

# Domestic Violence Program Standards 2016



**Maryland Network  
Against Domestic Violence**  
WORKING TOGETHER FOR A SAFER FUTURE

## Introduction

These service standards have been developed in collaboration by a group of conscientious and experienced practitioners. In the Spring of 2013, the Maryland Network Against Domestic Violence (MNADV) Board of Directors established a Domestic Violence Services Committee to develop program standards for domestic violence programs. Representatives from domestic violence programs began participating on monthly meetings and conference calls to develop standards that are firmly rooted in best practices and legal requirements and are flexible enough to meet the diverse needs and practices of programs throughout the State.

Beginning with a set of Guiding Principles, each section was developed in collaboration with MNADV staff, board members, and domestic violence program staff. The standards of other states were reviewed, adapted when relevant, and used along with Maryland's COMAR standards to develop the outline and scope of the standards.

The participation of domestic violence advocates has been crucial throughout this process. Their thoughtfulness and consideration into the language and practical application of these standards has been vital. Advocate and program buy-in into these standards is essential to their utilization and success of this project.

These standards are intended to be used as a guide and resource by new and existing organizations that offer domestic violence services. When considering developing or changing a service, policy, or practice, these standards can be adopted. While Maryland is one of the few states that does not have a formal domestic violence program certification process, these voluntary standards are an important step towards more consistent, quality, accessible services across the state.

Thanks to the following individuals and organizations for your participation throughout the process:

- Abused Persons Program
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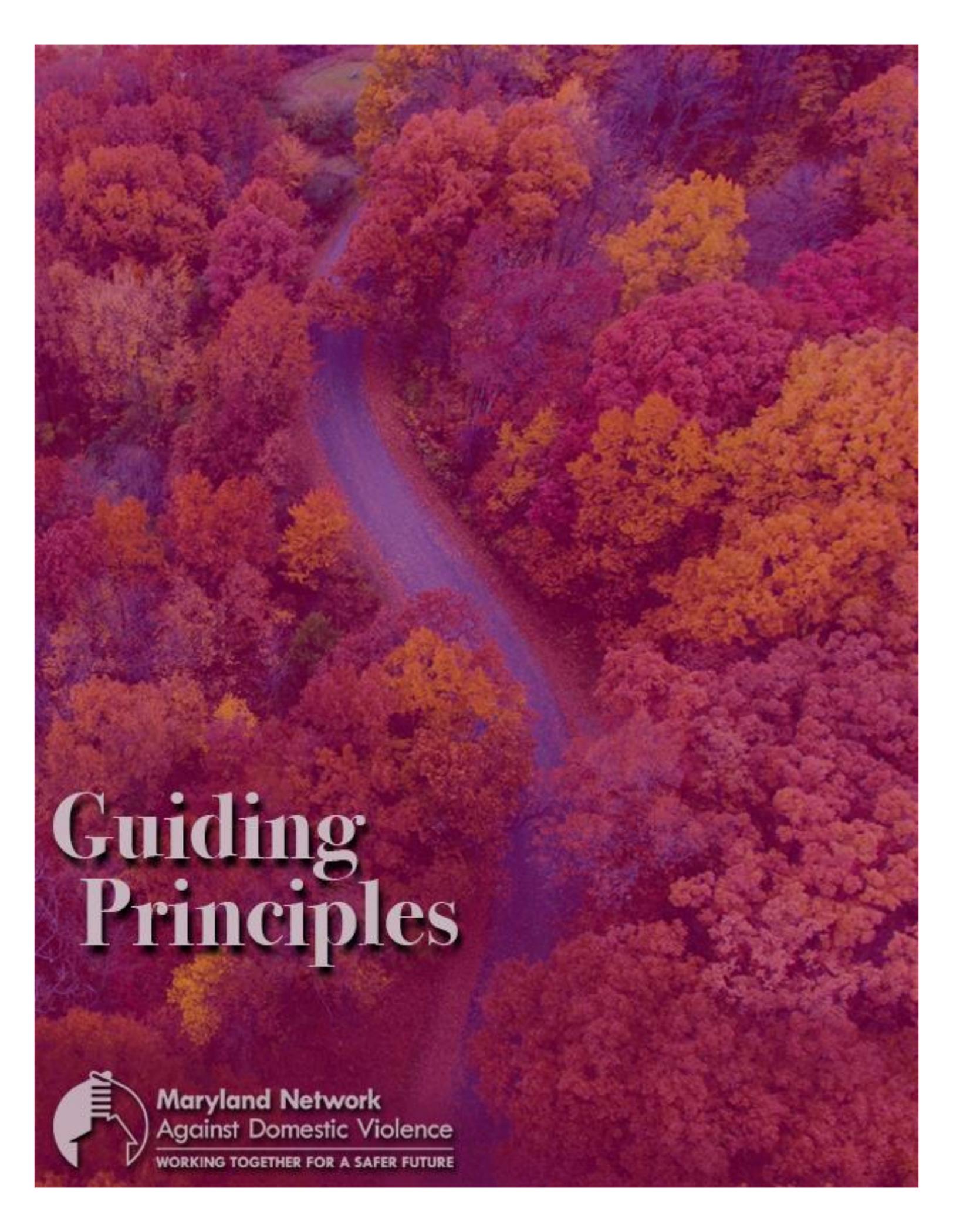
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# Guiding Principles



**Maryland Network  
Against Domestic Violence**

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## Guiding Principles

Provide access to physical and emotional **safety** for survivors of domestic violence and their children in a **continuum of care** environment.

Dedicate our program to **empowering** survivors of domestic violence by partnering with them to strategize for their safety, to provide access to supportive services and safe accommodations, to make available opportunities for education and healing, and to advocate for survivors to assist them in reaching self-defined goals.

Respect the **privacy and confidentiality** of survivors and their children by collecting only essential, necessary information, by keeping records and client information confidential to the fullest extent of the law, and by respecting their personal belongings.

Honor the language and spirit of local, state, and federal **laws, regulations, and grant requirements** that govern domestic violence service provision, provided that they are conducive to survivor safety, client confidentiality, and abuser accountability.

Respect the **culture and customs** of survivors, staff, and volunteers by honoring differences and by making reasonable accommodations, including meaningful language access, that allow everyone to participate in the program to the fullest extent possible.

Foster a **trauma-informed**, welcoming environment for survivors and their children that recognizes the impact of abuse and promotes self-sufficiency, independent decision-making, safer futures, and self-care for advocates and survivors.

Partner with local governmental and community organizations to foster effective **collaborations** that improve survivors' access to services and justice and that enhance survivor safety and abuser accountability.

# Non-Residential Services



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## Access to Non-Residential Services

1. **Disabilities:** Programs must make every effort to provide **reasonable accommodations** for the needs of survivors living with disabilities, including addiction and have written policies and a process for requesting and providing accommodations. Programs must consider as part of their accommodation plan:
  - individuals who require mental or physical care by caregivers
  - survivors with service animals,
  - survivors who are d/Deaf or hard of hearing,
  - survivors who are blind or low vision,
  - survivors who have limited mobility, and
  - survivors who have communicable diseases including HIV/AIDS or another at-risk health status.
  
2. **Special Populations:** Programs must make every effort to provide **reasonable accommodations** for the needs of survivors within special populations. Populations to consider include, but not be limited to:
  - males,
  - transgender and gender non-conforming individuals/LGBQ individuals,
  - minors as primary survivors (emancipated or youth-head-of-household),
  - survivors with low literacy,
  - dietary restrictions,
  - survivors with criminal histories (including sex offenses and child abuse),
  - cultural or religious requirements or restrictions, and
  - Limited English Proficiency (LEP).

## Initial Domestic Violence Program Intake

- 1. Beginning:** The intake process begins with an introduction to services in a structured interview using guiding questions that can be tailored to the individual needs of each survivor with the purpose of gathering information in order to support survivors in identifying needs, understanding their situation, and accessing services. This process can be ongoing and could take place over several sessions.
- 2. Guiding Principles:** The intake process will follow the guiding principles laid out in these standards, including empowering survivors, privacy and confidentiality, culture, and follow trauma-informed philosophy and practices. This includes, but is not limited to, conducting intake in a private space that is warm and inviting, describing the parameters around confidentiality and its limits, and obtaining an interpreter if the survivor's native language is a language other than English.
- 3. Structure:** Begin the initial intake session by explaining the purpose of the intake meeting and what is hoped to be accomplished with the client. Explain limits to confidentiality (see number 4 below). For example, staff may tell client that they hope to get to know the client better, hear about their immediate and short-term concerns, issues, needs, explore coping strategies and barriers to healing as appropriate, and together create some next steps for services and support. Staff will support the client in a non-judgmental way; empower the client to make their own decisions; inform the client that they are free to share as much or as little as they feel comfortable with; that the client is in control of the pacing of the process; and that staff ask questions to learn more about how they can help (*adapted from "Transitional Housing Intake Guide" by NNEDV*). Initial information obtained will be limited to: demographic information, safety planning, information and referrals, a brief history of current intimate partner violence, risk assessment (such as Lethality Assessment or Danger Assessment), and next steps.
  - a. For guidance on safety planning, see Appendix D for the High Risk Safety Planning Protocol.
  - b. Next steps could include linking client to community resources and additional follow-up at the program.
- 4. Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to survivors prior to information gathering. The only exceptions to confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - a. Staff must determine whether it would be safe and possible to engage and involve the survivor in the reporting process. If this is not possible, a report must still be made.
  - b. Survivors will be empowered to identify who should be contacted and under what circumstances.
- 5. Staff Capacity:** Staff responsible for facilitating the intake process must have familiarity with intake forms and have received training in the areas outlined below. Staff must also

have the ability to recognize the need for immediate referrals in instances when the survivor is in crisis. Supervision must be available for intake staff who need assistance in working with a client who is in crisis. Staff should be trained on the process and are responsible for accessing supervisory assistance when the situation warrants.

6. **Training:** Intake staff should receive a minimum of thirty hours of domestic violence and crisis intervention training. This training must include the following topics:
  - a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
  - b. Crisis intervention (listening, establishing rapport, de-escalation techniques, needs assessment, suicide prevention, etc.)
  - c. Screening and assessing for danger and/or lethality and to provide safety planning
  - d. Suicidal and homicidal risk assessment
  - e. Identifying imminent danger situations and knowing how to respond to them
  - f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how the intake process can trigger trauma reactions and how to minimize these re-traumatizations
  - g. Legal education or information (peace/protective orders, criminal charges, immigration, etc.). Staff should be knowledgeable about the difference between giving legal advice and providing legal information/advocacy.
  - h. Health information (medication, diagnosis, medical treatment, etc.). Staff should be knowledgeable about the difference between giving medical advice and providing referrals and community resources.
  - i. Cultural Competency (including sexual orientation, meaningful language access, race and ethnicity, socioeconomic status, etc.)

## Confidentiality

1. **Security:** Programs should consider other security features, such as alarms, locks, guards, etc.
2. **Visitors:** Clients and visitors can be asked to sign a confidentiality agreement upon entrance into program, where they agree to keep the location and identities of other clients confidential.
3. **Co-Location:** Programs that co-locate survivor and abuser services must consider safety issues that may arise as a result of co-location of services (considerations may include alternate dates for services and separate parking areas, entrances, and waiting areas).
4. **Releases of Information:** Programs are prohibited from releasing client information to an outside organization without a release from the survivor, which includes courts, police, and child welfare except under mandatory reporting requirements. In order to ensure that the release is informed, the release must originate from the survivor services agency. Survivors have a choice to determine whether or not to release their information. Instead of sharing survivor information with an outside agency, a domestic violence service provider is encouraged to write a letter directly to the survivor to use for his or her own purposes. The content of the documentation in any letter must be limited to the specific request of the client.
5. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to confidentiality are a threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - a. Staff must determine whether it would be safe and possible to engage and involve the survivor in the reporting process. If this is not possible, a report must still be made.
  - b. Survivors will be empowered to identify who should be contacted and under what circumstances.
6. **Client Records:** Programs must respect the privacy and confidentiality of survivors and their children by collecting only essential, necessary information and by keeping records and client information confidential to the fullest extent of the law.
  - a. Documentation of a client's services should contain factual and objective information, documented to the minimal extent of providing the service, limited to the time and length of interaction and services rendered.
  - b. Informed consent to release information must be survivor-centered, written, specific, time-limited, and narrow in scope and must expire upon termination of services. (For guidance, contact the National Network to End Domestic Violence or the Confidentiality Institute).
  - c. All client records should be kept double-locked (in a locked cabinet, behind a locked door).

- d. Confidential client records should be kept only for the required length of time determined by state and funder regulations.
  - e. Disposal of client records must occur through cross-cut shredding or incineration.
  - f. All efforts should be made to quash subpoenas for client records. If a client requests to have their file released to use in a court proceeding, staff should inform the client of the possible unintended consequences, including that opposing counsel will have the ability to use it to the detriment of client, in court.
    - i. Due to these consequences, a summary of services is preferable to the release of full client files.
    - ii. Subpoenas must be signed by a judge and properly served (hand delivered, not mailed or faxed, to the custodian of the records) before information can be released. (See Appendix C).
7. **Warrants, Subpoenas, and Summonses or Court Orders:** A clearly defined policy and procedure must be written to determine when and how to respond with law enforcement or the judicial system. All efforts should be made to maintain confidentiality and to work with a survivor to address pending legal action.
- a. Because of confidentiality and privacy, background checks on survivors will not be a part of policy of practice except when a survivor specifically requests the information (for guidance, contact the National Network to End Domestic Violence or the Confidentiality Institute).
  - b. If a program becomes aware of a warrant against a client, staff will notify the survivor and help him/her self-report to the police and/or get legal assistance. Staff will maintain confidentiality by stating they are unable to confirm nor deny whether or not an individual is seeking services at the program. A search warrant for the program must be issued in order for law enforcement to enter the premises. If an officer responds with an arrest warrant, staff will not allow the officer onto the premises.
  - c. Subpoenas for staff should be reasonably specific as to what information the court is seeking. All efforts should be made to quash subpoenas. If staff have to present in court, they have to make every effort to maintain the confidentiality of the program and the clients should be made under the provision of the law. Staff being subpoenaed to testify will consult with their supervisor and seek legal consultation.

