW administers 19 grant programs authorized originally by the Violence Against Women Act (VAWA) of 1994. Since 1994, OVW has awarded more than \$3 billion in grant funds. In fiscal year 2009, nearly \$612 million dollars in grant funding was awarded; Nebraska received 15 total awards totaling about \$7.9 million, or 1.3 percent of the total funds granted. The number of awards given to any state or territory ranged from 4 to 65, while total grant awards ranged from about \$800,000 to \$50 million. The top grant recipients in 2009 include California (\$50 million), New York (\$32 million), Minnesota (\$23 million), Michigan (\$22 million), Texas (\$21 million), and Oklahoma (\$20 million).

Stakeholders report accessing funding through some of these programs already, such as Grants to Encourage Arrest Policies and Enforcement of Protection Orders. In recent years, OVW has developed new grant programs, including Children and Youth Exposed to Violence Grant Program, Court Training and Improvements Program, Culturally and Linguistically Specific Services for Victims Program, Engaging Men and Youth Program, Services to Advocate For and Respond to Youth Grant Program, and Sexual Assault Services Program. The community is likely already aware of these funding sources, but for those who are not, the new grant programs in particular offer opportunities to address some of the key gap areas and underserved populations in the greater Omaha area. More information is available at <http://www.ovw.usdoj.gov>.

VOCA. The federal Victims of Crime Act (VOCA) was signed into law in 1984 to support victim compensation and victim assistance programs. It also established the federal Crime Victims Fund to help victims and victim service providers with program

funding in accordance with OVC's programming agenda for the year. OVC distributes approximately 90 percent of the money collected by the Fund in the form of two major formula grant programs to state agencies: Victim Compensation and Victim Assistance.

FVPSA. The Family Violence Prevention and Services Act (FVPSA) is the primary federal funding stream for emergency shelter and related assistance for victims of domestic violence and their children. The Family Violence Prevention and Services Program (FVPSP) administers FVPSA formula grants to states, territories and tribes, state domestic violence coalitions, and national and special-issue resource centers. In FY10, the Health and Human Services appropriations bill increased FVPSA funding to \$130.5, an increase of \$2.8 million. The President's FY11 Budget requested funding for FVPSA be at \$140 million, \$4 million dedicated to children exposed to violence and \$6 million for adult services.

Foundation and private dollars

Service providers also rely heavily on funding through foundations and other private donors. The Foundation Center identified 103 national foundations that provide funds related to the topic of domestic violence. Of these, the following organizations will potentially fund in Nebraska, and should be considered by the Omaha service provider community in their efforts to sustain and enhance services:

- Alcoa Foundation
- Allstate Foundation
- Avon Foundation for Women
- FISA Foundation
- Gannett Foundation
- Liz Claiborne Foundation
- Macy's Foundation
- Met Life Foundation
- Ms. Foundation for Women
- Mutual of Omaha Foundation
- NoVo Foundation
- Prudential Foundation
- Robert Wood Johnson Foundation
- The Hadassah Foundation
- The Overbrook Foundation
- Verizon Foundation
- Wal-Mart Foundation
- Woods Charitable Fund

More detailed information about the types and amount of funding provided by these organizations is available through the Foundation Center's Online Foundation Directory. To access this directory, and related funding opportunities, organizations can subscribe to the Directory for a fee (ranging from \$195 to \$1,295 per year). More information is available at: <http://fconline.foundationcenter.org>.

Future directions

The greater Omaha area has an extensive network of service providers working in the area of intimate partner violence who have the capacity to provide a range of needed services to survivors. In recent years, the IPV community has made great strides in several areas, including increased collaboration among service providers and the development of the Family Justice Center of the Midlands, increased outreach to target populations like colleges and universities, and more coordinated and informed service delivery from first responders like medical professionals and law enforcement due to increased training efforts. Based on the results of this study, researchers identified the following opportunities for enhancing service delivery and community-based efforts in the area of intimate partner violence. These opportunities are presented in order from highest to lowest priority, based on researchers' assessment of current circumstances.

- **Address community tensions regarding the Family Justice Center of the Midlands.** In order for the Family Justice Center of the Midlands to be successful, it will be important for planners to find ways to increase buy-in, ensure all vested stakeholders have input and stay informed, create regular opportunities to communicate, and share feedback about the process. Likewise, community providers who have concerns about the FJCM must take advantage of these opportunities to provide feedback, and be direct with FJCM leadership about what they perceive to be the barriers to success. Partners should stay focused on the common goal of providing the best possible services to survivors, and work together to build services around that goal. Also, partners should work together to determine how existing protocols for referring survivors will/should include the Family Justice Center of the Midlands. As of now, there is a lot of uncertainty about the processes and benefit of the FJCM. It will be important to clarify these issues for community providers so they have an understanding of how and when to use the Center, and are motivated to do so.
- **Examine agency and community practices.** To further enhance service delivery and potentially streamline services for IPV survivors, providers should examine both internal practices and community-wide efforts around this issue:
 - **Provide ongoing training and support for advocates and other front-line staff.** Several providers noted concerns about staff turnover, which can lead to discontinuity of services to survivors as well as additional resources spent on hiring and training new staff. To the greatest possible extent, agencies are encouraged to provide staff with resources they need to do their jobs as effectively as possible. For example, ensuring that there are clear protocols and procedures in place helps an advocate better serve a survivor. Agencies may also want to

- consider incorporating their advocate staff in prevention efforts, which may be beneficial to advocates and the community alike. Communities gain exposure to the unique perspective of advocates working in the field, while advocates can take a break from crisis work and apply their knowledge in a different arena.
- **Increased communication and authentic collaboration among providers.** On a community-level, service providers should consider opportunities for increased collaboration and communication around common practices (and common goals) in order to streamline service delivery. While it is clear that this is already happening to some extent, competition for funding and resources has created “turf wars” which may limit the effectiveness of these collaborative efforts. Can agency partnerships be further defined so each plays a distinct role in service delivery, ensuring survivors receive a comprehensive set of services yet avoiding a duplication of efforts? In particular, agencies might consider consolidating the multiple crisis hotlines available in the community. They also may wish to revisit the purpose and goals of the Domestic Violence Information Sharing System. This system may hold great potential in helping organizations to streamline their work and increase community safety by improving agencies’ ability to share information about survivors’ needs and risks.
 - **Expand awareness and outreach efforts, especially to underserved populations.** Consider new or enhanced strategies for increasing public awareness about IPV issues and marketing services, including broad-based media campaigns that use both traditional (TV/radio) and new (social network sites) media outlets that appeal to younger populations most at-risk for IPV. Additionally, making this information highly visible in everyday locations, such as grocery stores and banks, will bring increased awareness to the general public as well as those at risk for or currently experiencing domestic violence. Service providers should also work together to identify ways to engage less visible/underserved groups, like male survivors, the GLBT community, older adults, teenagers, the deaf and hard of hearing community, and culturally specific communities. Agencies might look for ways to partner with other organizations already serving or otherwise connected with these communities and spend time mutually learning about one another in order to better understand needs and determine the appropriate set of services. Consider opportunities for additional advocates to be located onsite (even on a part-time basis) at agencies that regularly serve these communities. Also consider ways to bring men to the forefront of education and awareness efforts, to rally other men around the issue of Intimate Partner Violence.
 - **Focus on prevention.** Most providers agreed that more efforts should be directed toward preventing intimate partner violence, particularly by teaching children and

youth about healthy relationships. Consider opportunities to expand partnerships with early childhood centers, schools, and colleges to discuss potential ways of integrating information about appropriate behaviors and healthy relationships in their work with students. Consider involving IPV advocates in this effort, who might appreciate the opportunity to step away from deep end services and share their wisdom in another venue. Service providers might also revisit their current public awareness efforts to make sure they are sending a dual prevention and intervention message: how to stop IPV before it starts, and how to seek help in crisis. Providers also noted that future violence can also be prevented by targeting and appropriately treating perpetrators. In the current economic climate where funding is somewhat scarce, it may be difficult to justify devoting significant resources to batterers. However, these programs should be considered both rehabilitative for the abuser and preventative for the broader community.

- **Address language/cultural barriers.** One of the barriers to service delivery repeatedly mentioned by service providers was linguistic and cultural differences between providers and survivors. Where possible, agencies should attempt to hire additional bilingual direct service staff, particularly Spanish-speaking therapists and individuals who speak Sudanese. Consider ways to collaborate with and educate women in other cultural communities about IPV, so they can serve as interpreters and assist with outreach.

