Arizona Service Standards for Domestic Violence Service Providers

History

These standards were developed to assist domestic violence programs provide quality services and implement best practices. They cover the core services provided to victims of domestic violence and their children. In 2000, the Arizona Coalition to End Sexual and Domestic Violence (hereafter “the Coalition”) presented a resource document titled the Best Practice Manual for Domestic Violence Programs. As a result, many providers, advocates and victims began to examine state requirements for domestic violence shelters, including funding for licensure requirements. Member programs of the Coalition and the director-at-the-time of the Arizona Department of Health Services Office of Behavioral Health Licensing (OBHL) gathered to discuss the licensing structure for shelters. Many member programs believed that OBHL licensing was required as a condition for funding. However, meeting participants concluded that OBHL licensing was written to provide oversight for counseling and psychological services as well as basic standards for housing adults – not to provide advocacy and crisis response services. It was apparent Arizona needed well-defined standards for all new and existing programs.

The Arizona Service Standards for Domestic Violence Service Providers (formerly the Arizona Service Standards & Guidelines for Domestic Violence Programs) was developed by the Shelter Standards Subcommittee of the State Agency Coordinating Team (SACT) as well as staff from the Coalition. Members of the subcommittee included administrators from state agencies, member programs, and Coalition staff.

In 2016, A.R.S. 36-3005 was amended to say that, in order to receive funding from the Domestic Violence Services Fund, “a domestic violence service provider shall adhere to statewide service standards for domestic violence programs that are approved by the Department of Economic Security in collaboration with a statewide coalition against domestic violence.”

In 2021, the Coalition, in collaboration with the Shelter Standards Subcommittee of the State Agency Coordinating Team (SACT), updated the Arizona Service Standards for Domestic Violence Service Providers to reflect changes in relevant legislation and new best practices.

These standards are to be used for implementing best practices for the operation of a domestic violence program. The most critical criterion of any service supporting domestic violence victims is that it is survivor-defined. Survivors are the experts in their own lives and utilize our programs and services to meet their unique, individualized needs. Safety is an especially important element, but it might not be the most pressing issue for the person seeking assistance. People come to service providers with their whole selves. Survivors each have strengths service providers must uplift and foster to facilitate self-determined safety and healing.
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Guiding Frameworks
The Full Frame Initiative

The Full Frame Initiative describes Five Domains of Well-Being: social connectedness; safety; stability; mastery; and meaningful access to relevant mainstream resources. This approach recognizes the full context of people’s lives and emphasizes that service providers have a responsibility to provide both internal and external support to individuals. It also recognizes safety might not be the most pressing issue facing the person or family if there are outside barriers or challenges keeping them from being whole. It recognizes the strength of their connectedness to others might be more important than getting an order of protection. It puts the individual and their family’s needs ahead of predetermined programming for domestic violence victims.

This approach also encourages service providers to have a trauma-informed approach to services. Providers must understand and tailor services to the trauma experienced by victims and their families. It is important to understand cultural and historical trauma affecting individuals and their ability to move from surviving to thriving. This also pertains to domestic violence program staff, many of who are survivors themselves. It is critical to support staff with addressing traumatic experiences impacting their ability to conduct work at their full potential, as well as any vicarious trauma they may experience as a result of their work. Having a trauma-informed framework is critical to providing best practices for all who seek services.

Services for victims of domestic violence should, at a minimum, address the following:
- Gender-based violence is rooted in a patriarchal ideology that creates systemic and institutional gender inequality, in turn leading to gender-role stereotyping, gender bias and misogyny;
- A victim of domestic violence is not responsible for the abuse;
- Programs and services should be survivor-defined/directed;
- Participation in programs and services must be voluntary;
- Programs and services should be trauma-informed;
- Programs and services should be strengths-based and empowering;
- Programs should not adopt policies or procedures creating additional barriers for victims or that would affect their ability to achieve safety;
- Programs and services for victims and their children must provide options and referrals;
- Confidentiality is mandatory. Survivors must have control over if and how their information is released and/or used.

Anti-oppression framework

In order to effectively prevent and respond to domestic violence, service providers and programs should have a strong understanding of oppression and anti-oppression work. Domestic violence is a form of oppression rooted in power and entitlement and supported by social structures and institutions that reinforce power imbalances. It is upheld by the intersection of multiple forms of oppression, including but not limited to sexism, racism, colonialism, classism, heterosexism, cissexism, and ableism. A person’s different experiences with oppression impact their experience with domestic violence. Domestic

1 www.Fullframeinitiative.org
violence service providers should use an anti-oppression framework when responding to domestic violence so that survivors receive the services they deserve and need in order to heal.

The following are recommendations for domestic violence service providers and programs for implementing an anti-oppression framework:

a. Learn the meaning of oppression (which can take the form of racism, sexism, colonialism, classism, heterosexism, cissexism, ableism, and more) and recognize that oppression is at the root of domestic violence and needs to be addressed to comprehensively work toward ending sexual and domestic violence.

b. Understand the concept of intersectionality (how different forms of oppression intersect, impact, and reinforce an individual or community’s experience of oppression). Many forms of oppression intersect and impact the way a person experiences the world; it is vital to recognize and understand these identities when providing services. It is also important to recognize your own intersecting identities and experiences with oppression, how they influence your personal experiences and responses to survivors, and how the identities you hold impact a survivor’s experience with you.

c. Acknowledge the long historical context of oppression and violence in the United States (such as the enslavement of Africans and the genocide of indigenous people), which continues to have impacts on individuals, communities, and generations of people at the individual, interpersonal, institutional, and ideological levels.

d. Recognize and consciously work to change how implicit and explicit biases, stereotypes, and victim blaming show up in sexual and domestic violence prevention and response, yourself, and the community. Actively identify and seek education on how these attitudes, behaviors, practices, and polices show up in service provision and programs, and change attitudes and behaviors to improve experiences for oppressed individuals seeking services.

Note on Language

Throughout these standards words such as client, participant, victim and survivor are used interchangeably to refer to the person who has experienced domestic violence. This is because different victim service providers use different language to refer to the people they serve; the laws that govern victim services use different terminology; and individuals who have experienced domestic violence may identify as a victim, a survivor, or neither.

Additionally, gender-neutral language has been used throughout these standards and to refer to survivors. This is because domestic violence happens to people of all genders, and not all people identify with gendered terms or the gender binary.
Organizational Standards
For the Board of Directors

The primary purpose of a board of directors is to govern the organization. The board for a domestic violence organization or an organization that includes a domestic violence program does not oversee day-to-day operations, unless the program is in a “start-up” or “transition” phase. A “start-up” program may be defined as, but is not limited to, one that has recently acquired paid staff, secured consistent funding, been operating or providing a new service for less than two years, or has undergone restructuring or reorganization.

1. The board of directors for a domestic violence organization, or for one that includes a domestic violence program, must abide by Arizona Revised Statutes (A.R.S.) Title 10: Corporations and Associations, Chapters 24-39. This includes, but is not limited to:
   a) A requirement the organization have current bylaws, which provide the governance structure for the organization and its elected board. Bylaws must include the following elements:
      i. Mission and purpose of the organization;
      ii. Board member requirements;
      iii. Quorum requirements;
      iv. Requirements regarding notice of meetings, agendas and relevant materials in a timely manner;
      v. Attendance requirements;
      vi. Process for holding meetings or votes in person;
      vii. Process for holding meetings or votes that are not conducted in person, for example by conference call or electronic methods;
      viii. Conflict of Interest policy;
      ix. Term limits for board and executive committee/officers;
      x. Process for removing board members; and
      xi. Process for committee creation.
   b) Both the Arizona Secretary of State and Arizona Corporation Commission require nonprofit organizations to report on the board of directors and organization, including a mandatory annual report that reflects maintenance or changes to the organization.
   c) Boards should maintain board and committee meeting minutes and have clear policies for when a public board meeting needs to move to a closed-session meeting. Reasons for a closed-session meeting may include, but are not limited to:
      i. Personnel issues;
      ii. Annual evaluation of the Executive Director/Chief Executive Officer (CEO).
   d) Minutes of board, committee and workgroup meetings should be maintained by the board secretary, kept at the program’s administrative office, and be available upon request. Closed-session meeting minutes should only include actions taken by the board.

Recommended resource: Board of Directors Toolkit for Nonprofit Sexual Assault and Domestic Violence Organizations

This standard only applies to non-governmental organizations and does not need to be followed by programs owned and operated by local or state government.
2. Boards should consider the following best practices in their organization:
   a) Periodically create and review a strategic plan in conjunction with staff, which includes a process to review the organization’s mission and vision, and setting the goals and objectives for the organization;
   b) Provide clear expectations about board members’ time and financial contributions to the organization; in addition, clear expectations of legal and financial responsibility should be provided;
   c) Include members who represent the racial, ethnic, sexual orientations, genders, abilities and socioeconomic diversity of the community to be served, including at least one former consumer of services; the board should also be comprised of individuals from diverse professions and backgrounds whose experience includes a wide range of skills and expertise;
   d) Offer orientation and training to new board members about their roles and responsibilities, program financial statements and procedures, program history, and services provided.

3. A board of directors should participate in fundraising and be the main fundraising body of the organization. This can include special events, but should also include soliciting individual donors. The board should attempt to find sustainable funding for the organization.

4. A board of directors should consider making board meetings open to all staff, apart from executive sessions.

5. A board of directors is responsible for the organization’s resources and should annually approve the organizational budget. The board should read and receive regular financial reports and ensure the organization receives an annual audit.

6. A board of directors is responsible for hiring and evaluating only one position in the organization, the Executive Director/CEO. The board should support and assist the Executive Director/CEO’s leadership role. Only the Executive Director/CEO should be responsible to the board; all other staff are the management responsibility of the Executive Director/CEO.

7. A board of directors’ personnel/governance or executive committee is responsible for annually evaluating the performance of the Executive Director/CEO and issuing a report to the board.

8. A board of directors is responsible for ensuring the legal and ethical integrity of the organization. The board should ensure the organization is in compliance with all laws and regulations. The board does this by setting policies for the organization in areas including personnel, finance, and conflict of interest.

For Rights of Individuals Receiving Services

1. A domestic violence program should have written policies concerning the rights of individuals receiving services, including but not limited to:
a) Individuals have a right to receive services in a professional manner, including to be treated with fairness, respect and dignity;
b) Individuals have a right to receive services free of discrimination, exploitation, oppression and abuse;
c) Individuals have a right to receive services that are confidential, and to be informed of limits to confidentiality;
d) Individuals have a right to receive services in the language identified as most appropriate for them;
   a. Materials provided to clients should be written in plain language\textsuperscript{4} and be readily available in alternative formats (e.g., large print)
e) Individuals have a right to receive services on a voluntary basis;
f) Individuals have a right to be informed of the program’s grievance procedure, including how to file a complaint/grievance, method of resolution notification in a timely manner, and appeals process; and
g) Individuals have a right to determine what information will be shared when collaborating on services with another agency, and the right to withdraw consent at any time.

For Non-Discrimination
1. In compliance with the Violence Against Women Act of 1994, Reauthorization Act of 2013, no person in the U.S. shall, on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity (34 U.S.C. § 12291 (b)(13)(A)).

2. If gender segregation or gender-specific programming is necessary to the essential operation of a program, providers must extend comparable services to individuals who cannot be provided the gender-segregated or gender-specific programming (34 U.S.C § 12291 (b)(13)(B)). This includes having a clear, written policy addressing the placement of transgender and nonbinary clients, providing the maximum amount of choice to clients about gender-segregated services as possible.

3. When determining comparable services, a program should consider:
   a) The nature, quality and duration of the service;
   b) The relative benefits of different therapeutic modalities; and
   c) The geographic location.

4. When determining if gender segregation or gender-specific programming is necessary for the essential operation of a program, a provider must:
   a) Evaluate each service separately – if one service is gender-segregated, it is not automatic that another service should be;
   b) Consider the consequences to all participants of making a service gender-segregated or gender- specific;
   c) Consider the literature on efficacy of service;

\textsuperscript{4} For tips on how to write in plain language, see “Creating Accessible Materials” from the Vera Institute.
d) Permit a transgender or nonbinary client to choose the appropriate gender-segregated or gender-specific programming based upon their own gender identity; and

e) Protect transgender and nonbinary clients from other clients’ complaints and harassment. A person cannot be removed from services because of their gender identity or perceived gender identity.

5. A victim’s immigration status cannot be a condition of eligibility for direct services in accordance with federal regulations (28 C.F.R. § 90.4-(c)).

6. Title II of the Americans with Disabilities Act (ADA) applies to state and local government domestic violence programs and Title III of the ADA applies to public domestic violence programs. The purpose of Titles II and III is to ensure that agencies do not discriminate against people with disabilities “in the full and equal enjoyment of goods, services and facilities.” Clients must be able to participate in the full range of services that are offered to others, in the most integrated setting possible, where other people receive services. Agencies shall take the necessary steps to ensure no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services. Agencies must also make reasonable modifications to policies, practices and procedures when necessary to provide equal opportunity to qualified individuals with disabilities, including applicants, participants, members of the public, and companions, unless making the modification would fundamentally alter the nature of the program, service, or activity. Beyond the requirement to modify or make services accessible, the ADA requires respect for the rights of clients to keep their disability status confidential. The ADA requires the bare minimum in services, but it is strongly recommended programs go beyond this when providing services to domestic violence victims. Programs are strongly encouraged to conduct an accessibility audit⁵.

7. A program should have clear written policies related to involuntary termination of services that are communicated to participants. Policies should be consistent with a trauma-informed approach to providing services. Policies should include that cultural and identity factors (e.g., a participant being Muslim, LGBTQ+, having a disability) are never grounds for involuntary termination of services. Clients with marginalized identities should be protected from involuntary termination due to other clients’ complaints or harassment and/or staff’s unconscious or conscious bias.

For Serving Minors and Adults with a Legal Guardian

1. Services should be provided to all victims of domestic violence. Programs who serve minors and adults with a legal guardian, under a full or limited guardianship, should adopt policies specifying how minors and adults with a legal guardian can access their services.

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⁵ For measuring your organizational capacity to serve survivors with disabilities, see “Measuring Capacity to Serve Domestic Violence Survivors with Disabilities: Non-residential Domestic Violence Programs” and “Measuring Capacity to Serve Domestic Violence Survivors with Disabilities: Residential Domestic Violence Programs” from the Vera Institute.
a) State law does not address whether unemancipated minors can or cannot consent to services without parental or legal guardian permission; therefore programs should consult with an attorney to develop their own policies related to minors’ consent to services.

b) Similarly, state law does not address whether adults with a legal guardian can or cannot consent to services. Arizona Revised Statutes (A.R.S.) § 14-5312(A) states "a guardian of an incapacitated person has the same powers, rights and duties respecting the guardian's ward that a parent has respecting the parent's unemancipated minor child," indicating a program’s policy for serving adults with a legal guardian should be similar to their policy for serving unemancipated minors. Programs should consult with an attorney to develop their own policies related to the ability of adults with a legal guardian to consent to services under the terms of the applicable guardianship and in line with the program’s mission.

2. Programs shall be aware of and comply with additional background checks/screening requirements of funders, as well as local, state and federal laws. This includes A.R.S. § 46-141 (Criminal record information checks; fingerprinting employees and applicants; definition), requiring employees and volunteers who provide services directly to juveniles or vulnerable adults to possess a fingerprint clearance card.

3. A program must develop policies ensuring staff disclose personally identifiable information only when legally mandated to do so or if they have a signed and dated Release of Information. Advocates are legally mandated to report child abuse and neglect per A.R.S. § 13-3620 (Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors; medical records; exception; violation; classification; definition).

4. For adult victims with dependent children, a best practice is to include access to childcare options. Situations in which childcare options should be provided include but are not limited to:
   a) During the victim’s intake;
   b) During a group attended by the victim;
   c) During periods when the victim seeks housing, employment, or educational opportunities;
   d) During medical appointments where medical advocacy/accompaniment is provided;
   e) During counseling or therapy attended by the victim;
   f) During court proceedings and meetings with lawyers; and
   g) During all appointments/meetings during which having to care for the child could be disruptive, or when the child might overhear the victim talking about the violence experienced.

For Confidentiality
The standard for confidentiality policies and procedures for domestic violence programs, and the interconnected standards for documentation, are based upon state and federal law. These include Arizona Revised Statutes (A.R.S.) Title 12, Chapter 13, Title 36, Chapter 30 and federal law: Violence Against Women Act (VAWA) Universal Grant Conditions: Nondisclosure of Confidential or Private Information (34 U.S.C. § 12291 and 28 C.F.R § 90.4), VAWA 2005 amended McKinney-Vento Homeless Assistance Act, Section 605 (42 U.S.C. § 11363), Victims of Crime Act (VOCA) (28 C.F.R. § 94.115), and Family Violence Prevention and Services Act (FVPSA) (42 U.S.C. § 10406(c)(5) and 45 C.F.R. § 1370.4).
In addition, 34 U.S.C. § 12291 (b)(2) prohibits sharing personally identifying information about victims without “reasonably time-limited” written and informed consent. “Personally identifying information” or “personal information” means individually identifying information for or about an individual, including information likely to disclose the location of a victim of domestic violence, dating violence, sexual assault, or stalking, regardless of whether the information is encoded, encrypted, hashed, or otherwise protected.

Policies must include how domestic violence program staff, volunteers and board members will respond to summonses, subpoenas, warrants, and other court orders in consultation with legal counsel. Policies should, whenever possible, provide details allowing for service of these court orders at a location other than that of the program. (Example in Appendix)

The following are requirements and recommendations regarding confidentiality.

1. A domestic violence program must have policies and procedures ensuring the confidentiality of any information potentially identifying individuals seeking, receiving or denied services. These policies should include, but are not limited to:
   a) Interagency communications;
   b) Storage and access to records and service documentation;
   c) Response to data breaches;
   d) Information systems and computers, including cell phones, containing personally identifying information; and
   e) Information contained in an individual’s service records or other verbal or written communications identifying individuals served by the program.

2. In accordance with federal and state laws and grant conditions, a domestic violence program must have policies and procedures in place to respond to an actual or imminent data breach. This includes if the program “uses or operates a Federal information system or creates, collects, uses, processes, stores, maintains, disseminates, discloses, or disposes of personally identifiable information within the scope of a Federal award” (U.S. Department of Justice, Office of Violence Against Women, Special Condition 6). This policy must include but is not limited to:
   a) Notifying people impacted by the breach. This process requires careful consideration of how to safely notify victims without disclosing to others whether the victim received services. Arizona law requires programs who own data that was breached to notify the client within 45 days of determining a breach occurred. Programs maintaining data that was breached must notify the owner of the data as soon as practicable. This notification must include: (1) the approximate date of the breach; (2) a brief description of the personal information included in the breach; (3) the toll-free numbers and addresses for the three largest nationwide consumer reporting agencies; and (4) the toll-free number, address and website address for the Federal Trade Commission or any federal agency that assists consumers with identity theft matters. The notification may be a written notice, an email notice, or a telephonic notice, but not a pre-recorded message (A.R.S. § 18-552).
   b) Notifying the federal or state agency or project manager, as applicable, no later than 24 hours after the occurrence of an actual breach or the detection of an imminent breach.

For a sample data breach policy, see Appendix “Model Data Breach Response Policy.”
3. To be eligible to receive financial support under the Domestic Violence Services Fund, a program shall:
   a) Require persons employed by or volunteering services to the program to meet existing licensing requirements, if any; and
   b) To maintain the confidentiality of any information that would identify persons served by the program or the services provided.

4. Domestic violence programs must have policies and procedures including the following provisions:7
   a) Protect the confidentiality and privacy of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families. Individual client information cannot be revealed without the informed, written, and reasonably time-limited consent of the person about whom information is sought.
   b) Information about when an unemancipated minor victim or an adult with a legal guardian can consent to services and the release of their own information. Provisions in 34 U.S.C. §12291(b)(2) state that if a minor or an adult with a legal guardian can legally consent to receive services, they can consent to release their information without additional parent or legal guardian consent. State law does not address, and therefore does not prohibit, services being offered to unemancipated minors or adults with a legal guardian. Programs should develop a policy regarding the ability of unemancipated minors and adults with a legal guardian to consent to release of information in accordance with their policy regarding when unemancipated minors and/or adults with a legal guardian can consent to services without parental or legal guardian permission.
   c) Maintaining the confidentiality of information released to the parent or legal guardian of an unemancipated minor, to the legal guardian of a person, or pursuant to statutory or court mandate (federal law prohibits consent for release to be given by the abuser of the minor, the abuser of the other parent of the minor, or the abuser of a person with a legal guardian).
   d) The process by which the program will make reasonable attempts to provide notice to victims affected by court or statutorily mandated disclosure of personal information and how they will protect the privacy and safety of the persons affected by the disclosure of information.
   e) Maintaining compliance with confidentiality provisions in federal law 42 U.S.C. §11363 and 34 U.S.C § 12291 (b)(2) that prohibit the disclosure of personally identifying victim information to any third-party-shared data system, including the Homeless Management Information System (HMIS). Personally identifying information is defined in 42 U.S.C. §11360 (16) and 34 U.S.C § 12291(a)(20) to include:
      a) A first and last name;
      b) A home or other physical address;
      c) Contact information (including a postal, e-mail or internet protocol address, or a telephone or facsimile number);

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7 Violence Against Women Act of 2013, 34 U.S.C. § 12291(b)(2)
d) A Social Security Number, driver’s license number, passport number, or student identification number; and

e) Any other information, including date of birth, racial or ethnic background, or religious affiliation that, in combination with any other non-personally identifying information, would serve to identify an individual.

5. A domestic violence program must have policies and procedures in place to ensure records of services sought by or provided to individuals will be kept confidential in order to comply with A.R.S. § 12-2239 (Domestic violence victim advocate; privilege; training; exception; definition) and A.R.S. § 13-4430 (Consultation between crime victim advocate and victim; privileged information; exception). Additionally, policies and procedures must account for privileged communication when supporting clients with civil proceedings.

6. A domestic violence program must have policies detailing the distinctions among procedures for release of records, in compliance with federal law, tribal law, state law, state court rulings and contract requirements. Contractual requirements cannot be in violation of federal law. The program must also have policies setting forth requirements for the informed, written, and time-limited consent for release of information by individuals seeking or receiving services or who have received or been denied services from the program.

7. A domestic violence program must have policies ensuring all release of information consent forms are signed by the person whose information is to be released. Under VAWA (2013), the release process must at minimum include the following: “Discuss with the victim why the information might be shared, who would have access to the information, and what information could be shared under the release; reach agreement with the victim about what information would be shared and with whom; and record the agreement about the scope of the release. A release must specify the duration for which information may be shared. The reasonableness of this time period will depend on the specific situation” (28 C.F.R. § 90.4 (b)(3)(ii)(A)). The release of information forms must specifically state:

a) The specific information a person who is receiving services, who has received services, or who has been denied services agrees can be released;

b) The person or entity to whom the information is to be released;

c) The date on which the form was signed;

d) Clear time limits for the consent of the release of information, which includes the date and time when the consent terminates; and

e) Language that clearly indicates the consent may be revoked at any time either orally or in writing.