## Advocacy

**Definition:** Each person working in the field of domestic violence can be considered an advocate. It is important to advocate for systems change as well as the individualized needs of each survivor. Advocacy occurs any time staff contacts or engages a third party on behalf of or in conjunction with a survivor in order to facilitate services, obtain benefits, encourage systemic changes, or make referrals.

1. **Requirements:** Advocacy programs must:
  - a. utilize survivor-centered advocacy and focus on building rapport while engaging in actively listening to identify the survivor's needs and wants.
  - b. work collaboratively as a team with other members of the staff to coordinate safety planning and services for each survivor.
  - c. use a collaborative approach to advocating and sharing confidential, private information with external partners. Information should only be shared when the survivor determines that it is appropriate and safe.
  - d. be equipped and positioned to address survivor needs in the following types of systems:
    - i. mainstream service providers,
    - ii. culturally specific service providers,
    - iii. housing services,
    - iv. social services,
    - v. child welfare services and child advocacy,
    - vi. legal services (rights, discrimination, documented and undocumented immigrants),
    - vii. health care services (including the full range of reproductive health options),
    - viii. meaningful language access services,
    - ix. attention to specialized populations who need accommodations (people with disabilities, LGBTQ, people with Limited English Proficiency (LEP), etc.), and
    - x. financial assistance services.
  - e. follow trauma-informed practices and advocate with systems to minimize survivor re-traumatization.
  - f. remain transparent with the survivor so they are informed of next steps, possible options, progress, and possible consequences throughout service provision.
  - g. use, practice, and provide cultural approaches to advocacy, including meaningful language access.
  - h. maintain and protect survivor confidentiality.
2. **Interpretation:** Bilingual advocates provide linguistically and culturally specific direct services to survivors. **Bilingual advocates are not substitutes for interpreters**, especially during court hearings. Interpretation is an art and a skill acquired through extensive education, training, and experience. It requires native-like fluency in both English and a foreign language; knowing the mechanics of interpretation; having training on a range of topics associated with the profession; possessing a technical

vocabulary; and adhering to a code of ethics emphasizing accuracy, proficiency, confidentiality and neutrality. These skills go beyond being bilingual (*adapted from the Asian Pacific Institute on Gender-based Violence*).

- a. If an organization plans to use part or all of a staff person's position for interpretation, this should be built into their job description, compensated fairly, and the person must be trained as an interpreter.
- b. If an advocate identifies an issue with an interpreter, such as lacking fluency or accuracy; incomplete interpretation; not being able to keep up with subject matter; ignorant to or uncomfortable with specialized terminology related to domestic and sexual violence; lacks neutrality; gives advice; does not reveal a conflict of interest; breaks confidentiality; allows personal and cultural bias; provides "cultural interpretation"; or allows gender bias, the following steps must be taken:
  - i. Documenting the concern, explaining how the advocate identified the concern, and alerting the appropriate officials who can take action (survivor's attorney, courts, interpretation service, and/or professional association). Consider confidentiality requirements, the timely nature of the situation, and involve the survivor whenever possible.
  - ii. Should any of the issues break confidentiality, or if the interpreter has a conflict of interest or knows the survivor and/or abuser, the advocate must safety plan with the survivor.
  - iii. For more information on using interpreters, go to: <http://www.api-gbv.org/files/TipSheet.Work.with.Interpreters-APIIDV-2009.pdf>

3. **Training:** Advocates should receive a minimum of thirty hours of domestic violence and crisis intervention training. This training must include the following topics:
  - a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
  - b. Crisis intervention (listening, establishing rapport, de-escalation techniques, needs assessment, suicide prevention, etc.)
  - c. Screening and assessing for danger and/or lethality and to provide safety planning
  - d. Suicidal and homicidal risk assessment
  - e. Identifying imminent danger situations and knowing how to respond to them
  - f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how counseling can trigger trauma reactions and how to minimize these re-traumatizations, self-care
  - g. Legal education or information (peace/protective orders, criminal charges, immigration, etc.). Staff should be knowledgeable about the difference between giving legal advice and providing legal information/advocacy.
  - h. Health information (medication, diagnosis, medical treatment, etc.). Staff should be knowledgeable about the difference between giving medical advice and providing referrals and community resources.

- i. Cultural Competency (including sexual orientation, meaningful language access, race and ethnicity, socioeconomic status, etc.)
  - j. Additional training for specialized populations
4. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
- a. Staff must determine whether it would be safe and possible to engage and involve the survivor in the reporting process. If this is not possible, a report must still be made.
  - b. Survivors will be empowered to identify who should be contacted and under what circumstances.
5. **Reasonable Accommodations:** Advocates must make every effort to provide reasonable accommodations to:
- a. survivors with disabilities, including substance use, and have written policies and a process for requesting and providing accommodations. Advocates must consider as part of their accommodation plan:
    - individuals who require mental or physical care by caregivers,
    - survivors with service animals,
    - survivors who are d/Deaf or hard of hearing,
    - survivors who are blind or low vision,
    - survivors who have limited mobility, and
    - survivors who have communicable diseases including HIV/AIDS or another at-risk health status.
  - b. special populations. Populations to consider include, but are not limited to:
    - males,
    - transgender and gender non-conforming individuals/LGBQ individuals,
    - minors as primary survivors (emancipated or youth-head-of-household),
    - survivors with low literacy,
    - dietary restrictions,
    - survivors with criminal histories (including sex offenses and child abuse),
    - cultural or religious requirements or restrictions, and
    - Limited English Proficiency (LEP).
6. **Safety Planning**
- a. A safety plan is an individualized plan to address the barriers faced by survivors in achieving safety. At a minimum, a safety plan addresses the risks posed by the abuser at home and in the community, whether the survivor is currently living with the abuser or not. Safety plans must take an empowerment approach in which the survivor is the one to identify their risks and develop strategies most likely to reduce those risks. A fully developed safety plan addresses both risks posed by the abuser as well as other life risks (including housing, employment, health care, etc.) that could be manipulated by the abuser. A safety plan takes into account the

likelihood that the survivor will move back and forth between being in and out of the relationship, breaks isolation, and identifies the resources necessary for the strategies to succeed (*adapted from the Iowa Coalition Against Domestic Violence*).

- b. Safety planning is an on-going series of conversations that should occur at each interaction with the survivor. Safety plans should be adapted and reviewed with the survivor as their circumstances change. The advocate's role is to support and provide additional information and resources to expand available options for the survivor.
7. **Legal Advocacy**, also known as court advocacy, consists of providing survivors with information about their legal rights and options concerning peace and protective orders, divorce, custody, prosecution of crimes, immigration, and other legal concerns; providing referrals for legal assistance; and may include accompanying and providing support during any legal proceedings (*adapted from the Iowa Coalition Against Domestic Violence's Service Delivery Standards for Member Programs*). Staff or volunteers providing Legal Advocacy Services must:
- a. have a working knowledge of current Maryland laws pertaining to domestic violence, legal options available to survivors, and victim rights.
  - b. **be sure not to engage in the unauthorized practice of law. A clear distinction between legal advice and legal information must be established. Advocates may not legally represent survivors in any way. Advocates must clearly explain to survivors this distinction and must ensure clear understanding of the role differences.** These boundaries can be clarified by sitting behind the survivor during court proceedings instead of at the table and by providing general legal information without assessing the fact pattern of a particular case and applying it to the law.
  - c. work to develop collaborative relationships with law enforcement, local criminal justice agencies, and court systems. This includes keeping contact information on local criminal justice agencies; local courts; local, state, and national resources; and legal aid updated and making it readily available to survivors. In addition to any legal representation that may be provided by the domestic violence program, programs are also encouraged to maintain and actively develop a referral list of attorneys in their community who are knowledgeable about domestic violence and/or are willing to provide low-cost or pro bono services to survivors. When an attorney is not familiar or comfortable with having a legal advocate present, the advocate can make efforts to clarify their role and their confidentiality limits. In some cases, such as to protect attorney-client privilege, it may be appropriate for the advocate to leave the room. Please refer to the Confidentiality section for more information.
  - d. have a working knowledge of various immigrant statuses and how to assess specific risk factors that a survivor may have based on their immigrant status and history as well as VAWA immigration laws and relief available to immigrant survivors (VAWA self-petitions, battered spouse waivers, U- and T-visas) of domestic violence. Programs must know the local agencies that work with

immigrant survivors and advocate for immigrant survivor rights, such as preventing removal (deportation) when someone is eligible for VAWA relief, receiving public benefits (e.g. after *prima facie*) has been approved, etc.

8. **Court Accompaniment** services may also be offered by programs and may be provided by trained staff or volunteers, whose role it is to accompany survivors to court proceedings. It is especially important when accompanying a survivor not to be mistaken for, or provide, legal representation (*see Legal Advocacy section above*).
  - a. The person accompanying the survivor to court may:
    - i. describe the logistics of court hearings (transportation, parking, where to sit, etc.),
    - ii. help the survivor emotionally prepare for court hearings,
    - iii. provide practical tips on body language, appearance, and manner,
    - iv. provide general information on court processes and outcomes, and
    - v. follow-up after proceedings to clarify outcome with the survivor, identify next steps, and provide emotional safety planning, and support.
  
9. **Medical Advocacy** refers to in-person advocacy provided in a health care facility and/or relating to the survivor's health needs (*adapted from the Iowa Coalition Against Domestic Violence*). The role of a Medical Advocate is to provide support to the survivor; focus on their immediate needs; provide information, resources, and referrals; and assist them through options, choices, and consequences.
  - a. Staff or volunteers providing Medical Advocacy Services must:
    - i. be relevant, trauma-informed, culturally competent, and survivor-centered based on the survivor's identified needs, such as: providing accompaniment, validation, and support during the hospital visit; de-escalation and stabilization of crises; safety planning; victim rights information; referrals and resources; options for follow-up; and assisting in applying for crime victim compensation for reimbursement of health expenses.
    - ii. be prepared to meet the changing dynamics and needs of the survivor by respecting privacy, including requests to leave the room when asked by the survivor. Survivors have the right to refuse any or all medical advocacy services.
    - iii. have staff or volunteers, who are either on-site or on-call 24-hour a day, to facilities in their county and/or area to provide prompt, in-person advocacy and assistance based on a call from on-site medical personnel and/or the survivor.
    - iv. develop partnerships with health care facilities in the area that include policies and protocols for an advocate to be contacted promptly by medical personnel when there is a positive screen for domestic violence and/or intimate partner sexual assault so an advocate can respond.
    - v. work with the health care facility (hospital, clinic, etc.) to develop policies and procedures, including a Memorandum of Understanding, to provide training, information, resources, and technical assistance to health care staff. This training must include the dynamics of domestic violence, screening best practices, confidentiality, and referral processes for additional support. **Note: In**

**Maryland, only child abuse and vulnerable adult abuse must be reported. Disclosures of domestic violence to health care providers must remain confidential.** For specifications in county laws regarding gunshot wounds, lethal weapons, and moving vessels, go to [http://healthymaryland.org/wp-content/uploads/2011/05/66090\\_DomVio\\_D\\_Confid.pdf](http://healthymaryland.org/wp-content/uploads/2011/05/66090_DomVio_D_Confid.pdf).

- vi. develop policies and procedures for the health care facility that focus on safety and security when an abuser may be on-site.
- b. Medical Advocates may also provide crisis intervention, resources, and referrals to non-offending individuals accompanying the survivor or secondary survivors who are present.
- c. If an advocate is concerned that a survivor is being re-traumatized, disrespected, or blamed while receiving treatment, the advocate can:
  - i. be present while the survivor expresses their concerns with the medical professional or law enforcement involved,
  - ii. discuss with the survivor the possible approaches that the advocate can take with the medical and law enforcement professionals and whether or not the survivor would like to be present,
  - iii. with the informed, written, and signed consent of the survivor, discuss issues identified by the survivor with the appropriate medical or law enforcement personnel without the survivor present. The focus of this conversation must be general information about trauma, dynamics of abuse, and/or victimization or information gathered during shared observations and must not include any confidential information mentioned during the advocate and survivor's discussions or interactions, or
  - iv. with the informed, written, and signed consent of the survivor, discuss specific issues related to the survivor's experience and/or situation with the appropriate medical or law enforcement personnel without the survivor present.
- d. If the survivor has anyone accompanying them to the health care facility, the advocate must ensure that they are safe people and not abusive or dangerous to the survivor. Furthermore, advocates must ensure that health care professionals speak to the survivor alone without any other accompanying persons present. If the medical professional does not speak to the survivor alone, then the advocate should have the conversation instead.

## Case Management

*(Adapted from Missouri Coalition Against Domestic and Sexual Violence's "Service Standards and Guidelines for Domestic Violence Programs")*

**Definition:** Case management (also known as individualized service coordination, service planning, etc.) is a collaborative process of assessment, planning, implementation of care, and advocacy which continuously adapts to survivor-identified needs and priorities.

Case management may include: referring clients to resources, providing culturally competent advocacy and support, reviewing and redesigning safety plans, reviewing changes to clients' circumstances, and systems education and orientation.