- **Evaluate funding criteria.** Funders in this area may want to evaluate current criteria for awarding funds as well as reporting requirements. Requiring grantees to report only outputs (number of survivors served, number of calls received) as a measure of effectiveness is not recommended as it is not a sufficient measure of program impact and appears to cause conflict and “turf wars” among providers. Consider a funding strategy that encourages and rewards collaboration, focuses on outcomes, and does not require individual agencies to assign credit for who is responsible for outcomes. This may alleviate some of the pressures of reaching targeted numbers served, and allow providers to focus on working together to meet the needs of survivors. In addition, funders should consider offering multi-year funding when possible, as this allows for greater flexibility in programming and increased stability among grantee organizations.

Future research opportunities

This study provides a broad overview of services and supports available to address intimate partner violence in the Omaha area. Through the course of this effort, researchers identified several areas where more focused research or evaluation efforts may be useful to further understand this issue. Potential areas for further study include:

- **Process and outcome evaluation of the Family Justice Center of the Midlands.** This will be important to further assess to what extent best practices are being implemented, and to determine the extent to which the program is achieving their intended outcomes. For this evaluation, FJCM should consider collecting process data about numbers served, referral source, and services received, and information about the level of involvement/buy-in of partners along the way. The evaluation effort should also include a method for collecting feedback data directly from survivors.

- **Prevention and early intervention.** There appears to be a significant amount of interest among providers around the issue of prevention and early intervention, as well as agreement that such efforts should be targeted toward children and youth. Additional research could be done to more deeply examine Omaha's current IPV prevention efforts and explore opportunities for future work in this area. This could include engaging additional community partners in the research effort such as representatives from Omaha public schools, youth serving organizations, and others.

- **Special populations.** Several service providers identified special survivor populations who may have unique needs including immigrants and refugees; people with disabilities; men; and gay, lesbian, bisexual, and transgender survivors. An additional population that may be of interest is children exposed to domestic violence. There is an extensive body of literature focusing on these and other special populations. Due to the broad scope of this study, researchers did not drill down into the unique needs and circumstances of these populations, but each could be the focus of an independent research study. This would be helpful to broaden the service community's knowledge and understanding of these populations and help inform future program development efforts.

Appendix

List of references

Description of participating agencies

Description of methodology

Review of best practices

Evaluation materials

Interview guide

Focus group script

Services summary form

List of references

- Alhabib, S., Nur, U., & Jones, R. (2009). Domestic violence against women: Systematic review of prevalence studies. *Journal of Family Violence, 25*, 369-382. doi:10.1007/s10896-009-9298-4
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2005). Prevalence and risk factors of intimate partner violence in eighteen U.S. States/Territories. *American Journal of Preventive Medicine, 34*(2), 112-118. doi:10.1016/j.amepre.2007.10.001
- Campbell, M., Neil, J. A., Jaffe, P. G., & Kelly, T. (2010). Engaging abusive men in seeking community intervention: A critical research & practice priority. *Journal of Family Violence, 25*, 413-422. doi:10.1007/s10896-010-9302-z
- Casey, E. (n.d.). *Promising practices in sexual violence prevention and community mobilization for prevention*. Seattle, WA: City of Seattle.
- Cho, H., & Wilke, D. J. (2010). Gender differences in the nature of the intimate partner violence and effects of perpetrator arrest revictimization. *Journal of Family Violence, 25*, 393-400. doi:10.1007/s10896-009-9300-1
- Corvo, K., Dutton, D., & Chen, W-Y. (n.d.). *Towards evidence based practice with domestic violence perpetrators*. Flagstaff, AZ: FFL Foundation.
- Davis, R., Parks, L. F., & Cohen, L. (2006). *Sexual violence and the spectrum of prevention: Towards a community solution*. Enola, PA: National Sexual Violence Resource Center.
- Easton, C. J., Lee, B., Wupperman, P., & Zonana, H. (2008). Letter to the editor, Substance abuse and domestic violence interventions: The need for theoretical based research. *The American Journal on Addictions, 17*, 341-342. doi: 10.1080/10550490802139101
- Ehrensaft, M. K. (2007). Intimate partner violence: persistence of myths and implications for intervention. *Children and Youth Services Review, 30*, 276-286. doi:10.1016/j.chilyouth.2007.10.005
- Eisikovits, Z., & Grauwiler, P. (2008). Introduction, Recent trends in intimate partner violence: Theory and intervention. *Children Youth Services Review, 30*, 249-251. doi:10.1016/j.chilyouth.2007.10.001
- Flynn, A., & Graham, K. (2010). "Why did it happen?" A review and conceptual framework for research on perpetrators' and victims' explanations for intimate partner violence. *Aggression and Violent Behavior, 15*, 239-251. doi:10.1016/j.avb.2010.01.002

- Giacomazzi, A., Hannah, E., & Bostaph, L. (2008). *Nampa Family Justice Center process and outcome evaluation*. Boise, ID: Boise State University.
- Gibson, K. (2008). *Through the eyes of survivors: An exploration of the San Diego Family Justice Center* (Clinical dissertation, Alliant International University San Diego).
- Gillum, T. L. (2008). The benefits of a culturally specific intimate partner violence intervention for African American survivors. *Sage publications, 14(8)*, 917-944. doi:10.1177/1077801208321982
- Gillum, T. L., Sun, S. J., & Woods, A. B. (2009). Can a health clinic-based intervention increase safety in abused women? Results from a pilot study. *Journal of Women's Health, 18(8)*, 1259-1264.
- Guoping, H., Yalin, Z., Yuping, C., Momartin, S., & Ming, W. (2010). Relationships between recent life events, social supports, and attitudes to domestic violence. *Journal of Interpersonal Violence, 25(5)*, 863-877. doi:10.1177/0886260509336959
- Gwinn, C., Strack, G., Adams, A., Lovelace, R., & Norman, D. (2008). The Family Justice Center collaborative model. *St. Louis University Public Law Review, 27(79)*, 79-120.
- Kelly, J. B., and Johnson, M. P. (2008). Special issue: Domestic violence: Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review, 46*, 476-49.
- Klein, A. R., & Crowe, A. (2008). Findings from an outcome examination of Rhode Island's specialized domestic violence probation supervision program. *Violence Against Women, 14(2)*, 226-246. doi:10.1177/1077801207312633
- Klostermann, K., Kelley, M., Mignone, T., Pusateri, L., & Fals-Stewart, W. (2010). Partner violence and substance abuse: Treatment interventions. *Aggression and Violent Behavior, 15*, 162-166. doi:10.1016/j.avb.2009.10.002
- Kropp, P. R. (2008). Intimate partner violence risk assessment and management. *Violence and Victims, 23(2)*, 202-220. doi:10.1891/0886-6708.23.2.202
- Krugman, S. D., Witting, M. D., Furuno, J. P., Hirshon, J. M., Limcangco, R., Perisse, A. R.S., & Rasch, E. K. (2004). Perceptions of help resources for victims of intimate partner violence. *Journal of Interpersonal Violence, 19(7)*, 766-777. doi:10.1177/0886260504265621
- McCullum, E. E., & Stith, S. M. (2008). Couples treatment for interpersonal violence: A review of outcome research literature and current clinical practices. *Violence and Victims, 23(2)*, 187-201. doi:10.1891/0886-6708.23.2.187

- Mitchell, C., & Anglin, D. (Eds.). (2009). *Intimate partner violence: A health-based perspective*. New York: Oxford University Press.
- Parks, L. F., Cohen, L., & Kravitz-Wirtz, N. (2007). *Poised for prevention: Advancing promising approaches to primary prevention of intimate partner violence*. Prevention Institute. Princeton, NJ.
- Prevention Institute. (2006). *Creating safe environments: Violence prevention strategies and programs*. Princeton, NJ: Author.
- Rolling, E. S., & Brosi, M. W. (2010). A multi-leveled and integrated approach to assessment and intervention of intimate partner violence. *Journal of Family Violence*, 25, 229-236. doi:10.1007/s10896-009-9286-8
- Saunders, D. G. (2008). Group interventions for men who batter: A summary of program descriptions and research. *Violence and Victims*, 23(2), 156-172. doi:10.1891/0886-6708.23.2.156
- Townsend, M., Hunt, D., & Rhodes, W. (2005). *Evaluability assessment of the President's Family Justice Center Initiative*. Cambridge, MA: Abt Associates Inc.
- U.S. Department of Justice, Office on Violence Against Women. (2007). *The President's Family Justice Center Initiative: Best practices*.
- Violence Against Women Online Resources (2009). *The Facts about Teen Dating Violence*. Minneapolis, MN: Minnesota Center Against Violence and Abuse.
- Wilt, S., & Olson, S. (1996). Prevalence of domestic violence in the United States. *Journal of the American Medical Women's Association*, 51(3), 77-82.