8. A domestic violence program must ensure that board members, staff, and volunteers sign a statement agreeing to maintain the confidentiality of all information pertaining to those who have sought, received, or been denied services through the program, in accordance with confidentiality requirements of state law, contracts for funding with state and/or federal

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8 For an annotated sample Release of Information form in plain language, see Appendix “Release of Information – Model Form in Plain Language”
agencies, and federal law and regulations. Additionally, a domestic violence program must require board members, staff and volunteers to maintain the confidential location of the program if it has not been publicly disclosed or is not generally known.

9. A domestic violence program must comply with all state and federal law governing confidentiality when working with any entity monitoring contracts or conducting audits or site visits. All personal information, including case files, pertaining to those who have sought, received, or been denied services through the program cannot be released to auditors without a signed release of information from the victim. A domestic violence program may also require entities that monitor contracts or audit confidential information to maintain the confidential location of the program if it has not been publicly disclosed or is not generally known.

10. Organizations should have policies and safeguards in place to prevent unauthorized access to information. A program must maintain all records, paper and/or electronic, which contain personally identifying information in a secure manner (e.g., locked storage and data encryption).

11. While traveling, mobile programs must keep a locked box, backpack, or tote of any necessary files. Electronic files must be encrypted to be transported by flash drive, tablet, laptop, or other mobile device. Records should be on the staff’s person at all times and must not be left in vehicles unattended by staff at any time. Mobile advocates should be provided with an agency device to best maintain confidentiality and should not use personal devices for their work.

12. A program must have policies allowing staff and volunteers access to records only as necessary to provide or supervise services, perform contract or audit reporting duties, respond to court orders subject to state law and court decisions, or when they have a Release of Information. In confidentiality policies, programs may identify which specific staff members, as identified by job responsibility and title, will have access to confidential information, records, and information systems.

13. A program should have a policy requiring individuals receiving services to maintain the confidentiality of staff and others who are also involved in the program.

14. A program must have policies and procedures requiring that staff and volunteers’ communications regarding services provided to individuals will occur in private locations and only to further meet the needs of victims. This includes any interagency communications when an appropriate release of information is in place.

15. A program must develop policies ensuring staff and volunteers only disclose personally identifiable information when legally mandated to do so or when they have a release of information. Advocates are only legally mandated to report child abuse and neglect per A.R.S. § 13-3620 (Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors; medical records; exception; violation; classification; definitions).
16. A domestic violence program’s duty to warn policy should only include mental health providers and not victim advocates, as there is no Arizona law requiring advocates to report imminent serious physical harm or death. A domestic violence program that provides mental health services must have policies and procedures for reporting the personally identifying information required when a client communicates “an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat” to the mental health provider (A.R.S. § 36-517.02). The mental health provider must:
   a) Communicate the threat to all identifiable victims when possible;
   b) Notify a law enforcement agency in the vicinity where the patient or any potential victim resides;
   c) Take reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate; and
   d) Take any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

17. A domestic violence program must have policies and procedures preventing staff and volunteers from taking on a role both internally and externally that would compromise federal and state requirements for victim confidentiality and privileged communication. Roles that can compromise confidentiality and privilege include but are not limited to:
   a) Providing interpretation services for a victim with an external agency or non-victim services division of the organization (e.g., law enforcement interviews, conversations with prosecutors);
   b) Holding a position that has different privilege or confidentiality obligations. A helpful guideline is if the other role or position would typically require a signed release of information for someone in that position to know the information an employee or volunteer of a domestic violence program would know, then the program employee or volunteer cannot take on that role and/or become an employee or volunteer while maintaining the other role (e.g., a law enforcement officer cannot volunteer as a victim advocate when off-duty because the information learned as a victim advocate would waive advocate privilege statutes and law enforcement discovery obligations).

18. A domestic violence program must have policies ensuring information about a client’s identities, including but not limited to being LGBTQ+, being a person living with HIV, disability status, immigration status, race, ethnicity, and/or religion, is kept confidential. This information must not be shared with other clients, service providers, parents/guardians, or community partners without a signed release of information.

For Voluntary Services
Voluntary services refers to an individual’s right to choose whether to participate in services, rather than being required to do so. It acknowledges each individual’s personal circumstances.

1. Use of program services by any individual must be on a voluntary basis (42 U.S. Code § 10408 (c)(1)). Individuals shall not be coerced into participating in services or making changes in their lives that are not acceptable to them.
2. With the exception of initial intake, individuals must not be required to participate in one service in order to be eligible for other services.

For Trauma-Informed Services
1. A domestic violence program should use a trauma-informed practice approach to facilitate healing of survivors and avoid re-traumatization. The components of trauma-informed care include, but are not limited to:⁹
   a) Safety: ensuring physical and emotional safety. This includes creating a safe and supportive physical environment, clearly communicating information about services to survivors, and ensuring staff safety.
   b) Trust: maximizing trustworthiness. Trust includes having open and transparent communication with survivors, maintaining clear and appropriate boundaries, prioritizing informed consent, and informing clients about mandatory reporting obligations.
   c) Choice: prioritizing survivors’ choice and control over decisions and healing journeys. Consider incorporating opportunities for survivors to make small choices into all interactions (e.g., drink preference, where they would like to sit) and survivors having choice over how they receive services.
   d) Collaboration: sharing power with survivors. Collaboration includes involving survivors in program planning and evaluation and creating a culture of working “with” and not “for” survivors.
   e) Empowerment: identifying and focusing on strengths, building skills promoting healing and growth. Empowerment includes validating and affirming survivors and working with survivors to reach their goals.
   f) Cultural humility: ensuring cultural applicability of services, sensitive to the role of culture in survivors’ lived experiences and decision making. Cultural humility includes representation of diverse cultures in materials and ensuring access to services regardless of a client’s background or identity.

2. Programs should strive to create a trauma-informed environment in which victims feel comfortable disclosing their needs and concerns pertaining to stigmatized issues, such as mental health, addiction, sex work and/or trafficking history, HIV+ status, gender and/or sexual identities, and other stigmatized identities or behaviors. A victim may or may not need services when they disclose a stigmatized issue or identity. If a victim identifies a need for services, the program should facilitate appropriate service delivery and referrals, and encourage the victim’s ongoing communication with the providers of additional services that may include, but are not limited to:
   a) Alcohol and substance abuse evaluation and education;
   b) Alcohol or substance abuse treatment;
   c) Mental health services;
   d) Healthcare services;

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⁹ Adapted from the Sexual Assault Demonstration Initiative’s Building Cultures of Care: A Guide for Sexual Assault Services Programs: [https://www.nsvrc.org/sites/default/files/2017-10/publications_nsvrc_building-cultures-of-care.pdf](https://www.nsvrc.org/sites/default/files/2017-10/publications_nsvrc_building-cultures-of-care.pdf)
e) Trafficking victim services (sex workers and/or sex trafficking survivors should not be forced to receive trafficking services if they do not wish to receive them);
f) LGBTQ+ support groups and other supportive services (LGBTQ+ victims should not be referred to conversion therapy).

For Cultural Humility

1. A domestic violence program should provide effective and equitable services to all survivors that are appropriate to their unique cultural beliefs, practices, and lived experiences. Cultural differences may include but are not limited to religion, race and/or ethnicity, gender identity, sexual orientation, ability, Deaf or hard of hearing status, geographic location, class, body type, and age. A program should be able to serve all survivors regardless of culture or background.

2. Cultural humility is an active process where programs and staff work to recognize and fix power imbalances and develop partnerships from a stance of humility and curiosity. Cultural humility includes cultural awareness, cultural sensitivity, cultural responsiveness, and cultural relevance:
   a. Cultural awareness is becoming aware of cultural values, beliefs and perceptions different from one’s own.
   b. Cultural sensitivity is being aware that cultural differences and similarities exist without assigning them a value.
   c. Cultural responsiveness is the ability to use information learned, heard, and observed about different cultures to guide services.
   d. Cultural relevance is making long-lasting, foundational, and ongoing changes to services so they are based in different cultural knowledge, experiences, and frames of reference.

3. A program should cultivate respect for and knowledge of how cultural beliefs and differences and oppression impact a survivor’s experience of, response to, and healing from domestic violence.\(^\text{10}\)

4. A program should accommodate all cultural and identity needs to the greatest extent possible. Such needs may include but are not limited to:
   a. Culturally or religiously appropriate food as needed, including a means to prepare kosher and halal meals or to meet specialized dietary requirements such as vegan or vegetarian;
   b. Cultural, religious, and/or gender affirming clothing, grooming, and personal hygiene items (e.g., head scarves/coverings, chest binders\(^\text{11}\), wigs, hair care for different textures);
   c. Culturally-specific healing modalities (e.g., sweat lodges, sage, acupuncture, sanación de brujería)

5. A program should incorporate culturally responsive and respectful language of all people in materials and practices.

\(^{10}\) See appendix “Cultivating Respect and Knowledge of Cultures” and “Cultivating Responsive and Respectful Language” for more information.

\(^{11}\) Compression undergarment to compress breast/chest tissue
6. A program should create policies and practices to protect survivors from bias and harm from other survivors who do not understand or are disrespectful of their culture or identity. This can include but is not limited to:
   a. Making clear the non-discrimination policy applies to all survivors and discriminatory behavior will not be tolerated;
   b. Educating survivors who are engaging in harmful behavior toward other survivors about why this behavior is harmful;
   c. Prioritizing access to services for the survivor being harmed if the survivors need to be separated and/or cannot engage in services at the same time due to one survivor’s harmful behavior (e.g., if there is only one support group provided by the program, the survivor causing harm should be referred to a different, external support group).

7. A program should engage in outreach activities that consider all community members within their service area. This can include specific outreach to LGBTQ+ communities, communities of color, religious communities, and disability communities, among others. Community education about domestic violence done as part of outreach and/or community engagement should also consider cultural humility and the impact of systemic oppression.

8. A program should connect with various communities and populations in their service coverage area and build trust with these communities. A program may do this by outreaching to community leaders and/or groups, participating in community events, and supporting community activities.

9. A program should develop relationships with culturally-specific service providers across different cultures and healing options, when available.

10. A program should require staff to be trained on cultural humility and oppression and how culture, identity, and systemic oppression impact a domestic violence survivor’s experience and healing.

For Staff Well-Being

1. Providing domestic violence services can be difficult and potentially traumatizing for staff. Many people working in sectors addressing domestic violence experience burnout and/or secondary trauma at some point in their career. It is important for domestic violence programs to prioritize staff well-being to ensure the safety and quality of services and keep staff safe and healthy. Individualized self-care is important, but it cannot be maintained without appropriate organizational support.  

2. Domestic violence programs should provide trauma-informed supervision to all staff. Trauma-informed supervision recognizes the impact of trauma in the lives of staff as well as their performance in the workplace. Trauma-informed supervision can include, but is not limited to:
   a. Providing regular supervision on cases and opportunities to debrief difficult cases;
   b. Providing clear and accurate job descriptions, including roles and responsibilities;

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12 For more ways to promote staff well-being in sexual violence programs, see Building Cultures of Care: A Guide for Sexual Assault Services Programs
c. Offering flexible workloads so that direct service staff can pause from providing direct services when experiencing secondary trauma;

d. Holding regular team and staff meetings; and

e. Encouraging staff to take breaks and paid time off.

3. Domestic violence programs should have a policy detailing program capacity and individual staff caseload capacity so staff know when to refer survivors to other staff or domestic violence programs. Individual staff capacity may vary based on role, modality, and type of services provided.

4. Programs should provide staff professional development opportunities, including regular trainings, additional responsibilities as appropriate, and leadership opportunities.

5. Programs should offer fair and competitive salaries and benefits to all staff.

6. All program staff should be trained on self-care and all program leadership should be trained on trauma-informed supervision.

For Activities that Threaten Victim Safety

1. A domestic violence program must refrain from activities that threaten the safety of victims and their children. These include, but are not limited to:

   a) Procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, gender expression, physical and/or mental disability, criminal record, work in the sex industry, or relationship to the perpetrator; or the age and/or gender of their children;

   b) Procedures or policies that compromise the confidentiality of information and privacy of persons receiving services;

   c) Requiring mediation or counseling for couples as a systemic response to domestic violence or sexual assault, or in situations in which child sexual abuse is alleged;

   d) Requiring LGBTQ+ victims to receive conversion therapy or religion-based therapy;

   e) Requiring victims to report sexual assault, stalking, or domestic violence crimes to law enforcement, or forcing victims to participate in criminal proceedings;

   f) Relying on court-mandated batterer intervention programs that use the coercive power of the criminal justice system to hold people who have done harm accountable for their behavior;

   g) Supporting policies or engaging in practices that impose conditions on a victim, such as drug testing, in order for them to receive services.

For the Documentation of Service Provision

This standard for programs’ documentation of policies and procedures, and interconnected standards for confidentiality, are based upon state and federal law. These include A.R.S. Title 12, Chapter 13 and Title 13, Chapter 40, and federal law 34 U.S.C. § 12291(b)(2), 42 U.S.C. §§11363 and 10406(c)(5), 28 C.F.R. § 90.4, and 45 C.F.R. § 1370.4, 28 C.F.R. § 94.115.
1. A domestic violence program must have written policies and procedures to ensure all services provided are documented in written and/or electronic form and these records are maintained in a manner protecting the confidentiality and privacy rights of individuals, groups and/or families receiving services. These policies may include but are not limited to:
   a) Defining documentation of victim services to only include the type(s) of services provided (e.g., lay legal advocacy, information and referrals, medical advocacy), without specific details of services (e.g., safety plan details, specific legal options provided);
   b) Guidance for documentation of mental health services, if provided. A licensed mental health professional should follow the professional guidelines and standards required of their licensing body and applicable state or federal laws;
   c) Requiring all staff to be trained in the program’s documentation policies.

2. A program must have policies allowing access to records only by victim services staff and volunteers as necessary to provide or supervise services, respond to a ROI, and respond to court orders subject to state, federal, and tribal law and court decisions. Programs may enact policies identifying which staff members, as specified by job responsibility and title, will have access to confidential information, records, and information systems.

3. A program should have written policies and procedures to respond to court orders and subpoenas. These policies and procedures should be written or reviewed by an attorney. This policy should include but is not limited to:
   a) Immediate notification of the executive director or appropriate member of leadership regarding the subpoena;
   b) Consultation with an attorney;
   c) Designation of one staff member, usually the executive director, as the “keeper of the records” whose responsibility is to maintain all program and client records and to formally respond to subpoenas;
   d) How the program will communicate with the person whose information is being requested. This should include:
      i. Identifying if the person is currently or has formerly been a client;
      ii. Determining if there is a safe and confidential way to contact the person whose information is being requested, whether they are a current or former client or have never been a client;
      iii. Designating a staff member to contact the person;
      iv. Informing the person of the subpoena, the information requested, all possible options and consequences, and referring for legal advice, if needed;
      v. Informing the person they are legally obligated to disclose the requested information, if the program is required to do so.
   e) How informed consent will be obtained from the person regarding how the program will respond to the subpoena. Clients should be fully informed of all the response options and the potential consequences of disclosing the requested information;

13 Learn more about responding to subpoenas here: https://www.techsafety.org/how-to-respond-to-a-subpoena
i. If the person whose information is being requested cannot be contacted, consider challenging the subpoena.

4. Organizations must have policies and safeguards in place preventing unauthorized access to information. A program must maintain all records containing personally identifying information, paper and/or electronic, in a secure manner (i.e., locked storage and data encryption).

5. While traveling, mobile programs should keep a locked box, backpack, or tote of any necessary files. Electronic files must be encrypted to be transported by flash drive, tablet or laptop. Records must be on the staff person at all times and must not be left unattended in vehicles by staff at any time. Mobile advocates should be provided with an agency device to best maintain confidentiality and should not use personal devices for their work.

6. Programs must enact a policy on record retention that includes how long specific forms are kept, destruction of paper files, and destruction of electronic files. Program administrators should consider the needs of the program and contract requirements when setting the length of time documents are to be kept. When there is no guidance from funders on records retention, it is recommended that case files be destroyed one year or less after a victim is no longer receiving services and files for grant reporting be destroyed after 7 years.\(^\text{14}\)

7. Written and/or electronic records documenting services provided in individual, group and/or family settings must be signed and dated by the staff member or volunteer providing the service.

8. Service recipients must be informed of their rights and allowed to exercise their rights to inspect their personal records and/or files, request changes or additions to the content of those records, submit rebuttal data or memoranda to their files, and/or file a grievance according to the program’s policies if objections are made to the content of those records or files.

9. A program should develop or utilize a data collection and record-keeping system allowing for the safe and efficient retrieval of data needed to measure the domestic violence program’s performance in relation to its stated goals and objectives and the funding received for services. Personal identifying information must not be shared outside of the victim services program without a release of information.

For Traumatic Brain Injury Screening
Domestic violence is a common cause of traumatic brain injury among survivors. Traumatic brain injuries are not hereditary or degenerative and can be temporary or permanent. This includes injuries obtained through deprivation of oxygen (e.g., strangulation)\(^\text{15}\), as well as actions causing the brain to impact the skull (e.g., being forcefully shaken). Traumatic brain injuries can be life-threatening and symptoms may worsen rapidly without intervention.

\(^{14}\) For a sample records retention policy, visit: [https://www.techsafety.org/confidentiality-templates](https://www.techsafety.org/confidentiality-templates)

\(^{15}\) [www.biav.net](http://www.biav.net)
1. TBI can add to the complexity of barriers faced by survivors of domestic violence. While it is not mandatory for agencies to provide screening and services related to TBI, the following practices are strongly recommended:
   a. It is recommended that program staff and volunteers receive basic training on TBI, including common symptoms and possible complications of traumatic brain injuries.
   b. The use of a basic screening tool such as HELPS\textsuperscript{16} is strongly recommended. If there is reason to believe a TBI is present, professional medical screening and services should be considered.
   c. Programs are encouraged to develop community partnerships increasing access to tools and assistance for survivors living with TBI, such as:
      • State or local brain injury associations
      • Local brain injury and rehabilitation service providers
      • Independent living centers

2. Advocates and program staff working with survivors with TBI should utilize a strengths-based approach. Safety planning and other services must account for symptoms of TBI among affected survivors, including memory and concentration deficits, difficulty with abstract thinking, visual and speech impairment, and difficulty completing tasks. Accommodations should be discussed with the survivor and frequently revisited to ensure current needs are being met.

For Training:

1. An initial 30-hour training is required for all program staff who need to meet the requirements of the domestic violence victim advocate privileged communication statute [A.R.S. § 12-2239]. A program may accomplish the initial training through a combination of internal and external resources such as:
   a) Attending The Sharing Experience 40-hour Domestic Violence Core Advocacy training facilitated by the Arizona Coalition to End Sexual and Domestic Violence or an equivalent organization;
   b) One-on-one instruction and discussion with a fully trained, experienced advocate or supervisor;
   c) Shadowing a fully trained, experienced advocate performing job duties, such as hotline coverage and intake procedures;
   d) A practicum – defined as a supervised activity meant to develop or enhance the trainee’s ability to provide direct services. This is to be followed by a minimum of 8 hours of ongoing training annually.

2. Employees and volunteers shall be provided a training manual. Training topics should include, at minimum:
   a) A framework for understanding the nature and dynamics of domestic violence that includes, but is not limited to:
      i. Types and prevalence of domestic violence;
      ii. The relationship between violence and other tactics of control;
      iii. Survival strategies and barriers to leaving an abusive relationship;

\textsuperscript{16} https://abitoolkit.ca/assets/images/HELPS-tool.pdf
iv. Victims who remain in contact with their partners;  
v. Characteristics of people who commit domestic violence and societal influences on this behavior;  
vi. Neurobiology of trauma;  
vii. The traumatic impact of domestic violence, including social, physical, financial, and psychological impacts;  
viii. The complex effects of domestic violence on children and families;  
ix. The role of society in perpetuating gender-based violence and the social changes necessary to eliminate it, including the elimination of discrimination based on ethnicity, color, gender identity, age, sexual orientation, disability, substance abuse, economic or educational status, religion, HIV/AIDS or health status, or national origin.

b) Domestic violence advocacy and case management:  
i. The role of the advocate;  
ii. Hospital/medical advocacy;  
iii. Legal advocacy;  
iv. General advocacy;  
v. Hotline advocacy;  
vi. Systems coordination, including the definition and role of a Coordinated Community Response Team (CCRT);  
vii. Considerations of cultural humility which may include serving: people with disabilities, LGBTQ+ individuals, Black, Indigenous and People of Color (BIPOC), older individuals, men, and more.

c) Advocacy and empowerment for victims that includes, but is not limited to:  
i. Victim-defined advocacy;  
ii. Trauma-informed care;  
iii. Healing-centered care;  
iv. Trauma-informed intake;  
v. Safety planning including short- and long-term strategies;  
vi. Confidentiality and ethical service provision;  
vii. Privileged communication and mandatory reporting;  
viii. Working with victims in crisis;  
ix. Medical options for victims, including medical forensic exams and other health care;  
x. Criminal and civil legal options for victims, including Victim Rights;  
xi. Documentation of services;  
xii. Maintaining appropriate boundaries;  
xiii. Appropriate resource and referral information.

d) Related topics including but not limited to:  
i. The organization’s history and mission statement;  
ii. History of the anti-domestic violence movement;  
iii. Volunteer opportunities;  
iv. Specific program policies and procedures;  
v. Suicide risk assessment;  
vi. Strangulation assessment;  
vii. Traumatic brain injury;
viii. Secondary/vicarious trauma and burnout;
ix. Self-care.

3. Recommended continuing education and additional training topics include but are not limited to:
   a. Serving LGBTQ+ Survivors of Domestic Violence
   b. Serving Survivors Living with HIV
   c. Responding to Domestic Violence Survivors with Disabilities
   d. Serving Black Survivors of Domestic Violence
   e. Serving People of Color who are Survivors of Domestic Violence
   f. Serving Latinx Survivors of Domestic Violence
   g. Serving Older Domestic Violence Survivors
   h. Responding to Survivors of Intimate Partner Sexual Violence
   i. Responding to Male Survivors
   j. Serving Immigrant Survivors of Domestic Violence
   k. Advanced Emotional and Sexual Safety Planning
   l. Serving Indigenous & Native Survivors of Domestic Violence
   m. Serving Child Survivors of Domestic Violence
   n. Serving Survivors of Human Trafficking
   o. Adverse Childhood Experiences (ACEs)
   p. Financial Empowerment
   q. Serving Survivors with Traumatic Brain Injuries

4. Programs shall be aware of and comply with additional training requirements of funders, local, state and federal laws and accreditation and professional bodies.