1. **Training:** Case management services are provided by qualified, trained staff members or volunteers who must be trained in:
  - a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
  - b. Crisis intervention (non-psychiatric) (listening, establishing rapport, de-escalation techniques, needs assessment, referral, etc.)
  - c. Screening and assessing for danger and/or lethality and to provide safety planning
  - d. Suicidal and homicidal (identifying signs and referring)
  - e. Identifying imminent danger situations and knowing how to respond to them
  - f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how case management can trigger trauma reactions and how to minimize these retraumatizations, self-care
  - g. Legal education or information (peace/protective orders, criminal charges, immigration, etc.). Staff should be knowledgeable about the difference between giving legal advice and providing legal information/advocacy.
  - h. Cultural Competency (including sexual orientation, meaningful language access, race and ethnicity, socioeconomic status, etc.)
  - i. Additional training for specialized populations
  
2. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to client confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - a. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.
  - b. Clients will be empowered to identify who should be contacted and under what circumstances.

3. **Community Resources:** An advocate providing case management services must have access to and be familiar with a complete list of community resources, and the program should have established relationships with other service providers.
4. **Referrals:** Based on the self-identified needs of the survivors, an advocate providing case management services will facilitate service delivery and referrals and encourage ongoing communication with providers of additional services that may include but are not limited to:
  - a. Ongoing and long-term safety planning (*see Safety Planning in Advocacy section*);
  - b. Medical, nutritional, and/or health services;
  - c. Law enforcement assistance;
  - d. Crime Victims' Compensation;
  - e. Legal remedies and services;
  - f. Public assistance services, including job training and support services;
  - g. Short-term, transitional, and/or permanent housing;
  - h. Child care services and parenting education;
  - i. Child protection services;
  - j. Alcohol and drug evaluation and education;
  - k. Treatment services for alcohol or substance abuse and other potentially harmful coping behaviors;
  - l. Mental health service providers;
    - i. For psychiatric emergencies, immediate access for help
  - m. Services for persons with disabilities;
  - n. Transportation assistance;
  - o. Education, continuing education, GED, and/or literacy classes;
  - p. Lesbian, gay, bisexual, or transgender support services;
  - q. Employment readiness services and/or job training;
  - r. Interpreter/translation services and/or immigration assistance;
  - s. Explaining and demystifying systems and norms;
  - t. Financial planning and credit rights information and services; and/or
  - u. Other related services as needed.
5. **Skills Capacity:** An advocate providing case management must have the capacity to address the following topics and issues in a culturally sensitive and accessible manner:
  - a. Types of abuse;
  - b. The relationship between violence and other tactics of control;
  - c. Survival strategies and dilemmas in leaving an abusive relationship;
  - d. Individuals who abuse, their selective behaviors and societal influences;
  - e. Trauma-informed practices and an understanding of how multiple traumas can affect an individual, as well as the complex effects of domestic violence on children; and
  - f. Social change necessary to eliminate rape and abuse, including the elimination of discrimination based on ethnicity, color, gender, gender identity, sexual orientation, marital or partner status, age, disability including substance use,



economic or educational status, religion, HIV/AIDS or other physical health status, mental health status, national origin, or immigration status.

## Crisis Intervention

(Adapted from Missouri Coalition Against Domestic and Sexual Violence's  
"Service Standards and Guidelines for Domestic Violence Programs")

1. **Definition:** Crisis intervention consists of the interactions and activities conducted over the telephone or in person by qualified, trained staff members or volunteers with an individual in crisis to stabilize emotions, clarify issues, and provide support and assistance to help explore options for resolution of the individual's self-defined crisis and needs.
  - a. Examples of crises include, but are not limited to:
    - i. Suicidal ideation
    - ii. Homicidal ideation
    - iii. Lack of basic needs
    - iv. Emergencies and imminent danger situations
      - A. Violence and abuse
      - B. Medical emergency
      - C. Substance use
  - b. Crisis intervention is *not*:
    - i. professional counseling.
    - ii. necessarily involving a detailed discussion of the event that caused the distress.
    - iii. asking someone to analyze what happened to them or to put time and events in order.
    - iv. about pressuring people to tell you their feelings and reactions to an event.
2. **Purpose:** Crisis intervention services must be provided with a primary focus on the provision of information, advocacy, validating feelings, safety planning, and empowerment to reinforce the individual's autonomy and self-determination.
3. **Services:** Crisis intervention services are based upon a problem-solving model to provide information and referrals that assist an individual in crisis. Crisis intervention services include, but are not limited to:
  - a. Assessing risk and/or danger (via instruments such as Danger Assessment, Lethality Assessment, suicide assessment, conversation with survivor, etc.);
  - b. Assessing needs;
  - c. Listening;
  - d. Establishing rapport and communication;
  - e. Validating feelings and providing support;
  - f. Identifying the major problems;
  - g. Safety planning;
  - h. Providing referrals;
  - i. Offering general legal information regarding domestic violence;
  - j. Exploring possible alternatives;
  - k. Formulating an action plan; and

- I. Taking follow-up measures.
4. **Steps:** This model assumes that individuals will take steps forward and backward in their healing process. While there are common phases, it is not a linear progression and will be different for every person. However, a typical flow of crisis intervention commonly includes the following steps:
  - a. Establishing contact, assessing risk, and identifying the crisis;
  - b. Providing information, intervention, and safety planning; and
  - c. Reviewing and planning for future contact.
5. **Training:** Crisis intervention services is something that can be conducted by professionals and non-professionals. Qualified staff members or volunteers must be supervised and trained in:
  - a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
  - b. Crisis intervention (non-psychiatric) (listening, establishing rapport, de-escalation techniques, needs assessment, referral, etc.)
  - c. Screening and assessing for danger and/or lethality and to provide safety planning
  - d. Suicidal and homicidal risk assessment and response (identifying signs and referring)
  - e. Identifying imminent danger situations and knowing how to respond to them
  - f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how case management can trigger trauma reactions and how to minimize these retraumatizations, self-care
  - g. Legal education or information (peace/protective orders, criminal charges, immigration, etc.). Staff should be knowledgeable about the difference between giving legal advice and providing legal information/advocacy.
  - h. Cultural Competency (including sexual orientation, meaningful language access, race and ethnicity, socioeconomic status, etc.)
  - i. Additional training for specialized populations
6. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to client confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - a. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.
  - b. Clients will be empowered to identify who should be contacted and under what circumstances.

## Counseling Program Standards

1. **Purpose:** Domestic violence counseling can be an important process for adults and children who have experienced or witnessed abuse. The purpose of counseling is to support the survivor in developing coping strategies when dealing with trauma and abuse, explore barriers to healing, provide ongoing safety planning and psychoeducation, and to address symptomology.
2. **Individual Counseling:** Individual counseling includes therapy or counseling delivered by an individual who is a licensed clinician or Master's level clinician or an intern under the supervision of a licensed clinician. This must be a psychologist, counselor, or social worker who also has specific training in addressing issues of domestic and sexual violence with a trauma-informed lens (Missouri Coalition Against Domestic Violence).
3. **Support Groups:** Support groups are interactive group sessions that may be non-directed, topic oriented or informational and educational which are facilitated by qualified, trained staff members or volunteers (Missouri Coalition Against Domestic Violence).
4. **Training:** Clinical staff should receive a minimum of thirty hours of domestic violence and crisis intervention training. This training must include the following topics:
  - a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
  - b. Crisis intervention (listening, establishing rapport, de-escalation techniques, needs assessment, suicide prevention, etc.)
  - c. Screening and assessing for danger and/or lethality and to provide safety planning
  - d. Suicidal and homicidal risk assessment
  - e. Identifying imminent danger situations and knowing how to respond to them
  - f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how counseling can trigger trauma reactions and how to minimize these re-traumatizations, self-care
  - g. Legal education or information (peace/protective orders, criminal charges, immigration, etc.). Staff should be knowledgeable about the difference between giving legal advice and providing legal information/advocacy.
  - h. Health information (medication, diagnosis, medical treatment, etc.). Staff should be knowledgeable about the difference between giving medical advice and providing referrals and community resources.
  - i. Cultural Competency (including sexual orientation, meaningful language access, race and ethnicity, socioeconomic status, etc.)
  - j. Clinical modalities that are effective in treating trauma survivors (i.e. Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, or Eye Movement Desensitization and Reprocessing, Trauma-Focused Cognitive Behavioral

Therapy, Play and Art Therapy, Parent/Child Interactive Therapy or Strengthening Families Coping Resources).

k. Additional training for specialized populations

5. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to client confidentiality are a threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - a. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.
  - b. Clients will be empowered to identify who should be contacted and under what circumstances.
6. **Supervision**
  - a. Staff should be trained on the process and are responsible for accessing supervisory assistance when the situation warrants.
  - b. Supervision must be available for staff who need assistance in working with a client who is in crisis.
7. **Recording:** Due to confidentiality and safety, video and/or audio recording of client sessions is prohibited. Instead, process recording can include notes and memory and cannot include personally identifying information, which can be used as tools of transcription. Interns, universities, and domestic violence service agencies must be aware of this and include this in their contracts prior to making placements. For licensing purposes only, counselors with their LGPC, LGSW or LGMFT qualifications may discuss cases for the purposes of clinical supervision with a Board-approved supervisor. When carefully considered, certain exceptions to the above policies may apply:
  - a. Specific trauma-informed, evidence-based treatment models where recording is part of the model and where the clients or child clients' parents have provided their informed consent. An unwillingness to consent must not preclude access to others services or treatment.
  - b. Particular purposes of supervision so that the supervisor can ensure the counselor is using the model correctly or
  - c. Before considering a modality that includes recording, a counselor must consider possible client re-traumatization. Clients must be informed of their right to terminate recording at any time.
8. **Intake for Adult Survivors:** Intake for adults includes the following components:
  - a. Written, interpreted and signed informed consent to participate and confidentiality
  - b. Current domestic violence situation
  - c. History of domestic violence
  - d. Current and past mental health concerns
  - e. Substance use
  - f. Suicidal risk assessment

- g. Survivor's goals
- h. Written, interpreted, and signed client agreement that includes shared expectations such as the therapeutic process, meeting times, phone calls and emergencies, etc.
- i. Written, interpreted, and signed permission to release aggregate or non-identifying demographic information for reporting purposes

9. **Intake for Children:** Intake for children exposed to domestic violence includes the following components:

- a. Meeting with non-abusive guardian to obtain the following:
  - i. Written, interpreted, and signed permission to treat that includes limits of confidentiality
  - ii. Written, interpreted, and signed permission to release aggregate or non-identifying demographic information for reporting purposes
  - iii. Written, interpreted, and signed agreement that includes shared expectations such as the therapeutic process, meeting times, phone calls and emergencies, transportation, safety planning etc.
  - iv. Current situation
  - v. History of domestic violence and trauma
  - vi. Current and past mental health concerns
  - vii. Significant developmental concerns
  - viii. Child's current functioning
  - ix. Child's strengths
  - x. Family functioning needs and barriers
  - xi. Caretaker's goals for initial treatment plan
- b. Child Intake
  - i. Confidentiality
  - ii. Symptomology assessment(s)
  - iii. Developmental assessment(s)
  - iv. Substance use
  - v. Suicidal risk assessment
  - vi. Review of child's goals for treatment plan. If deemed developmentally appropriate, child should sign an agreement that includes shared expectations
  - vii. For children age 16 or over and deemed developmentally appropriate:
    - A. Informed consent to participate if age 16 or over
    - B. Permission to release aggregate or demographic information for reporting purposes if age 16 or over
    - C. Written, interpreted, and signed agreement that includes shared expectations

10. **Family Counseling with Non-Offending Caretaker**

- a. Parent-child and/or family therapy with the non-offending parent or caretaker can be useful for repairing relationships that have been disrupted by violence, rebalancing the family structure and providing tools for co-regulation.

- b. If the abusive partner is involved, special considerations must be taken to protect the physical and emotional safety of both survivor/caretaker and child/ren, including:
  - i. Assessing the level of danger and risk of abusive partner involvement
  - ii. Creating appropriate security measures to meet in an area separate from survivor services
  - iii. Safety planning with the survivors around transportation and meeting location
    - A. Confidential location
    - B. Added security measures

**11. Marriage/Couples Counseling:** Marriage counseling and couples counseling can pose great risk for the survivor and/or their children and could be used as a tool to continue abuse. Therefore, marriage and couples counseling are not recommended.

## **12. Abuser Intervention Program**

- a. For guidance, please see the Maryland Abuser Intervention Collaborative Guidelines.
- b. When AIP and survivor service programs are co-located, the following guidelines should apply:
  - i. For safety and confidentiality reasons, it is a best practice to have separate meeting spaces and entrances and if possible, separate facilities for survivors and abusers.
  - ii. It is not recommended for the same therapist to see the survivor and abusive partner or have access to both records as it can pose danger.
  - iii. When attempting to make survivor contact per MAIC's AIP guidelines, the information recorded in the abuser's file should be limited to attempts to contact and should not include any information provided by the survivor.
    - A. Any correspondence with the survivor should be made using the contact information provided by the abuser.
  - iv. Survivor and abuser's records must be stored in separate filing cabinets and if possible, separate record storage rooms. Organizational policies and procedures must be in place to ensure that records are kept separate and apart.

## Hotline and Crisis Response

**Definition:** Hotline refers to crisis intervention, information and referral provided 24 hours a day, every day of the year, by any means of communication, by qualified, trained staff members or volunteers. Comprehensive domestic violence programs are required to receive and respond to crisis calls on a 24-hour basis (COMAR 01.04.05A1).