Model Programs

- Holmes, L., & Davies, J. (2006). *HarborCOV: One community's effort to build comprehensive solutions to domestic violence*. Harrisburg, PA: National Resource Center on Domestic Violence.
- Warchaw, C., & Moroney, G. (2002). *Mental health and domestic violence: Collaborative initiatives, service models, and curricula*. Chicago, IL: The Domestic Violence and Mental Health Policy Initiative.

Description of participating agencies

One or more individuals from each of these agencies was interviewed for the study.

Coordinating agencies and coalitions

Nebraska Domestic Violence and Sexual Assault Coalition. The coalition is a statewide advocacy organization committed to the prevention and elimination of sexual and domestic violence that provides local and statewide training and education.

Domestic Violence Coordinating Council (DVCC). Located in Douglas County, the DVCC partners with agencies involved in domestic violence and advocates for system change through education and training. It recently launched the Family Justice Center of the Midlands in the summer of 2010, a community-wide collaborative aimed at providing services in a centralized “one-stop shop” location.

Coalition Against Sexual and Domestic Abuse (CASDA) of Sarpy County. Sarpy County’s Coordinated Response Team of law enforcement, IPV service providers, medical professionals and others, who work together to develop protocols for addressing domestic violence and sexual assault incidents that occur in Sarpy County.

Core service providers

YWCA. The domestic violence and sexual assault program at the Omaha YWCA provides services such as a 24-hour hotline, advocacy, counseling, and legal services, as well as programs around domestic violence education, empowerment, and parenting. Non-violence (batterer) programs for men and women are also available. The YWCA also provides youth and community education and training.

Heartland Family Service. Located in Sarpy County, Heartland offers a 24-hour hotline, transitional shelter at Safe Haven (see below), and advocacy and counseling services for survivors in the greater Omaha area, as well as a children’s support group, a non-violence (batterer) group for men, and community education and training.

Catholic Charities. Catholic Charities of the Archdiocese of Omaha, Inc. offers a range of domestic violence services/programs including: a 24-hour hotline, counseling and advocacy, and emergency shelter. Services are available at The Shelter (see below) or the Juan Diego Center, which houses the Latina Resource Center (LRC) offering culturally-specific services for Latina women; the LRC is a collaboration between Catholic Charities (lead agency), Heartland Family Services, and the YWCA.

Shelters

Several facilities provide emergency shelter to survivors of domestic violence, and include both domestic violence-specific shelters as well as other types of shelters.

Safe Haven. Operated by Heartland Family Service in Sarpy County, the Safe Haven Transitional Shelter is a confidential (concealed location) shelter that can accommodate up to 20 women and children. Residents may stay up to two years, and receive services such as individual therapy, groups teaching life skills and stress management, employment assistance, and support securing permanent housing.

The Shelter. Operated by Catholic Charities of the Archdiocese of Omaha, The Shelter provides emergency shelter and temporary housing, as well as a 24-hour hotline and counseling and advocacy. The Shelter can accommodate up to 10 clients at one time, including six women and their children.

Phoenix House. Operated by Catholic Charities, Diocese of Des Moines, IA and located in Council Bluffs, Phoenix House provides a 24-hour emergency confidential (concealed location) shelter that can house up to eight families. Other services for survivors include a 24-hour crisis hotline, legal advocacy, hospital response, and education and support groups. Phoenix House also offers public education presentations.

Open Door Mission. Providing a range of services to address homelessness and poverty, Open Door provides emergency shelter for up to 400 men, women, and children in the Omaha area. This includes Lydia House, which provides emergency shelter for 300 women and families fleeing domestic violence, and other services to address basic needs and programming related to abuse, addiction, or employment.

MICAH House. The MICAH House is an emergency (30-day), 90-bed homeless shelter in Council Bluffs, IA. It serves as an overflow shelter for the area's domestic violence shelters. Approximately one-quarter of the families served at MICAH House have a domestic violence history

Siena/Francis House. Siena/Francis House is a shelter facility in downtown Omaha, providing emergency overnight shelter to men, women, and women with children, as well as case management. The Siena House is a 40-bed shelter accommodating women, and women with children, while the Francis House is a 222-bed facility accommodating men.

Stephen Center. The Emergency Shelter at the Stephen Center provides shelter for homeless men, women and children, and is the area's only dry (drug-free) shelter. The shelter houses up to 40 single men and 20 single women, as well as up to 25 children and their mothers. The shelter is open on an emergency basis from a few nights to two weeks or longer depending upon the situation.

Hospitals and clinics

Charles Drew Health Center. Charles Drew Health Center provides a range of medical services for the entire family, as well as other education and prevention programs, in the Omaha area. A proportion of patients seeking medical care at the Center have sustained injuries related to domestic violence.

OneWorld Community Health Centers. OneWorld is a primary health care clinic providing a range of services including medical, dental, vision, diabetes education, nutrition programs, a pharmacy, and behavioral health therapy. OneWorld focuses on the underserved; a majority of patients are Spanish-speakers.

Douglas County Health Department. The Health Department offers programs promoting environmental safety, healthy life choices, safe food, wellness for children, disease control and more. As a provider of resources such as WIC and health clinics, the Department has access to individuals experiencing domestic violence.

Methodist Hospital (SANE/SART program). The Heidi Wilke SANE/SART Survivor Program at Methodist Hospital provides specialized care for victims of sexual assault. The program includes the Sexual Assault Response Team (SART), comprised of the Sexual Assault Nurse Examiner (SANE), a physician, a victim advocate from the YWCA, and law enforcement.

University of Nebraska Medical Center (UNMC). The Medical Center's main campus is based in Omaha. UNMC is Nebraska's only public academic health sciences center and includes six colleges and two institutes, serving more than 3,100 students in more than two dozen programs. The Emergency Department routinely serves victims of domestic violence and screens for IPV.

Colleges and universities

Creighton University. The Omaha-based University operates more than 50 undergraduate and 20 graduate programs, serving over 7,000 students.

University of Nebraska at Omaha (UNO). The UNO campus at Omaha offers more than 200 undergraduate and graduate programs of study and serves nearly 15,000 students. Student Health Services and the Counseling Center provide services to students experiencing domestic violence, as well as campus education training.

Metropolitan Community College (MCC). MCC is comprised of several campuses, several of which are located in Omaha. The college serves nearly 15,000 students.

Support and referral agencies

Justice for Our Neighbors. JFON provides free, professional legal services to immigrants in monthly clinics. In 2005, the agency began working with victims of domestic violence.

Lutheran Family Services. LFS is a faith-based, not-for-profit, multi-service human care agency providing services in the areas of behavioral health, children's services, and community services. LFS opened the International Center of the Heartland in 2007, offering direct on-site services and referrals for refugees and immigrants.

Project Harmony. The accredited child advocacy center provides services for children who have been abused or witnessed violence, including forensic interviews, medical exams, assessment and referrals, multidisciplinary teams that review cases, and trainings for professionals. The agency serves eastern Nebraska and southwest Iowa.

Other systems

Nebraska Crime Commission. The Crime Commission develops comprehensive plans and coordinates activities related to the improvement of criminal justice administration among state and local agencies. The Commission is the recipient of the federal VAWA grant funds. The Commission distributes the grant dollars to sub-grantees, monitors their programs, and coordinates the Community Response Teams (CRTs).

Douglas County Victim Assistance. The Victim Assistance Unit provides guidance to victims involved in the criminal justice system and responds to police reports in cases of domestic violence arrest by providing information and referrals to victims. The Unit works closely with the County Attorney's office in IPV cases that go to court.

Douglas County Probation. The Probation Office conducts presentencing investigation of domestic violence cases and provides the court with a recommendation of community supervision (probation) or prison/jail for the offender. Offenders released under community supervision are monitored by the Probation Office. The Office also provides services to victims, including taking the victim impact statement.

Douglas County Attorney's Office. The County Attorney is responsible for prosecuting all misdemeanor and felony domestic violence cases in Douglas County, and works with victims to help them understand the judicial process.

Legal Aid of Nebraska. Legal Aid operates multiple offices across the State, including one in Omaha that serves Douglas and Sarpy Counties, and provides free civil legal services to low income Nebraskans. It includes a specialized program in domestic violence providing legal services related to protection orders, custody, and divorce.

As previously noted, other entities in Omaha (such as law enforcement and the school system) have a large role in addressing domestic violence, but were not included in this study due to the focus on direct service providers.