For the Use of Volunteers

1. A domestic violence program may use unpaid volunteers to augment the program’s services.
   a. A program must have written policies and procedures regarding the recruitment, screening, training, recognition, supervision and dismissal of volunteers who provide services. Such policies will clarify volunteers’ roles and responsibilities, with specific details concerning professional boundaries, disclosure, and how, when, where and at what frequency volunteers will be used.
   b. A program should not use volunteers whose external occupation has different privilege or confidentiality obligations than those of the program or the role for which they are volunteering.

2. A program must have a written job description for each volunteer position that follows the format of job descriptions for staff members. Job descriptions are to be provided to volunteers upon acceptance in the program, unless requested beforehand.

3. Per A.R.S. § 12-2239: Domestic violence victim advocate; privilege; training; exception; definition: “a domestic violence victim advocate who is a volunteer shall perform all activities under qualified supervision.” The volunteer must also meet the training requirements set forth in the “For Training” section on page #.
4. A program shall maintain a confidential file for each volunteer including, but not limited to, the volunteer’s application, fingerprint clearance card with the Arizona Department of Public Safety as applicable, criminal background check as applicable, licensures and certifications as applicable, reference checks, a signed confidentiality statement, and a record of all trainings completed by the volunteer.

5. Programs shall be aware of and comply with additional background check/screening requirements of funders as well as local, state and federal laws that apply to volunteers. Per A.R.S. § 46-141 (Criminal Record Information checks; fingerprinting employees and applicants; definition), volunteers who provide services directly to juveniles or vulnerable adults must possess a fingerprint clearance card, unless they are under the direct visual supervision of a trained staff member. Volunteers who provide services to juveniles or vulnerable adults in a shelter setting must possess a fingerprint clearance card regardless of direct supervision.

6. A program will use a volunteer training manual that is supplemental to the volunteer training.

7. Volunteers may be used in the provision of direct services to victims, based upon the training and qualifications of the volunteer, including but not limited to:
   a. Facility coverage, hotline coverage, crisis intervention, case management, medical advocacy, court advocacy, support group facilitation for adults and/or children, professional therapy intake or assessment of service needs, and development or implementation of service plans;
   b. Transportation or accompaniment;
   c. Recreational activities for adults and/or children;
   d. Services related to educational achievement, job readiness, job training and/or other assistance in obtaining employment.

8. Volunteers may be used in the provision of non-direct services, including but not limited to:
   a. Administrative duties;
   b. Fundraising or other activities for obtaining donations to the program;
   c. Event organizing;
   d. Outreach;
   e. Public speaking upon completion of domestic violence training and supervision;
   f. Maintenance or other activities related to the upkeep and improvement of program facilities.

9. Evaluations of both the volunteer program and its volunteers should be conducted to ensure quality of services.
By Service Modality

Definitions

Services can be provided in a variety of settings:

**On-site Emergency Shelter:** Shelter is temporary emergency housing and related supportive services provided in a safe, protective environment for individuals and their children who have experienced domestic or sexual violence.

**Hotel/Motel Emergency Shelter Placement:** Hotel/motel emergency shelter is temporary housing and related supportive services provided in a safe, protective environment for individuals and their children who have experienced domestic or sexual violence. Hotel/motel shelter placement is an alternative to emergency shelter when on-site shelter placement is not viable.

**Housing Interventions:** Housing interventions vary in the length of time they may be offered. Transitional housing is longer-term than shelter, usually ranging from six months to two years, but is not permanent housing. Rapid re-housing and Housing First are programs that emphasize getting individuals and families into independent housing in the community as quickly as possible, with wrap-around support services accompanying the housing.

**Systems-based:** Systems-based victim services are services provided by advocates employed by a law enforcement agency, prosecutor’s office, court or other entity within the city, county, state, or federal government. These services assist victims as they proceed through legal systems. Systems-based victim services enhance victims’ access to the criminal justice system, empower victims to have a voice in the system, and coordinate services to promote victims’ safety and well-being. An advocate providing systems-based victim services acts as a liaison between victims and legal systems. It should be noted that prosecutors’ goals can vary from those of victims, and advocates should assist victims in navigating that conflict.

**Community-based:** Community-based services are those offered within the community by a non-governmental entity, typically a non-profit service provider. For example, a domestic violence program might have an advocate stationed at an Outreach Office, Medical Facility, or Community Health Center, or one of these entities might directly employ an advocate. This includes services embedded in a community or grassroots program, as well as mobile advocacy.

**Mobile Advocacy:** Mobile advocacy is provided in a location that is best suited to the victim seeking the service. This could include the victim’s home, a park, restaurant, library, a government facility, a crime scene, or a workplace, among many potential locations. Efforts should be made to ensure confidentiality is maintained when meeting in public spaces, and victims should know the risks associated with different meeting locations. Mobile advocates will maintain materials and records on their persons.

**Virtual and Digital Advocacy:** Virtual and digital advocacy includes services occurring via telephone, video call, online chat, video conference, text messaging, and other modalities that are not in-person. Services provided in this manner are critical to expanding the geographic reach of programs and increasing accessibility for survivors, particularly those with disabilities and/or without access to transportation.
**Family Advocacy Center:** Family advocacy centers (FACs) are centers where representatives from multiple disciplines, including victim advocates, forensic examiners, law enforcement, and child protection professionals, among others, work together to respond to survivors of sexual and domestic violence. FACs may be referred to as “one-stop shops” for survivors, as they are designed to minimize the number of times a survivor must share their victimization experience with multiple responders or travel to different agencies to receive care and/or report a crime. Most FACs serve adult and child victims. FACs are an expansion of the child advocacy center (CACs) model. CACs only serve children. FACs may be community-based or systems-based programs, as they may be nonprofits or government owned and operated.

**Campus-based:** Campus-based services are those offered at college and university campuses, including community colleges and trade schools. Campus-based services are specifically designed to serve a student population and are physically located on or near the school. Campus-based services may be owned and operated by the school or may be a partnership between a community-based program and a school.

**For On-site Emergency Shelter**

1. On-site emergency shelter should provide access, admittance, and residence in temporary shelter for victims of domestic and sexual violence and their children 24-hours-a-day, every day of the year, pending bed availability.

2. An on-site emergency shelter shall have a property review protocol that includes:
   a. Regular inspections and preventative maintenance of the facilities;
   b. Compliance with Occupational Safety and Health Administration (OSHA) standards;
   c. Compliance with state and local health sanitation and fire codes;
   d. Compliance with Certificates of Occupancy; and
   e. Compliance with the Americans with Disabilities Act.

3. An on-site emergency shelter should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away;
   b. Publish days and hours of operation in which services will be accessible (e.g., case management, support groups);
   c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
   d. Not require a victim to report to law enforcement to receive services;
   e. Follow state-mandated reporting laws (i.e., child abuse);
   f. Not require criminal background checks on program participants;
   g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed;
   h. Not require participation in religious groups or use religious materials;
   i. Programs should participate in a centralized domestic violence program intake process in communities in which such intake processes exist;
   j. Maintain the safety and security of residents as described in the program’s policies;
k. Ensure that crisis intervention services are accessible, available and offered 24-hours-a-day, every day of the year, with trained staff/volunteers available to provide emergency services;
l. Provide free food, emergency clothing and personal hygiene items for residents and their children;
m. Provide culturally or religiously appropriate food as needed, including a means to prepare kosher meals or to meet specialized dietary requirements such as vegan or vegetarian;
n. Consider cultural or religious preferences in providing clothing and personal hygiene items;
o. Provide at least one telephone for incoming and local outgoing calls available for residents’ use;
p. Have access available for residents to make reasonable long-distance phone calls to seek support, employment, or relocation, and to share documents as needed;
q. Have a protocol in place for answering the phone, taking messages for residents, and maintaining residents’ confidentiality.

4. On-site emergency shelters must create policies and procedures to support survivors with personal care attendants. If a survivor needs a personal care attendant, but does not have one, it is recommended to contact your local Independent Living Center for assistance.¹⁷

5. On-site emergency shelter should provide education and information about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial and psychological impacts;
      a) The traumatic impact of domestic violence on children;
      b) Safety planning that includes short- and long-term strategies;
      c) Civil and criminal legal options including Victim Rights;
      d) Healing modalities and options; and
      e) Referrals to medical forensic exam facilities, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

6. An on-site emergency shelter program should arrange transportation for a resident’s child to attend school or connect the resident to the Homeless Liaison in the School District per the McKinney-Vento Homeless Assistance Act. If possible, the shelter program should provide transportation for a child to participate in extracurricular activities.

7. An on-site emergency shelter program should provide recreational and educational activities/opportunities for children and their parents.

8. An onsite emergency shelter should ensure that staff members:
   a) Have face-to-face contact with a newly admitted resident upon arrival to determine emergency needs;

¹⁷ Arizona Regional Independent Living Centers
b) Initiate a face-to-face intake process either in-person or virtually, based on the resident’s preference, within 24-hours of the resident’s admission;

c) Provide each resident with information about shelter policies that include, but are not limited to:
   i. Confidentiality rights and agreements, including records and accessibility;
   ii. Release of information options;
   iii. Resident Guidelines;
   iv. Resident rights, including grievance procedures;
   v. The development of an individual or family plan of self-defined needs and actions that address needed services and assist in maintaining safety.

d) Are trained in the dynamics of communal living including, but not limited to:
   i. Trauma-informed principles;
   ii. Conflict resolution;
   iii. Facilitating group dynamics; and

9. On-site emergency shelters should create a welcoming and inclusive environment in which all survivors are empowered to identify and access the support and resources they need. The shelter must not discriminate against or “screen out” survivors based on their substance use or abuse. On-site emergency shelters should be fully accessible regardless of a person’s substance use.¹⁸

10. Staff and volunteers should never store or dispense medication or monitor how survivors access medications. An on-site emergency shelter should have a written policy for the safe storage of medication that includes:²
   a) Requiring that medications are secure;
      i. The on-site emergency shelter should provide every survivor with an individual locking box, locker, or locking cabinet for storage of medications and valuables.
   b) Residents’ right to have access to their medication;
      i. The on-site emergency shelter must not limit or monitor the survivor’s access to their locked space, such as holding the key in the office.
   c) Safe and secure storage of medications needing refrigeration; and
   d) Disposal of medications abandoned by residents, including documenting the name of the drug, the name of the staff person responsible for its disposal, and the amount, method, time and date of disposal.

11. An on-site emergency shelter should have resident guidelines that promote communal living. These guidelines should use a trauma-informed approach and avoid re-creating the power dynamics present in abusive relationships. Resident guidelines should be evaluated annually to identify oppressive practices and unnecessary limitations. These guidelines may include, but are not limited to:

¹⁸ National Center on Domestic Violence, Trauma & Mental Health
a) Regularly scheduled community meetings to facilitate communal living; while it is strongly recommended that residents attend, a resident shall not be penalized for non-attendance;
b) No requirement for residents to provide services for the shelter, including housekeeping chores, in order to receive safe housing or other services;
c) A suggested time to return in the evening; residents should not be refused entry, withheld services, or receive other penalties for not returning by the suggested time; the issue shall be addressed on an individual basis, with focus on the victim’s individual needs.

12. On-site emergency shelter programs are encouraged not to report residents to the police for minor crimes that are consistent with trauma responses of survivors and can be handled internally at the organization.

13. An on-site emergency shelter must establish a flexible length-of-stay policy that balances victims’ needs with the program’s ability to meet those needs.

14. Programs should have trauma-informed policies and procedures regarding the possession and handling of weapons in their program. Survivors should not be shamed or judged for ownership of a weapon. All individuals, especially individuals escaping harm, have a right to safety and self-determination regarding their security. Policies and procedures should:
   a. Identify what items are and are not considered weapons. Consider classifying firearms, mace, pepper spray, tasers, knives, and personal protection key chain attachments as weapons;
   b. Include individual rules and procedures for different types of items considered weapons;
   c. Identify a response for survivors who request assistance in obtaining personal safety items;
      i. In situations where survivors ask for personal safety items, it is recommended programs provide flexible funding so the survivor can purchase items that support their sense of safety and security.
   d. Detail if, when, and how searches of client’s possessions may be conducted if possession of prohibited weapons is suspected;
   e. Inform clients of what is considered a weapon and all weapons policies, and clearly list any prohibited items during intake and before entrance into shelter.

15. Programs should strive to create a trauma-informed environment in which victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services including but not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment; and
   c. Mental health services.
16. If the on-site emergency shelter is full, staff should assist individuals requesting emergency shelter with obtaining other temporary shelter. The required minimum assistance to be offered by shelter staff consists of information and referrals to other safe shelters and notice of the resident’s right to call back for additional assistance.

17. An on-site emergency shelter shall have clear written policies in plain language related to involuntary termination of shelter services, including the right to appeal. Policies should be consistent with a trauma-informed approach and clearly communicated.

18. An on-site emergency shelter should offer recreational, life-skill-building social activities or groups for resident children at least once a week. Group services may include, but are not limited to:
   a. Safety planning;
   b. Active listening;
   c. Domestic and sexual violence education and prevention;
   d. Problem solving; and
   e. Identifying and expressing emotions.

19. An on-site emergency shelter must provide accommodations for survivors with service animals and should provide accommodations for emotional support animals and all other pets. An on-site emergency shelter should:
   a. Create policies and procedures supporting survivors and their pets including but not limited to:
      i. Safety planning;
      ii. Co-sheltering (e.g., in-room agreement, pet shelter agreement);
      iii. Liability waiver;
      iv. Pet sitter agreement (i.e., supervision of the pet when the survivor is not at the shelter); and
      v. Expectations while pets are in shelter.
   b. Educate staff on how to provide pet-inclusive services including but not limited to:
      i. Safety planning;
      ii. Dynamics and prevalence related to the intersection of pet abuse and domestic violence;
      iii. Supporting animal traumatic responses (e.g., excessive barking, biting); and
      iv. Healing with survivors and their pets (e.g., spending time together, going on walks).
   c. Have strong partnerships with local pet welfare agencies and veterinarians.

For Motel/Hotel Emergency Shelter Placement

1. Motel/hotel emergency shelter placement is a source of safe shelter and should provide services comparable to those offered in the on-site emergency shelter. Gender cannot be a determining factor to place someone in emergency motel/hotel shelter unless that need is identified by the participant.
2. Motel/hotel emergency shelter may be used by residential programs in circumstances that include, but are not limited to:
   a. The on-site emergency shelter is full;
   b. The distance between the person seeking shelter and the shelter precludes immediate access to the facility;
   c. The person seeking shelter has unique needs best served by a motel/hotel placement, with such victims receiving equal access to services; or

3. Motel/hotel emergency shelter placement by domestic violence programs should also abide by the policies contained in these standards and ensure that confidentiality extends to the motel/hotel where an individual or family is residing:
   a. Inform participants in a motel/hotel placement of information shared with the motel/hotel, if necessary;
   b. Alternatively, create agreements with the motel/hotel provider regarding confidentiality of participants in the program.

For Housing Interventions
1. Transitional housing, transition-in-place and rapid re-housing are intervention strategies that differ in length of time needed to re-establish a safe and independent household. They also vary in strategies needed to achieve self-sufficiency and in the amount of supportive services needed.

2. Domestic violence housing intervention services may be provided through any of the following types of housing:
   a. Organization-owned or leased;
   b. Organization-owned and managed by a property management company;
   c. Co-located with the emergency shelter;
   d. Government supported;
   e. Privately-owned, one location; and
   f. Privately-owned, more than one location/scattered site.

3. A housing intervention program should have clear, written policies regarding the following:
   a. Flexible length-of-stay policy that balances victims’ needs with the program’s ability to meet those needs;
   b. An established application and acceptance process to identify eligible residents, including eligibility criteria;
   c. Consideration of how to best support participants who face barriers to independent housing related to their credit and/or criminal history;
   d. Prior participation in victim services shall not be a requirement to be eligible for housing intervention services;
   e. Victims shall not be required to be “clean and sober” or compliant with medication or treatment plans in order to be accepted into a housing intervention program;
   f. Residents should be fully informed of their rights and responsibilities;
   g. Confidentiality, privileged communication, and mandator reporting; and
   h. Providing resources and referrals.
4. A domestic violence housing intervention program should:
   a. Inform residents about how to obtain 24-hour crisis intervention services;
   b. Provide referrals for free emergency food, clothing and personal hygiene items for residents and their children;
   c. Provide referrals to ensure that services are available to children as needed;
   d. Provide voluntary educational opportunities and information including but not limited to:
      i. Safety planning;
      ii. Housing stability planning;
      iii. Landlord/tenant responsibilities;
      iv. Legal options;
      v. Financial empowerment; and
      vi. The nature and dynamics of domestic violence.
   e. Provide financial empowerment information including but not limited to:
      i. Job training;
      ii. Financial literacy;
      iii. Social Security Administration;
      iv. Public assistance or other available income supports;
      v. G.E.D. classes;
      vi. Resources for higher education;
      vii. Maintaining tenancy; and
      viii. Childcare.

5. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim's identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim's ongoing communication with providers of additional services that may include, but are not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment; and
   c. Mental health services.

6. A housing intervention program should adhere to organizational and service standards found in other sections of this manual if those services are provided.

7. A lease required in a housing intervention program should, whenever possible, be taken out in the name of the victim, to assist them in beginning to build a positive rental and credit history. When a lease must be placed in the program’s name, it should be transferred to the victim’s name at the earliest opportunity.

8. A scattered-site housing intervention program should include mobile advocacy to reduce barriers to supportive services. Mobile advocacy meetings shall be at safe locations in the community as agreed upon by the victim and advocate.
9. Advocates should have training about legal protections for victims under VAWA, the Fair Housing Act, Arizona state law and local ordinances in the event that advocacy is needed for victims in housing programs.

10. Advocacy services should include advocating with property managers for additional security measures as needed.

For Systems-Based Victim Services

1. Systems-based victim advocates should be trained to provide the following services:
   a. Education about domestic violence dynamics and traumatic impacts;
   b. Education regarding victim rights, including assisting the victim in asserting their rights throughout the criminal justice process;
   c. Education about the criminal justice process and options;
   d. Education about civil legal processes and options;
   e. Education and assistance with victim compensation and other economic recovery options;
   f. Court accompaniment;
   g. Assistance with a victim impact statement;
   h. Assistance with obtaining orders of protection or injunctions against harassment;
   i. Assistance with safety planning;
   j. Considerations of cultural humility, which may include serving: people with disabilities, LGBTQ+ individuals, Black, Indigenous, and people of color (BIPOC), immigrants, older individuals, men, and more;
   k. Referrals to community-based programs that address other victim needs; and
   l. Follow up contact as needed after case disposition.

2. Advocates providing systems-based victim services are not attorneys and cannot provide legal advice, which should be made clear to the victim at the start of services.

3. Systems-based victim services may also be mobile. Systems-based victim services providing mobile advocacy should have clear, written policies regarding:
   a. The use of technology, including the use of passcodes, keeping software up-to-date, appropriate security settings, and not sharing devices. It is strongly recommended that mobile advocates be provided with agency devices and never use personal devices to deliver services due to confidentiality risks;
   b. How to determine meeting locations, prioritizing the safety of the victim and the advocate; and
   c. The transport of confidential files.

4. Advocates providing systems-based services should adhere to standards of crisis intervention, case management, and lay legal advocacy, as appropriate.

For Community-Based Advocacy

1. A domestic violence community-based program should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away;
   b. Publish days and hours of operation in which services will be accessible;
c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
d. Not require a victim to report to law enforcement to receive services;
e. Follow state-mandated reporting laws (i.e. child abuse);
f. Not require criminal background checks on program participants;
g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed; and
h. Not require participation in religious groups or use religious materials.

2. A community-based program should provide education and information to victims about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial, and psychological impacts;
   d. Safety planning that includes short- and long-term strategies;
   e. Civil and criminal legal options, including Victim Rights;
   f. Healing modalities and options; and
   g. Referrals to medical forensic exam facilities, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

3. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services that may include, but are not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment;
   c. Mental health services.

4. If the program is at capacity, staff should assist individuals requesting services with referrals to other safe programs and provide notice of the victim’s right to call back for additional assistance.

5. A program should have clear written policies related to involuntary termination of services that are clearly communicated to the participants. Policies should be consistent with a trauma-informed approach to providing services.

For Mobile Advocacy
1. A domestic violence mobile advocacy program should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away if appropriate for the program;
   b. Publish days and hours of operation in which services will be accessible, as well as the service area of the program;
c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
d. Not require a victim to report to law enforcement to receive services;
e. Follow state mandated reporting laws (i.e. child abuse);
f. Not require criminal background checks on program participants;
g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed; and
h. Not require participation in religious groups or use religious materials.

2. A mobile advocacy program should provide education and information to victims about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial and psychological impacts;
   d. Safety planning that includes short- and long-term strategies;
   e. Civil and criminal legal options, including Victim Rights;
   f. Healing modalities and options; and
   g. Referrals to medical forensic exam facilities, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

3. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services that may include, but are not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment;
   c. Mental health services.

4. A mobile advocacy program should have clear, written policies regarding:
   a. The use of technology, including using passcodes, keeping software up-to-date, appropriate security settings, and not sharing devices among staff. It is strongly recommended that mobile advocates be provided with agency devices (e.g., mobile phones, laptops, tablets) and never use personal devices to deliver services due to confidentiality risks;
   b. How to determine meeting locations, prioritizing the safety of the victim and the advocate; and
   c. The transport of confidential files.

5. If the program is at capacity, staff should assist individuals requesting services with referrals to other safe programs and provide notice of the victim’s right to call back for additional assistance.

6. A program should have clear written policies related to involuntary termination of services that are clearly communicated to the participants. Policies should be consistent with a trauma-informed approach to providing services.
For Virtual and Digital Advocacy

1. A domestic violence virtual and digital advocacy program should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away if appropriate for the program;
   b. Publish days and hours of operation in which services will be accessible, as well as the service area of the program;
   c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
   d. Not require a victim to report to law enforcement to receive services;
   e. Follow state mandated reporting laws (i.e. child abuse);
   f. Not require criminal background checks on program participants;
   g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed; and
   h. Not require participation in religious groups or use religious materials.

2. A virtual or digital advocacy program should provide education and information to victims about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial and psychological impacts;
   d. Safety planning that includes short- and long-term strategies;
   e. Civil and criminal legal options, including Victim Rights;
   f. Healing modalities and options; and
   g. Referrals to medical forensic exam facilities, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

3. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services that may include, but are not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment;
   c. Mental health services.