### Service Standards and Guidelines

1. **24 Hour Service:** A domestic violence hotline must provide 24 hour crisis access to domestic violence services.
2. **Outreach:** The hotline number must be widely distributed, listed, advertised, and be available from local information services within the domestic violence program's service area. The domestic violence program should engage in culturally appropriate and linguistically specific marketing of the hotline number, which considers the key demographics of the community.
3. **Telephone Capacity:** To ensure 24 hour hotline accessibility, domestic violence programs must ensure that they have the capacity to adequately respond to the volume of calls so that callers can get through.
  - a. Callers should not reach a busy signal.
  - b. Staff should always be available to pick up the phone. A special ring tone can signal to staff that a hotline call is coming through and must be picked up.
  - c. If callers must be placed on hold, an appropriate message they could receive is, "Please stay on the line. If this is an emergency, please hang up and call 911. Hold for the next available advocate."
  - d. Having callers leave a voicemail is not ideal and returning calls can jeopardize the privacy and safety of callers. Efforts should be made to avoid having callers leave a voicemail. If callers must leave a voicemail, messages must be checked promptly. Instruct callers to indicate the safest number and time to return the call.
  - e. In case of emergency, such as losing power or failure of hardware, domestic violence programs must have a backup plan to be able to receive hotline calls that protect a caller's privacy.
4. **Interpretation:** Survivors who are deaf or hard of hearing, who have Limited English Proficiency (LEP) must be accommodated on the hotline through the availability of bilingual staff, language line interpretation, TTY, and/or Relay. Language interpretation access is available at a reduced rate to domestic violence programs through MNADV.
5. **Lethality Assessment Program:** Each program that implements the Lethality Assessment Program—Maryland Model must have procedures to respond to LAP calls on a 24/7 basis. The LAP procedure must provide detailed instruction on gathering information from the survivor and the first responder making the LAP hotline call; building

report with the survivor; reinforcing the danger the survivor is in; expectations for High-Danger safety planning, service provision, and priority; data collection; and follow-up expectations. For specifics, see the LAP Hotline Guidelines in Appendix A.

6. **Confidentiality:** The hotline must be answered in a manner that identifies the purpose of the hotline and that discloses the limits to confidentiality early in the call (see box). All hotline workers are mandated reporters. Everything that is shared on the hotline must be kept confidential, except for instances of imminent danger to oneself or others, or suspected past or present child abuse (see section on Confidentiality). The use of caller ID and call recording equipment is in conflict with the spirit of anonymity. Programs must inform callers of the use of such equipment.

**CONFIDENTIALITY**  
**How Can We Say It?**

*Hi, my name is Sarah. I am here to help and listen but, before we talk, I want you to know your rights. Everything you talk about on this call is confidential, unless you tell me that you're going to hurt yourself or someone else, or if you tell me that a child is being or has been harmed. If you choose to tell me any of these things, a report may have to be made. Do you have any questions about that? If not, let's talk about the reason for your call.*

7. **Safe Follow-up:** Hotline workers may want to call survivors back, in order to follow-up later, in case the call is disconnected, etc. To promote survivor safety and to protect their privacy, hotline workers will ask callers for permission to call back. If permission is given, hotline workers should obtain one or more “safe” numbers where the survivor can be reached. Additional safety precautions include: the best day and time to reach them, if it is safe to leave them a message, what to do if someone else answers the phone, and any special instructions. When following up, messages and calls should be discreet.

8. **Victim-Initiated LAP:** For programs implementing Victim-Initiated LAP, when answering a hotline call that is not made by a LAP first responder including law enforcement, the hotline advocate should administer the LAP Screen themselves if they believe that the survivor is in an intimate partner relationship and that potential lethality factors may be present. After the LAP Screen is administered by the hotline advocate, the advocate should follow the domestic violence program’s LAP procedure detailed in section 5.

**Warm Hand-Off Sample Language**  
(adapted from California Mental Health Services Authority)

*It sounds like you're going through a really difficult and scary time right now. I work with someone who specializes in situations like yours, who may be able to brainstorm some new strategies with you, and I would like to ask them to speak with you. Is it all right if I put them on the line?*

9. **Referrals:** When providing callers with referral information, hotline workers should be well-informed about the services to which they are referring. The referral resources should be updated continually. When referring to a service provider, hotline workers should use warm hand-off practices (see box). If a caller is asking hotline workers to assist in service coordination, hotline workers must obtain and document a verbal information release for the caller’s information to be shared. A separate release should be obtained for each service provider.

10. **Training:** The hotline must be answered by a program staff member or volunteer who has had domestic violence crisis intervention training.
- a. Domestic violence programs should offer training on agency policies and procedures including how and when to address confidentiality, how to introduce oneself to callers (ex: first name only or a pseudonym), the process for obtaining information for data collection and call sheets, how to handle homicidal or suicidal callers, how to screen or refer for safehouse services, and how to handle Lethality Assessment Program (LAP) calls.
  - b. Hotline workers should receive a minimum of thirty hours of domestic violence and crisis intervention training. This training must include the following topics:
    - i. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
    - ii. Crisis intervention (listening, establishing rapport, needs assessment, suicide prevention, etc.)
    - iii. Screening and assessing for danger and/or lethality and to provide safety planning
    - iv. Lethality Assessment Program (LAP) training including administering the LAP Screen and answering a High-Danger LAP Screen call (for comprehensive domestic violence programs).
    - v. Identifying imminent danger situations and knowing how to respond to them
    - vi. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how counseling can trigger trauma reactions and how to minimize these re-traumatizations, self-care
    - vii. Availability of legal remedies and the difference between giving legal advice and providing legal information (peace/protective orders, criminal charges, immigration, etc.)
    - viii. Suicidal and homicidal risk assessment
    - ix. Referrals and community resources
  - c. Training resources include: MNADV's 5 day Comprehensive Intimate Partner Violence Training, MNADV's LAP Training, House of Ruth MD's Comprehensive Intimate Partner Violence Training, Dr. Campbell's Danger Assessment, National Center for Suicide Prevention Training, etc.
11. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to client confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
- a. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.

- b. Clients will be empowered to identify who should be contacted and under what circumstances.

12. **Services:** Programs offering hotline services must provide emergency crisis intervention and advocacy. These services include, but are not limited to:

- a. **Assessment and Establishing Contact:** Crisis intervention begins by establishing contact, listening to the person tell about what happened, determining what the crisis is, administering the LAP Screen, and setting up time for future activities geared towards alleviating the crisis.
- b. **Providing Information, Intervention, and Support:** Then crisis intervention focuses on implementation, which includes identifying tasks and who will carry out tasks to solve specific life problems, modifying previous ways of dealing with the situation, identifying strengths, and learning new skills.
- c. **Summary:** Lastly, review the interaction; provide validation and support; provide next steps; review the safety plan; and review referrals and resources established. This may include planning for future ongoing contact, if appropriate (See #6 above for safe follow-up).
- d. **Follow-up:** Domestic violence program advocates should follow-up with survivors after the completion of a hotline call, especially if the survivor scored as a High-Danger survivor on the LAP Screen. Follow-up usually includes phone calls to the survivor by an advocate and/or scheduled or unscheduled home visits by a team of an advocate and an officer.
  - i. The method of follow-up as a standard operating procedure should be determined by the capability of the domestic violence program as to which level of outreach it is capable of conducting and, in the case of the potential law enforcement partner, by its capability and willingness to participate as a team with the domestic violence program in conducting home visits.

- ii. In individual cases, the method of follow-up should best be determined by examining the circumstances of the situation, especially the level of danger the survivors are in, with specific consideration given to empowering and informing survivors of the danger they are in and connecting them with services.

13. **Data and Records:** The hotline administrative procedures including data collection and record-keeping should be in accordance with the organization’s standards outlined in the Administrative section. The Hotline should have written procedures regarding: confidentiality, assessing risk; record keeping and record purging; assessing and responding to crisis (ex: suicidality); and self-disclosure on the hotline (ex: hotline workers providing their first name or a pseudonym to protect their privacy).

14. **Evaluation:** The hotline service should be evaluated for effectiveness on an ongoing basis (see box on following page). Evaluation questions should reflect the extent to which you have effectively met the stated goals and purpose of the hotline.

15. **LAP:** Each program must have procedures to respond to Lethality Assessment Program (LAP) calls on a 24/7 basis. Each domestic violence program should have a LAP procedure that details instruction on gathering information from the survivor and the first responder making the LAP hotline call, building rapport with the survivor and reinforcing the danger the survivor is in. Expectations for High-Danger safety planning and service provision and priority should also be outlined in the procedure along with data collection and follow-up expectations. For specifics, see the LAP Hotline Guidelines in Appendix A.

**Hotline Evaluation**

*Ways to qualitatively measure the effectiveness of calls include:*

- asking one or more questions throughout the call, such as:
  - “Did you get the help you needed today?”
  - “Did you learn something new?”
  - “Was there anything I could have done to be more helpful during this call?”
  - “Are you aware of steps that will help you feel emotionally or physically safer?”
  - “Did this call meet your expectations?”
  - “How was this call helpful for you?”
- providing another avenue for obtaining caller feedback and satisfaction
- obtaining permission from the caller to safely conduct a sample survey to measure longer-term effectiveness of the hotline.

# Residential Services



**Maryland Network  
Against Domestic Violence**  
WORKING TOGETHER FOR A SAFER FUTURE

## Residential Services

**Definition:** Shelter, preferably called a safehouse, refers to temporary, emergency housing and related supportive services provided in a safe, protective environment for individuals and their dependents (minors of all ages and dependent adults who are abused by their current or former intimate partners and for who are without other safe housing options. Over the last 35 years, much has been learned about the effects of trauma on domestic violence survivors. These standards were developed through a trauma-informed lens.

### Service Standards and Guidelines

1. **Eligibility:** A domestic violence safehouse must provide access, admittance, and residence in a temporary safehouse for survivors of domestic violence and their dependents (minors of all ages and dependent adults) 24 hours a day, every day of the year. Survivors in imminent danger must be accommodated as capacity allows. Survivor safety is the highest priority when determining safehouse admissions.
  - a. Domestic violence safehouse services may be provided through any of the following types of housing:
    - i. A physical safehouse facility operated in partnership with a comprehensive domestic violence service provider.
    - ii. Other accommodations, such as time-limited motel/hotel placement arranged and provided through the comprehensive domestic violence service provider.
  - b. A domestic violence safehouse **will**:
    - i. Have policies that maintain **safety and security** of clients
    - ii. Ensure that crisis intervention services are accessible, available, and offered **24 hours a day, every day of the year**, with trained advocates.
    - iii. Provide **access** to food, clothing, and personal hygiene items for clients and their dependents (minors of all ages and dependent adults), free of charge. Accommodations will be made to meet culturally diverse and various dietary needs. Staff will ensure that items will be readily available at all times.
    - iv. Provide **meaningful language access** and develop a Language Access Plan (see Appendix B).
    - v. Provide access to **supportive services**, free of charge with minimum barriers to access and maximum efforts to engage. Participation in supportive services must be voluntary. The Family Violence Prevention Services Act (applicable to FVPS/DOMV grantees) states, “receipt of supportive services under this title shall be voluntary. No condition may be applied for the receipt of emergency safehouse” (PL111-320 Sec. 308(d)(2)). These services include but are not limited to counseling, therapy, support groups, house meetings, and case management. Participation in services will be voluntary and length of stay and access to resources will not be reduced for opting out of services.
      - A. Programs must provide access to counseling and service planning.

- B. Programs may provide access to legal, housing, employment, parenting, childcare, etc., free of charge.
- vi. Utilize **screening questions** that focus on gathering information on the relevant domestic violence history. Specific questions will be limited to determining eligibility. Information that can be collected include name, name and ages of dependents, address, reason for service request, and residency requirement if applicable (exceptions may apply based on imminent danger). Shelter programs should use evidence-based screening tools to determine eligibility (Danger Assessment, Lethality Assessment Program (LAP) Screen, etc.). Questions pertaining to mental health and substance use concerns and accommodations should be asked after admission, preferably during intake.
- c. Discuss the following factors when **planning for arrival**:
- the confidential location of the safehouse
  - privacy and confidentiality of other clients
  - safety planning around technology use
  - transportation arrangements
  - important suggested items to bring
  - basic expectations of communal living
  - immediate needs to be addressed upon safehouse entry
  - additional client concerns
- Staff will make any necessary preparations such as making the client's bed/s, gathering toiletries, etc.
- d. Discuss the following **upon arrival**: Prior to intake paperwork, staff will address basic immediate personal needs. As clients will react differently to arriving to safehouse, staff will consider the impact of trauma on the individual client and adjust the process accordingly.
- e. **Welcome** and ease the client's transition into safehouse and provide a general tour to orient them to the safehouse space.
- f. Begin the **intake process** by explaining the purpose of the intake meeting and what is hoped to be accomplished with the client. For example, staff may tell client that they hope to get to know the client better, hear about their immediate and short-term concerns, issues, needs, and together create some next steps for services and support. Staff will remind the client that they are the client's ally, and will not judge or make decisions for the client; that the client is free to share as much or as little as they feel comfortable with; and that staff ask questions to learn more about how they can help the client gain safety and economic stability (from "Transitional Housing Intake Guide" by NNEDV).
- To minimize re-traumatization, the information obtained upon intake will be limited to inquiring about the client's most pressing, immediate needs, health and well-being, safety, and special needs and accommodations.
  - Essential demographic information, if not previously obtained, will be collected at this time.