Description of methodology

Additional description of qualitative data analysis

Analysis of all qualitative data (i.e., key informant interviews and survivor focus groups) was performed at two levels by the primary project researchers.

Level one: ATLAS.ti coding. The three researchers who conducted all of the interviews and focus groups were also involved in coding the interview and focus group transcripts. Interviewers read select transcripts and worked together to develop a multi-level codebook. The codebook included a total of 59 individual codes, several of which were organized into higher-level categories such as demographics, survivor needs, types of services, service coordination, and prevention, among others. The researchers jointly coded select portions of several transcripts to establish a systematic process for assigning codes. Once the process was firmly established, the three researchers shared the task of coding the transcripts using ATLAS.ti (v6), a qualitative analysis software package. The researchers primarily coded the interviews they personally conducted because of their unique understanding of the context and nuance of those interviews. More than one code could, and often was, assigned to sections of the text that addressed multiple issues.

Level two: Identification of themes. Following the coding process, the text was reprinted and organized by code. The authors of this report reread the coded transcripts and identified the key themes within each code. The authors discussed these themes in order to identify commonalities across codes, their alignment with the literature where relevant, and the implications of these themes for the community (i.e., opportunities for improving services and outreach). This information was synthesized and summarized in this report. The report reflects the primary, common themes and ideas that emerged from this analysis process.

Review of best practices

Review of select Intimate Partner Violence evidence-based practices and/or models			
Program name	Description	Evidence	Source/More info
Organizational models/approaches			
The Sanctuary Model	<p>The Sanctuary is a program formed in 1991 by a team of health professionals (including mental health, psychiatry, nursing and social work) that deals specifically with trauma for adult survivors. The team developed inpatient and outpatient trauma informed approaches to the treatment of adults, realizing that they had survived extreme stressful and traumatic experiences which usually began at childhood.</p> <p>The Sanctuary Model has since been adapted by residential treatment settings for children, public schools, domestic violence shelters, group homes, outpatient settings, substance abuse programs, parenting support programs, and has been used in other settings as a method of organizational change.</p> <p>The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals related a sound treatment environment:</p> <ul style="list-style-type: none"> Culture of Nonviolence Culture of Emotional Intelligence Culture of Inquiry & Social Learning Culture of Shared Governance Culture of Open Communication Culture of Social Responsibility Culture of Growth and Change 	<p>The Sanctuary Model is an evidence-supported, trauma-informed methodology for creating or transforming an organizational culture so that it is better equipped to buffer staff, thus enabling them to deliver better quality services to their clients while keeping themselves both safe and effective. The organizational culture is more effectively able to provide a cohesive context within which healing from psychological and social traumatic experience can be addressed.</p>	<p>http://www.sanctuaryweb.com/</p> <p>http://www.cnrq-portland.org/node/15625</p> <p>http://www.andruschildren.org/Sanctuary_Model.htm</p>

Program name	Description	Evidence	Source/More info
Organizational models/approaches (continued)			
<p>US Department of Justice Office on Violence Against Women</p> <p>The President's Family Justice Center Initiative (PFJCI)</p>	<p>In Oct 2003, President Bush provided \$20 million to create co-located, multidisciplinary service centers for victims of domestic violence, sexual assault, and elder abuse, called Family Justice Centers. The Family Justice Centers are based on the San Diego Family Justice Center Model.</p> <p>After a reduction of nearly 95% in domestic violence homicides over the last 15 years, the San Diego Family Justice Center is hailed as a national and international model of a comprehensive victim service and support center. Since 2004, the President's Family Justice Center Initiative has opened 15 family justice centers in urban, rural, suburban, and tribal communities across the United States.</p> <p>Congress recognized the importance of the family justice center model in Title I of the Violence Against Women Act (VAWA 2005). Family justice centers are now identified as a "purpose area" under VAWA 2005.</p> <p>During the President's Family Justice Center Initiative, and in subsequent evaluations, focus groups, and feedback surveys, ten best practices were identified.</p> <p>(1) Co-located, multi-disciplinary services for victims of DV and their children increases safety and support; (2) Pro-arrest/mandatory arrest policies in FJC communities increased accountability for offenders; (3) policies incidental to arrest/enforcement reduces re-victimization of victims; (4) victim safety/advocacy must be the highest priority in the FJC service delivery model; (5) victim confidentiality must be a priority; (6) offenders must be prohibited from on-site services at centers; (7) community history of DV specialization increased the success of collaboration in the FJC model; (8) strong support from local elected officials and other local and state government policymakers increased the effectiveness and sustainability of FJC; (9) strategic planning is critical to short-term and long-term success in the FJC service delivery model; and (10) strong/diverse community support increased resources for victims and their children. Co-located, multi-disciplinary services for victims of DV and their children increases safety and support</p>	<p>The family justice center model is identified as a best practice in the field of domestic violence intervention and prevention services.</p> <p>The documented and published outcomes have included: reduced homicides; increased victim safety; increased autonomy and empowerment for victims; reduced fear and anxiety for victims and their children; reduced recantation and minimization by victims when wrapped in services and support; increased efficiency in collaborative services to victims among service providers; increased prosecution of offenders; and dramatically increased community support for services to victims and their children through the family justice center model.</p>	<p>United States Department of Justice Office on Violence Against Women</p> <p>www.ovw.usdoj.gov</p> <p>www.familyjusticecenter.org</p> <p>(See Casey Gwinn, Gael Strack, <i>Hope for Hurting Families: Creating Family Justice Centers Across America</i> (Volcano Press 2006).</p> <p>http://www.familyjusticecenter.com/index.php?/History/the-san-diego-story.html</p>

Program name	Description	Evidence	Source/More info
<i>Organizational models/approaches (continued)</i>			
Texas Council on Family Violence: Nine Key Elements of Best Practice Prevention Programs	<p>The Nine Key Elements of Best Practice Prevention Programs are drawn from published research identifying the key elements of prevention programs identified as best practices. These elements may help you when developing and evaluating your own domestic violence prevention programs.</p> <ol style="list-style-type: none"> 1. Comprehensive 2. Varied Teaching Methods 3. Positive Relationships 4. Appropriate 5. Small Successes 6. Sufficient Dosage 7. A Well-Equipped Team 8. Theory-Driven 9. Outcome Evaluation 	<p>The website also highlights current best practice prevention programs such as “Expect Respect”, “My Strength”, “Healthy Relationships” and “Too Good for Violence”, and current promising practice prevention programs, such as “Mentors in Violence Prevention”, “Students Taking Action for Respect”, and “Young Asianz Rising”.</p>	<p>http://www.tcfv.org/prevention/providing-information-and-resources-about-the-prevention-of-domestic-violence-and-dating-abuse/nine-key-elements-of-best-practice-prevention-programs/</p>

Program name	Description	Evidence	Source/More info
Interventions/treatment for survivors			
Seeking Safety	<p>Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It started in 1992, funded by the National Institute on Drug Abuse. Developed by Lisa Najavits, PhD at Harvard Medical School/McLean Hospital.</p> <p>The treatment was designed for flexible use. It is available as a book with handouts for clients and guides for clinicians. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics (25 total) or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.</p> <p>The 5 key principles of Seeking Safety are:</p> <ol style="list-style-type: none"> 1) Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions). 2) Integrated treatment (working on both PTSD and substance abuse at the same time) 3) A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse 4) Four content areas: cognitive, behavioral, interpersonal, case management 5) Attention to clinician processes (helping clinicians work on counter transference, self-care, and other issues) 	<p>Seeking Safety is identified as a SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) intervention.</p> <p>This is the only psychotherapy model for co-occurring PTSD and substance abuse thus far that has enough studies to be classified as “effective”. See the summary of research and also the website section Outcomes.</p> <p>The evidence base on Seeking Safety includes pilot studies, controlled trials, multisite trials, and dissemination studies. They address different populations and modalities.</p>	<p>(Brown et al., 2007). Implementing an evidence-based practice: Seeking Safety group. Journal of Psychoactive Drugs, 39, 231-240</p>
Trauma Recovery and Empowerment Model (TREM)	<p>The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24–29 session group emphasizes the development of coping skills and social support. It addresses both short- and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse.</p> <p>TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.</p>	<p>Listed on SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP)</p> <p>All evaluations (reviewed by NREPP) found that at 12-month follow-up, trauma symptoms were reduced among TREM participants compared with recipients of alternative care (p < .05). In one evaluation, at follow-up, TREM participants averaged 15.6 on a trauma symptom scale, while the comparison group averaged 20.8.</p> <p>One evaluation found significantly reduced symptoms of psychological problems among TREM participants 1 year after the intervention (p = .008). Another evaluation found significantly lower scores on GSI 1 year after the intervention (p = .021). A third evaluation reported no significant findings for this outcome.</p>	<p>http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=158</p>