4. A domestic violence virtual advocacy program should have adequate technological safety measures in place. This includes, but is not limited to:
   a. Procedures should clearly indicate which digital platforms (e.g., Zoom, Skype) and forms of communication (e.g., text messages, video chat) are allowable for service provision and the types of services that may be conducted virtually (e.g., general advocacy, support groups);
   b. Policies that minimize data collection (e.g., caller ID, IP address, contact information) that a digital vendor may require to use the service. Policies should include how this information will be destroyed if it is necessary to use the service and/or how settings should be adjusted.
on the virtual platforms so that minimal information is collected and saved instead of the default (e.g., disabling saving of the chat transcript);
c. Selecting a vendor that only collects necessary data to conduct the service and does not retain this data after the service has ended;
d. Policies regarding when it is safe to leave voicemails and how to call survivors back safely;
e. Policies that cover the frequency of deleting chat and text histories. Many platforms store entire conversation histories. Best practice is to delete the chat history after every conversation ends and inform the survivor how they may delete the chat or text history on their end. Consider using a vendor that automatically deletes conversation history at the end of each conversation;
f. Informing survivors of potential risks of virtual services (e.g., interception, data privacy) and how to safety plan around them;
g. Having strong passwords on agency devices (e.g., computers, tablets, phones);
h. Using agency devices, rather than personal devices, to conduct services; and
i. Developing clear organizational policies related to privacy, safety, and confidentiality when providing virtual services, and providing and explaining these policies to survivors in clear language.

5. To minimize miscommunication that can occur with digital communication, staff and volunteers should receive training on active listening and online communication styles.

6. Survivors should be supported to make informed decisions about the use of technology and the services they receive. The following best practices are strongly encouraged:
   a. Safety plans should include issues arising from the use of platforms being used for services;
   b. Creating opportunities for survivors to learn and increase comfortability around technology as part of case management;
   c. The survivor should always have the liberty to refuse the use of digital services, or make changes within the scope of the agencies services as necessary; and
   d. Satisfaction with digital services should be included as a part of program evaluations

7. If the program is at capacity, staff should assist individuals requesting services with referrals to other domestic violence programs and provide notice of the victim’s right to call back for additional assistance. When determining capacity, it is important to note that often virtual services may take longer or more of staff time than other types of traditional in-person services given the nature of online chat and text conversations.

8. Virtual advocacy programs that provide specific services (e.g., virtual support groups, virtual helpline) should follow the appropriate standard by service type.

For Campus-Based Advocacy

1. A domestic violence campus-based program should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away;
   b. Publish days and hours of operation in which services will be accessible;
c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
d. Not require a victim to report to law enforcement to receive services;
e. Follow state mandated reporting laws (i.e. child abuse);
f. Not require criminal background checks on program participants;
g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed; and
h. Not require participation in religious groups or use religious materials.

2. A campus-based program should provide education and information to victims about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial, and psychological impacts;
   d. Safety planning that includes short- and long-term strategies;
   e. Medical options following domestic violence;
   f. Civil and criminal legal options, including Victim Rights;
   g. Title IX and Clery Act options and accommodations;
   h. Healing modalities and options; and
   i. Referrals to medical forensic exam facilities, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

3. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services that may include, but are not limited to:
   a. Alcohol and substance abuse evaluation and education;
   b. Alcohol or substance abuse treatment;
   c. Mental health services.

4. A campus-based domestic violence program that is owned and operated by the education institution (i.e., where the staff are employees of the educational institution), should have clear, written policies in line with their professional and funding-related requirements regarding:
   a. Confidentiality, which must align with federal, state, and tribal laws. Many educational institutions may designate certain school employees and faculty as mandated reporters of instances of domestic and sexual violence to school officials. Employees and volunteers of a campus-based domestic violence program should not be designated as mandated reporters of this nature. Employees and volunteers of a campus-based program should only be mandatory reporters when statutorily designated (i.e., in instances of reported child abuse) and cannot report personally identifying information of victims regarding domestic violence cases to the school. Campus-based programs may report data in the aggregate to the school related to demographics and total number of victims served so long as it is not personally identifying information.
b. When the educational institution or an employee of the educational institution is a defendant in a sexual violence or harassment civil or criminal case, the educational institution, including the campus-based domestic violence program, should have policies and procedures in compliance with the VAWA Code of Federal Regulations (28 C.F.R. 90.4(b)(2)(iii)) confidentiality requirements. This includes not disclosing information from the victim services division or components of an organization, agency or government to other non-victim service divisions of the organization, agency or government nor to the leadership of the organization, agency or government. Campus-based programs may still be subjected to case depositions and subpoenas. A campus program owned and operated by an educational institution should also explain the potential confidentiality risks relating to that ownership and operation and be prepared to refer victims to a local, non-campus-based domestic violence program, if needed.

5. A campus-based program that is not owned and operated by the educational institution (e.g., a community-based program with a satellite office on campus, a program that contracts with the educational institution) should have clear, written policies regarding:
   a. Confidentiality that are in line with federal, state, and tribal laws. The campus-based program cannot share personally identifying information with the educational institution without a signed and dated release of information or when legally mandated to do so. Contractual obligations with the educational institution cannot supersede federal, state, or tribal confidentiality laws.

6. If the program is at capacity, staff should assist individuals requesting services with referrals to other domestic violence programs and provide notice of the victim’s right to call back for additional assistance.

For Family Advocacy Centers
1. A family advocacy center should:
   a. Participate in a screening process that ensures victims who report they are victims of domestic violence are properly screened and not turned away;
   b. Publish days and hours of operation in which services will be accessible;
   c. Provide services to individuals on a voluntary basis and not require victims to participate in any services;
   d. Not require a victim to report to law enforcement to receive advocacy or a forensic exam;
   e. Follow state mandated reporting laws (i.e., child abuse);
   f. Not require criminal background checks on program participants;
   g. Ensure victims have access to an advocate, as desired, including partnering with other service providers when needed; and
   h. Not require participation in religious groups or use religious materials.

2. Family advocacy centers should provide education and information to victims about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, financial, and psychological impacts;
d. Safety planning that includes short- and long-term strategies;

e. Medical options following domestic violence;

f. Civil and criminal legal options, including Victim Rights;

g. Healing modalities and options; and

h. Referrals to community-based advocacy programs, medical and mental health resources, basic needs, culturally-specific services, and other services as needed.

3. Programs should strive to create a trauma-informed environment where victims feel comfortable disclosing their needs and concerns pertaining to mental health and addiction. Upon a victim’s identification of needed services, a staff member shall facilitate service delivery and referrals, and encourage the victim’s ongoing communication with providers of additional services that may include, but are not limited to:

   a. Alcohol and substance abuse evaluation and education;

   b. Alcohol or substance abuse treatment;

   c. Mental health services.

4. If the family advocacy center is at capacity, staff should assist individuals requesting services with referrals to other domestic violence programs and provide notice of the victim’s right to call back for additional assistance.

5. Family advocacy centers that serve minors should be in good standing with and accredited by the National Children’s Alliance.
For Service Type
For Crisis Line

1. A crisis line, hotline, or helpline is a phone- or computer-based response operated by a domestic violence program. Crisis lines provide a way for survivors, secondary survivors, and community members who have difficulty accessing in-person resources to connect with services. They also allow for survivors to access support while maintaining some level of anonymity. To ensure effectiveness and a trauma-informed response, it should include the following elements:
   a. A crisis line number and other relevant contact information (e.g., phone number, online chat link, and text line number, if different than the phone helpline) that is widely disseminated and available through a variety of media. It is recommended that hours of operation be included in the information shared. Additionally, it is recommended programs clearly state services are free of charge and available in other languages and Text Telephone (TTY) (when applicable).
   b. The use of caller-identification equipment or services should be used with discretion and in the spirit of anonymity. If caller-ID is used (or other personally identifying information), the log should be cleared at the end of each shift or business day. Ideally, a caller-ID system will be disabled on the platform being used.
   c. If chat or mobile applications such as text are being used to communicate with a survivor, all logs and data should be purged regularly or set to delete automatically by default.

2. The crisis line must be answered by a program staff member or volunteer who has had domestic violence crisis intervention training. In addition to this training, advocates should be trained on:
   a. Ways to provide empathetic and nonjudgmental support on the crisis line through multiple platforms;
   b. Safety planning;
   c. Medical, legal, and other resources and options;
   d. Ways to self-regulate in terms of tone, pacing, and volume as applicable;
   e. The program’s phone intake and data collection policies and procedures;
   f. The program’s additional policies and procedures regarding helpline advocacy.

3. Best practice is that crisis line services should be available 24-hours-a-day and seven-days-a-week.
   a. If this is not possible, programs should develop policies and procedures to maximize consistent coverage between business hours, including partnering with other domestic violence, sexual violence, and/or multi-service organizations.

4. To provide crisis line services, programs should at a minimum engage in the following activities:
   a. Assess the caller’s critical needs;
   b. Listen to and validate the caller’s experience and choices;
   c. Provide emotional support;
   d. Support safety planning (emotional, physical, and sexual);
   e. Provide information and referrals to available agency and community resources.

5. Crisis lines should also be structured in ways that:
a. Are adequately staffed and allow staff to give sole and immediate attention to survivors needing support;

b. Allow advocates to respond to the crisis line (e.g., calls, text, chat) in a confidential location, as not to be overheard by non-staff or volunteers;

c. Are responsive to survivors of all genders:
   i. Staff should not assume someone’s gender over the crisis line. This includes judging the caller’s voice or tone in association with a certain gender.
   ii. It is recommended that staff introduce themselves with their names and pronouns when responding to callers on the helpline and then ask their caller for their name and pronouns.
   iii. When providing crisis line services, advocates should take care to mirror and repeat the terms survivors use to identify themselves, their identities, and experiences as appropriate.
   iv. Advocates should speak in plain language when providing crisis line services.

d. Are flexible to the needs of domestic violence survivors. There should be no suggested time length and/or number of times a survivor can access crisis line services. Crisis line services should be available to all survivors despite the frequency or infrequency of its use by a particular person;

e. Recognize active listening may be the only service requested or needed; and

f. Acknowledge procedures may vary for culturally and linguistically-specific services and specific populations of survivors.

6. Victims of domestic violence who are D(d)eaf or hard of hearing, or otherwise have a disability affecting their ability to communicate, must have equal access to the domestic violence crisis line/chat/text using an assisted listening or visual device or other form of electronic communication.
   a. TTY-based Telecommunications Relay Services permit persons with a hearing or speech disability to use the telephone system via a text telephone or other device to call persons with or without such disabilities. Survivors who are D(d)eaf or hard of hearing may accesses a helpline by dialing 711, the national relay service number. It is also recommended that programs use this service when reaching out to communicate with survivors who are D(d)eaf or hard of hearing. For more information about the TTY-based Telecommunications Relay Services in Arizona, please visit the Arizona Commission for the Deaf and Hard of Hearing 711 Information webpage.\(^\text{19}\)

7. A program should have written procedures on how advocates will respond to non-English speaking persons. Use of an over-the-phone interpretation service is recommended.

8. A program should have written policies and procedures on how staff will respond to survivors’ active suicidal ideation while on the crisis line. The policy should include but is not limited to:
   a. Volunteer considerations and guidance on how volunteers should respond to these calls. It is recommended that volunteers direct these calls to a staff member. The transfer from the volunteer to the staff member should be done in way that is trauma-informed, empathetic and reaffirms the caller’s decision-making abilities.

\(^\text{19}\) Arizona Commission for the Deaf and Hard of Hearing 711 information:  
https://www.acdhh.org/telecommunications/relay-services/711-information/
b. An outline of next steps for how those on the crisis line should respond if a survivor discloses suicidal ideation, including referrals and resources (e.g., statewide crisis lines or other mental health providers). It is recommended staff prioritize helping the survivor through their trauma by utilizing grounding and de-escalation tools and techniques, engaging in active listening, and employing other skills learned in trainings on suicide.

c. Training requirements on providing services to those experiencing mental health crises, suicidal ideation, suicide risk assessment, and suicide prevention; and

d. Duty to warn for mental health providers for reporting personally identifying information that is required when a patient communicates “an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat” to the mental health provider (A.R.S. 36-517.02). A domestic violence program’s duty to warn policy should only include mental health providers and not victim advocates, as there is no Arizona law requiring advocates to report imminent serious physical harm or death.

e. Crisis line services may take place at a variety of settings including community-, mobile-, virtual-, and campus-based programs, family/child advocacy centers, and on-site emergency shelter, as long as safety and confidentiality requirements are met.

For Crisis Intervention and Supportive Services

1. Crisis intervention consists of emergency support to survivors and secondary survivors. This may be immediately after experiencing domestic violence or at any point in a survivor’s lifetime.
   a. Frequent access of services may not be used as a disqualifier from crisis intervention services. Survivors should have continuous access to trauma-informed services no matter how frequently they use the service.
   b. Programs should have in-house crisis intervention services that are distinct from but collaborate with other emergency and crisis services within their service area.

2. Crisis intervention services can be performed by telephone, virtually, or in-person.
   a. Programs should have ongoing face-to-face support options available that are distinct from their therapy services.
   b. In places where in-person advocacy may be difficult or inaccessible (e.g., due to geographic distance or other accessibility challenges), telephonic and virtual advocacy can be used to bridge the gaps in services.

3. Crisis intervention services should be available 24-hours-a-day and seven-days-a-week.
   a. If this is not possible, programs should develop policies and procedures to maximize consistent coverage between business hours, including partnering with other domestic violence organizations.

4. Crisis intervention services should be provided by a trained domestic violence program staff member or volunteer.

5. Crisis intervention services must be provided with a primary focus on the provision of safety planning information, advocacy, emotional validation, and empowerment to reinforce the individual’s autonomy and self-determination.

6. Crisis intervention services should include, but not be limited to:
   a. Assessing risk and/or danger;
b. Assessing critical needs and safety concerns;
c. Listening to and validating victims’ experiences;
d. Assisting with physical, emotional, and sexual safety planning; and
e. Providing information and referral to community resources including but not limited to:
   i. Basic needs (e.g., food, shelter, clothing);
   ii. Employment;
   iii. Legal options;
   iv. Medical options (e.g., medical forensic exams, general care);
   v. Mental health options; and
   vi. Culturally responsive healing and grounding resources.

7. Crisis intervention and supportive services may take place at in a variety of settings including systems-, community-, mobile-, virtual-, and campus-based programs, family/child advocacy centers, and on-site emergency shelter, as long as safety and confidentiality requirements are met.

For Case Management/Advocacy:

1. Case management/advocacy services are intended to provide referrals, education, and support to increase survivors’ short- and long-term well-being and safety.

2. Case management/advocacy services must be provided by a trained domestic violence program staff member or volunteer.

3. Programs providing case management/advocacy services should:
   a. Have access to and be familiar with a complete up-to-date list of community resources;
   b. Build collaborative relationships with other service providers;
   c. Build collaborative relationships that ensure a coordinated community response;
   d. Help the survivor identify their own needs and available resources and services; and
      i. Coordinate service delivery, referrals and ongoing communication with service providers in the community.

4. Additional services may include but are not limited to:
   a. Assistance with ongoing and long-term safety planning;
   b. Information on victims’ rights and crime victims’ compensation;
   c. Assistance navigating civil and criminal justice systems, without giving legal advice;
   d. Parenting education;
   e. Transportation assistance;
   f. Culturally-specific resources;
   g. Employment readiness;
   h. Financial literacy and planning;
   i. Other services as needed.

5. If services are offered to adults with minor children, the program must offer information and referrals to children’s services, if appropriate.

6. Case management and advocacy may take place at in a variety of settings including, community-, mobile-, virtual-, campus-based, and housing intervention programs, family/child advocacy
centers, and on-site, motel/hotel emergency shelters, as long as safety and confidentiality requirements are met.

For Lay Legal Advocacy

1. Lay legal advocacy supports survivors of domestic violence during their involvement with criminal and/or civil legal processes. This advocacy can take many forms and should be tailored to the unique needs of each survivor. Lay legal advocacy may extend beyond the immediate domestic violence case and can include indirect legal needs such as tenant right and legal name changes.

2. A program providing lay legal advocacy services should:
   a. Provide information about legal options, without providing legal advice, so victims can identify needed interventions and actions from civil and/or criminal justice systems;
   b. Have a working knowledge of current state, federal and applicable tribal law pertaining to domestic violence, as well as the local justice system’s response to domestic violence, including local court rules and practices, in each county where services are provided;
   c. Establish working relationships fostering victim safety with relevant justice system members;
   d. Ensure appropriate staff members and volunteers can identify an individual’s legal options (without giving legal advice) as part of a service and safety plan, which should evolve in line with the recipient’s needs.

3. A program providing lay legal advocacy services should maintain current lists including but not limited to:
   a. Local criminal justice agencies and contact persons in each jurisdiction in which services are provided;
   b. Local, state, tribal, and national resources for specific pertinent legal issues, such as immigration; and
   c. Local legal services, including pro bono or low-cost attorneys (if available), who are sensitive to and familiar with domestic violence legal issues and orders of protection, to whom referrals can be made for representation and/or consultation in civil and criminal cases in each jurisdiction in which services are provided.

4. A program providing lay legal advocacy services should develop and/or participate in a Coordinated Community Response Team (CCRT) in the program’s service area. The CCRT should include advocates and governmental and organizational allies with whom victims of domestic violence interact. The focus of these efforts should be on improving community, criminal and civil justice systems’ responses to victims and harm-doers.

5. Lay legal advocacy services should include but are not limited to:
   a. Providing education and options such as:
      i) The nature and dynamics of domestic violence;
      ii) The criminal and/or civil legal process;
      iii) Safety planning related to legal options the survivor is seeking;
      iv) The advocate’s mandatory reporting duties;
      v) Arizona victims’ rights;
   b. Accompanying and supporting a victim during reporting to law enforcement and prosecution;
c. Accompanying and supporting a victim through civil options and court cases. Civil options for survivors may include but are not limited to:
   i) Orders of protection and injunctions against harassment;
   ii) Terminating a rental lease;
   iii) Immigration options, such as U-Visa, T-Visa, and VAWA Self-Petition;
   iv) Victim’s rights violations;
   v) Child custody and other family law;
   vi) Civil lawsuits/torts;
   vii) Legal transition options for transgender clients; and
   viii) Civil rights violations (e.g., Americans with Disabilities Act, Family and Medical Leave Act);

d. Accompanying and supporting a victim through campus adjudication and Title IX processes;

e. Providing education and options for legal-adjacent options. This can include but is not limited to:
   i) Arizona’s Crime Victim Compensation Program;
   ii) Arizona’s Address Confidentiality Program;
   iii) Equal Employment Opportunity Commission filings;
   iv) Filing grievance reports to employment/licensing agencies.

6. Lay legal advocacy services may take place at in a variety of settings including community-, systems-, mobile-, virtual-, and campus-based programs and family/child advocacy centers, as long as safety and confidentiality requirements are met.

7. Lay legal advocacy services may take place at in a variety of settings including systems-, community-, mobile-, virtual-, and campus-based programs, family/child advocacy centers, and on-site emergency shelters, as long as safety and confidentiality requirements are met.

Unauthorized Practice of Law

1. On January 15, 2003, the Arizona Supreme Court instituted new rules regarding the regulation of the practice of law. The most recent amendment went into effect January 1, 2021.20 Rule 31(b) defines “practice of law” to mean “providing legal advice or services to or for another” by:
   a. preparing or expressing legal opinions to or for another person or entity;
   b. representing a person or entity in a judicial, quasi-judicial, or administrative proceeding, or other formal dispute resolution process such as arbitration or mediation;
   c. preparing a document, in any medium, on behalf of a specific person or entity for filing in any court, administrative agency, or tribunal;
   d. negotiating legal rights or responsibilities on behalf of a specific person or entity; or
   e. preparing a document, in any medium, intended to affect or secure a specific person’s or entity’s legal rights.

2. Rule 31.2 goes on to describe “unauthorized practice of law” as:
   a. engage in the practice of law or provide legal services in Arizona; or
   b. use the designations “lawyer,” “attorney at law,” “counselor at law,” “law,” “law office,” “J.D.,” “Esq.,” “alternative business structure (ABS),” or other equivalent words that are

20 For the most recent language of the rule please see: https://govt.westlaw.com/azrules/Document/NBCE25930018911EB86B0F57A06562D82?viewType=FullText&ori ginationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
reasonably likely to induce others to believe that the person or entity is authorized to engage in the practice of law or provide legal services in Arizona.

3. Rule 31.2 contains key exceptions that may be relevant to some advocates. This rule states: “Notwithstanding Rule 31.2, a person or entity may engage in the practice of law in a limited manner as authorized in Rule 31.3(b) through (e), but the person or entity who engages in such an activity is subject to the Arizona Supreme Court’s jurisdiction concerning that activity.”
   a. Under Rule 31.3(3)(4), advocates who are certified as Legal Document Preparers “may perform services in compliance with the Arizona Code of Judicial Administration.”

4. An advocate who is not certified as a Legal Document Preparer can help complete prepared forms by transcribing information from the victim, because this is something victims could do themselves and does not require legal training.

5. Mediating between the victim and the court can potentially fall into the category of “practicing law” if the advocate is making arguments on behalf of the victim. The advocate may ask if they can sit in the courtroom as support, but the court has to agree. The advocate must advise the victim they are not a lawyer and therefore the victim cannot rely upon anything the advocate says as legal advice. The advocate cannot accept any compensation or payment in exchange for giving assistance, including food items, gifts, and gift cards.

Limitations on the Role of the Lay Legal Advocate:
1. As of July 1, 2003, a lay legal advocate in Arizona is able to do the following:
   a. Tell someone how to get an order of protection or injunction against harassment and where to get the forms, and how to use and access AZPOINT;
   b. Provide information about court procedures;
   c. Accompany a victim to court;
   d. Represent the victim/act as an agent in proceedings before the Department of Economic Security (DES), the Department of Health Services (DHS), or the Arizona Health Care Cost Containment System (AHCCCS); and
   e. Tell a victim how and where to obtain divorce and/or other legal forms.

2. Advocates can provide victims with information about law and court procedures, facilitate critical thinking about safety planning and legal options, and empower them to speak and advocate for themselves in legal proceedings in which they seek relief. Advocates cannot make decisions for, act on behalf of, speak for, or otherwise represent victims.

3. As of July 1, 2003, a lay legal advocate who is not trained as a Legal Document Preparer may not do the following:
   a. Prepare any document to affect or secure legal rights;
   b. Negotiate on behalf of the victim;
   c. Prepare any legal document for filing in court or an administrative agency.
   (Note: To avoid giving legal advice, do not answer victims’ “should” questions [e.g., Should I ask for sole custody of my children? Should I call my 13-year-old son as a witness?] Giving advice is strictly prohibited.)