- g. Establish a **length-of-stay policy** that is flexible and that balances the needs of those abused by intimate partners and the program’s ability to meet those needs. This policy should be written in clear language. The policy could include minimum and maximum lengths of stay, assessment periods, etc. The length of stay should be provided to the survivor verbally prior to entering safehouse and a copy of the length of stay policy should be given to clients upon arrival. Clients can choose to leave at any time without penalty. A client will be able to access safehouse as often as needed. Readmission decisions will be based on current situation or need.
- i. **Length of Stay:** Programs that define length of stay based on individual needs should also have clear and consistent criteria by which their length of stay is determined.
  - ii. **Extension:** Each program should have consistent and well-defined criteria for granting extensions to their length of stay policy. This should be based on individual needs, individual progress, survivor’s safety, and program capacity. A clear procedure should exist for requesting and granting an extension.
- h. Establish **exiting procedures**. Prior to exiting, whether voluntarily or involuntarily, safehouse staff will attempt to offer to explore alternate accommodations/housing options, provide community resources, conduct safety planning, and offer follow-up domestic violence and other services.
- i. **Involuntary Exiting:** Reasons for ending someone’s length of stay prematurely should be clearly defined and communicated. Involuntary exiting should only occur when a client or children present menacing or threatening behavior and/or violence to the safehouse community.
  - ii. An **abuser’s knowledge of the safehouse location or a breach in confidentiality** is not grounds for exiting in and of itself. Additional safety planning with the client should occur if the client feels safe enough to stay at the safehouse. If the survivor no longer feels safe at the safehouse or, if the abuser poses a clear and present danger to clients or safehouse staff and safety planning will be insufficient, then safehouse staff should offer to explore options to transfer the client to another safehouse.
2. A domestic violence safehouse must make every effort to provide **reasonable accommodations** for the needs of survivors living with disabilities, including addiction and have written policies and a process for requesting and providing accommodations. Shelters must consider as part of their accommodation plan:
- individuals who require mental or physical care by caregivers
  - clients with service animals (for guidance, see WSCADV’s “Model Protocol on Service Animals in Domestic Violence Shelters”),

**INVOLUNTARY EXITING**  
**Examples of Valid Reasons**

- *Client threatens to cause bodily harm to a client or staff.*
- *Client assaults another client or staff.*
- *Client intentionally and maliciously violates another client’s confidentiality.*
- *Client uses prohibited substances on the premises*

- survivors who are d/Deaf or hard of hearing,
  - survivors who are blind or low vision,
  - survivors who have limited mobility, and
  - clients who have communicable diseases including HIV/AIDS or another at-risk health status.
3. A domestic violence safehouse must make every effort to provide reasonable accommodations for the needs of survivors within special populations. Populations to consider include, but not be limited to:
- males,
  - transgender and gender non-conforming individuals/LGBQ individuals,
  - minors as primary survivors (emancipated or youth-head-of-household),
  - survivors with low literacy,
  - dietary restrictions,
  - survivors with criminal histories (including sex offenses and child abuse),
  - cultural or religious requirements or restrictions, and
  - Limited English Proficiency (LEP).
4. **Safety and Security of the Shelter Location**
- a. Shelters should consider other security features, such as alarms, locks, guards, etc.
  - b. Generally, safehouses should do their best to keep the location of the safehouse confidential. The address or location of any FVPSA-funded safehouse should not be made public. However, a safehouse may determine that disclosing or publicizing the safehouse location is safer than having a confidential location, in which case the individual responsible for the operation of the safehouse would have to sign off on that decision (PL111-320 Sec. 306(c)(5)(H)).
  - c. Shelter clients and visitors can be asked to sign a confidentiality agreement upon entrance into safehouse, where they agree to keep the location and identities of other safehouse clients confidential.
5. **Emergency Preparedness**
- a. All safehouses must be up-to-date with fire and health code regulations at all times.
  - b. Shelters must have written emergency procedures in place that are communicated to the clients and staff and that are practiced on a regular basis, including:
    - i. Evacuation plans
    - ii. Alternate staffing plans
    - iii. Material accommodations (food, warmth)
    - iv. Alternate safehouse accommodation plans for circumstances when the safehouse is destroyed or uninhabitable for a period of time
6. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to clients prior to information gathering. The only exceptions to client confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.

- a. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.
- b. Clients will be empowered to identify who should be contacted and under what circumstances.

7. **Privacy and Confidentiality:** Programs must respect the privacy and confidentiality of survivors and their children by collecting only essential, necessary information, by keeping records and client information confidential to the fullest extent of the law, and by respecting their personal belongings.

a. **Client Records**

- i. Documentation of a client's stay should contain factual and objective information, documented to the minimal extent of providing the service, limited to the time and length of interaction and services rendered.
- ii. Other clients' written names should not appear in a client file.
- iii. Informed consent to release information must be survivor-centered, written, specific, time-limited, and narrow in scope and must expire upon termination in safehouse. (For guidance, contact the National Network to End Domestic Violence or the Confidentiality Institute).
- iv. All client records should be kept double-locked (in a locked cabinet, behind a locked door).
- v. Confidential client records should be kept only for the required length of time determined by state and funder regulations.
- vi. Disposal of client records must occur through cross-cut shredding or incineration.
- vii. All efforts should be made to quash subpoenas for client records. If a client requests to have their file released to use in a court proceeding, staff should inform the client of the possible unintended consequences, including that opposing council will have the ability to use it to the detriment of client, in court.
  - A. Due to these consequences, a summary of services is preferable to the release of full client files.
  - B. Subpoenas must be signed by a judge and properly served (hand delivered, not mailed or faxed, to the custodian of the records) before information can be released. (See Appendix C).

b. **Warrants, Subpoenas, and Summonses or Court Orders:** A clearly defined policy and procedure must be written to determine when and how to respond with law enforcement or the judicial system. All efforts should be made to maintain confidentiality and to work with a client to address pending legal action.

- i. Because of confidentiality and privacy, **background checks** on clients will not be a part of policy of practice except when a client specifically requests the information (for guidance, contact the National Network to End Domestic Violence or the Confidentiality Institute).
- ii. **Warrants:** If a safehouse becomes aware of a warrant against a client, staff will notify the survivor and help him/her self-report to the police and/or get

legal assistance. Staff will maintain client confidentiality by stating they are unable to confirm nor deny the presence of any client at the safehouse. A search warrant for the safehouse must be issued in order for law enforcement to enter the safehouse. If an officer responds with an arrest warrant, staff will not allow the officer onto the premises.

- iii. **Subpoenas for staff:** Subpoenas should be reasonably specific as to what information the court is seeking. All efforts should be made to quash subpoenas. If staff have to present in court, they have to make every effort to maintain the confidentiality of the safehouse and the clients should be made under the provision of the law. Staff being subpoenaed to testify will consult with their supervisor and seek legal consultation.
- c. **Communications within Shelter:**
  - i. Communications between staff and clients or among staff about a client's matters should be handled in a private setting. Care should be given to maintain each client's confidentiality.
  - ii. When handling house conflict, care should be taken not to disclose any other client's confidential information.
- d. **Use of Technology:**
  - i. Staff and clients should be educated on the potential breach of confidentiality that can occur by taking photos, videos, posting information or locations and posting on social media, or by using video telephone services (Skype, FaceTime, etc.).
  - ii. Staff and clients should be educated on preventing unintentional breaches of confidentiality by using devices or online applications with GPS tracking or location services.
- e. **HMIS:** As stated under HUD regulations, domestic violence safehouses are not to input any identifying or demographic information into the Homeless Management Information Systems (HMIS). Necessary information must be maintained in a separate database.
  - i. Only aggregate totals can be provided.
  - ii. Client-level data, even encoded, is prohibited.
- f. **Exceptions to Confidentiality:** Exceptions to confidentiality should be explained to safehouse clients upon entrance into safehouse. The only exceptions to client confidentiality are threat to kill self, harm others, suspected child abuse and/or abuse against vulnerable adults, or a valid court order.
  - i. Staff must determine whether it would be safe and possible to engage and involve the client in the reporting process. If this is not possible, a report must still be made.
  - ii. In cases of reportable abuse, if another client reports to staff, staff should encourage the client who saw the incident firsthand to make the report. Staff must report as mandated by law.
  - iii. Clients will be empowered to identify who should be contacted and under what circumstances.

8. **Shelter Rules** should be kept to a minimum and only address issues of health or safety. Violence or abuse of any kind, including physical, verbal, emotional, or threats, is inappropriate and prohibited. The goal of safehouse rules is to protect the safehouse community. Isolated incidents are not enough to warrant the creation of a rule.
9. **Pet Policy:** A policy for clients whose pets are also in danger should be established. The best practice is to house pets of survivors on the safehouse property. Another option is to have a partnership with a pet foster placement agency (Humane Society, pet safehouse, etc.). (For guidance, see *Sheltering Animals & Families Together™* at [alliephillips.com/saf-tprogram](http://alliephillips.com/saf-tprogram)).
10. **Goal, Action, and/or Service Planning:** Efforts should be made to engage and encourage clients to utilize the program's available services voluntarily. A client's goals should be self-identified, individualized, and able to be modified on an ongoing basis. Progress on goals should not be the sole measure for a clients' success in safehouse. Barriers, including trauma, health conditions, and immigration status, should be considered. Progress, referrals, and follow-through should be documented in a trauma-informed manner. If staff concerns arise regarding a client's engagement in the program's services, they should initiate contact with the client to discuss the concerns, possible explanations, and solution-based options.
11. **Community Guidelines** should be provided that outline the expectations of community living, such as kitchen and bathroom courtesy and use, use of laundry facilities, storage of food and medications, security precautions for exit and entry, phone and computer use, available services, and days and times of community meetings and support groups. Community living arrangements, such as chores, meal times, quiet times, children's bedtimes, etc., may be determined by the clients. Such arrangements will be flexible and supported by safehouse staff. House meetings will be conducted regularly and frequently and/or at the request of staff or clients. House meetings are voluntary and attendance should be encouraged to discuss community living issues and to obtain feedback from clients about safehouse-related activities.
  - a. In order to promote self-sufficiency and survivor empowerment, certain decisions should be left up to the individual, including:
    - i. **Curfew, bedtime, and wake-up times:** To promote self-sufficiency and survivor empowerment, a set curfew or bedtime should be determined by each individual client.
    - ii. **Stays away from safehouse:** Clients should be able to choose to stay away from safehouse for a short period of time without jeopardizing their bed space. Staff should develop a safety plan and discuss any safety concerns they have related to a stay away from safehouse. The period of time should be reasonable based on the circumstances and available bed space.
    - iii. **Extended Absences:** Upon entrance into safehouse, staff should inform clients of the potential consequences of losing bed space if they stay away from safehouse for a longer than agreed upon time.

- iv. **Contact with abuser:** Contact with an abuser should be determined by each individual client. Staff should safety plan with clients if a survivor might have contact with their abuser.
- v. **Access to medications:** Shelters will provide clients with individual, locked, storage for their medications to access at any time, unmonitored and unimpeded.

**12. Room Searches/Inspections:** Planned or unplanned room searches can re-traumatize clients and can repeat a pattern of coercive control and are not recommended. Room inspections for health and safety must minimize invasion of privacy, maximize respect to the clients, and will be done by staff in a trauma-informed manner. Room inspections must be explained and planned in advance with the collaboration of all clients affected.

**13. Training:** Safehouse workers should receive a minimum of thirty hours of domestic violence and crisis intervention training. This training must include the following topics:

- a. General domestic violence training (History and Framework of Domestic Violence; Empowerment Advocacy; Trauma; Survivor-Centered, High-Danger Safety Planning; Protective and Peace Orders; Child Witnessing and Teen Dating Abuse; Elder Abuse and Abuse of People who have Disabilities; Minority Sexual Orientations and Gender Identities; Religion, Ethnicity, and Culture; Vicarious Trauma and Burnout)
- b. Crisis intervention (listening, establishing rapport, needs assessment, suicide prevention, etc.)
- c. Screening and assessing for danger and/or lethality and to provide safety planning
- d. Lethality Assessment Program (LAP) training.
- e. Identifying imminent danger situations and knowing how to respond to them
- f. Effects of trauma, principles of trauma-informed services, trauma specific techniques, an understanding of how the safehouse environment and interactions can exacerbate trauma reactions and how to minimize these re-traumatizations, self-care
- g. Availability of legal remedies and the difference between giving legal advice and providing legal information (peace/protective orders, criminal charges, immigration, etc.)
- h. Availability of health services and the difference between giving medical advice and providing health information (medication, diagnosis, medical treatment, etc.)
- i. Referrals and community resources
- j. Mediation
- k. Conflict Resolution
- l. Cultural Competency (including sexual orientation, language, race and ethnicity, socioeconomic status, etc.)
- m. Suicidal and homicidal risk assessment

- n. Universal precautions
- o. CPR and First Aid (recommended)

14. **Evaluation and Feedback:** Evaluation, including the written and verbal feedback from clients of the domestic violence safehouse, must be conducted to ensure quality of services. These should be:

- a. gathered throughout the stay from all clients
- b. used to inform service and practice and program development
- c. feedback should be written, anonymous, and voluntary
- d. The program should elicit the most accurate and honest; elicit trust; create opportunity for the most honest feedback. Possible ways to do so include:
  - i. Suggestion box
  - ii. Periodic satisfaction surveys
  - iii. Exit surveys
  - iv. Exit interviews- should be offered to all clients leaving the safehouse. Include feedback for program improvements, assessment of stay, etc.
  - v. House meetings
  - vi. Focus groups
  - vii. Advisory board of current or former emergency safehouse clients and staff who review policies and procedures.
  - viii. The program will have a written policy on grievances that is accessible and available to all clients.