Program name	Description	Evidence	Source/More info
<i>Interventions/treatment for children</i>			
Child Parent Psychotherapy (CPP)	<p>CPP is a treatment for trauma-exposed children aged 0-5. The child is seen with his or her primary caregiver, and the dyad is the unit of treatment. <i>CPP</i> examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory.</p> <p>A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors).</p> <p>Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.</p>	<p><u>Scientific Rating of 2—Supported by Research Evidence</u> This program has been rated by the California Evidence-Based Clearinghouse for Child Welfare in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Exposure to domestic violence, Physical abuse, Physical neglect, and Sexual abuse</p> <p>Child Welfare Outcomes: Safety and child/family well-being.</p>	<p>http://www.cebc4cw.org/program/49</p>

Program name	Description	Evidence	Source/More info
<i>Interventions/treatment for children (continued)</i>			
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	<p>The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina.</p> <p>CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.</p>	<p>Listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)</p> <p>In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean CPSS score at 3-month follow-up than the wait-list group (8.9 vs. 15.5; $p < .001$). The effect size for this finding was large (Cohen's $d = 1.08$). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CPSS scores was no longer significant (8.2 vs. 7.2).</p> <p>In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CPSS score decreased significantly from 19 to 13 ($p < .001$), while the wait-list group had a nonsignificant decrease from 18 to 16. In addition, in a subsample analysis of students with clinically significant PTSD symptoms at baseline (CPSS score > 11), the improvement in mean CPSS score was significantly greater for the intervention group (from 20 to 13) than for the wait-list group (from 19 to 16; $p < .05$).</p>	<p>http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=153</p>

Program name	Description	Evidence	Source/More info
<i>Interventions/treatment for children (continued)</i>			
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	<p>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement.</p> <p>The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development.</p> <p>Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.</p>	<p>Listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)</p> <p>Earned a scientific rating of 1 ("Well-supported by research evidence") by the California Evidence-Based Clearinghouse for Child Welfare (CEBC)</p> <p>In one study, children and their female guardian were randomly assigned to one of three intervention groups--child only, guardian only, or guardian and child--or to a comparison group receiving standard community care. Children receiving the intervention (i.e., those in the child-only group and guardian and child group) exhibited significantly fewer PTSD symptoms at posttreatment than did those assigned to the guardian-only group or the comparison group ($p < .01$).</p> <p>In another study, children and their female or male guardian were randomly assigned to the intervention group or a group receiving child-centered therapy. Children in the intervention group demonstrated significantly greater reductions in PTSD symptoms from pre- to posttreatment relative to those in the comparison group (all p values $< .01$). Children in the intervention group continued to have fewer PTSD symptoms than those in the comparison group at 6- and 12-month follow-up (all p values $< .01$).</p>	<p>http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=135</p> <p>http://www.cebc4cw.org/program/17/detailed#relevant-research</p>

Program name	Description	Evidence	Source/More info
<i>Interventions/treatment for families (mothers and children)</i>			
Project SUPPORT	<p>The program is for families (mothers and children) who had recently sought refuge at domestic violence shelters, with children aged 4-9 exhibiting clinical levels of elevations on externalizing problems (e.g., disruptive, defiant behaviors).</p> <p>The intervention includes two main components: providing instrumental and emotional support to the mother during her transition from the women's shelter and teaching the mother to implement a set of child management and nurturing skills that have been shown to be effective in the treatment of clinical levels of conduct problems.</p>	<p><u>Scientific Rating of 2—Supported by Research Evidence</u> This program has been rated by the California Evidence-Based Clearinghouse for Child Welfare in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Emotional abuse, Exposure to domestic violence, and Physical abuse</p> <p>Child Welfare Outcomes: Safety and child/family well-being.</p>	<p>http://www.cebc4cw.org/search/topicarea/12</p> <p>http://www.cebc4cw.org/program/50</p>
The Community Advocacy Project	<p><i>The Community Advocacy Project</i> involves providing home-based and community-based advocacy services for survivors of intimate partner abuse. Highly trained paraprofessionals, receiving intensive supervision, work with survivors of domestic abuse (and their children), helping them obtain the community resources and social support they desire. This is an empowerment-based, strengths-focused intervention designed to increase women's quality of life and decrease their risk of re-abuse.</p>	<p><u>Scientific Rating of 2—Supported by Research Evidence</u> This program has been rated by the CEBC in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children.</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Emotional abuse, Exposure to domestic violence, Physical abuse, and Sexual abuse</p> <p>Designed for and tested with survivors of domestic abuse who have utilized shelters. Can be expanded to non-shelter users.</p> <p>Child Welfare Outcomes: Safety and child/family well-being</p>	<p>http://www.cebc4cw.org/program/53</p>

Program name	Description	Evidence	Source/More info
<i>Interventions/treatment for families (mothers and children) (continued)</i>			
Kids Club Empowerment	<p><i>The Kids' Club & Moms Empowerment</i> are two programs designed to coincide with each other and are most effective when both the mother and child participate in the intervention.</p> <p><i>Kids Club</i> is a preventive intervention program that targets children's knowledge about family violence; their attitudes and beliefs about families and family violence; their emotional adjustment; and their social behavior in the small group. The program is phase-based, such that early sessions are designed to enhance the child's sense of safety, to develop the therapeutic alliance, and to create a common vocabulary of emotions for making sense of violence experiences. Later sessions address responsibility for violence, managing emotions, family relationship paradigms, and conflict and its resolution. Activities rely on displacement and group lessons are reviewed and repeated, as needed, each week.</p> <p><i>Moms Empowerment</i> is a parenting program that provides support to mothers by empowering them to discuss the impact of the violence on their child's development; to build parenting competence; to provide a safe place to discuss parenting fears and worries; and to build connections for the mother in the context of a supportive group. In essence, this ten-session intervention is aimed at improving mothers' repertoire of parenting and disciplinary skills, and enhancing social and emotional adjustment, thereby reducing the children's behavioral and adjustment difficulties.</p>	<p>Scientific Rating of 3—Promising Research Evidence This program has been rated by the CEBC in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children.</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Exposure to domestic violence Child Welfare Outcomes: Child/family well-being</p>	<p>http://www.cebc4cw.org/program/79</p>

Program name	Description	Evidence	Source/More info
<i>Interventions for batterers</i>			
AMEND, Inc. (Abusive Men Exploring New Directions)	<p><i>AMEND</i> is an organization that provides treatment for men voluntarily seeking or court-ordered into domestic violence counseling.</p> <p>Following an intake assessment, <i>AMEND</i>'s counselors design a treatment plan to help the client eliminate physical, verbal, and emotional abuse. The treatment plan focuses on identification and awareness of the problem; taking responsibility for the abuse; enhancing self-esteem; building anger management, conflict resolution, communication, and stress-management skills; and remaining chemically free. Specific group sessions discuss family of origin, addictions, sexuality, irrational beliefs, gender stereotypes, parenting, etc..</p>	<p><u>Scientific Rating of 3—Promising Research Evidence</u> This program has been rated by the CEBC in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children.</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Emotional abuse and Physical abuse</p> <p>Child Welfare Outcomes: Safety and child/family well-being</p>	<p>http://www.cebc4cw.org/program/54</p>
Domestic Abuse Intervention Project (DAIP)	<p>The <i>DAIP</i> was designed in 1981 as a Coordinated Community Response (CCR) and includes law enforcement, the criminal and civil courts, and human service providers working together to make communities safer for victims. The <i>DAIP</i>, located in Duluth, Minnesota, includes a 28-week education program for offenders. This model is commonly referred to as the "Duluth Model." The program uses the curriculum <i>Creating a Process of Change for Men Who Batter</i>, which was developed by the <i>DAIP</i>. Advocates at the <i>DAIP</i> contact the partners of men court-ordered to the program to offer advocacy, community resources, and education groups for women.</p>	<p><u>Scientific Rating of 3—Promising Research Evidence</u> This program has been rated by the CEBC in the area of Domestic/Intimate Partner Violence: Services for Women Victims and their Children.</p> <p>The CEBC helps to identify and disseminate information regarding evidence-based practices relevant to child welfare.</p> <p>Type of Maltreatment: Exposure to domestic violence</p> <p>Child Welfare Outcomes: Safety and child/family well-being</p>	<p>http://www.cebc4cw.org/program/55</p>