4. Violations and Sanctions
a. Arizona Supreme Court Rule 75(a) gives the court jurisdiction over any person engaged in the unauthorized practice of law, as defined by Rule 31(b) discussed above. The following sanctions listed in Rule 76(b) may be imposed on someone found to be in violation of Rule 31 (i.e., an act found to constitute the unauthorized practice of law):

i. Agreement to Cease and Desist: Respondent and unauthorized practice of law counsel may enter into a “Consent to Cease and Desist Agreement” prior to formal proceedings, stating respondent agrees to cease and desist from engaging in acts found to be unauthorized practice of law, to refund fees collected, to pay costs and expenses, and to make any other restitution.

ii. Cease and Desist Order: The superior court may enter an order for a respondent to immediately cease and desist from conduct that constitutes engaging in the unauthorized practice of law. After entry of a cease and desist order or judgment, and service thereof upon the respondent, respondent shall:
   1. notify existing customers, opposing counsel or opposing parties, if not represented by counsel, of such sanctions;
   2. return to all customers in pending matters any documents or other property to which they are entitled, including their files; and
   3. cease use of any reference to titles or descriptions prohibited in the order or judgment on all advertising, business cards, and letterhead.

iii. Injunction: The superior court, at any stage in an unauthorized practice of law proceeding, may enjoin a respondent from engaging in the unauthorized practice of law and order a respondent immediately to cease and desist such conduct. An injunction or order to cease and desist may be issued without proof of actual damages to any person.

iv. Civil Contempt: The superior court may issue a civil contempt citation and determine if the respondent is guilty of contempt and, by order, prescribe the sanction, including assessment of costs, expenses, and reasonable attorney fees.

v. Restitution: In the event actual damages are shown, restitution may be ordered to any individual for money, property, or other items of value received and retained by a respondent.

vi. Civil Penalty: The superior court may order a civil penalty up to $25,000 against every respondent upon whom another sanction is imposed. Civil penalties against an alternative business structure shall be deposited in the Alternative Business Structure Fund. Civil fines against a legal paraprofessional shall be deposited in the fund established by the Arizona Supreme Court for that program.

vii. Costs and Expenses: Costs, expenses, and attorney fees relating to the proceedings shall be assessed against every respondent upon whom another sanction is imposed. Assessment shall be included in the order or judgment.

b. Implementation of Cease and Desist Sanction: Orders or judgments of the superior court imposing cease and desist sanctions shall be effective thirty days after entry, unless another date is specified. 21

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For Support Groups

1. Support groups are a healing modality where survivors can share experiences and coping skills, as well as support and learn from each other. Support groups provide a valuable opportunity to decrease feelings of isolation and stigma for survivors and potentially build an ongoing network of support among participants. Support groups may be based in education, discussion, art, movement, crafts, culturally-rooted practices and more.

2. It is increasingly understood the traditional support group model is no longer the only method for providing group intervention, and other formats might elicit greater participation from culturally-specific communities and communities of color (e.g., “coffee/tea chats” or groups promoted as “parenting classes” with a domestic violence component). Programs should consider developing and providing alternative support group formats with input from culturally-specific organizations and survivors.

3. Attendance at groups must be voluntary, and it should be clear to survivors that program services are still available to them if they do not engage in group services.

4. A program that provides support groups may provide:
   a. Open groups, that should be held regularly and accept new members at any time;
   b. Closed groups, that do not add new members for a specified period of time and are scheduled based on times determined by those attending the session;
   c. Topic-oriented groups;
   d. Informational or educational groups; and/or
   e. Non-traditional gatherings promoting healing and community building.

5. A program must discuss confidentiality and mandatory reporting policies, and group agreements with participants. This includes addressing actions affecting virtual settings such as screenshots or abuse of online forums or chats.

6. It is recommended programs provide childcare or a children’s group during the adults’ group.

7. Support groups may include the provision of education and information about:
   a. The nature and dynamics of domestic violence;
   b. Safety planning (emotional, physical, and sexual);
   c. The neurobiology of trauma;
   d. The traumatic impact of domestic violence, including social, physical, financial, sexual, and psychological impacts;
   e. Coping skills and grounding techniques, including triggers and flashbacks;
   f. Exploring feelings and problem-solving techniques, including fear, shame, and anger;
   g. Healthy relationships and sexuality;
   h. Establishing boundaries;
   i. Social change necessary to eliminate sexual violence and domestic abuse, including the elimination of discrimination based on ethnicity, color, gender, gender identity, sexual orientation, marital or partner status, age, disability including substance abuse, economic or educational status, religion, HIV/AIDS or other physical health status, mental health status, national origin or immigration status.
8. It is best practice to have transportation options available to survivors when holding in-person support groups.

9. A program that provides support groups geared towards minors must ensure staff members or volunteers facilitating groups provide age-appropriate programming.

10. When possible, it is best practice to provide multiple support group options, including gender-specific and mixed-gender groups. Support groups should be available to people of all genders, including men, transgender and/or nonbinary individuals. Facilitators should be trained on serving male, transgender and/or nonbinary survivors. If a program has gender-specific groups that do not include male, transgender and/or nonbinary clients, an equal and similar service must be provided in accordance with VAWA for those who are excluded (34 U.S.C 12291 § (b)(13)(B)).

11. Support groups may be provided based on identity and/or experiences of different survivors, including but not limited to:
   a. LGBTQ+ survivors
   b. Black survivors
   c. Native survivors
   d. Latinx survivors
   e. Immigrant or refugee survivors
   f. Survivors with disabilities
   g. Male survivors
   h. Secondary survivors (e.g., parents, siblings, partners, friends of survivors)

12. A domestic violence program providing virtual support groups should have adequate technology safety measures in place, in line with the Standards by Service Modality for virtual and digital services. Efforts should be made to protect clients’ data and create a safe virtual safe space, free from “Zoom-bombing” or other harmful violations of the virtual space.

13. A support group may be facilitated by a staff member or volunteer advocate. A domestic violence program providing group services should ensure that the facilitator has sufficient training, education or experience in domestic violence, facilitation, and group dynamics.
   a) When possible, it is suggested that at least two facilitators (made up of program staff and volunteers) are available to facilitate each support group. This allows for the facilitators to demonstrate healthy communication and collaboration, model activities for the group, and provide individual support to survivors privately while group is in session.

14. A support group may be facilitated by a licensed clinical mental health provider, which would be considered group counseling or therapy. This type of group must follow the Standard by Service Type for Therapy in addition to the Standard by Service Type for Support Groups.

15. Support groups may be in-person or virtual and may take place in a variety of locations.

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23 See the Appendix “LGBTQ+ Inclusive Domestic and Sexual Violence Services” to learn more.
24 “Zoom-bombing” occurs when a malicious actor joins a video call or meeting to disrupt, mock, threaten, or otherwise harm participants in the call.
16. Support groups may take place at in a variety of settings including community-, mobile-, virtual-, and campus-based programs, family/child advocacy centers, and on-site emergency shelters, as long as safety and confidentiality requirements are met.

For Secondary Survivor Advocacy

1. The term “secondary survivor” is used here to describe individuals, such as friends, relatives, and loved ones, who are proximate to the person(s) who directly experienced domestic violence (i.e., the primary victim and their children) and/or the person who committed the abuse. It is important to recognize secondary survivors often have traumatic direct experiences with the person causing harm, and may have vicarious trauma as a result of supporting the primary victim(s). The term “secondary” does not suggest the traumatic impact experienced by these individuals is any less than that of the primary survivor(s), and providers should uplift this fact during service provision. Domestic violence service providers may prefer to use other terms to describe these individuals, such as “vicarious survivors,” “proximate survivors,” or simply “survivors.”

2. Advocacy for secondary survivors should include the provision of education and information about:
   a. The nature and dynamics of domestic violence;
   b. The neurobiology of trauma;
   c. The traumatic impact of domestic violence, including social, physical, sexual, financial, and psychological impacts, on both primary and secondary survivors;
   d. Supporting a loved one who has experienced domestic violence;
   e. Redirection of victim blaming and common myths about domestic violence;
   f. Active listening and validation skills.

3. Domestic violence programs may provide various types of services to secondary survivors, such as case management/advocacy, crisis line support, crisis intervention, support groups, and therapy.

4. Secondary survivor advocacy may take place at in a variety of settings including community-, mobile-, virtual-, and campus-based programs, and family/child advocacy centers, as long as safety and confidentiality requirements are met.

For Therapy and Mental Health Services

1. Therapy and mental health services are types of domestic violence programming provided by a trained and licensed mental health professional. This may include the fields of counseling, marriage and family therapy, and social work.

2. A trained and licensed mental health professional may provide:
   a. Education and information about the impacts of domestic violence and trauma;
   b. Planned interventions and goals;
   c. Clinically-based interventions;
   d. A safety plan to address coping skills and trigger plans;
   e. Evidence-based trauma therapy modalities, such as Eye Movement Desensitization and Reprocessing Therapy (EMDR), Internal Family Systems Model (IFS), Traumatic Incident Reduction Therapy (TIR), Trauma-focused Cognitive-Behavioral Therapy (TF-CBT), Cognitive-Processing Therapy (CPT), and Dialectical Behavioral Therapy (DBT);
f. Group therapy; and
g. Evaluation of therapy delivery and outcomes.

3. Staff providing clinical mental health services should be trained in:
   a. Types and dynamics of domestic violence;
   b. The neurobiology of domestic violence;
   c. The traumatic impact of domestic violence, including social, physical, sexual, financial, and psychological impacts;
   d. Considerations of cultural humility which may include serving: people with disabilities, LGBTQ+ individuals, Black, Indigenous and people of color (BIPOC), older individuals, men, and more; and
   e. Trauma therapy modalities.

4. A domestic violence program must ensure individuals providing therapy and mental health services comply with state and federal laws, state licensure rules and regulations and national professional ethical standards.26

5. A domestic violence program providing mental health services must have policies and procedures for reporting personally identifying information required when a client communicates “an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat” to the mental health provider (A.R.S. 36-517.02). The mental health provider must:
   a. Communicate when possible the threat to all identifiable victims;
   b. Notify a law enforcement agency in the vicinity where the patient or any potential victim resides;
   c. Take reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate; and
   d. Take any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

6. A domestic violence program’s duty to warn policy should only include mental health providers and not victim advocates, as there is no Arizona law requiring advocates to report imminent serious physical harm or death.

7. A domestic violence program providing mental health services must have a policy to obtain written informed consent authorizing treatment of the client in accordance with state licensing requirements.

8. Mental health screening and/or treatment of an unemancipated minor or adult with a legal guardian must have written or oral consent of the parental or legal guardian (A.R.S. 36-2272).

9. Therapy and mental health services may take place at in a variety of settings including community-, virtual-, and campus-based programs, family/child advocacy centers, and on-site emergency shelters, as long as safety and confidentiality requirements are met.

26 To learn more about state licensing of behavioral health providers see the Arizona State Board of Behavioral Health Examiners: [https://www.azbbhe.us/]
For Flexible Financial Assistance

1. The main purpose of flexible financial assistance is to address financial barriers interfering with victims’ ability to create safe and stable lives. These activities comprise a wide range of unique needs, from transportation, childcare, and necessary personal items (e.g., car seats, professional clothes for an interview) to rental assistance or car repair. Advocacy accompanying flexible financial assistance should be client-directed and trauma-informed and may include, but not be limited to, the following:
   a. Case management and legal assistance to help a family remain in its current housing;
   b. Advocacy with landlords, housing authorities, and housing service providers;
   c. Connections to community resources;
   d. Access to information on budgeting and financial planning; and
   e. Safety planning based on a victim’s unique needs, circumstances and strengths.

2. Financial assistance shall be determined by a victim’s individual needs, rather than by a predetermined reason, amount or length of time. Programs shall work with each household individually to determine how to best structure the assistance.

3. Programs shall have established eligibility requirements for flexible financial assistance.

4. Flexible financial assistance services may take place at in a variety of settings including community-, virtual-, family/child advocacy centers, and on-site emergency shelters, as long as safety and confidentiality requirements are met.

For Transportation Services

1. An organization providing transportation services for victims by staff or volunteers should have written policies, including but not limited to:
   a. All personal and organization-owned vehicles that transport victims and/or their children must have Arizona minimum insurance coverage as required by law;
   b. All drivers providing transportation must have a valid Arizona driver’s license;
   c. All drivers providing transportation must provide an annual Arizona Department of Transportation Motor Vehicles Department report to the organization;
   d. All passengers must follow all safety laws related to seat belts and child safety seats.

2. An organization that provides transportation to victims must comply with all other applicable city, state and federal laws.

3. Transportation services may take place at in a variety of settings including systems-, community-, mobile-, and campus-based programs, family/child advocacy centers, and on-site emergency shelters, as long as safety and confidentiality requirements are met.

Evaluation

Evaluation is a critical component of every service type and within every service modality. Consider logistical limitations related to staff role and service modality when determining evaluation methods for each service type.

1. Evaluations should be voluntary and anonymous. Anonymous evaluations may include:

27 [https://servicearizona.com/motorVehicleRecord](https://servicearizona.com/motorVehicleRecord)
a. Periodic satisfaction surveys;
b. Exit surveys; and
c. Follow-up surveys.

2. Those conducting non-anonymous evaluations may include, but are not limited to:
   a. An advisory board consisting of current and former participants;
   b. Staff who review policies and procedures; and/or
   c. Focus groups of former program participants.
Appendix

Sample Forms

Below is a collection of forms that can be used as a guide for your programs. These forms may need to be adapted to your program and grant reporting requirements. When adapting forms, ensure they are in line with the “For the Documentation of Service Provision” standard on page 19. It is best practice to collect as little personally identifying information as possible to protect confidentiality.

Do not keep extensive notes regarding clients served – only collect information needed for the case file and grant reporting purposes. Remember clients can ask to review their case file at any time and the information therein belongs to the client.

Sample forms include:

- Hotline Form
- Intake Form (Non-residential)
- Intake Form (Residential)
- Aggregate Data Form
- Service Documentation Form
- Client Needs Assessment
- Emergency Information
- Release of Information – Model Form in Plain Language
Instructions for Programs: A hotline call should be anonymous. A name is not required, but it is often helpful to ask the survivor by which name they would prefer to be called. A hotline call should be conversational. At no time should the caller feel like you are asking questions in order to fill out a form. This form should never be used to document the specifics of a call or case and should only be used to document information needed for grant reporting purposes.

VICTIM/SURVIVOR INFORMATION

Are you safe right now? _____Yes _____No

(If not, how can I assist you? Do you want me to help arrange transportation to a safe place or hang up so you can do so? Have you considered calling 9-1-1?)

Reasons for seeking assistance (What prompted your call today? Check all that apply.)

☐ Domestic violence/Dating violence
☐ Sexual violence
☐ Stalking
☐ Someone I know has experienced or been affected by sexual violence, domestic violence, and/or stalking
☐ Human trafficking (Sex)
☐ Human trafficking (Labor)

First name (What can I call you?) ________________________________

Pronouns (What pronouns can I use to refer to you, for example, mine are [share your pronouns]) ____________________________

Do you have a pet? __________________

Do you fear for your pet’s safety? ____________________________

Is there a safe place for your pet to go, if needed? ____________________________

Services provided (What can I help you with? – Note, this should only be used to document the type of service provided but nothing specific about services or referrals. For example, if a caller asks about orders of protection, you would write “lay legal advocacy provided.” If a referral is provided to a specific therapist, you would write “referral provided to therapist,” without naming the therapist or organization.)

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

28Adapted from the Missouri Coalition Against Domestic and Sexual Violence Thoughtful Documentation handbook
PROGRAM INFORMATION

First name of person taking call____________________________________

Date____________________

Beginning time_____________   Ending time_____________
Intake Form (Non-residential) 29

All information is confidential. This form will be kept in your case file and will be destroyed one year after you are no longer receiving services.

VICTIM/SURVIVOR INFORMATION

Name (What can I call you? Note, this not does not need to be someone’s legal name)

______________________________________________________________________________

Pronouns (What pronouns can I use to refer to you? For example, mine are [share your pronouns]) _________________

Communication needs (Do you have any communication needs that we should be aware of? For example, some people need interpreters or assistance with filling out forms.)

______________________________________________________________________________

Reasons for seeking assistance (What has brought you here today? Check all that apply)

☐ Domestic violence/Dating violence
☐ Sexual violence
☐ Stalking
☐ Someone I know has experienced or been affected by sexual and/or domestic violence or stalking
☐ Human trafficking (Sex)
☐ Human trafficking (Labor)

Contact information (What is a safe way to contact you?) ____________________________

______________________________________________________________________________

INFORMATION ABOUT HARM-DOER (Note, only collect this information for Domestic/dating violence or if the survivor feels unsafe)

Name _____________________________________________________________

Gender _____________________________________________________________

CHILDREN

(If services related to children are not requested, this section can be omitted)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Related to abuser?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29Adapted from the Missouri Coalition Against Domestic and Sexual Violence Thoughtful Documentation handbook
**PETS**

*(Note: may need to change the address of the microchip)*

<table>
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<th>Name</th>
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**IMMEDIATE NEEDS**

**Immediate Needs** *(What can I help you with? What brought you in today? Are there any immediate concerns we can help you with? – Note, this should only be used to document the type of service provided but nothing specific about services or referrals. For example, if a client asks about orders of protection, you would write “lay legal advocacy provided.” If a referral is provided to a specific therapist, you would write “referral provided to a therapist” without naming the therapist or organization.)*

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**PROGRAM INFORMATION**

First name(s) of advocate(s) working with the victim/survivor
____________________________________________________________________________________

Date of initial contact ___________________________

Date of last contact ____________________________
Intake Form (Residential)

All information is confidential. This form will be kept in your case file and will be destroyed one year after you are no longer receiving services.

VICTIM/SURVIVOR INFORMATION

Name (What can I call you? Note, this not does not need to be someone’s legal name)
______________________________________________________________________________

Pronouns (What pronouns can I use to refer to you? For example, mine are [share your pronouns]) ________________

Accessibility needs (Do you have any accessibility needs that we should be aware of? For example, some people need interpreters or need a wheelchair accessible room.)
______________________________________________________________________________

Reasons for seeking assistance (What has brought you here today? Check all that apply)

☐ Domestic violence/Dating violence
☐ Sexual violence
☐ Stalking
☐ Someone I know has experienced or been affected by sexual and/or domestic violence or stalking
☐ Human trafficking (Sex)
☐ Human trafficking (Labor)

Contact information (What is a safe way to contact you?) ________________________________
______________________________________________________________________________

INFORMATION ABOUT HARM-DOER (Note, only collect this information for Domestic/dating violence or if the survivor feels unsafe)

Name ___________________________________________________________________________

Gender __________________________________________________________________________

Special Concerns (Periodically we have individuals from the community – plumber, law enforcement, etc.- who come to the shelter. Please let us know if you have any specific concerns about allowing these service providers into the shelter.)
______________________________________________________________________________

______________________________________________________________________________
CHILDREN

(Only collect this information if services/shelter are requested for the victim/survivor’s child[ren])

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<tr>
<th>Name</th>
<th>Age</th>
<th>Related to abuser?</th>
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PETS

(Collect this information if a pet is not residing in shelter)

Do you have a pet? ______________________

Do you fear for your pet’s safety? ______________________

Is there a safe place for your pet to go, if needed? ______________________

(Collect this information if a pet is residing in shelter)

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IMMEDIATE NEEDS

Immediate Needs (What can I help you with? What brought you in today? Are there any immediate concerns that we can help you with? – Note, this should only be used to document the type of service provided but nothing specific about the services or referrals. For example, if a client asks about orders of protection, you would write “lay legal advocacy provided”. If a referral is provided to a specific therapist, you would write “referral provided to a therapist” without naming the therapist or organization.)

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

PROGRAM INFORMATION

First name(s) of advocate(s) working with the victim/survivor

____________________________________________________________________________

Date of entry _____________________________

Date of exit _____________________________
Aggregate Data Form

Instructions for Programs: Programs should adapt this form in line with their grant reporting requirements. This form should only contain required grant reporting information. This form should be filed with the grant reporting files and NOT filed with the case files.

Grants do not always ask for information in a culturally appropriate or trauma-informed way. Efforts should be made to adapt the questions and answers accordingly. For example, a grant may require your program to report the number of men, women, and transgender individuals served, however these categories are not mutually exclusive. You can revise the question to prompt respondents to “check all that apply,” to ensure sensitivity and inclusivity regarding gender identity.

This form helps us at [Your Organization Name] to complete our grant reports so we can continue to provide services to anyone who needs them. We can go through the form together or you can go through it on your own. The options listed on this form are collected to fulfill grant reporting requirements. If you do not identify as any of the listed options, please select “not specified” or “unknown”. Some questions might seem obvious, but we do not want to make assumptions. This form is anonymous. It will not be connected to you or stored in your file.

You do not have to answer any of the questions below if you do not want to. You will still receive services if you do not wish to answer these questions.

What age range do you fit into?
- Age 0-6
- Age 7-12
- Age 13-17
- Age 18-24
- Age 25-59
- Age 60 and older
- Prefer not to share

How do you identify your gender? Please check all that apply.
- Male
- Female
- Nonbinary and/or gender nonconforming
- Transgender
- Prefer not to share

How do you identify your race and/or ethnic background? Please check all that apply.
- American Indian or Alaska Native
- Asian
- Black or African American
Do you identify with any of the following groups of people? Please check all that apply.

- Deaf/Hard of Hearing
- Immigrant/Refugee/Asylum Seeker
- LGBTQ+
- Veteran
- Person who is experiencing homelessness
- Person with a disability
- Person with Limited English Proficiency
- Person who lives in a rural area
- Person who is in a correctional setting (e.g., prison, jail, immigration detention)
- I do not identify as part of any of these groups
- Prefer not to share

What is your relationship to the person who harmed you?

- Current or former spouse/intimate partner
- Other family or household member (child, step-child, sibling, etc.)
- Dating relationship
- Acquaintance (neighbor, employee, co-worker, student, schoolmate, etc.)
- Stranger
- Relationship unknown
- Prefer not to share

What has brought you here today seeking services? Please check all that apply.

- Domestic violence/Dating violence
- Sexual violence
- Stalking
- Someone I know has experienced or been affected by sexual and/or domestic violence or stalking
- Human trafficking (Sex)
- Human trafficking (Labor)
**Service Documentation Form**

**Instructions for Programs:** This form is used to document services provided to a survivor and should be kept in the survivor’s case file. The only information that should be documented under “Service(s) Provided” is the service type you must track for your grant requirements, such as “Crisis intervention,” “Victim/survivor advocacy,” “Medical accompaniment,” “Referral,” etc. Details about the specific case, services, or referrals should not be included in this document.

<table>
<thead>
<tr>
<th>Date</th>
<th>Service(s) Provided</th>
<th>Name of Staff Providing Service</th>
</tr>
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<tbody>
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</tbody>
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30Adapted from the Missouri Coalition Against Domestic and Sexual Violence Thoughtful Documentation handbook
Client Needs Assessment\textsuperscript{31}

**Instructions:** This form is meant to be used as a tool for advocates to determine desired services. This should be used to guide an organic conversation and should not be used as a checklist. Survivors may need services beyond this list.

After completing the Client Needs Assessment, the advocate should ask the client if they would like to keep the form or if they would like the advocate to destroy it. **This form should NEVER be saved or kept in the client’s file and should always be destroyed if the survivor does not wish to retain it.** Only the Service Documentation Form should record the services provided.