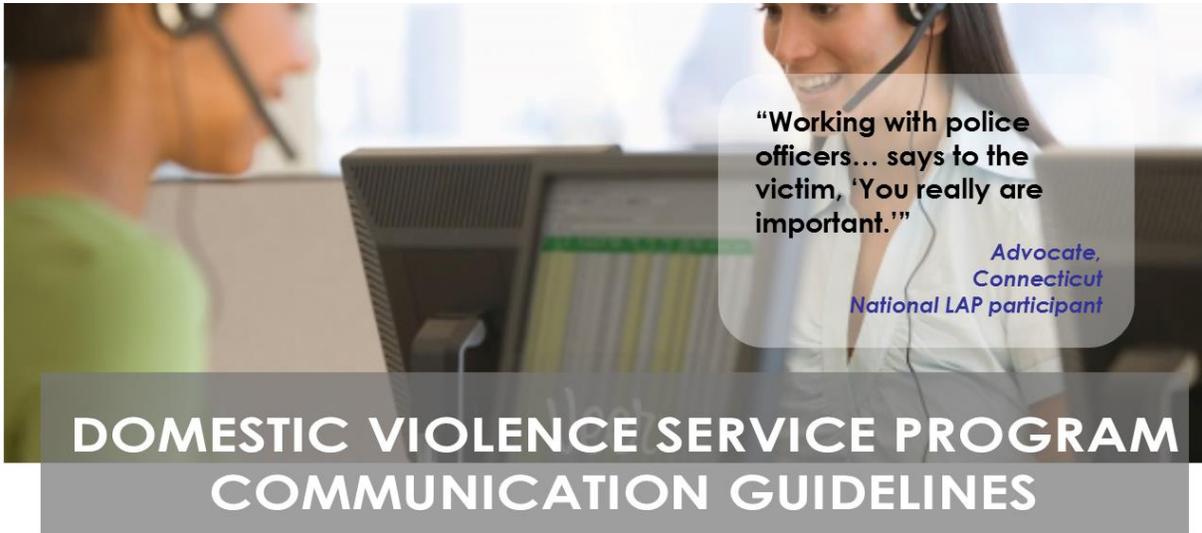
# Appendices



**Maryland Network**  
**Against Domestic Violence**

WORKING TOGETHER FOR A SAFER FUTURE

## Appendix A: LAP Hotline Guidelines



### Key Points of Conversation

**Gather Information**

**Build Rapport**

**Reinforce Danger**

**Educate and Safety Plan**

**Encourage**

The purpose of these guidelines is to convey the points of conversation. We want to help you focus the conversation to better assure that the hotline advocate effectively, but briefly, communicates essential information. You’ll do immediate safety planning and encourage the victim to come in for services.

### Key Feature of Conversation | BREVITY

The conversation between the victim and the hotline advocate is a brief one of no more than 10 minutes, demonstrating the collaborative effort between your program and law enforcement, supporting the victim, and connecting the victim to your services.

## Guideline 1: Gather Information from the Officer

### When the officer calls, he/she will:

- Introduce him/herself by giving his/her name and agency,
- Advise you that he/she has a high danger victim, and
- Answer your questions, providing you with the following information:
  - Names of the victim and offender (if the victim has consented to this information being shared),
  - Case number,
  - Victim's "yes" responses to the Lethality Screen, and those questions the victim declined to or could not answer,
  - Briefly what happened and what actions the officer has taken,
  - Whether the victim is initially willing to speak with you.

If the officer does not identify him/herself or provide you with the above information, ask him/her so you are able to record it.

When you address the officer, identify yourself by your name. You do not need to include your surname.

### Victim Declines to Speak with the Hotline Advocate

Once you have gathered all of the information listed above from the officer, and the officer tells you that the victim has declined to speak with you, **the officer will advise you that he/she will encourage the victim to speak one more time. The officer will then interrupt the conversation, and ask the victim if she/he has reconsidered.** If the officer does not indicate that he/she will ask the victim a final time if the victim would like to speak with you, request that the officer ask the victim.

**If the victim then agrees to speak with you, the officer will turn the phone over to the victim and you will proceed with [Guideline 2: Building Rapport](#).**

**If the victim again declines to speak with you, convey brief safety planning** (refer to [Safety Planning Checklist](#)) considerations to the victim through the officer, as well as other brief points you believe are relevant based on the victim's Lethality Screen responses or the officer's comments, that may be helpful in the victim's situation. **Request the officer to ask the victim if you may follow up with the victim tomorrow.**

After you have provided safety planning information and obtained a safe plan to follow up with the victim, you can **hang up the phone.**

## Guideline 2: Build Rapport

### Victim Agrees to Speak with the Hotline Advocate

**When the victim comes to the phone, introduce yourself.**

→ *My name is Michelle. Thank you for talking with me today*

**Thank the victim for speaking with you** and acknowledge that you understand how difficult speaking with you is for her/him.

→ *I appreciate your speaking with me now; I know it's a very stressful time.*

**Briefly explain your program's confidentiality policy and services.** Your explanation about services should include shelter/safe house. Describe the type of accommodation features it includes, such as private rooms, meals, provisions for children, etc.

→ *Before we get started, I would just like to take a moment to tell you about our organization and our confidentiality policy.*

→ *Just to let you know, we have many services here that are available to you. We have a twenty-four hour hotline, a safe house where you can stay for a few months, a free-clothes closet, no-cost counseling, etc.*

**Empathize with the victim's situation; and express your admiration of the victim's courage and cooperation and your and the officer's support of her/him.**

→ *I am so sorry that you have had to go through this; it seems like it was a scary time.*

→ *I hope you realize how much strength and courage it took for you to talk to Officer Hunt and me. I'm glad you decided to talk with me.*

## Guideline 3: Reiterate Danger

**Reiterate how dangerous the situation is and express your concern for the victim's (and her/his children's) well-being.**

→ *I'm really concerned about you and your son after hearing what happened and what your responses to the screen that you did with Officer Hunt were.*

**Reinforce what the officer has already told the victim: that in situations such as this people have been killed.**

→ *The officer may have already told you, but mothers and their children in your situation have died as a result of the abuse and I really want to make sure that you and your son are going to be okay.*

## Guideline 4: Provide Education and Safety Plan

Explain that the abuse is not the victim's fault, that it is an issue of control, that it is characterized by a pattern, and may become worse and more frequent.

Provide examples, if appropriate, from the power and control wheel, cycle of violence, or specifically from the victim's Lethality Screen responses. Do not let the victim, without a remedial comment, rationalize or minimize the abuser's behavior, such as, "He only does this when he starts drinking." Focus your statements on the abuser's accountability.

- *It's so important for you to know that this isn't, in any way, your fault.*
- *There isn't anything that you could ever do that could justify him hurting you the way he did tonight.*
- *The reason that people are abusive is because of a need to be in control.*
- *It's really important for you to know that incidents will only get worse and happen more often.*
- *She made the choice to react that way.*
- *Drinking doesn't cause her to hit you.*
- *He's responsible for what he does, and hitting you is a crime.*
- *I'm not sure if you're familiar with it, but there tends to be a cycle to violence. After an incident occurs, you find yourself in a honeymoon phase, where things seem okay again. Maybe he's apologetic or, like you said before, he may start to feel bad about what happened. At some point later, things get tense again, little things start to happen and then, before you know it, another incident has occurred.*

**Note: If there is a need for a longer conversation, call a "time-out."**

A conversation that you believe needs more time requires you to:

- Interrupt it,
- Speak with the officer, and
- Allow the officer to decide if his/her presence is still needed at the scene.

If the officer believes his/her presence is still required or he/she must soon depart, you and the officer must quickly negotiate an arrangement. For example, you would agree to temporarily discontinue the phone conversation so that the officer can wrap-up on the scene, and arrange with the victim that the victim can call you back once the officer leaves, if the use of her/his phone is a safe option, or that you will call the victim back within a certain time period. Whatever the arrangement is with the victim, ensure that it is clearly worked out before you hang up.

## Guideline 4: Provide Education and Safety Plan

Safety plan with the victim for her/his immediate needs (i.e., safety and specific living arrangements over the next 24 hours).

See the **Safety Planning Checklist** in the appendix as a guide. But, remember, not all High-Danger victims will consider themselves to be in danger at that time.

Safety planning over the next 24 hours may not be a priority for the victim, in which case you should concentrate on options if the victim would find her/himself in a dangerous situation.

### Technology Tip:

As you safety plan, be aware of which phone the victim is using. If it is her/his personal cell phone or landline, that call may be tracked or recorded by the abuser. Be cautious in giving a shelter address or confirming specific safety precautions (such as who exactly the victim will be staying with or where the victim hid the abuser's weapons) when the victim is using his/her personal phone.

Should the victim decide to go in now for shelter, you don't need to complete the remaining steps of these guidelines, except:

- Tell the victim what she/he may consider bringing to shelter.
- Ask the victim that if she/he changes her/his mind and decides not to go into shelter, whether a DVSP advocate can follow up with her/him the next day just to make sure she/he is safe, in which case you need a safe phone number on which to reach the victim.
- Conclude by speaking with the officer to advise him/her about the victim's wishes to go into shelter. In this case, you will need to discuss arrangements for the victim's transportation.

### Beginning the Conversation:

It is crucial to find out what the victim's biggest safety concerns are—do not try to impose your concerns on the victim. Tailor your suggestions to the issues the victim is prioritizing.

Ask: **“What is your biggest concern right now?”**

→ *If you don't mind, I'd like to spend a little time creating a safety plan with you for tonight. I know that Lee is being taken into custody, but he might be released within several hours.*

→ *As I mentioned before, we have a safe house here that can keep you and your son safe. Is that something that you might be interested in?*

→ *I understand that you want to stay in your house. Can we try to think of a place that, in case of an emergency, you and your son would be comfortable and safe if you had to leave right away?*

→ *It would also be a good idea to teach your son how to call the police. Do you think that you could do that?*

→ *Another step you can take to stay safe is to identify the safest route outside of your house. That way, if something happened and you needed to get out right away, you would have already thought through the safest way.*

→ *You can also consider picking up a 911 cell phone from us. That's something you could always have with you, or put in your packed bag, just to feel a little safer.*

## Guideline 5: Encourage the Victim to Come in for Services

### Explain the services that your organization offers.

- **Focus on programs that the victim can use immediately:** a 24-hour hotline, shelter, assistance with protective orders, support group meetings, advocacy at the hospital, a 911 phone, food bank, clothes give-away, etc.
- **Meet the victim where she/he is.** If the victim does not recognize she is in danger and is not ready to leave the relationship yet, highlight programs that can help her/him *now*: economic empowerment classes, support groups of people still in their relationships, legal advocacy.
  - **Explain how these programs work** (example: a legal advocate can explain what is happening in the criminal case, case management could help the victim apply for government benefits).
- **Do not explain every service you provide.** The victim does not need to hear about prevention or training programs, for example, or programs targeting children with parents in abusive relationships if the victim does not have children.
- **Use a conversational tone.**
  - Do not have a prepared statement that you use for everyone—tailor the conversation to the victim's needs and ability to process information at the moment.

**Remember:** The goal is to get the victim to come in for further services. You can explain other programs in detail at the appointment.

### Encourage the victim to come in for services and try to schedule an appointment at the earliest possible time.

→ *It sounds like you could really benefit from our services. I know it's been hard talking to me tonight, especially with everything that's going on around you at home. But I want you to know that it can be really helpful to have the opportunity to come in and talk to someone when you can feel safe and comfortable. We have an appointment available with Shannon at 10:00 a.m. Would that work with your schedule? Our services are no cost to you.*

→ *We have a legal advocate who could meet you at the bail hearing tomorrow to explain what is happening.*



**Maryland Network**  
Against Domestic Violence  
LETHALITY ASSESSMENT PROGRAM

## CONCLUDING THE CALL

### **Validate the victim's feelings and confirm plan (including follow up):**

- Thanks again for talking with me Elizabeth.
- I hope you realize how strong and courageous you have been through this difficult process.
- Just try to take some time tonight to relax and maybe do something fun with your son to take your mind off of things.
- The officer will make sure that you have our hotline number before he/she leaves.
- We'll see you at your appointment tomorrow at noon.
- I'll call you on your work-line tomorrow to check in with you.
- If you miss the appointment, I will call your sister to confirm that you are okay.

### **Ask for permission to speak with the officer and to convey the basic plan you have developed.**

- Do you mind if I talk to Officer Hunt about the plan that we came up with together?
- Can I tell Officer Hunt it's all right to leave, and that you have an appointment to come in tomorrow?

### **Conclude the call, convey the basic plan to the officer, ensuring the victim has the hotline phone number, and thank the officer.**

- Thanks for waiting. Elizabeth made an appointment to come in tomorrow. Will you make sure she has the victim's card, and will you point out our number?
- I appreciate you waiting for us to wrap up the call. Elizabeth is going to stay at her sister's tonight. Can you stay until she finishes packing her bag?
- Thank you for calling tonight. Elizabeth did not make an appointment, but I have permission to follow up with her tomorrow and to contact her sister if I can't reach her.

Note: The officer stays with the victim during this call, to show the victim support and to demonstrate that you and law enforcement are working collaboratively to help the victim. It is important to show that you are all on the same team, working toward the same goal: the victim's safety.

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## Appendix B: Tipsheet: Developing a Language Access Plan for Your Agency

Asian & Pacific Islander Institute on Domestic Violence • [www.apiahf.org/apidvinstitute](http://www.apiahf.org/apidvinstitute)  
450 Sutter Street, Suite 600, San Francisco, CA 94108 Tel: 415-568-3315

### **Guidelines:**

If your organization receives federal funds, either directly or through the state, your agency is required to develop a language access plan (this does not mean hiring staff for every conceivable language spoken by your clients).