Program name	Description	Evidence	Source/More info
<i>Prevention programs (targeting children and youth)</i>			
<p>R.E.S.P.E.C.T.² <i>(Relationship Empowerment for Students, Parents, Educators & Community Through Theatre)</i></p>	<p>Dr. Patricia Newman, a clinical child psychologist and a nationally certified school psychologist, founded the idea and the model for what has become the R.E.S.P.E.C.T.² program in the spring of 2000. She developed a volunteer, community collaboration and the funding to bring educational theatre, for the purpose of addressing violence in the relationships of children, to Omaha. In the summer of 2001, R.E.S.P.E.C.T.² built a cast of Omaha actors to further develop this concept. Since this time, the company has been writing and producing professional, educational theatre productions for children and teens throughout Nebraska, Iowa, and South Dakota. Together they have produced and directed 15 violence prevention plays and have presented and facilitated over 1800 performances of these plays. By the end of the 2008-2009 school year, over 215,000 students will have participated in their programs.</p> <p>R.E.S.P.E.C.T.² is responsible for developing the educational goals and objectives that guide their professionally facilitated discussions and the resource and evaluation materials that have been developed for participating teachers, students, and parents.</p> <p>R.E.S.P.E.C.T.² Objectives</p> <ol style="list-style-type: none"> 1. To teach students the dynamics of bullying & teen dating violence. 2. To teach and demonstrate to students behavioral choices & strategies to help themselves & their peers with bullying & teen dating violence. 3. To provide & teach about resources available to help students with bullying & teen dating violence 	<p>R.E.S.P.E.C.T.² is a best practice, research-based organization. The theatrical content we continually develop stems directly from the surveys collected from our audiences; we aim to be relevant at all times. Additionally, this survey data proves theatrical education has a place in the classroom and can over time make a meaningful impact on behavior (see 2005-2007 Research Results). We are thankful to Dr. Charles "Tim" Dickel and Dr. Patricia Sullivan from Creighton University for their on-going support and work in helping us process our student and teacher data.</p>	<p>http://respect2all.org/resources/research/ch.cfm</p> <p>2005-2007 Research Results</p> <p>http://respect2all.org/aboutus/history.cfm</p>

Program name	Description	Evidence	Source/More info
Prevention programs (targeting children and youth) (continued)			
Safe Dates	<p><i>Safe Dates</i> is a curriculum that helps teens recognize the difference between caring, supportive relationships and controlling, manipulative, or abusive dating relationships. Designated as a Model Program by the Substance Abuse and Mental Health Services Administration. In 2006, <i>Safe Dates</i> was selected for the National Registry of Evidence-based Programs and Practices (NREPP), and received high ratings on all criteria.</p> <p><i>Safe Dates</i> can be used as a dating abuse prevention tool for both male and female middle- and high-school students. <i>Safe Dates</i> would fit well within a health education, family life skills, or general life skills curriculum.</p> <p>Because dating violence is often tied to the abuse of alcohol and other drugs, you may want to consider using <i>Safe Dates</i> in conjunction with alcohol and other drug prevention programs, as well as any other general violence prevention programs. A school counselor could offer <i>Safe Dates</i> as part of a support group or counseling/education program or it could be used in after school, community youth enrichment, and faith-based youth programs. <i>Safe Dates</i> could also be used as an intervention tool at domestic abuse or crisis centers, in juvenile diversion programs, and with victim support groups.</p> <p>The goals of this program are:</p> <ul style="list-style-type: none"> • To raise student awareness of what constitutes healthy and abusive dating relationships. • To raise student awareness of dating abuse and its causes and consequences. • To equip students with the skills and resources to help themselves or friends in abusive dating relationships. • To equip students with the skills to develop healthy dating relationships, including positive communication, anger management, and conflict resolution <p>The curriculum consists of five components:</p> <ul style="list-style-type: none"> • A nine-session dating abuse curriculum • A play about dating abuse • A poster contest • Parent materials • A teacher training outline <p>Each session is approximately 50 minutes in length. <i>Safe Dates</i> can be flexibly scheduled (e.g., daily or weekly sessions).</p>	<p>Listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)</p> <p><i>Safe Dates</i> is an evidence-based program with strong, long-term outcomes. It was the subject of substantial formative research in fourteen public schools in North Carolina using a rigorous experimental design. The program was found to be effective in both preventing and reducing perpetration among teens already using violence against their dates.</p> <p>Adolescents participating in the program, as compared with those who did not participate, also reported:</p> <ul style="list-style-type: none"> • less acceptance of dating violence • stronger communication and anger management skills • less gender stereotyping • greater awareness of community services for dating abuse <p>Researchers studied the same group of students four years after implementation and found that students who participated in the <i>Safe Dates</i> program reported 56 percent to 92 percent less physical, serious physical, and sexual dating violence victimization and perpetration than teens who did not participate in <i>Safe Dates</i>. The program has been found to be equally effective for males and females and for whites and non-whites.</p>	<p>http://www.hazelden.org/web/public/safedates.page</p> <p>National Registry of Evidence-based Programs and Practices</p> <p><i>Safe Dates</i> research outcomes</p> <p><i>Safe Dates</i> Scope & Sequence</p>

Program name	Description	Evidence	Source/More info
Prevention programs (targeting children and youth) (continued)			
Incredible Years	<p>The Incredible Years Series is a set of three comprehensive, multi-faceted, and developmentally-based curriculums for parents, teachers and children designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotion problems in young children.</p> <p>Children, ages two to ten, at risk for and/or presenting with conduct problems (defined as high rates of aggression, defiance, oppositional and impulsive behaviors). The programs have been evaluated as "selected" prevention programs for promoting the social adjustment of high risk children in preschool (Head Start) and elementary grades (up to grade three) and as "indicated" interventions for children exhibiting the early onset of conduct problems.</p> <p>This series of programs addresses multiple risk factors across settings known to be related to the development of Conduct Disorders in children. In all three training programs, trained facilitators use videotape scenes to encourage group discussion, problem-solving, and sharing of ideas. The BASIC parent series is "core" and a necessary component of the prevention program delivery. The other parent training, teacher, and child components are strongly recommended with particular populations that are detailed in this document.</p>	<p>Deemed a "model program" by Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado Listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)</p> <p>Earned a scientific rating of 1 ("Well-supported by research evidence") by the California Evidence-Based Clearinghouse for Child Welfare (CEBC)</p> <p>Multiple randomized control group evaluations of the parenting series indicate significant:</p> <ul style="list-style-type: none"> • Increases in parent positive affect such as praise and reduced use of criticism and negative commands. • Increases in parent use of effective limit-setting by replacing spanking and harsh discipline with non-violent discipline techniques and increased monitoring of children. • Reductions in parental depression and increases in parental self-confidence. • Increases in positive family communication and problem-solving. • Reduced conduct problems in children's interactions with parents and increases in their positive affect and compliance to parental commands. <p>Multiple randomized control group evaluations of the teacher training series indicate significant:</p> <ul style="list-style-type: none"> • Increases in teacher use of praise and encouragement and reduced use of criticism and harsh discipline. • Increases in children's positive affect and cooperation with teachers, positive interactions with peers, school readiness and engagement with school activities. • Reductions in peer aggression in the classroom. <p>Multiple randomized control group evaluations of the child training series indicate significant:</p> <ul style="list-style-type: none"> • Increases in children's appropriate cognitive problem-solving strategies and more prosocial conflict management strategies with peers. • Reductions in conduct problems at home and school. <p>Independent replications in England, Wales, Norway, Canada, and the US confirm these findings.</p>	<p>http://www.colorado.edu/cspv/blueprints/modelprograms/YS.html</p> <p>http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=93</p> <p>http://www.cebc4c.w.org/program/1</p>