**CURRENT NEEDS**

**Needs** *(What do you need right now? What are you worried about?)*

______________________________________________________________________________

______________________________________________________________________________

**Medical needs** *(Do you have any medical needs right now? Do you want or need assistance in finding a healthcare provider or a medical forensic exam location?)*

______________________________________________________________________________

______________________________________________________________________________

**Financial needs** *(Do you have any financial needs? Are you struggling to pay for anything as a result of what happened [medical fees, legal fees, counseling fees, etc.? Do you want or need assistance in finding a job or improving your job skills?)*

______________________________________________________________________________

______________________________________________________________________________

**Legal needs** *(Do you have any legal needs or do you need assistance with any civil or criminal matters? This could include an injunction against harassment, breaking a lease, filing a civil suit, reporting the crime to police, filing for divorce, and more.)*

______________________________________________________________________________

______________________________________________________________________________

\textsuperscript{31}Adapted from the Missouri Coalition Against Domestic and Sexual Violence Thoughtful Documentation handbook
Children needs (What school does your children attend? Do you need assistance with transportation needs for your child’s school?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Custody needs (Are you the legal guardian of these children? Do you have authority to make decisions on behalf of your child/ren? Do you want help or support in addressing custody issues?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Visitation needs (Are there any requirements or agreements about visitation arrangements that we should be aware of?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Pet needs (Do you fear for your pet’s safety? Is there a safe place for your pet to go, if needed? Is your pet spayed or neutered? Do you need assistance keeping your pet safe?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

TRIGGER PLANNING/SAFETY PLANNING

Physical safety (What do you need in order to feel safe? What does safety look like or feel like to you?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Emotional safety (What makes you feel unsafe? What triggers you? What helps you feel calm? What helps you feel like yourself?)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
**Sexual safety** (Do you sometimes feel triggered during intimate or sexual interactions? If you are triggered during sex, what are some ways you can return to yourself? What do you want to happen? Do you want your partner involved in that process? Do you need support with preparing for those conversations?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Social safety** (What helps you feel safe during interactions with unfamiliar people, in public places, or in an unfamiliar environment?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**HEALING SERVICES**

**Support groups** (Would you be interested in connecting with other survivors through a support group?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Counseling services** (Have you thought about whether you might be interested in counseling services?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Culturally specific** (Is there anything in your culture that may help you heal? Is there anything you would like me to know about your culture?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Holistic healing** (Would you be interested in doing activities that engage your body and mind, like Yoga or Martial Arts? Are there things you enjoy doing in nature, like hiking or gardening?)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Spiritual healing (What might help you feel connected to your spirituality or faith?)

___________________________________________________

___________________________________________________

___________________________________________________

___________________________________________________

___________________________________________________
Emergency Information

The information on this emergency contact form is used to support your safety during your stay in shelter. It is not required for program participation and will not be released without your prior approval. In the event that you become unconscious, unable to respond to questions or unable to make decisions for yourself, information on this form will be shared on an as-needed basis. We will ask you to review it periodically for accuracy and to use in your safety plan. Since it is important the information on this page be kept confidential for your safety, it will be destroyed after you leave the program.

EMERGENCY CONTACT INFORMATION

Emergency contact (In case there is an emergency, whom would you like us to contact? How would you like us to contact them?)

______________________________________________________________________________

Work phone number (In case there is an emergency and we need to contact you while you are at work, what is your work phone number?) __________________________

Cell phone number __________________________________________________________

MEDICAL INFORMATION

Accommodations (Do you or your children need any accommodations or assistance?)

______________________________________________________________________________

______________________________________________________________________________

Medical/health conditions (In case we need to call medical personnel, is there anything you would want them to know about you or your children?)

______________________________________________________________________________

______________________________________________________________________________

Allergies (Do you or your children have any allergies we should be aware of?)

______________________________________________________________________________

______________________________________________________________________________

OTHER INFORMATION

Make and model of your vehicle ________________________________________________
Sharing My Information

I, _______________, have talked with ________________ [Victim Service Provider Staff/Volunteer’s Name] who works at [Agency/Program Name] about why I want some of my information shared. We talked about what can happen if my information is shared. **It is okay with me if [Agency/Program Name] shares the information below:**

The information that is okay to share is:

<table>
<thead>
<tr>
<th>The information that is okay to share is:</th>
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<tbody>
<tr>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Where they work/their position:</td>
</tr>
<tr>
<td></td>
<td>Phone number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who I let this information be shared with:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Where they work/their position:</td>
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<tr>
<td></td>
<td>Phone number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How my information can be shared:</th>
<th>Check the box(es):</th>
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<tbody>
<tr>
<td></td>
<td>□ In Person</td>
</tr>
<tr>
<td></td>
<td>□ By Phone (Phone Number: ________________)</td>
</tr>
<tr>
<td></td>
<td>□ By Email (Email Address: ________________)</td>
</tr>
<tr>
<td></td>
<td>□ By Mail (Address: ________________)</td>
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</tbody>
</table>

I understand that:

___ [Agency/Program Name] will work with me even if I do not sign this form.

___ Someone might be able to find out where I am and/or where I live if this information is shared.

___ By sharing this information, some or all of it may no longer be privileged.

  □ I talked with someone from [Agency/Program Name] about what “**privilege**” means and I understand it.

  □ I talked with someone from [Agency/Program Name] about what “**waiver**” means and I understand it.

---

32 Adapted with permission from the Victim Rights Law Center.
I know I can always talk to ______________ [Victim Service Staff/Volunteer’s Name] when I have any questions about “privilege,” “waiver,” or anything else in this release. 

I can change my mind about sharing this information. If I do not want this information shared, I will tell someone at [Agency/Program Name] in person, on the phone, or in writing that I changed my mind and I do not want this information shared. I know that I cannot take back information that [Agency/Program Name] shared before I changed my mind.

(For best practice, the amount of time should not go past fourteen days. Any longer and confidentiality could become a risk as information is passed between shared interests. Expiration should meet the needs of the victim, which is typically no more than 3-14 days, but may be shorter or longer.)

This release starts ____ / _____ / ______ and ends ____ / ____ /_____.

Today’s Date  End Date

Signature: ________________________________
Date: ________________________________

Parent/Guardian Signature (if needed): ________________________________
Date: ________________________________

I want this release to last longer. This release will now end on _____ / _____ / ______. 

Signature: ________________________________
Date: ________________________________

Note that per federal law (34 U.S.C. § 12291(b)(2)), if an unemancipated minor or person with a legal guardian consents to receive services, they can consent to release their information without additional parent or legal guardian consent.
Sample Policies

Model Data Breach Response Policy

[Your Organization] has a responsibility to protect the personally identifying information of clients, technical assistance recipients, and employees of the organization. While [Your Organization] takes great care to secure this data (e.g., using locked file cabinets, contractor confidentiality agreements, data encryption, controlled authorized users, mandatory passwords for electronic devices and electronic file access, and enhanced privacy policies) breaches can occur. This Data Breach Response Policy outlines immediate and ongoing responses [Your Organization] will undertake in the event of an actual, suspected, or imminent breach of personally identifying information. This policy and the procedures set out below comply with both the federal grant conditions and the A.R.S. 18-552 Notification of security system breaches; requirements; enforcement; civil penalty; preemption; exceptions.

This policy does not include information on preventing breaches and protecting privacy proactively; rather it dictates the steps that [Your Organization] will take when breaches are suspected or occur. Those interested in policies for the prevention of breaches should reference [Your Organization]’s Privacy Policy.

1. What is a breach?
A breach is the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where: (1) a person other than an authorized user accesses or potentially accesses personally identifying information (PII) or (2) an authorized user accesses, or potentially accesses, PII for an unauthorized purpose.

A breach is not limited to electronic “hacking” occurrences, but can also include the loss of control over, or theft of, physical documents or electronic devices that contain PII (such as client files, smart phones, and laptops). Some common examples of a breach include:

- A laptop or portable storage device storing PII is lost or stolen;
- An email containing PII is inadvertently sent to the wrong person;
- A box of documents with PII is lost or stolen during shipping;
- An unauthorized third party overhears [Your Organization] employees discussing PII about an individual;
- A user with authorized access to PII sells it for personal gain or disseminates it to embarrass an individual;
- An IT system that maintains PII is accessed by a malicious actor; or
- PII that should not be widely disseminated is posted inadvertently on a public website.

2. What information is this policy protecting?

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34 This policy was adapted for Arizona with permission from the Victim Rights Law Center.
36 The purpose of this policy is to allow both [Your Organization] and its grant funders to take steps to mitigate harm in the event of a breach. The required steps are intended to assist in protecting PII and consumers/clients of [Your Organization].
37 See https://www.azleg.gov/ars/18/00552.htm
38 See OMB M-17-12.
This policy protects both “personally identifying information” as defined in federal regulations and “personal information” as defined in Arizona law. PII is defined in 2 C.F.R. § 200.139 as information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. The definition of PII is not anchored to any single category of information or technology. Rather, it requires a case-by-case assessment of the specific risk that an individual can be identified. Non-PII can become PII whenever additional information is made publicly available, in any medium and from any source, that when combined with other available information could be used to identify an individual.

In Arizona, “personal information” is defined in A.R.S. 18-551(7) as:

- An individual's first name or first initial and last name in combination with one or more specified data elements.
- An individual's user name or e-mail address, in combination with a password or security question and answer, that allows access to an online account.
- Does not include publicly available information that is lawfully made available to the general public from federal, state or local government records or widely distributed media.

Notably, all personal information (as defined under Arizona law) does not meet the federal definition of PII. [Your Organization] follows the federal definition of PII.

3. What must [Your Organization] employees do if a breach of PII is suspected or confirmed?

If a breach is discovered or detected by an employee, the employee shall notify their supervisor immediately. The supervisor shall notify the appropriate state and/or federal grant manager. If the employee’s supervisor is not available, the employee shall notify [Names of Staff/Positions to Be Contacted listed].

Reports of imminent, suspected, or actual breaches, whether electronic or analog, shall include (if known):

- Reasons for suspecting breach;
- Type of information breached;
- Date or time period breach occurred; and
- Any other relevant, known information.40

4. What steps shall [Your Organization] take if a breach or suspected breach of PII is reported?

39 According to the FY 2019 Special Conditions for VAWA Grantees, all grant recipients and sub-recipients at any tier must have written procedures in place to respond to actual or imminent breach (defined in OMB M-17-12) of PII as defined in 2 C.F.R. § 200.1. This is different from, although compatible with, the definition of PII given by 34 U.S.C. §12291(a)(20), which VAWA grantees are likely more familiar with.

40 See OMB M-17-12
[Your Organization] will report any actual or imminent breach of PII to the appropriate federal and/or state grant manager no later than 24 hours after an actual breach or the detection of an imminent breach.\textsuperscript{41} [Your Organization] will document all steps taken under this policy.

Reports of imminent, suspected, or actual breaches, whether electronic or analog, shall include (if known):

- Reasons for suspecting breach;
- Type of information breached;
- Date or time period breach occurred; and
- Any other relevant, known information.\textsuperscript{42}

5. What happens after someone reports a breach or suspected breach?

Upon receiving a report, [Your Organization] will investigate the incident to determine whether an actual breach occurred and, if it did, what kind of PII was exposed or accessed. (This investigation will not extend the time required to report to the appropriate grant manager(s).) If the PII exposed or accessed included personal information under Arizona law (see question 2-above), [Your Organization] will notify consumers as required by A.R.S. 18-522 (see question 6 below).

If the PII breached belonged to someone who came to [Your Organization] for victim services, [Your Organization] will also make “reasonable attempts to provide notice to victims affected by the disclosure of information” and take “steps necessary to protect the privacy and safety of the persons affected by the release of the information” as described in VAWA Regulations found at 28 C.F.R. Subpart A § 90.4(b)(3)(iii).

6. What does Arizona law require [Your Organization] to do if the breach involved personal information?

Arizona law requires a program who maintains the data that was breached to notify the owner of the data as soon as practicable. This notification must include: (1) the approximate date of the breach, (2) a brief description of the personal information included in the breach, (3) the toll-free numbers and addresses for the three largest nationwide consumer reporting agencies\textsuperscript{43}, (4) the toll-free number, address and website address for the federal trade commission or any federal agency that assists consumers with identity theft matters. The notification may be a written notice, an email notice, or a telephonic notice but not a pre-recorded message (A.R.S. 18-0552).

While telephonic notice is permissible under Arizona law, [Your Organization] staff should not call or leave a message asking a current or former client to contact us regarding a breach unless they are confident that the phone number is the client’s current number and the client has let us know it is a safe number. Similar care should be taken when sending notice to a current or former client.

Notice shall comply with all the requirements laid out in A.R.S. 18-552.

\textsuperscript{41} FY 2019 Special Conditions for VAWA Grantees.
\textsuperscript{42} See OMB M-17-12.
\textsuperscript{43} These agencies are Equifax, Experian and TransUnion
Annual Review

[Your Organization] will review this policy at least annually and will update it whenever the information is no longer accurate.
Model Medication Policy for Domestic Violence Shelters

Introduction

As state domestic violence coalitions and local domestic violence programs across the country work to create more accessible and trauma-informed shelter programs, staff and advocates have sought guidance on designing medication policies that better serve survivors who are experiencing mental health symptoms or living with disabilities.

This Model Medication Policy for Domestic Violence Shelters, developed in response to these requests, is intended to provide programs with guidance on designing medication policies that reflect survivor-centered values and create more accessible and trauma-informed shelter environments. It also responds to requests from domestic violence programs for guidance on drafting policies that comply with their ethical and legal obligations under the Americans with Disabilities Act (ADA)\textsuperscript{45}, the Fair Housing Act (FHA)\textsuperscript{46}, and Section 504 of the Rehabilitation Act.\textsuperscript{47} These federal statutes have implications for how domestic violence shelters screen and admit survivors and how they store and handle medications.

While this Model Policy is intended to guide domestic violence programs as they work to draft medication policies and train staff in ways that support survivors and their children who are experiencing mental health symptoms or living with mental health disabilities, it is not a substitute for legal counsel. Domestic violence programs should consult with an attorney to ensure that their policies comply with all relevant local, state, and federal laws.

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\textsuperscript{44} Adapted from: 2011 National Center on Domestic Violence, Trauma & Mental Health’s “Model Medication Policy for Domestic Violence Shelters” \url{http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Model-Medication-Policy-for-DV-Shelters.pdf}

\textsuperscript{45} The Americans With Disabilities Act (42 U.S.C. §§ 12101 et seq.).

\textsuperscript{46} The Fair Housing Act (FHA Amendments Act of 1988, 42 U.S.C. §§ 3601 et seq.).

Shelter Policy on Medications

I. Purpose

_______________________ (“the shelter”) is committed to providing a safe, accessible, and trauma-informed environment for survivors of domestic violence and their children. In addition, the shelter acknowledges its ethical and legal obligations to serve survivors of domestic violence and their children without regard to disability status. To these ends, the shelter has adopted this medication policy. All staff and volunteers will receive training on and copies of this policy. Staff and volunteers are responsible for complying with the policy and for seeking guidance from a supervisor if they have any questions or concerns about the policy.

II. Definitions

For purposes of this policy, the following definitions will apply:

1) Medication means any drug that is legally in the possession of the survivor, their children, or a person seeking admittance to the shelter or their children; this definition includes prescription medications and medications available for legal purchase without a prescription.

2) Dispensing medication means distributing or providing medication to a person staying at the shelter by opening a locking closet or container and handing the medication container or individual dosage to another person.

3) Mental health disability, as defined by the ADA, means a mental health related (1) “impairment that substantially limits one or more major life activities,” (2) “a record of such an impairment,” or (3) “being regarded as having such an impairment.”

The World Health Organization International Classification of Functioning, Disability and Health (ICF) defines disability as “the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives.” Thus, disability is not a static state of impairment but “falls on a continuum from enablement to disablement.” Trauma and mental health conditions can precede psychiatric disability but do not always do so. Psychiatric disability occurs when the effects of trauma and/or mental health conditions significantly interfere with the performance of major life activities. Psychiatric disability may come and go, remit, or be more persistent. Safety and support can reduce psychiatric disability.

A person who is in recovery from an addiction to illegal drugs or alcohol is considered to have a disability and is protected from discrimination under the ADA. However, disability status is not conferred by the use of illegal drugs. Current users of illegal drugs and persons convicted for

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48 The Americans With Disabilities Act (42 U.S.C. §§ 12101 et seq.).
illegal manufacture or distribution of a controlled substance are not considered to have a
disability by virtue of that activity or status.\textsuperscript{49}

\textbf{III. Policy Provisions}

\textbf{A. Advocacy Related to Mental Health and Medications}

The shelter seeks to create a welcoming and inclusive environment in which all survivors are empowered to identify and access the support and resources that they need. The shelter does not discriminate against or “screen out” survivors based on their or their children’s disability status or use of medications. However, the shelter recognizes that offering advocacy related to mental health, disability, and use of medication can be a critical component to comprehensive safety planning and to ensuring that all of the survivor’s needs are addressed.

1. Staff and volunteers will not ask questions about survivors’ or their children’s mental health status, disability, or use of medications as part of the screening process.
2. Staff and volunteers will provide every survivor who is residing at the shelter with a copy of this medication policy and/or an explanation of the policy.
3. Staff and volunteers will offer every survivor information and advocacy related to mental health, disability, and medications. Here are some examples of how staff and volunteers can start this conversation:
   - “Experiencing abuse can affect how we feel and respond to other people and the world around us.”
   - “Many people who have been abused experience strong feelings such as anger, sadness, or hopelessness, or they may have difficulty sleeping, eating, or getting things done in a day.”
   - “I hope that this can feel like a safe space to talk about how you’re feeling.”
   - “At this shelter, we don’t judge people or refuse services to people based on their mental health status.”
   - “If you want to, I hope that this can feel like a safe space to talk about any mental health needs you might have.”
   - “When people come to shelter, they sometimes have to leave important medications behind. If you need help getting medications that you left behind, you can let us know and we will try to help.”
4. Staff and volunteers will not make assumptions about the mental health status, disability, or use of medications by survivors or their children; instead, staff and volunteers will offer the same information and advocacy related to mental health, disability, and medications to every survivor.

\textbf{B. Storage and Dispensation of Medications}

The shelter seeks to afford shelter residents with the greatest possible privacy and autonomy, while also providing a safe shelter environment.

\textsuperscript{49} Neither the ADA nor the FHA prohibits programs from serving survivors who are currently using illegal drugs. The survivor would simply not be protected under the ADA and FHA on that basis. While not considered a disability under the ADA or FHA, use of alcohol or other drugs can be disabling and is often a form of self-medication for the traumatic effects of abuse or mental health conditions. Survivors may also be coerced into using alcohol or other drugs by an abusive partner. Therefore, while not the focus of this policy, employing strategies to support survivors with regard to alcohol and other drugs is a critical part of ensuring that domestic violence services are accessible and survivor-centered.
1. Staff and volunteers will not store or dispense medication or monitor how survivors access medications.
2. The shelter will provide every survivor with an individual locking box, locker, or locking cabinet (“locked space”) for storage of medications and valuables.
3. The shelter will not limit or monitor the survivor’s access to their locked space, such as by holding the key in the shelter office.
4. If a survivor indicates that they need access to refrigerated storage space, the shelter will provide refrigerated storage space in the manner that provides the greatest possible privacy and autonomy.

C. Safety Agreement
During a survivor’s stay at shelter, staff and volunteers will ask them to make sure that any medications they have are safety secured.

1. The shelter will ask every survivor to sign an agreement that will store any medications in their individual locking box, locker, or locking cabinet provided, or if it is one requiring refrigeration, as otherwise provided. The agreement will provide that survivors who have medications that must be taken in the event of a medical emergency may carry them on their person (e.g., in a fanny pack).
2. In the event that the survivor has concerns about signing the agreement, staff or volunteers will ask the survivor if an accommodation or change to the policy would allow them to comply. If the staff or volunteer and the survivor cannot find a reasonable accommodation to the policy and non-compliance poses a direct threat to the safety of the survivor or to others, the survivor can be asked to leave shelter.

D. Accommodations
The shelter recognizes that survivors come to the shelter with many diverse needs. As advocates, we are committed to meeting the individual needs of each survivor. Whenever possible, we will make accommodations to ensure that our shelter is accessible to all survivors.

1. Survivors will not be required to take medication as a condition of shelter or receipt of services.
2. If a survivor has difficulty following any rule or policy of the shelter because of their mental health condition or use of medication, the shelter staff will work with the survivor to find a reasonable accommodation.50
3. If a survivor engages in behavior that is related to their mental health condition or use of medication and that poses a direct threat to themselves or other people, the shelter will: (1) take steps to ensure the immediate safety of all individuals and then, (2) work with the survivor to find a reasonable accommodation that is aimed at eliminating future threats.
4. A survivor will not be asked to leave shelter unless: (1) their behavior or inability to follow a rule or policy poses a direct threat to themselves or other people, (2)

50 Examples: (1) A client whose medication causes them to experience nausea will not be required to participate in meal preparation; (2) A client whose medication makes it difficult for them to sit through group meetings may be excused when they feel they must leave; (3) A client whose medication makes them very sleepy and/or who needs extra sleep may work out an alternative schedule with staff for their attendance at job training or other required activities.
there is no reasonable accommodation that would eliminate the direct threat, and (3) all possible and appropriate referrals are made to ensure the safety and well-being of the survivor and others.

E. Providing Access to Information About Medications
   1. Staff and volunteers will not provide advice about medications unless they are authorized by law and the shelter to do so.
   2. Staff and volunteers may provide Internet access for clients to find out information about medications.

F. Nurse and Physician Visits
The shelter recognizes that abuse can affect a person’s mental health and that mental health services can sometimes be a critical component of the services that survivors and their children need to heal from trauma. The shelter also recognizes the right of each person to control their own mental health care.

   1. The shelter will make every effort to provide access to mental health services including, when possible, arranging for a mental health professional to visit the shelter on a regular basis to answer questions about medications, to provide medication evaluations, and/or to prescribe medication.
   2. Survivors and their children will not be required to meet with mental health professionals, participate in mental health treatment, or take medication as a condition of shelter or receipt of services.

G. Policy Violation
   1. If a staff member or volunteer becomes aware of a violation of this policy by another staff or volunteer, they are required to report the violation to their direct supervisor or to the appropriate person as indicated in the employee manual.
   2. If a supervisor becomes aware of a violation of this policy, the supervisor is responsible for addressing the issue with the staff member or volunteer observed violating the policy or that person’s supervisor.
   3. When addressing a violation of the policy with a staff member or volunteer, the supervisor will employ reflective supervisory practices, including discussion about the individual’s understanding of the policy and rationale for violating it, steps to remediate, and plan for follow-up supervision.
   4. Violation of this policy by a staff member or volunteer can result in verbal warning, written reprimand, temporary suspension, or termination, depending on the nature of the violation.