1. Learn the requirements of Title VI, Executive Order 13166, and your state laws.
2. Determine language needs using DOJ's four-factor assessment:
  - a. Number or proportion of persons with Limited English proficiency (LEP) in the eligible service population.
  - b. Frequency with which these LEP persons come into contact with your program.
  - c. Importance of the benefit or service.
  - d. The resources available.
3. Based on the assessment's results, identify the languages that will be included in the agency's language access plan and how the agency will provide interpretation services to LEP clients.
4. Develop an outreach plan to notify LEP persons that services are available.
5. Integrate your agency's language access policies and procedures into the agency's regular policies and procedures manual for use by all, not only bilingual, staff.
6. Train all staff and volunteers on language access laws:
  - a. Federal laws: Title VI and Executive Order 13166.
  - b. State laws on court interpretation to determine:
    - i. clients' rights to interpreters in civil courts,
    - ii. who provides the interpreters,
    - iii. who pays for interpretation.
  - e. Protocols for filing a Title VI complaint with the Department of Justice should a client's language access rights be denied by a federal grant recipient.
1. Implement and train staff about language access advocacy and agency protocols on:
  - a. Responding to LEP callers and in-person contacts.
  - b. Advocating for and asserting LEP clients' rights to qualified interpreters in courts and other systems.
  - c. Providing LEP clients with tools (such as "I speak..." cards) that assist them in asserting their right to language access in the courts and other public agencies.
  - d. Responding to court requests that bilingual advocates interpret by attempting to decline and disclosing their conflict of interest on record.
  - e. Working with interpreters, including basic knowledge about interpretation: types, modes, code of ethics, qualifications and roles.
  - f. Identifying and responding to poor, incorrect or biased interpretation.

2. Evaluate plan's effectiveness regularly to ensure it meets the needs of LEP persons.
3. Monitor demographic changes and immigration/refugee resettlement patterns to identify new LEP populations your agency will need to serve.
4. Engaging courts and public agencies in a dialogue on language access and Title VI.

**Resources:**

1. **American Bar Association:** List of state statutes on the provision of language interpreters in civil cases.  
[http://www.abanet.org/domviol/docs/Foreign\\_Language\\_Interpreters\\_Chart\\_12\\_2008.pdf](http://www.abanet.org/domviol/docs/Foreign_Language_Interpreters_Chart_12_2008.pdf)
2. **American Bar Association's Commission on Domestic Violence:** Materials on integrating interpretation in civil representation of domestic and sexual violence survivors.  
[http://www.abanet.org/domviol/institute/integration\\_of\\_interpreters.html](http://www.abanet.org/domviol/institute/integration_of_interpreters.html)
3. **Department of Justice, Office of Civil Rights, Executive Order 13166 Limited English Proficiency Resource Document: Tips and Tools from the Field:** Overview and tips and tools for law enforcement, domestic violence specialists and service providers, 911 call centers, courts, federally conducted programs and activities.  
[http://www.lep.gov/resources/tips\\_and\\_tools-9-21-04.htm](http://www.lep.gov/resources/tips_and_tools-9-21-04.htm)
4. **Department of Justice, Office of Coordination & Review:** File complaints for Title VI violations. <http://www.usdoj.gov/crt/cor/complaint.php>
5. **Legal Services Corporation:** Guidance to LSC programs on training, procedures and policies.  
[http://www.abanet.org/domviol/institute/integration\\_of\\_interpreters/Guidance\\_to\\_LSC\\_Programs\\_for\\_Serving\\_Client\\_Eligible\\_Individuals\\_with\\_LEP.pdf](http://www.abanet.org/domviol/institute/integration_of_interpreters/Guidance_to_LSC_Programs_for_Serving_Client_Eligible_Individuals_with_LEP.pdf)
6. **National Association of Judiciary Interpreters and Translators (NAJIT):** Professional certification, training, policy advocacy, how to work with interpreters. <http://www.najit.org>
7. **National Center on Immigrant Integration Policy:** Policy, research, technical assistance, training and an electronic resource center on immigrant integration issues with a special focus on state and local policies and data.  
[http://www.migrationinformation.org/integration/language\\_portal](http://www.migrationinformation.org/integration/language_portal)
8. **National Consortium of State Courts:** Materials on court interpretation including tests for certifying interpreters and model guide.  
[http://www.ncsconline.org/D\\_RESEARCH/CourtInterp.html](http://www.ncsconline.org/D_RESEARCH/CourtInterp.html) and  
[http://www.ncsconline.org/wc/publications/Res\\_CtInte\\_ModelGuideChapter10Pub.pdf](http://www.ncsconline.org/wc/publications/Res_CtInte_ModelGuideChapter10Pub.pdf)
9. **Ohio State, Dept of Public Safety/Office of Criminal Justice Services:** Training materials for law enforcement and judges. <http://www.ocjs.ohio.gov/LEPResources.htm>

## Appendix C: Response to Subpoenas

Excerpted from the National Network to End Domestic Violence (NNEDV)'s Safety Net Project's Technology and Confidentiality Resources Toolkit FAQ located at <http://tools.nnedv.org/faq>

### **What should our DV/SA program do if we get a subpoena?**

First, have a plan, including an attorney to call in the event that a subpoena is received. Most importantly, get legal advice and assess the best means to resist the subpoena, which could include: contacting the attorney who issued it and asking them to rescind it, challenging service, filing a motion to quash the subpoena with the court, seeking other types of orders to protect the information, working with the survivor whose information is sought to determine her position and whether she will also be resisting the request for information, among other actions. Whatever you do, please do not ignore the subpoena and hope it will go away on its own, and certainly don't destroy documents that may be subject to a subpoena once it has been served on your agency.

VAWA 2005 & Confidentiality

### **Is a subpoena for records a court mandate exception?**

Generally not. In the vast majority of U.S. states, a subpoena is not a court order. Best practice in every state is to ask the court to quash (invalidate) any subpoena that asks for a program's records. Responding to subpoenas can raise unique questions. For help in responding to subpoenas, programs should contact a local attorney with knowledge about U.S. federal VAWA and state laws regarding confidentiality. Programs may also contact NNEDV's Safety Net Project for resources to address subpoenas.

# Appendix D: High-Danger Safety Planning Model Guidelines

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## A. Introduction

This protocol seeks to develop a set of guidelines on how to safety plan with victims of domestic violence, including High-Danger victims. This protocol was developed by the Maryland Network Against Domestic Violence (MNADV) in collaboration with domestic violence advocates from across the state.

## B. Defining Safety Planning

A safety plan is an individualized set of strategies that victims develop to reduce risks to themselves and their families.<sup>1</sup> Safety planning is a lifesaving service focused on the victim and her/his immediate needs. Safety plans must be comprehensive and address the victim's basic human needs, developing a life plan and responding to the physical violence a victim is facing. Safety plans vary depending on whether a victim has separated from the abuser, plans to leave, remains in the relationship, has other life circumstances impacting the situation, as well as what resources are available to her/him.

Safety planning is a dynamic process. Safety plans change depending on the victim's individual circumstances, and includes immediate, short- and long-term strategies<sup>2</sup>. Victims constantly "safety plan," often without realizing it. There are numerous risks that victims face when considering whether or not to leave an abusive relationship. The ongoing process of safety planning is complex and includes:

- Understanding the risks to safety created by an abuser,
- Understanding how life-generated risks affect a victim's decision-making,
- Understanding the cultural norms and values of the victim,
- Understanding the variety of strategies used by a victim to reduce risks, and
- Understanding the role of advocates in responding to safety concerns and meeting basic human needs.

## C. Defining High-Danger

Victims in "High-Danger" need additional layers of safety planning and support to ensure their safety. "High-Danger" is a term used to describe a victim who is at the greatest risk of being killed or seriously injured by an intimate partner. A victim is assessed as being at "High-Danger" either based on the victim's answers on the Lethality Screen, Danger Assessment or based on the belief of the practitioner<sup>3</sup>.

## D. Role of Advocates

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<sup>1</sup> Definition of safety planning adapted from Davies, J., Lyon, E., Monti-Catania, D., (1998). *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, Thousand Oaks, CA: Sage.  
[http://www.vawnet.org/Assoc\\_Files\\_VAWnet/BCS\\_SafePlan.pdf](http://www.vawnet.org/Assoc_Files_VAWnet/BCS_SafePlan.pdf)

<sup>2</sup> Immediate, short- and long-term strategies for safety planning are detailed in *Safety Planning with Battered Women: Complex Lives/Difficult Choices* cited above.

<sup>3</sup> This definition of High-Danger was created by the Maryland Network Against Domestic Violence Lethality Assessment Program. <http://mnadv.org/lethality/>

The advocate's role in the safety planning process is to educate, empathize and empower the victim to make her/his own choices and to offer referrals and options.<sup>4</sup> Advocates should empathize with and empower victims, while engaging in active listening. The advocate should ensure that the safety planning process is trauma-informed, victim-centered, individualized, focused on strengthening the victim's risk analysis, culturally sensitive and ongoing. Advocates have information and access that can impact a victim's safety plan and should be prepared to explain and encourage the victim to make her/his own choices about safety using that information.

The advocate's part in the safety planning process begins with describing a safety plan and the reasons for making one, encouraging the victim's bravery and gathering information about the victim's situation. While gathering information from the victim, the advocate should listen for risk factors and barriers to safety that the victim might not recognize her/himself. If the advocate's initial point of contact with the victim is a victim-initiated hotline call, the advocate should complete the Lethality Screen to further evaluate the lethality impacting the victim (*see Lethality Assessment Program Victim-Initiated Hotline Call Guidelines*). The advocate should work to build a rapport and establish trust with the victim. A positive, supportive relationship is key for helping the victim as s/he makes what may be the scariest and most difficult decisions in her/his life. Once a risk assessment is completed, communicating the level of danger a victim is in is critical as it influences the safety planning process (*see Section E, Steps in Safety Planning in High-Danger Cases*). Safety plans that solely focus on getting victims to use traditional resources, such as counseling, parenting education, support groups, shelter, and/or legal options are helpful, but are limiting because:

- It may not include resources that address the risks identified by the victim;
- It may not validate the victim's experiences as unique;
- It may cause the victim to feel the domestic violence program is not considering her/his own needs and may not return for services; and
- It may not take into consideration the victim's cultural norms and values.

Advocates should constantly re-evaluate, expand, and update their referral base to include organizations that serve all members of the community, especially when they recognize the presence or emergence of culturally specific communities.

Safety planning conversations with a victim should be held in a private space whenever possible. Advocates must engage in active listening<sup>5</sup> throughout the process. Working through a trauma-informed<sup>6</sup> lens, the advocate must create a non-judgmental space for the victim to discuss her/his feelings and instincts as these will help create a well-defined plan. It is helpful to encourage the victim's strengths and to recognize what the victim is already doing or has done to keep her/himself safe. The advocate must explain that the safety plan can and will change for a variety of reasons, often outside of the victim's control, and that it is not the victim's fault if a safety plan does not occur as planned.

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<sup>4</sup> Information on the role of an advocate provided by the MNADV's *Domestic Violence Service Provider Communication Guidelines*.

<sup>5</sup> Active listening is a [communication](#) technique which requires the listener to repeat back what they hear by way of re-stating or [paraphrasing](#) to confirm they are listening and accurately understand what they are being told.

<sup>6</sup> According to the Substance Abuse and Mental Health Services Administration, "a program, organization, or system that is trauma informed realizes the widespread impact of trauma and understands potential paths for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others, responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (<http://www.samhsa.gov/nctic/trauma-interventions>)

The advocate may not have the same concerns as the victim. The advocate may feel the victim is undervaluing one aspect of her/his situation and, though it is acceptable to encourage and educate the victim about her/his circumstances including risk of danger, advocates should never make decisions about the victim's safety plan.

## **E. Steps to Safety Planning in High-Danger Cases**

### ***Step 1: Identify High-Danger Victim***

The advocate may identify a High-Danger victim through a 1) completed Lethality Screen, and/or 2) a completed Danger Assessment (see *Lethality Screen, LAP Protocol and Danger Assessment*). The Lethality Screen may be administered on-scene by a law enforcement officer, on the hotline by a victim advocate, through another field practitioner, and/or while a victim is utilizing other program services (see *MNADV Lethality Assessment Program Victim-Initiated Hotline Call Guidelines*). The Danger Assessment can be administered by an advocate at any point in time.

Using the Lethality Screen<sup>7</sup> and/or Danger Assessment<sup>8</sup> will help guide the advocate and victim as they create a safety plan. These tools illustrate areas of current risk and warns the victim of possible signs of increasing lethality. The Danger Assessment or the Lethality Screen can be re-done as the victim's situation changes or the advocate's perception about the victim's risk evolves. During the process of administering a risk assessment tool, the advocate should listen for escalating risk factors or family dynamics that might heighten the victim's level of danger. Assessment tools examine the abuser's behaviors, not the actions the victim takes to protect her/himself. As such, they are not suitable replacements for an in-depth and detailed safety plan.

Factors that may place a victim at higher danger include<sup>9</sup>, but are not limited to, those factors itemized in the Danger Assessment.

### ***Step 2: Strengthen Victim's Risk Analysis***

Victim-centered advocacy, stemming from Jill Davies' woman-centered advocacy, is a risk analysis based on the victim's perceptions.<sup>10</sup> An advocate must ask and identify what a victim perceives as her/his risks, and how to most effectively use this information to advance the victim's plans and priorities.

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<sup>7</sup> The Lethality Assessment Program—Maryland Model (LAP), created by the Maryland Network Against Domestic Violence (MNADV) in 2005, is an innovative strategy to prevent domestic violence homicides and serious injuries. It provides an easy and effective method for law enforcement and other community professionals—such as health care providers, clergy members, case workers, and court personnel—to identify victims of domestic violence who are at the highest risk of being seriously injured or killed by their intimate partners, and immediately connect them to the local domestic violence service program.  
[www.mnadv.org/lethality](http://www.mnadv.org/lethality)

<sup>8</sup> Campbell, J., Webster, D., Glass, N. (2008). *The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide*, Thousand Oaks, CA: Sage.  
[http://www.dangerassessment.org/uploads/DA\\_Validation\\_of\\_a\\_Lethality\\_Risk\\_Assessment\\_Instrument-Campbell.pdf](http://www.dangerassessment.org/uploads/DA_Validation_of_a_Lethality_Risk_Assessment_Instrument-Campbell.pdf)

<sup>9</sup> Factors taken from *The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide*, Thousand Oaks, CA: Sage. Full citation in footnote 9.