Program name	Description	Evidence	Source/More info
Prevention programs (targeting children and youth) (continued)			
Olweus Bullying Prevention Program (BPP)	<p>The Olweus Bullying Prevention Program is a universal intervention for the reduction and prevention of bully/victim problems. The main arena for the program is the school, and school staff has the primary responsibility for the introduction and implementation of the program. Program targets are students in elementary, middle, and junior high schools. All students within a school participate in most aspects of the program. Additional individual interventions are targeted at students who are identified as bullies or victims of bullying.</p> <p>Core components of the program are implemented at the school level, the class level, and the individual level:</p> <p><i>School-wide components</i> include the administration of an anonymous questionnaire to assess the nature and prevalence of bullying at each school, a school conference day to discuss bullying at school and plan interventions, formation of a Bullying Prevention Coordinating Committee to coordinate all aspects of school's program, and increased supervision of students at "hot spots" for bullying.</p> <p><i>Classroom components</i> include the establishment and enforcement of class rules against bullying, and holding regular class meetings with students.</p> <p><i>Individual components</i> include interventions with children identified as bullies and victims, and discussions with parents of involved students. Teachers may be assisted in these efforts by counselors and school-based mental health professionals.</p>	<p>Deemed a "model program" by Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado</p> <p>The Olweus Bullying Prevention Program has been shown to result in:</p> <ul style="list-style-type: none"> • a substantial reduction in boys' and girls' reports of bullying and victimization; • a significant reduction in students' reports of general antisocial behavior such as vandalism, fighting, theft and truancy; and • significant improvements in the "social climate" of the class, as reflected in students' reports of improved order and discipline, more positive social relationships, and a more positive attitude toward schoolwork and school. 	<p>http://www.colorado.edu/cspv/blueprints/modelprograms/BPP.html</p>

Evaluation materials

Omaha IPV survivor focus group script

Service provider interview protocol

Services summary form

Omaha IPV survivor focus group script

Introduction by Wilder Facilitator

Welcome! Thank you for joining us here today. My name is _____ and I work for Wilder Research, a nonprofit human services research organization in St. Paul, Minnesota. We were hired by The Women's Fund of Omaha to conduct a study of the needs of and services available for people who have experienced domestic violence. We have invited you here today to talk about your experience as a survivor of domestic violence, and to share what other supports might have been helpful for you.

Before we start talking, I want to let you know a few things.

- First, we are using this information for research purposes only. What you say will not affect your participation in any programs, or your ability to receive services from any organization.
- Second, we will be taking notes, but no one outside of this group will know who said what. We recognize that this is a sensitive topic, and we want everyone to feel safe to share their comments. It is important for everyone to agree that what is shared in the room is not shared outside the room.
- Third, we want to hear what everyone thinks. Sometimes, you might have an idea that is different from another person's idea. That's O.K. We are here to listen to everyone's ideas. There are no right or wrong answers. Also, we are interested in hearing what everyone has to say. Please try not to interrupt if someone else has the floor.
- Fourth, you will receive a \$25 Target Gift Card for participating in the focus group. You can get the gift card from me when we are finished.
- Finally, we would like to record this discussion so that we make sure that we don't miss any opinions that are discussed here – especially since _____ (notetaker) may not be able to write as fast as you can talk. Is that O.K. with everyone here? (START RECORDING IF IT IS OK WITH EVERYONE).

Are there any questions? OK, let's get started. First, I would like us to go around the room and introduce ourselves. If you are comfortable doing so, please share your first name. (Record number of participants present, gender and race of participants, if known. Recorder may wish to draw a diagram of where participants are sitting and then assign them a number or initials for ease of note-taking.)

1. We recognize that you are all here because you share a common experience of being a survivor of domestic violence. We also want to acknowledge that while you may have some things in common, your individual experiences are unique. For this project, we have been asked to focus on the services you needed and sought out, and your experience with those services. Your interactions with other entities like law enforcement or the court system are certainly very important, but it is not something we will focus on today in our conversation.

We realize this is a difficult topic, but before we begin asking you specific questions about the services you received as a survivor of domestic violence, would anyone feel

- comfortable sharing very briefly about their experience, such as how long ago it happened, where you were living at the time, etc.? {Note: *limit time/depth*}
2. Thinking back to a time when you were in a crisis as a result of domestic violence, what services or support did you most need in the days and weeks around that time?
 - a. Where did you go?
 - b. Were you able to find the help you needed?
 - c. How was [service] helpful?
 - d. Was there anything you needed that you didn't get help with?
 - e. Did you have children with you at the time? Did they get the help they needed?
 3. Once you were out of crisis, what services or supports did you need in the months or years following that time?
 - a. Where did you go?
 - b. Were you able to find the help you needed?
 - c. How was [service] helpful?
 - d. Was there anything you needed that you didn't get help with?
 - e. Did you have children with you at the time? Did they get the help they needed?
 4. As a survivor of domestic violence, what services or supports do you need now?
 - a. Do you have the help you need in these areas?
 - b. Is there anything else you need right now, in terms of your long term safety?
 5. Overall, what has been most helpful in your recovery from the abusive relationship/domestic violence experience?
 - a. Any particular programs or services?
 - b. How was it helpful?
 6. What do you think are the biggest barriers to getting help when in a domestic violence situation?
 7. What would you want for other people so they don't have to go through what you went through?
 - a. Based on your experience, what advice would you give a friend in a similar situation?
 - b. What kind of support could the community or others provide?
 - c. What advice would you give the organizations or people that could have helped you?
 - d. What, if anything, could have been done to help you get the service or support you needed earlier? {*early identification*}
(Probe for prevention angle, without specifically referring to "prevention")

OMAHA INTIMATE PARTNER VIOLENCE

Service provider interview protocol

April 21, 2010

Introduction

Thank you for your willingness to participate in this interview. As was mentioned in the letter emailed to you/during our phone conversation, Wilder Research is working with the Women's Fund of Omaha, in partnership with Dianne Lozier of the Lozier Corporation, to explore strategies to end intimate partner violence in the Omaha community. The purpose of the report is to gather information about existing resources for survivors of intimate partner violence, the process of identifying survivors, the needs of survivors and their families, gaps in and barriers to service, the communication and collaboration between service agencies, and opportunities for improving services.

You were identified as someone we should speak with for this study because of your work in this area. In addition to conducting interviews with key informants such as yourself, Wilder Research is also gathering information about best practices in this work and conducting a focus group with survivors. A report summarizing the state of IPV services in Omaha will be released by the end of this year.

The information that you provide will be combined with the feedback from other informants and will be reported in terms of key themes and lessons. You will not be directly identified in the report. We may quote you in the report but will only attribute quotes to individuals in general terms (for example, as a "service provider").

Would it be okay if I recorded our conversation, just to make sure I do not miss anything we discussed today? (*Note: Please record interview if possible – save audio file in common*)

Do you have any questions before we continue?

Background of informant/agency

1. What is the role of your agency related to Intimate Partner Violence? What services are provided for this population?
 - a. Does your agency serve a specific population?
 - b. Have you seen any changes over time in who you serve? [*Probe for trends related to age, gender, race/ethnicity/immigrant status*]
2. What is your role related to services for survivors of intimate partner violence, or IPV?
3. Can you briefly describe the history of your agency with regard to IPV? How do you fit into the larger spectrum of services for IPV survivors in this community?

Identification and outreach

4. How do survivors of IPV learn about the services offered in your community? What types of outreach do you do?
 - a. How do they learn about your agency's services? Are they referred? If so, by whom?
 - b. How does your organization identify survivors in the community who may be in need of your services?
5. In your experience, where do survivors of IPV and their families most commonly turn for help? [*Probe for both formal networks (such as police, victim advocates and community-based services) and informal networks (such as family, friends, neighbors, and faith leaders)*]
6. What other types of outreach strategies should be used to reach out to survivors? Are there different strategies that need to be considered depending on survivors' age, gender, or racial/ ethnic/immigrant status?

Needs of survivors

7. From your experience in the field, what is the impact of IPV on survivors?
 - a. What are the immediate and long-term effects? [*Probe for physical and emotional consequences*]
8. What do IPV survivors often want or need in order to recover/heal?
 - a. What kinds of needs do they have during or immediately after the experience? [*Probe for concrete supports, if not mentioned*]
 - b. What kinds of needs do they have for their longer-term healing?
 - c. Have you seen any changes over time in terms of what survivors need?
9. Do factors such as the survivor's age, gender, and racial/cultural background impact their experience of IPV and the recovery process?
 - a. Is it important to provide age-specific, gender-specific, or culturally-specific services to survivors of IPV? If so, why?
 - b. How effective are the services currently available for survivors from different age, gender, or racial/ethnic/immigrant groups?
10. What is the impact of intimate partner violence on the *children* of IPV survivors? [*limit time*]
 - a. What are their needs?
 - b. Are there services available for these children in Omaha? If so, what types of services? What else would be beneficial?

Services

11. How familiar are you with other service providers and programs for IPV survivors in the Omaha area? How much contact or communication do you have with them?
 - a. If little familiarity or contact -> can you say more about this (why not)?
12. What types of services are currently available in the Omaha area for survivors of IPV?
 - a. What services are used most frequently?
 - b. Of the services that are currently available, which do you think are the most beneficial? Why?
 - c. Are there any services being offered that you think are less important/beneficial for survivors?