This policy was adopted on ____________________ (date).

Authorized Signature

________________________________________
TALKING ABOUT MENTAL HEALTH AND MEDICATIONS WITH SURVIVORS IN SHELTER

TALKING POINTS FOR DOMESTIC VIOLENCE ADVOCATES

As advocates, we are committed to making every survivor and child feel welcomed at the shelter. We know that everyone comes to shelter with different needs and we are committing to providing everyone with the support and advocacy they need to access safety and heal from trauma.

The shelter does not discriminate against or “screen out” survivors based on their or their children’s disability status or use of medications. At the same time, offering advocacy related to mental health, disability, and use of medication can be a critical component to comprehensive safety planning and to ensuring that all of the survivor’s needs are addressed.

Don’t ask. Offer.

When speaking with a survivor, you should not ask them to reveal information about their or their children’s mental health status, disability, or medications. Instead, you should simply offer the same advocacy related to these issues to every survivor by using conversation starters such as the following:

- “Experiencing abuse can affect how we feel and respond to other people and the world around us.”
- “Many people who have been abused experience strong feelings such as anger, sadness, or hopelessness, or they may have difficulty sleeping, eating, or getting things done.”
- “I hope that this can feel like a safe space for you to talk about how you’re feeling.”
- “At this shelter, we don’t judge people or refuse services to people based on their mental health status.”
- “If you want to, I hope that this can feel like a safe space to talk about any mental health needs you might have.”
- “When people come to shelter, they sometimes have to leave important medications behind. If you need help getting medications that you left behind, you can let us know and we will try to help.”

• ____________________________________________________________
• ____________________________________________________________
• ____________________________________________________________
MEDICATION SAFETY AGREEMENT

Welcome to the shelter. We are committed to providing you with the greatest possible privacy and autonomy during your shelter stay, while also providing a safe shelter environment for everyone.

We recognize that you or your children may have medications with you. If so, you must keep them secured during your stay. We will provide you with an individual locking box, locker, or locking cabinet (“locked space”) for storage of these medications. You are responsible for making sure that any medications belonging to you or your children are safety secured in this locking space at all times. You may also use the locked space to store other belongings.

If you have medications that must be taken in the event of a medical emergency, you may carry them on your person (e.g., in a fanny pack). You are responsible for keeping these medications out of the reach of children at all times.

If you have any questions or concerns about this policy, or if you need a change or accommodation to this policy, please alert a staff member before signing. We would be happy to work with you to find a reasonable accommodation.

If you agree to this policy, please sign below.

_____________________________________
Name

_____________________________________
Signature

_____________________________________
Date
Victim Confidentiality Considerations for Domestic Violence Programs When Responding to Rare or Emergency Situations
(Adapted from Victim Confidentiality Considerations for Domestic Violence and Sexual Assault Programs When Responding to Rare or Emergency Situations.)

A wide range of situations can arise for programs providing services to victims of domestic violence, dating violence, sexual assault, or stalking. Given the complex and critical safety issues faced by victims, programs should have policies to address victim safety and confidentiality in unusual or emergency circumstances. Examples of special situations that might arise include: medical and other emergencies; instances where a victim/client (or the victim’s child) commits a crime while accessing or using services; if there is an active shooter or armed intruder on premises; and situations where a victim brings civil or criminal claims against another client or the agency. Programs should practice best confidentiality and safety practices in each special circumstance that arises. However, situations vary. This piece cannot address all special circumstances that will arise for programs and is not to be considered legal advice. When addressing these or other situations, a program should always obtain legal advice from an attorney who is familiar with all the confidentiality and privilege laws relevant to your program and the victims you serve.

First and foremost: be an advocate. Remember it is the survivor’s information. The survivor retains the right to choose when, how and what personal information will be shared, or not shared, and with whom. Agencies and advocates are responsible for respecting and honoring the victim’s wishes and safeguarding any of the survivor’s information that they collect or hold.

Law and General Principles: Your program must know the law that governs confidentiality and any exceptions to those laws. For more information on confidentiality, see “For Confidentiality” on page 9.

How Programs Can Respond:
These examples illustrate several ways a domestic violence program can protect victim confidentiality when responding to special circumstances such as: medical and other emergencies; instances where a victim/client (or the victim’s child) commits a crime while accessing or using services; and situations where a survivor brings claims against another client or the agency.

A. Medical or Other Emergency Situations:

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51 Exceptions include court or statutory mandates which are generally defined by state law, and can include things such as reporting of suspected child abuse or neglect, or dependent adult abuse, or the reporting of threats made to hurt oneself or others. Confidentiality and privilege laws vary by jurisdiction, as do other laws that may affect an agency or individual staff person’s response. Furthermore, a particular situation may require a closer analysis of the ways federal, state/territorial/tribal, and local law apply, which may require localized legal advice. The Arizona Coalition to End Sexual and Domestic Violence is not providing legal advice to individual programs in this regard. This piece is not intended to be a substitute for local legal advice from an attorney who is familiar with a particular jurisdiction’s laws related to confidentiality and privilege of victim/victim advocate relationships.
Programs should honor victim confidentiality to the greatest extent possible, even in an emergency situation. Programs can request emergency services for medical or other emergencies without revealing a survivor’s/client’s personally identifying information. For example:

a. The program can call to request emergency medical services and still not allow unnecessary responders (people) into the program. The program is also not required to share the survivor’s personally identifying information with a medical or law enforcement responder.

b. The program can provide the emergency operator enough information to respond (e.g., location of the program and the general nature of the emergency) without giving out personally identifying information about a client. For example, the program can say “there is a middle-aged woman having chest pains,” or, “there is a person attempting to enter the shelter and putting someone in immediate risk of bodily harm”.

c. The conscious survivor can choose what information they will or will not share with the medical or police responders when they arrive. The fact that the survivor has chosen not to share certain information with the responders is THEIR choice; it is not the program’s right or obligation to “fill in the blanks.”

d. If the survivor is unconscious, this does not negate confidentiality between the program and the survivor. Without an informed, written, reasonably time-limited release of information, program staff should report the facts that led them to request an emergency response without revealing personally identifying information about the client (e.g., “She came into the room about 15 minutes ago; her skin color went gray, and she passed out.”) Remember that emergency medical personnel are experienced with handling non-responsive patients, without needing to know the detailed backstory.

e. If a perpetrator attempts to enter the agency, a call to 911 can alert the police to the description of the abuser, express concern for staff and resident safety, without providing the name or any information about the victim (or victim’s children), or even whether the victim has ever received services from the program. An abuser may become dangerous to people at the agency regardless of whether your agency actually provided assistance to the victim.

f. Once the emergency situation has been resolved, emergency responders may still ask for follow up. In the wake of an emergency situation, the agency must still get informed, written, reasonably time-limited consent from the victim for any release of personally identifying information to medical responders, law enforcement or others.

B. Crime or Other Claim Against the Domestic Violence Program:
Programs should honor victim confidentiality to the greatest extent possible, even if a crime (or potential crime) occurs at the domestic violence program, or if a program participant (client) brings a lawsuit against the agency.

a. If a current or former program participant (client) brings a lawsuit against a domestic violence program, make sure your program consults a lawyer. Some situations may evoke exceptions to confidentiality laws that apply to the program or individual staff. For example, if a client sues their attorney for malpractice, that client cannot then invoke full client privilege to prevent the attorney from defending themselves in the lawsuit.
b. If the current or former client sues an agency or commits a crime against the program, the program should assess the situation and may take appropriate legal steps.
   i. However, the program is still obligated to limit the disclosure of information concerning the survivor to the minimum amount necessary to address the issue.
   ii. The program is also required to take steps to notify the victim of the disclosure and do what it can to protect the victim’s privacy and safety.

   c. If a client commits an infraction against the agency/program itself, it is important to determine whether the incident truly rises to the level where police need to be involved or a civil lawsuit or criminal claim is really necessary. Sometimes clients damage or steal property. This can legally be viewed as a non-emergency criminal activity in which the domestic violence program has been “injured” (e.g., damage to property, stolen property). Sometimes, your insurance company may only cover the claim if a police report is filed. However, the program still needs to fully assess the impact on the victim’s safety and confidentiality. The program still has legal confidentiality obligations and might decide not to take legal action in order to protect the confidentiality and safety of the victim (or the victim’s children). Things to evaluate include:
   i. How significant was the incident? Is it relatively minor? In other words, is it essentially the cost of doing business? For example, is it a case of a client taking small items (blankets, sheets) when leaving or causing incidental or relatively minor damage to their room or the shelter.
   ii. Can you change your practices so the incident is no longer technically a crime? For example, if you notice a trend where survivors sometimes need to take blankets or the alarm clock when they leave, consider getting additional clocks and blankets donated and tell victims they are welcome to take these items when they leave, if needed and helpful.
   iii. What was the intention and context? Was it an accident? Was the victim’s child involved? Can the unusual incident be understood in the context of the abuse this person has experienced?
   iv. What is the cost of the damage? How will the harm to the program/agency compare with the potential harm to the victim if the agency decides to make a public report (criminal or civil)? Programs should assess the potential message that will spread across the community if the program files claim against a victim/survivor.
   v. Can the program find other ways to address the issue rather than taking action through a criminal or civil claim for the alleged harm? For example, could the program consider arranging restitution rather than initiating prosecution?

d. If the program/agency determines that the harm rises to the level where law enforcement should be contacted or a civil action brought to protect the agency’s interests, the program is still obligated to limit the disclosure of information concerning the survivor to the minimum amount necessary to accomplish the purpose, and the program is required to take steps to notify the victim of the disclosure and do what it can to protect their privacy.

C. Crime or Other Claim by One Survivor Against Another Survivor Using Program Services
Programs should honor victim confidentiality to the greatest extent possible, even in the event of a non-emergency criminal activity where a survivor claims to have been wronged by another survivor (e.g., property taken).

a. Before involving outside authorities, such as the police, try to address the issue internally. Discuss options for resolution and the safety and confidentiality implications of each option with both parties.

b. The survivor who claims to have been wronged by the other survivor may choose to contact law enforcement and report the alleged crime. If they make that choice, here are some confidentiality implications:

i. The survivor who chooses to contact law enforcement may do so, but the program may not share any personally identifying or individual information about either the complaining survivor or the survivor who allegedly engaged in wrong-doing without an informed, written, and reasonably time-limited release signed by each survivor.

ii. The survivor who chooses to contact law enforcement should be advised to go to the police station to make a report, rather than having law enforcement come to the domestic violence program, which could implicate other survivors’ confidentiality and privacy.

iii. In the case where one survivor (most likely, the complaining survivor) chooses to sign an informed, written, reasonably time-limited release of information and the other survivor does not, the program must be extraordinarily vigilant to avoid revealing any information that is not subject to the specific terms of the release. Additionally, the program may not reveal any individual personally identifying information about the survivor who did not sign a release.
Cultivating respect and knowledge of cultures

Culture\textsuperscript{52} is a key part of a person's identity and thus should be a crucial consideration when providing domestic violence services and support. It is essential to know that while some cultures might share certain aspects (e.g., languages, ties, ancestral homelands, traditions), each culture is complex, unique, and vibrant. It is important for sexual violence service providers to know how to cultivate respect and knowledge of different cultures, which includes understanding and honoring the way survivors interact with and experience their own culture. There are some critical steps to practice cultural humility while providing domestic violence services. One does not master cultural humility; programs should cultivate respect and knowledge of different cultures daily and as a continuous practice. These steps involve an analysis of cultural groups on the societal, institutional, interpersonal, and individual levels.

- **Proactively research the culturally-specific group.** Programs should remember it is not a cultural group's responsibility to explain preliminary information about their culture to service providers. Advocates should access readily available information about the specific cultural group and the impact of sexual violence in the community. Research should also include historical context of the group/community within the larger society so the advocate can identify historical/general traumas that will influence domestic violence services and response. This research can stem from books, reports, articles, documentaries, novels, works of art, media, and first-hand accounts.
  - While doing this research, reflect on how sexual violence and oppression may have impacted the cultural groups’ experience.
  - Programs should uplift and center the community’s values, triumphs, and strengths. Programs should take time to celebrate these things and be mindful not to further exploit a group’s trauma.

- **Begin to contextualize the experience of the cultural group in the present as it relates to different systems and policies and other societal factors.** This should come from research within books and other media. It can also include analyzing current news, social media, and other representations of the cultural group in your environment.
  - Think about how rape culture has influenced these depictions (e.g., stereotypes). Many cultural groups have a multi-layered experience regarding domestic violence, rape culture, gender roles, disclosing domestic violence, healing, and the legal system.
    - Consider how your services may impact these experiences and think about how they can assist them in healing from those experiences instead of exacerbating them.

- **Actively listen, and start dialoguing with the cultural group.** Active listening may be the most crucial step in the process, and it should be reciprocal, consistent, and ongoing. Individuals, programs and advocates should come from a position of curiosity when interacting with different communities and cultures. Programs should:
  - Have meaningful relationships with members of the cultural group in their community to provide services reflective of the community as a whole.

\textsuperscript{52} Culture can be described as a set of characteristics, ideas, beliefs, and social norms shared by a particular group of people. Examples of culture include Latinx culture, Black culture, LGBTQ+ culture, and Deaf culture.
Adjust services, policies, outreach, and other approaches after having conversations with the community. These conversations should be:

- Reflective of how the community communicates and shares information, and should be led in conjunction with community members and community support.
- A mix of both individual (informal talks, personal conversations, sharing a meal) and community-wide conversations (town halls, community meetings, group discussions). Before discussing domestic violence and/or domestic violence services, consider how to approach these topics with various audiences and in different settings.

Compensate community members for their input when possible.

Build connections by:

- Making a genuine effort to cultivate trust and relationships with community members and also seek to deepen these connections.
- Being transparent and open about intentions and goals with the community, and be available to answer questions.
- Acknowledging and taking accountability for past harms and unresolved issues, and work to repair those harms before the collaboration moves forward.

Support the community in the ways asked. This could be providing funding or materials, physically showing up and supporting events and community gatherings, amplifying community messages and struggles, and working to dismantle systems of injustice that directly impact this community.

- When offering support, programs should do so in a sincere way and follow the direction of the community.
- It is also essential to follow through when offering or requesting support of any kind and be proactive when it comes to communication.

Intentionally build and expand culturally-inclusive services. Consistent and equitable time, money, effort, and resources need to be allotted to creating, implementing, maintaining, updating, and evaluating services as appropriate in collaboration with key stakeholders (i.e., those from that cultural group). When services are culturally-inclusive from the beginning, they are more effective for survivors. Culturally-inclusive programs should:

- Update current policies, procedures, and materials to be inclusive of different groups' cultural needs.
- Have agency documents and outreach materials available in multiple languages.
- Reflect and accommodate different cultural needs within a program's services, policies, and outreach. These accommodations also extend to the program's physical environment. Some cultural differences to consider include:
  - Grooming products and clothing
  - Music, art, and drama
  - Relationship to personal space, displays of affection, and time
  - Food
  - Language
  - Holidays
  - Religions
- Traditions and customs
- Discussing domestic violence (especially to someone outside of their culture and in group settings)

- Reflect on your own identity, actions, beliefs, and biases. Everyone's perception is framed by their own identity, culture, and prejudices, which influence the program's identity.
  - Domestic violence advocates should to be aware of how their own identities, actions, and beliefs can impact:
    - What privileges they hold and oppressions they face.
    - What they see as "normal" or standard" behaviors, practices, and beliefs.
    - The services they provide.
    - How other survivors and staff members may perceive and interact with them based on their own experiences and identities.
  - Advocates should also be mindful not to let their privileges, biases, or worldview dictate their actions and behavior in a way that contradicts the principles of trauma-informed care.
Cultivating responsive and respectful language

A part of cultural humility is cultural responsiveness and cultural relevance. Cultural responsiveness uses cultural knowledge, prior experiences, frames of reference, and performance styles to make learning encounters more relevant and effective. Cultural relevance is the ability to apply what you’ve learned, heard, and observed to guide your services. Domestic violence programs should work to be culturally responsive and relevant in their programs and specifically with the language and materials they use. Similar to the section above, cultivating responsive and respectful language relies on a combination of researching available information, seeking out community input, and honoring survivors’ individual experiences.

1. Research different terms and concepts pertaining to the culture, including but not limited to:
   a. The context (both historical and present) of the dynamics and prevalence of sexual violence.
   b. How other culturally-specific organizations discuss sexual and domestic violence, perpetration, and healing (e.g., Alianza Latina en contra la Agresión Sexual, Black Women's Blueprint, Southwest Indigenous Women's Coalition, Hopi-Tewa Women’s Coalition to End Abuse; Tahirih Justice Center, FORGE, Red Canary Song, INCITE!, 1in6, VERA, Coalition to Stop Violence Against Native Women, Just Detention, National Organization of Asians and Pacific Islanders Ending Sexual Violence)
   c. How people from that culture:
      i. Refer to and identify themselves, loved ones, and their larger community
      ii. Speak in formal and informal environments
      iii. Share and receive information
      iv. Honor their traditions, customs, and holidays
      v. Have been impacted by different systems (e.g., criminal legal, medical, child welfare, welfare, housing)

2. Proactively invite members from that community to review, critique, revamp, and evaluate your agency's materials.
   a. This review could include, but is not limited to:
      i. Ensuring the language used to discuss domestic violence on agency materials and documents is easily understood and accessible to that cultural group
      ii. Accuracy and relevance of translation and interpretation services
      iii. Accessibility to that specific community
      iv. Effectiveness of outreach, including:
         1. Design and information presented on agency outreach materials (e.g., fact sheets and handouts, program website, and social media)

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2. Methods and locations of previous and current outreach efforts
   b. Programs should repeat this process periodically to keep up with societal, political, internal policy, and cultural changes.
3. Ask survivors about their specific experiences with their identity and culture. Advocates should remember:
   a. While people may be from the same cultural group, each will have a different experience within their cultural group and other intersecting identities.
   b. Questions should be based in curiosity and asked to understand, not make judgments or validate biases. Some sample questions to ask when inquiring about a survivor’s cultural background are:
      i. "What is your cultural background? How would you define your cultural identity?"
      ii. “What cultures are you a part of?"
      iii. "How do you want me to refer to your culture?"
      iv. "Can you tell me what it was like for you growing up?"
      v. "Are there things about your culture that are important for me to know?"
      vi. "I heard you say (repeat the term they used). Can you explain to me what that means?"
   c. Actively listen to the answer given by the survivor. Advocates should also ensure the subsequent actions, services, and referrals are guided by the answers given by that survivor and the survivor has the opportunity to evaluate the services and referrals provided.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFAB and AMAB</td>
<td>Acronyms meaning “assigned female at birth” and “assigned male at birth.” No one, whether cisgender or transgender, gets to choose what sex they are assigned at birth. The terms “AFAB/AMAB” are preferred to “biological male/female,” “male/female bodied,” “natal male/female,” and “born male/female,” which are inaccurate.</td>
</tr>
<tr>
<td>Agender</td>
<td>An umbrella term encompassing many different genders of people who commonly do not have a gender and/or have a gender that they describe as neutral. Many agender people are transgender. As a new and quickly-evolving term, it is best you ask how someone defines agender for themselves.</td>
</tr>
<tr>
<td>Aromantic</td>
<td>The lack of romantic attraction, and one identifying with this orientation. This may be used as an umbrella term for other emotional attractions such as demiromantic.</td>
</tr>
<tr>
<td>Asexual</td>
<td>The lack of sexual attraction, and one identifying with this orientation. This may be used as an umbrella term for other sexual attractions such as demisexual.</td>
</tr>
<tr>
<td>Bisexual</td>
<td>A term for people who experience sexual and/or emotional attraction to more than one gender.</td>
</tr>
<tr>
<td>Bisexual+ Or Bi+</td>
<td>An umbrella term for people who experience sexual and/or emotional attraction to two or more genders. See also: pansexual, fluid, omnisexual, and queer.</td>
</tr>
<tr>
<td>Cisgender/Cis</td>
<td>Adjective that means, “identifies as their sex assigned at birth,” derived from the Latin word meaning “on the same side.” A cisgender/cis person is not transgender. The term cisgender is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life. In discussions regarding trans issues, one would differentiate between women who are trans and women who are not by saying trans women and cis women. Note that cisgender does not have an “ed” at the end and should be used as an adjective. Cisgender can be shortened to &quot;cis.&quot;</td>
</tr>
<tr>
<td>Cissexism</td>
<td>Refers to a system where sex is assigned at birth and binary genders that align with the sex assigned at birth are favored within the system or society or given greater rights or value. Being cisgender is the presumed norm.</td>
</tr>
<tr>
<td>Dyadic People</td>
<td>Refers to someone who is not intersex.</td>
</tr>
<tr>
<td>Gender Affirming</td>
<td>When some engages in behaviors or physical or structural changes to validate or uplift their gender or that of someone else</td>
</tr>
<tr>
<td>Gender Affirming Surgery</td>
<td>Surgery a trans or nonbinary person may have to affirm their gender identity. These surgeries may be only one aspect of a trans person’s transition and not all trans people chose to have surgery. If the surgery is related to their chest, it may be called “top surgery.” If the surgery is related to their genitals, it may be called “bottom surgery.” Trans people may have other surgeries to affirm their gender beyond top or bottom surgery. The following terms are inaccurate, or may be considered offensive or outdated: sex change operation, gender</td>
</tr>
</tbody>
</table>