<sup>10</sup> Davies, J., Lyon, E., Monti-Catania, D., (1998). *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, Thousand Oaks, CA: Sage. [http://www.vawnet.org/Assoc\\_Files\\_VAWnet/BCS\\_SafePlan.pdf](http://www.vawnet.org/Assoc_Files_VAWnet/BCS_SafePlan.pdf)

Victim-centered advocacy can be achieved by:

- Making the physical space as comfortable as possible and giving the victim choices (temperature, option to close or open the door, beverage, restroom breaks, etc.);
- Listening;
- Creating a “safe space” for the victim to talk;
- Asking open-ended questions, such as those on the Safety Planning Considerations handout (see *Safety Planning Considerations*);
- Validating the victim’s experiences and feelings;
- Avoiding the use of jargon, especially legal and clinical phrases and acronyms;
- Being aware of the victim’s assessment of you:
  - Does the victim trust you?
  - Is the victim comfortable with you?
- Identifying the partner-generated risks<sup>11</sup>:
  - For some victims, leaving may create new risks or increase existing ones. Partner-generated risks may include, but are not limited to:
    - Physical injury
    - Psychological harm, such as threats to the victim’s mental health, drug and alcohol abuse, or suicidal ideation
    - Child-related risks
    - Financial risks
    - Risks to family and friends, including the possible loss of relationship with the abuser
    - Arrest and legal status
- Identifying the life-generated risks<sup>12</sup>:
  - Life-generated risks are the type of risks anyone might face. The advocate must assist the victim in identifying real or perceived life-generated risks, and discuss how the abuser may manipulate these risks to hurt the victim. Life-generated risks may include, but are not limited to:
    - Finances
    - Home location
    - Physical and mental health
    - Discrimination based on race, ethnicity, country of origin, limited English proficiency, gender, sexual orientation, age, ability or other form of bias
    - Inadequate response from major social institutions including the legal system, health system, and workplace

Technological considerations should be a part of every safety plan. Technology can be used as a tool to help victims document abuse, call for help or communicate with supportive family and advocates, but it can also be used against the victim. Safety planning around technology including tracking applications and venues for communicating threats should be discussed. See the *NNEDV Technology Safety Plan, A Guide for Survivors and Advocates* for additional information.

### **Step 3: Identify strategies used by victim previously**

<sup>11</sup> Davies, J. M., & Lyon, E. (2014). How Women Form Perspectives and Priorities. In *Domestic Violence Advocacy* (2nd ed., pp. 77-88). SAGE.

<sup>12</sup> Davies, J. M., & Lyon, E. (2014). How Women Form Perspectives and Priorities. In *Domestic Violence Advocacy* (2nd ed., pp. 77-88). SAGE.

The advocate will help assess the victim's past and current safety plans and whether those plans were effective. Obtaining a history of help-seeking actions and their consequences is important in understanding the victim's risk analysis and perception of systems. While obtaining the victim's history, it is important to gather information without overwhelming or re-traumatizing the victim with extensive questioning. If the victim does not trust the advocate, think the advocate will be helpful, or believe the advocate will be sympathetic, the victim may not accurately recount the story to reflect all risks<sup>13</sup>. Advocates should be aware that victims often seek help from non-traditional resources. If this is the way that the victim is most comfortable seeking assistance, the advocate should use those resources in helping the victim create a safety plan<sup>14</sup>.

#### ***Step 4: Develop safety plan with victim***

Safety plans take many forms and should be adapted to fit the needs of the victim. For example, a written safety plan can be helpful so that the victim does not forget any of the suggestions. Unfortunately, they also pose a risk to the victim if the abuser sees it. In addition, if a victim does not read or write very well, a written safety plan is of limited use. The advocate and the victim should create the safety plan together and not just hand over the information and expect the victim to complete it independently. For more tips on safety planning, see *Safety Planning Considerations worksheet*.

Safety planning with High-Danger victims will incorporate many aspects of basic planning; however, with victims assessed as being in greater danger of being killed, more extensive, comprehensive approaches should also be address their specific risk factors. Advocates should consider the help of community partners during the safety planning process when working with High-Danger victims. With the victim's permission, advocates may partner with law enforcement, victim advocates, prosecutors, civil attorneys, culturally specific organizations, faith-based programs or other individuals who can assist in protecting the victim by limiting the abuser's access to her/him through arrest, bail/bond, criminal stay away orders, protective orders, filing for divorce or custody and/or enforcement of probation/parole violations. Following up in-person with a High-Danger victim at her/his home with the assistance of law enforcement can be very helpful in supporting the victim through a tumultuous time (see *High-Danger Follow-Up Model Guidelines*). Also, victims in High-Danger situations may be more likely to need relocation services including safe accommodations in outside jurisdictions or transportation support to safe locations (see *MNADV's Shelter to Shelter Referral Form and FAQ Sheet*).

Once the partner-generated and life-generated risks are identified, the advocate can begin the process of offering the victim complete and accurate information and addressing any concerns that the victim may have. It cannot be overemphasized that leaving the relationship provides neither a guarantee for the victim's safety nor a guarantee that other risks will be reduced. Victims use complex and creative safety plans to reduce the risks they and their children face. As any person making a significant life decision, victims must consider the consequences of pursuing certain options. Some examples may include:

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<sup>13</sup> Davies, J., Lyon, E., Monti-Catania, D., (1998). *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, Thousand Oaks, CA: Sage. [http://www.vawnet.org/Assoc\\_Files\\_VAWnet/BCS\\_SafePlan.pdf](http://www.vawnet.org/Assoc_Files_VAWnet/BCS_SafePlan.pdf)

<sup>14</sup> For additional information on community connected safety planning, read Lisa Goodman's article on IPV and Social Networks. Goodman, L.A. & Smyth, K.F. (2011). A call for a social network-oriented approach to services for survivors of intimate partner violence. *Psychology of Violence*, 1, 2, 79-92.

- “If I call the police they can stop him from hitting me, but my husband will lose his job (that supports our family).”
- “If I get a protective order she’ll have to leave the house. I won’t be able to pay the rent without her help.”
- “If I stop seeing him, he said he’d kill me.”
- “If I report her, she can have me deported. Then I wouldn’t have anything, my family and my children are all here.”

Such consequences may make a particular option undesirable or present additional risks the victim must address in her/his plan. One safety planning strategy that victims use is to remain in the relationship until they reach certain goals, such as waiting until children are in school or saving up a certain amount of money. Other victims hope and believe the abuser will stop abusing them and they decide to stay in the relationship. Others may stay because of their culture, threats, or because of life-generated risks. Victims who choose or are forced to remain in an abusive relationship also benefit from safety planning and strategizing to enhance safety.

High-Danger victims need additional support as they work to reduce the violence in their lives. Engaging community partners in protecting these victims is critical. With the victim’s permission, asking community partners such as law enforcement or probation/parole to “flag” High-Danger cases or addresses could be helpful should the victim reach out to first responders in a crisis. Also, safety planning around High-Danger factors is critical to reducing the risk of homicide.

For example, because of the increased lethal predictability that access to firearms creates, when an advocate is assisting a victim with a protective order petition, the advocate should address the matter of firearms with the victim to ensure the hearing judge is aware of their availability. The advocate should also encourage the victim to be as specific and detailed as possible as to the number, type, and exact location of the firearms. Precise information will allow law enforcement to remove as many of the firearms as possible. If the abuser fails to surrender the firearms, it will also provide officers with better information on which to establish probable cause for a search warrant application.

Another example, especially in extreme High-Danger cases, might be a consideration to seek witness protection through the local state’s attorney’s office.

### ***Step 5: Ongoing Safety Planning***

Both the advocate and the victim can expect a safety plan to change over time as life-generated and partner-generated risks change. The Lethality Screen or Danger Assessment can be administered multiple times to reassess the victim’s situation. It can be helpful to reinforce to the victim that the safety plan may not reduce or eliminate the threat of or actual violence. Advocates should review safety plans at every meeting with the victim.

There are times when an advocate must have conversations with a victim regarding her/his safety. These conversations could include discussions of behaviors such as survival sex, substance use and/or mental health concerns. An advocate may also have to talk about locations or relationships that put the victim in danger. For example, if the advocate believes the victim is putting her/himself in danger by attending family gatherings, encouraging the victim to disconnect with beloved in-laws or to stop attending social events where the abuser may be able to locate the victim could be a difficult conversation. These difficult conversations are necessary and should be done with empathy and in a non-judgmental manner.

After the victim's safety plan is complete, the advocate's efforts on behalf of the victim continue. Ongoing case work, especially for High-Danger victims, is critical to keeping a victim safe. Some options for promoting safety in these cases might include high-risk case review and use of a strangulation investigation team approach when applicable. <sup>15</sup>Strangulation Response Teams exist in Baltimore and Calvert Counties and are comprised of professions, trained to recognize strangulation indicators and to promote medical identification, treatment, documentation and prosecution. This can assist in the investigation and prosecution of offenders for strangulation, which is a significant predictor of high danger and lethality. A <sup>16</sup>[coordinated community response](#) is an intervention strategy developed by the Domestic Abuse Intervention Project (DAIP) in Duluth. This strategy, often called the "Duluth model," is a "system of networks, agreements, processes and applied principles created by the local shelter movement, criminal justice agencies, and human service programs that were developed in a small northern Minnesota city over a fifteen year period. It is still a project in the making." Multi-disciplinary teams, such as Montgomery County's ALERT (Assessment Lethality Emergency Response Team), Baltimore City's Fast Track, the [Domestic Violence Enhanced Response Team \(DVERT\)](#) in Colorado Springs, Colorado, and the [Domestic Violence High Risk Team \(DVHRT\)](#) in Newburyport, Massachusetts, serve as examples of proactive models for community partners joining together to respond to victims in need and to address matters of abuser accountability.

## F. Resources

- [Safety Planning Considerations](#)
- [Lethality Screen](#)
- [Lethality Assessment Program Protocol](#)
- [Lethality Assessment Program Victim-Initiated Hotline Call Guidelines](#)
- [High-Danger Follow-up Model Guidelines](#)
- [Danger Assessment](#)
- [MNADV Shelter to Shelter Referral Form and FAQ Sheet](#)
- [NNEDV Technology Safety Plan, A Guide for Survivors and Advocates](#)

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<sup>15</sup> Information provided by the National Domestic Violence Fatality Review Initiative.  
[http://www.ndvfri.org/reports/maryland/Maryland\\_Statewide\\_AnnualReport\\_2012.pdf](http://www.ndvfri.org/reports/maryland/Maryland_Statewide_AnnualReport_2012.pdf)

<sup>16</sup> Information provided by the National Criminal Justice Reference Service.  
<https://www.ncjrs.gov/App/publications/abstract.aspx?ID=187551>

## Appendix E: Mandatory Reporting Resources

### Maryland Laws, Regulations, and Legal Opinions

#### CHILD ABUSE AND NEGLECT

Maryland COMAR Regulations 07.02.07.02 (defines child abuse and neglect)

Maryland Family Law § 5-704 (reporting by specified professionals, including human service workers)

Maryland Family Law § 5-705 (reporting by all others)

78 OAG 189 (Attorney General Opinion on reporting an adult who was abused as a child)

74 OAG 128 (Attorney General Opinion on reporting an adult who was sexually assaulted)

Form DHR/SSA 180 (to report suspected child abuse)

Family Law § 5-620 (immunity for reporting)

No criminal penalty for failure to report child abuse in MD

#### DUTY TO WARN

Maryland Courts and Judicial Proceedings Annotated Code § 5-609

### Safety Considerations

Should domestic violence program staff or volunteers to report to authorities, it is good practice to inform the survivor first and solicit the survivor's cooperation to promote empowerment whenever possible. There are several safety considerations you should make to determine if and how to do this:

Will notifying the survivor create more danger for the child/dependent?

→If not, notify the survivor.

→If yes, do not notify the survivor.

Will notifying CPS/APS endanger the survivor?

→If yes, safety plan with the survivor.

Is the survivor willing to report with you?

→If yes, make the report together.



# Appendix F: Template: Client Limited Release of Information Form

Created for adaptation by Julie Kunce Field, J.D. and NNEDV.

**READ FIRST:** Before you decide whether or not to let [Program/Agency Name] share some of your confidential information with another agency or person, an advocate at [Program/Agency Name] will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want [Program/Agency Name] to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that [Program/Agency Name] has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow [Program/Agency Name] to release some of my personal information to certain individuals or agencies.

I, \_\_\_\_\_, authorize [Program/Agency Name] to share the following specific information with:  
 name \_\_\_\_\_

<b>I want to have my information:</b>	Address: _____ Phone Office at Agency: _____ Phone Number: _____
---------------------------------------	------------------------------------------------------------------------

The information may be shared:  in person  by phone  by fax  by mail  by e-mail

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

<b>info about me will be shared:</b>	as specifically as possible, for example: name, dates of service, any documents).
<b>Why I want my info shared: (purpose)</b>	as specifically as possible, for example: to receive benefits).

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by [Program/Agency Name].

**I understand:**

- That I do not have to sign a release form. I do not have to allow [Program/Agency Name] to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like [Program/Agency Name] to release information about me in the future, I will need to sign another written, time-limited release.
- That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from [Program/Agency Name].
- That [Program/Agency Name] and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

*Expiration should meet the needs of the survivor, which is typically no more than 15-30 days, but may be shorter or longer.*

**This release expires on** \_\_\_\_\_  
 Date Time

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_  
 Time: \_\_\_\_\_

**Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)**

I confirm that this release is still valid, and I would like to extend the release until \_\_\_\_\_  
 New Date New Time

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_