SKIP 13 AND 14 IF RESPONDENT ANSWERS “LITTLE FAMILIARITY” FOR Q11

13. How effective are the current services?
 - a. Are there particular forms of support or other services that are most effective with survivors of IPV (i.e., best practices)? What are these services?
 - b. What kind of an impact do these services have on short-term and longer-term healing?
 - c. What might make current services more effective? [*Probe: For example, are survivors' needs being met in the most efficient way?*]
 - d. What other services are needed (i.e., where are there gaps in service)?
14. How available or accessible are services in Omaha for survivors of IPV?
 - a. In general, have services become more or less available?
 - b. Are there services that used to exist that are no longer available?
 - c. What has led to these changes in the availability of services over time? [*Probe: changes in funding availability, significant policy directions, changes in evidence-based practices, etc.*]
 - d. Are there any barriers that prevent survivors from receiving services? What types of barriers?

Cross-agency collaboration

15. Do you partner with other agencies in the community around the issue of intimate partner violence?
 - a. What type of agencies do you partner with? Who do you work with at these agencies?
 - b. How did this/these partnership(s) develop? Can you share some examples of ways in which you collaborate?

- c. What do you see as the benefits of this type of collaboration for IPV survivors?
 - d. Are there any barriers to collaborating with other organizations? What types of barriers?
16. Do you feel there is a sufficient level of collaboration between local programs and agencies in the area of IPV? What more could be done to enhance collaboration?
17. Do you think there is general agreement in the community about the best way to serve IPV survivors?

Prevention/early intervention

18. The funder of this project is interested in learning what efforts can be made to help prevent IPV in the future. In your experience, who should these prevention efforts target? Are there certain populations you might consider more “at risk” of experiencing IPV in the future? [*Probe for different groups based on age, gender, and racial/ethnic/immigrant status*]
19. What types of strategies or approaches are needed to prevent IPV?
- a. What prevention efforts are underway in the Omaha community? What strategies do you think are most effective?
 - b. Who do you think is best positioned to implement prevention efforts? [*Probe for different levels: individual (youth/young adults), parents/families, larger community*]
 - c. What role can other organizations play in helping to reduce IPV?
20. What programs or services are available in Omaha for those *at-risk* for IPV?
- a. How do those at-risk learn about existing programs and services? What methods are being used to reach this population (e.g., social network sites) and are they effective?
 - b. Are the available services meeting their needs? What more is needed for those at-risk?

Future direction

21. What would you say are the most important accomplishments related to providing services to survivors of IPV locally in Omaha, over the past 10 years?
22. What would you recommend as a future direction for IPV services? If you had a “magic wand” and unlimited funds, what do you believe would be the most effective means of improving services for survivors of IPV and their families in Omaha?
23. Is there anything else you want us to know about this topic that we haven’t asked you about?

Other requests

24. Are there any reports or other documents that you think will be useful for our report (either those developed at your agency or others that you know of, such as success stories from other communities)? [*Request a copy, if available*]
25. Is there anyone you would recommend that we speak with about the issue of intimate partner violence in Omaha – either at your organization or in the broader community? [*Gather name, role, and contact information*]
26. For this study, we plan to gather information directly from survivors of IPV in order to obtain a first-hand perspective about experiences related to accessing IPV services in the community. Do you know of any survivors who would be willing to participate in a focus group or be interviewed about their service use experience?
 - a. We are looking for individuals who are obviously not in crisis and far enough along in their recovery to speak comfortably about their experience as an IPV service recipient without causing further trauma.
 - b. All information will be kept confidential and all identifying information protected.
 - c. Individuals will be compensated for their time (with a \$20 gift card or other appropriate item).
 - d. The focus group or interviews will occur in early June, in person.
27. As part of this study, we are gathering information about “best practices” or “promising programs” in the field and plan to follow up directly with these programs when possible. Are there any promising services or approaches to working with survivors of IPV that you are aware of in other communities, or in the research, that should be considered in Omaha? If so, do you have any connection to the individuals at this program/service? If so, could we get the name of a contact person for that program and their contact information?

Study of Omaha Intimate Partner Violence (IPV) Provider Services Summary form –

Please complete one Services Summary form for your organization (you may need to consult with other individuals from your agency to compile this information). For this study, Wilder Research is only interested in **services you provide for individuals at risk of or experiencing intimate partner violence**. If your organization or program provides services to other populations, please DO NOT include that information on this form. If you do not have exact numbers to answer these questions, please provide an estimate.

Organization name:

Program name:

Staff contact (first and last name):

Phone number:

Individuals served

1a. Total number of participants* served in 2009 (or during your most recent fiscal year)
* If your organization serves children or families of individuals affected by IPV, please count each family as one participant. DO NOT count each child/family member as a separate participant.

1b. Please specify 12 month time period covered in Q1:
(month/year – month/year)

2. Do you serve children of individuals affected by Intimate Partner Violence?

- Yes, shelter only
 Yes, direct services only
 Yes, direct services and shelter
 No

Program services

Please complete the table about the participants you counted in Question 1 above

3. Services provided this year	Number of participants served
a. Information/referral	
b. Shelter	
c. Transitional housing	
d. Victim outreach/advocacy services	
e. Counseling/therapy/support groups	
f. Crisis line	
g. Other (Please specify:)	
h. Other (Please specify:)	

Program capacity

Please answer the following questions about program capacity.

Program capacity	Shelter	Other direct services
4a. Did you have to turn anyone away from services this year because of lack of capacity?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Skip to 5a</i>) <input type="checkbox"/> Don't offer this service (<i>Skip to 5a</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Skip to 5a</i>) <input type="checkbox"/> Don't offer this service (<i>Skip to 5a</i>)
4b. If yes, how many people were you unable to serve due to capacity limits?		
5a. Did you have capacity to serve additional participants this year (vacancies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Skip to 6</i>) <input type="checkbox"/> Don't offer this service (<i>Skip to 6</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Skip to 6</i>) <input type="checkbox"/> Don't offer this service (<i>Skip to 6</i>)
5b. If yes, about how many additional people could you have served?		
6. Average length of enrollment/participation in your program (in days)		

Program capacity	Number
7. Total number of staff (FTEs) in your program	
8. Total number of participants (or families, if you serve children) served on a typical day	

Participant Demographics

Please complete the following tables about the participants you counted in Question 1 above, across service type. You may provide the number of participants – **OR** – the percent of participants who fit each description. You do not need to complete both columns. If you do not have exact numbers to answer these questions, please provide an estimate (in the % column).

9. Racial/ethnic background (<u>not</u> including children of participants)	Number of participants	OR	% of participants
a. African American/African Native/Black			
b. American Indian/Alaskan Native			
c. Asian American/Asian/Pacific Islander			
d. Hispanic/Latino			
e. White/Caucasian			
f. Multi-racial			
g. Other identification			
h. Unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

10. Place of birth (<u>not</u> including children of participants)	Number of participants	OR	% of participants
a. Foreign born*			
b. US born			
c. Unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>
* Please indicate primary populations served (country of origin):			

11. Age (<u>not</u> including children of participants)	Number of participants	OR	% of participants
a. 17 and younger			
b. 18-25			
c. 26-54			
d. 55 and over			
e. Unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

12. Gender (<u>not</u> including children of participants)	Number of participants	OR	% of participants
a. Male			
b. Female			
c. Unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

13. Children	Number of participants	OR	% of participants
a. Participants who have children under 18 living with them			
b. Participants who do not have children under 18 living with them			
c. Unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

14. Participant income (use poverty guidelines below if needed)	Number of participants	OR	% of participants
a. Participants <u>above</u> the federal poverty guideline			
b. Participants <u>at or below</u> the federal poverty guideline			
c. Poverty level unknown			
Total			
	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

15. History of intimate partner violence (IPV)	Number of participants	OR	% of participants
a. Participants receiving services for first incidence of abuse			
b. Participants receiving services for ongoing abuse			
c. IPV history unknown			
Total	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

16. Service history	Number of participants	OR	% of participants
a. Participants receiving services for first time at this program			
b. Participants returning for services at this program			
c. Service history unknown			
Total	<i>(should add up to Q1)</i>		<i>(should add up to 100%)</i>

2009 Poverty Guidelines (use for Question 14)							
Persons in family	2	3	4	5	6	7	8
Poverty guidelines	14,570	18,310	22,050	25,790	29,530	33,270	37,010
For families with more than 8 persons, add \$3,740 for each additional person.							

Please email or fax completed forms to Maggie Skrypek at Wilder Research by May 14, 2010
 Email: mmg2@wilder.org
 Fax: 651-280-3700

Thank you!