55 Adapted from the Trans Student Educational Resource’s glossary
56 Note, LGBTQ+ terminology is frequently evolving.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Dysphoria</td>
<td>Anxiety and/or discomfort regarding one’s sex assigned at birth. This term replaced Gender Identity Disorder in the DSM-5.</td>
</tr>
<tr>
<td>Gender Euphoria</td>
<td>The feeling of satisfaction, joy, or intoxication, with the congruence, or rightness, between one’s internal and external gender-related reality (sex and gender, internal experience and outside expression).</td>
</tr>
<tr>
<td>Gender Expression</td>
<td>The physical manifestation of one’s gender identity through clothing, hairstyle, voice, body shape, and more (typically referred to as masculine or feminine). Many transgender people seek to make their gender expression (how they look) match their gender identity (who they are), rather than their sex assigned at birth. Someone with a gender-nonconforming gender expression may or may not be transgender.</td>
</tr>
<tr>
<td>Gender Fluid</td>
<td>A changing (“fluid”) gender identity and/or presentation.</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>One’s internal sense of being male, female, neither of these, both, or other gender(s). Everyone has a gender identity. For transgender people, their sex assigned at birth and their gender identity are not necessarily the same.</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>An identity commonly used by people who do not identify or express their gender within the gender binary. Those who identify as genderqueer may identify as neither male nor female, may see themselves as outside of or in-between the binary gender boxes, or may simply feel restricted by gender labels. Not everyone who identifies as genderqueer identifies as trans.</td>
</tr>
<tr>
<td>Heterosexism</td>
<td>Refers to a system where “opposite” (typically conceptualized as male/female) gender relationships and sexuality are favored and valued over other types of gender relationships, and heterosexuality is the presumed norm.</td>
</tr>
<tr>
<td>Intersex</td>
<td>Describing a person with a less common combination of hormones, chromosomes, and anatomy that are used to assign sex at birth. There are many examples such as Klinefelter Syndrome, Androgen Insensitivity Syndrome, and Congenital Adrenal Hyperplasia. Parents and medical professionals usually assign intersex infants a sex and have, in the past, been medically permitted to perform surgical operations to conform the infant’s genitalia to that assignment. This practice has become increasingly controversial as intersex adults speak out against the practice. The term intersex is not interchangeable with or a synonym for transgender (although some intersex people do identify as transgender).</td>
</tr>
<tr>
<td>LGBTQ+</td>
<td>A collection of identities short for lesbian, gay, bisexual, trans, queer, and more. Sometimes this acronym is replaced with “queer.”</td>
</tr>
<tr>
<td>Mis-gendering</td>
<td>When someone uses inaccurate pronouns or other inaccurate language to identify an individual’s gender (e.g., using he/him pronouns for someone who identifies as a woman and uses she/her pronouns). Mis-gendering can be harmful and is often traumatic for trans and nonbinary individuals.</td>
</tr>
<tr>
<td>Nonbinary</td>
<td>Preferred umbrella term for all genders other than female/male or woman/man, used as an adjective (e.g., Jesse is a nonbinary person). Not all nonbinary people identify as trans and not all trans people identify as nonbinary. There are many different nonbinary identities and nonbinary is not a “third gender.”</td>
</tr>
<tr>
<td>Pansexual</td>
<td>Refers to someone who is attracted to all genders or is attracted to someone regardless of gender.</td>
</tr>
<tr>
<td><strong>Queer</strong></td>
<td>Umbrella term for gender and sexual minorities who are not cisgender and/or heterosexual. There is a lot of overlap between queer and trans identities, but not all queer people are trans and not all trans people are queer. The word queer is still sometimes used as a hateful slur, so although it has mostly been reclaimed, be careful with its use.</td>
</tr>
<tr>
<td><strong>Sex Assigned at Birth</strong></td>
<td>The assignment and classification of people as male, female, intersex, or another sex assigned at birth often based on physical anatomy at birth.</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td>A person’s physical, romantic, emotional, aesthetic, and/or other form of attraction to others. In Western cultures, gender identity and sexual orientation are not the same. Trans people can be straight, bisexual, lesbian, gay, asexual, pansexual, or queer. For example, a trans woman who is exclusively attracted to other women may identify as lesbian.</td>
</tr>
<tr>
<td><strong>The Gender Binary</strong></td>
<td>A system of viewing gender as consisting solely of two opposite categories, termed “male and female,” in which no other possibilities for gender or anatomy are believed to exist. This system is oppressive to anyone who defies their sex assigned at birth, but particularly those who are gender nonconforming or do not fit neatly into one of the two standard categories.</td>
</tr>
<tr>
<td><strong>Trans Woman / Trans Man</strong></td>
<td>Trans woman generally describes someone assigned male at birth who identifies as a woman. This individual may or may not actively identify as trans. It is grammatically and definitionally correct to include a space between trans and woman. The same concept applies to trans men. Often it is most appropriate to simply use the term woman or man. Sometimes trans women identify as male-to-female (also MTF, M2F, or trans feminine) and sometimes trans men identify as female-to-male (also FTM, F2M, or trans masculine). Please ask before identifying someone. Use the term and pronouns preferred by the individual.</td>
</tr>
<tr>
<td><strong>Transgender/Trans</strong></td>
<td>An umbrella term for people whose gender identity differs from the sex they were assigned at birth. The term transgender is not indicative of gender expression, sexual orientation, hormonal makeup, physical anatomy, or how one is perceived in daily life. Note that transgender does not have an “ed” at the end and should be used as an adjective. Transgender can be shortened to “trans”.</td>
</tr>
<tr>
<td><strong>Transition</strong></td>
<td>A person’s process of developing and assuming a gender expression to match their gender identity. Transition can include: coming out to one’s family, friends, and/or co-workers; changing one’s name and/or sex on legal documents; hormone therapy; and possibly (though not always) some form of surgery. Not all trans people transition. It is best not to assume how one transitions as it is different for everyone.</td>
</tr>
<tr>
<td><strong>Transmisogyny</strong></td>
<td>Originally coined by the author Julia Serano, this term recognizes the intersections of transphobia and misogyny and how they are often experienced as a unique form of oppression against trans women.</td>
</tr>
<tr>
<td><strong>Transphobia</strong></td>
<td>Systemic discrimination or violence against trans people, associated with attitudes such as fear, discomfort, distrust, or disdain. This word is used similarly to homophobia, xenophobia, or misogyny.</td>
</tr>
<tr>
<td><strong>Two Spirit</strong></td>
<td>An umbrella term referring to various indigenous gender identities in North America. This term is not used by all Native American Tribes or individuals and should not be used simply because someone identifies as Native American/indigenous.</td>
</tr>
</tbody>
</table>
Inclusive Language Guidelines

- Programs should prioritize the use of gender inclusive language in all forms of written communication (e.g., intake forms, informational materials, handouts), in addition to ensuring verbal communication between staff and participants is gender inclusive. See below for a gender inclusive language resource chart.
- Consistent mis-gendering, or habitually using a person’s incorrect pronouns, should not be tolerated. Similar to the way in which program staff must be diligent in using a colleague or participant’s correct name, using a person’s correct pronouns both in their presence and when referring to them when not in their presence must be intentionally prioritized. Mirroring language, or using the same terms a participant uses when describing a situation or experience, should be implemented -- especially when communicating with a participant who uses language in reference to their gender identity or sexual orientation that staff with which staff may be unfamiliar.
- Questions specific to a participant’s gender identity or sexual orientation should only be asked to better serve the participant or for grant reporting purposes. If these questions are required by funders, participants should have the option to decline to answer. Generally, the only information a program needs is a person’s name and pronouns.
- Trans and non-binary participants may have a different legal name than their chosen name. Program staff should be transparent with participants who may be required to record their legal name that the use of their legal name is only for legal purposes and their chosen name will be used and respected in all other settings. This includes explaining the specific context in which their legal name may need to be documented and maintaining their privacy and confidentiality in regards to the use of their legal name.

<table>
<thead>
<tr>
<th>Inclusive Language Dos and Don’ts</th>
<th>DO say</th>
<th>DO NOT say</th>
</tr>
</thead>
<tbody>
<tr>
<td>trans/transgender</td>
<td>transvestite, transsexual, transgenders</td>
<td></td>
</tr>
<tr>
<td>gender affirming surgery</td>
<td>sex reassignment surgery, sex change</td>
<td></td>
</tr>
<tr>
<td>cis or cisgender man/cisgender woman</td>
<td>biological man/biological woman</td>
<td></td>
</tr>
<tr>
<td>she/her</td>
<td>feminine/female pronouns</td>
<td></td>
</tr>
<tr>
<td>he/him</td>
<td>masculine/male pronouns</td>
<td></td>
</tr>
<tr>
<td>pronouns/personal pronouns</td>
<td>preferred pronouns</td>
<td></td>
</tr>
<tr>
<td>lesbian or gay</td>
<td>homosexual</td>
<td></td>
</tr>
<tr>
<td>orientation/identity</td>
<td>preference/lifestyle</td>
<td></td>
</tr>
<tr>
<td>intersex</td>
<td>hermaphrodite</td>
<td></td>
</tr>
<tr>
<td>dead name/legal name</td>
<td>real name</td>
<td></td>
</tr>
<tr>
<td>name</td>
<td>preferred name</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Inclusive Language: Making the Shift</th>
<th>Gender-inclusive language</th>
<th>Binary assumptive language (to avoid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>everyone/all/folks/folks</td>
<td>ladies and gentlemen / guys and gals</td>
<td></td>
</tr>
<tr>
<td>young people / youth / kids / children</td>
<td>boys and girls</td>
<td></td>
</tr>
<tr>
<td>siblings</td>
<td>brothers and sisters</td>
<td></td>
</tr>
<tr>
<td>they</td>
<td>he or she</td>
<td></td>
</tr>
<tr>
<td>all genders</td>
<td>both genders</td>
<td></td>
</tr>
<tr>
<td><strong>Quick fixes + long-term language inclusivity practices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quick fixes</strong></td>
<td><strong>Long-term</strong></td>
<td></td>
</tr>
<tr>
<td>Include your pronouns in your email signature</td>
<td>Revisit your organization’s name + mission</td>
<td></td>
</tr>
<tr>
<td>Include your pronouns in your Zoom name</td>
<td>Implement program policies specific to mis-gendering</td>
<td></td>
</tr>
<tr>
<td>Share your pronouns when introducing yourself</td>
<td>Update intake forms to include a pronoun fill-in option</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Update written materials with gender-inclusive language</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Update related forms to include the setting in which a participant’s name or pronouns are safe to be used</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Require LGBTQ+ training as part of the onboarding training process for new employees</td>
<td></td>
</tr>
</tbody>
</table>
Non-discrimination Policy\footnote{Model adapted from the Transgender Law Center}

It is the policy of [Your Organization Name], in accord with federal, state, and local laws, to prohibit all forms of harassment and discrimination of or by clients, employees, visitors, and volunteers, on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity, based on an individual’s association with a person or group with one or more of these actual or perceived characteristics. Retaliation against an individual who files a complaint of harassment or discrimination against [Your Organization Name] employees, visitors, volunteers, or other clients, or who participates in an investigation of such a complaint, is strictly prohibited. [Your Organization Name] shall ensure that all clients, employees, visitors, and volunteers receive notice of this policy.

TRANSGENDER AND GENDER NONCONFORMING INCLUSIVE INTAKE AND SHELTER PRACTICES\footnote{For additional information see “Is Your “T” Written in Disappearing Ink? A Checklist for Transgender Inclusion” from FORGE}

Establishing Gender Identity of Client

The self-identified gender identity of each person shall be respected and is sufficient for the purposes of determining gender-appropriate shelter. A person’s gender does not depend on whether or not they have had surgery or other medical treatments or whether or not they are perceived to “pass” as the gender with which they identify. Simply put, a person is the gender they say they are. Staff may not inquire into the medical or surgical status of a transgender client’s transition outside of what is asked of all clients (e.g., specific physical and mental health needs being addressed by the program).

Confidentiality and Privacy

A person’s transgender status is confidential and private and shall be treated like all other confidential personal and medical information. Staff must never disclose a client’s transgender status to other clients or staff, unless such disclosure is specifically necessary for service provision, or authorized with express permission by the client.

Physical Accommodations

[Your Organization Name] will make gender-appropriate bathroom and bedroom facilities as well as changing areas available to transgender and gender nonconforming (TGNC) clients. People who identify as women and who feel safer housed with women rather than with men are to be housed with the women and use the women’s showers and bathrooms. Transgender women shall have the same access to bathrooms, showers, changing areas, and bedrooms as persons assigned female at birth. People who identify as men and who feel safer housed with men rather than women are to be housed with the men and use the men’s showers and bathrooms. Transgender men shall have the same access to bathrooms, showers, changing areas, and bedrooms as persons assigned male at birth. People who do not feel safe in the shelter that matches their gender identity, or who identify as neither male or female, are to be housed in and
use the bathrooms and showers in the section in which they feel safest. TGNC clients should be subject to the same rules about appropriate behavior in bathrooms and showers as all clients. No additional rules are required.

**Safety and Privacy of Physical Accommodations**
Reasonable accommodations may be made for any individual, transgender or not, who has expressed safety or privacy needs. Reasonable accommodations are made according to each individual’s needs and the ability of the agency to provide such accommodations. Under no circumstances will a TGNC person be required to use alternative facilities—including as an “accommodation” for another person’s discomfort. Reasonable accommodations may include:

- Doors on bathroom stalls that can be latched or locked
- Curtains or other devices in bathrooms or showers that provide the client with privacy
- Alternate times to use the bathrooms or showers, if requested
- Monitoring of showers or bathrooms to control entrance and exiting
- Alternate housing arrangements for unique situations
- Set-aside sleeping, such as rooms or beds that are separate from others, if requested
- Segregated sleeping where one wing is set aside
- Availability of beds close to night staff

**Eligibility for Services**
Gender identity and gender expression will not be used to deny services to any individual.

**Provision of Services**
TGNC clients who are approved for services shall be provided with the same range of services available to other similarly situated clients.

**Pronoun Use**
Staff shall only refer to clients using the client’s preferred gender pronoun (generally speaking, common pronouns include she/her, he/him, they/them. Some people use multiple pronouns, such as she/they. Some people use neo pronouns, such as ze/zir). This includes all verbal or written communications with the client, as well as those communications about or in reference to the client with other staff or clients, and in all reports or other documents relating to the client’s case. If staff members are unsure of what pronoun to use with a client they should privately ask that person what pronoun they prefer. If there is no immediate opportunity to speak with the client, in the interim the client’s name should be used to substitute the pronoun (for example: Alex told me that Alex was feeling depressed and would like to participate in the support group), or staff can use a gender-neutral pronoun (e.g., they/them) until they have a chance to confirm the client’s preferred gender pronoun.

**Dress Code**
No additional dress code restrictions shall be placed on transgender clients outside of what is asked of all clients. If a dress code is deemed necessary by the Agency/Organization, it should be gender neutral. If there are gendered dress codes, transgender clients should be asked to comply
with the dress code associated with their gender identity; gender nonconforming clients should be allowed to choose the dress code with which they feel most comfortable.

**Harassment**
Harassment of all kinds is prohibited. Discriminatory and prejudice-motivated comments or other behavior that creates a hostile environment will not be tolerated whether from staff, volunteers, or other clients. If clients, staff, or volunteers are harassing any person, including a TGNC person (or someone perceived to be TGNC), staff must intervene and ensure that the harassment stops. Any staff person’s or volunteer’s refusal to work with a TGNC client should result in disciplinary action.

**Guidance for Addressing Concerns of Other Clients**
If clients approach either shelter staff or transgender or gender nonconforming clients with concerns, fears, or objections to the presence of a TGNC client, staff should immediately intervene to explain the program’s nondiscrimination policy. When approached by clients who are concerned about sharing accommodations with TGNC clients, staff should patiently explain to those clients that the TGNC person is not a threat to them and they should be respectful of everyone’s right to access the shelter, including people whom they perceive to be or who identify as transgender or gender nonconforming. Clients need to understand that the shelter is a community where everyone is to be welcomed and respected. Staff can address these situations the same way they would deal when a client does not want to sleep near a person with a disability or a person of a different religion.

**Posting and Distribution of Policies**
Anti-discrimination policies shall be publicly posted and distributed to staff, volunteers, and clients. Written copies of these policies shall be made available to anyone who requests them or who might benefit from familiarizing or re-familiarizing themselves with them.

**Training**
In furtherance of these policies, training curricula and educational materials shall be developed for clients, staff, and volunteers. The training curricula and educational materials developed under this policy should: (1) inform clients, staff, and volunteers about the policy, (2) increase cultural competency about transgender and gender nonconforming identities, and (3) inform clients, staff, and volunteers how to comply with the policy and the legal right of all people to be free from discrimination on the basis of gender identity or gender expression.
Gender-Segregated Services Policies

It is best practice to have gender-inclusive domestic and sexual violence services; however, if gender-segregation or gender-specific programming is necessary to the essential operation of a program, providers must extend comparable services to individuals who cannot be provided the gender-segregated or gender-specific programming (34 U.S.C § 12291 (b)(13)(B)). This includes having a clear, written policy addressing the placement of transgender and nonbinary clients, providing the maximum amount of choice to clients about gender-segregated services as possible. Transgender and nonbinary placement policy criteria for gender-segregated or gender-specific services:

- Policy is written
- It is clear to clients and staff who can be admitted to or included in programming, shelter, and services
- Policy explicitly addresses how placement of trans and nonbinary clients into services will be determined
- Policy explicitly addresses room, roommate placement, if applicable
- Client allowed maximum self-determination
- Placement decisions are explicitly protected from other clients’ complaints (e.g., a trans person won’t be removed or re-assigned due to another client’s gender-based complaint)
- Equal access to services is guaranteed (this can refer to adherence to funder/federal guidance or internal policies that note that all clients entering a program/service will have equal access to services as other clients allowed entrance)

Sample gender-segregated policy for shelter placement

Due to the limited number of beds and rooms, [Your Organization Name] provides gender-segregated shelter services. All survivors in need of shelter services will be offered shelter or a motel/hotel placement unless we have reached capacity.

A. Shelter placement: The shelter is available to women only. Men in need of shelter are to be placed in a hotel. Those who identify outside of the gender binary are to be given a choice of placement. Participants who identify as women and who feel safer housed with women rather than with men are to be housed with the women and use the women’s showers and bathrooms. Transgender women shall have the same access to bathrooms, showers, changing areas, and bedrooms as persons assigned female at birth. Participants who identify as men and who feel safer housed with men rather than women are to be placed in a hotel. Transgender men shall have the same access to bathrooms, showers, changing areas, and bedrooms as persons assigned male at birth. Participants who do not feel safe in the shelter or hotel that matches their gender identity, or who identify outside of the gender binary (e.g., nonbinary, genderqueer, agender) are to be given a choice of placement in the shelter or hotel, wherever they feel safest. Some transgender participants may not disclose their trans status and should not be forced to disclose their status to...
receive shelter services. During intake, all participants will be asked their gender and placement will be determined based on the response to that question (e.g., a participant identifies as a woman and will be placed in shelter). Placement decisions will not be made based on perceived gender or gender expression. In the case where a participant does not wish to disclose their gender, the client will be given a choice of shelter or hotel placement.

B. **Room sharing/Roommates:** Depending on shelter and hotel capacity, single participants may need to share a room with other participants. Single participants who disclose they identify as transgender will be ensured that their identity will be protected as much as they wish it to be. If a trans participant expresses discomfort or is harmed by their roommate (harm including but not limited discrimination, microaggressions, verbal and/or physical abuse), efforts will be made to change rooms of the person causing harm depending on space capacity and shelter staff will work with the person causing harm to remind them of the non-discrimination policy and educate them about transgender issues.

C. **Protection from transphobia:** Shelter staff will ensure all transgender and nonbinary clients are protected from transphobia from other residents. In the event staff are made aware of a transphobic act (e.g., a resident informs staff, staff witness the act), staff will take measures to separate the person who caused harm from the trans client. Staff will remind the person causing harm about the shelter’s non-discrimination policy and provide education about transgender issues. Depending on the severity of the transphobic act (e.g., violence occurring, recurring transphobic behaviors after staff intervention), the person causing harm may be removed from services in accordance with the termination of services policy.

D. **Equal access to services:** The shelter will guarantee equal access to services for all participants placed in the hotel. A number of services take place specifically at the shelter, such as support groups. All participants in the hotel will be informed as to what services are taking place and how to access them. Transportation will be provided to and from the hotel and shelter for hotel participants who want to participate in these services.

E. **Children:** Trans, nonbinary, and gender nonconforming children who accompany a parent will not be discriminated against and will be placed with the parent in the shelter or hotel depending on the parent’s gender identity. Children’s identity shall not determine where the family is placed or be a reason to deny services. Children shall not be forced or encouraged to act or behave in ways that conform to the gender binary or to their sex assigned at birth.
Vetting Referrals for LGBTQ+ Clients

When giving LGBTQ+ clients referrals it is imperative to vet these resources to ensure that are truly LGBTQ+ inclusive. LGBTQ+ clients face considerable barriers accessing inclusive services, and receiving a referral to an organization that is discriminatory or uninformed on LGBTQ+ considerations may further discourage that individual from accessing services and impact their trust of you and your organization.

Consult with LGBTQ+ movement leaders and organizations in your community. Identify LGBTQ+ specific organizations and learn what services and programs they provide. Take time to meet them and learn about the work they do, and share information about your program. This can be a way to verify the work they do, build a connection, and identify additional community resources. When you discover resources online, read reviews and participant experiences on social media and call or tour organizations learn about their work. Pay attention to how they talk about LGBTQ+ clients and ask them specific questions to ensure the services they provide are LGBTQ+ inclusive.

Do not refer to LGBTQ+ conversion therapy.
Conversion therapy is a dangerous and ineffective practice and clients should never be referred to these practitioners. Youth are often targeted for conversion therapy, and it increases risk of depression, anxiety, substance abuse, homelessness and suicide.

Tools on Vetting:

Take note of language: from employees, the company website or materials onsite:

- Are services unnecessarily gendered for who they serve, LGBTQ+-friendly providers should be using words like “person who menstruates,” “pregnant person,” instead of labeling all of these as “women’s” services.
- Are employees using gendered language, including assuming pronouns and sexuality
- Do they have resources and services specifically for LGBTQ+ clients mentioned or listed on their website or social media
- Do a google search to see if they provide donations to LGBTQ+ or allied organizations and search their litigation history

Questions to ask. Keep note of answers, as well as response time, tone, and general reaction to the question.

- Do you regularly work with LGBTQ+ clients or would someone coming here be one of the first?
  - Note, it is important to also ask about specific identities, especially trans and bisexual+ identities. Being competent in serving one identity does not mean an organization is competent to serve all LGBTQ+ identities.
- How long have you been serving LGBTQ+ clients?
- Does your facility have gender-inclusive bathrooms?
- Do you have a nondiscrimination policy? How are LGBTQ+ individuals included in this policy?
- Does your program have any LGBTQ+ employees on staff?
• Does your organization require any LGBTQ+ competency trainings?
• Does your program regularly ask pronouns upon intake?
• How do you ensure names and pronouns of clients are respected?
• Ask to see copies of any intake/client/patient forms: look at language and whether it aligns with *Inclusive Language Guidelines* above.
Outreaching to the LGBTQ+ Community

Providing gender-inclusive services begins with an agency’s outreach efforts. How do members of the LGBTQ+ community identify an agency as inclusive and safe? Are LGBTQ+ survivors given equal space and representation in outreach efforts? The following recommendations aim at providing inclusive messaging and imagery in various common forms of outreach:

Website and Social Media

- Language in all forms of written communication used for promoting services online (website, agency social media profiles) should prioritize the use of gender-inclusive language. See LGBTQ+ inclusive Language Chart.
- Acknowledge the barriers LGBTQ+ survivors face in disclosing, accessing services, and healing.
- Remember a picture tells a thousand words. Visual content such as photos of LGBTQ+ individuals should be used throughout all media, not only as part of LGBTQ+ specific segments or posts. Images should show a range of relationships, everyday situations, and empowering imagery. Ensure imagery is respectful and appropriate for the intended communication.60
- Be inclusive with titles. If you have a contact form or chat option, allow the selection of gender-inclusive titles (e.g., Mx.).
- If the webpage includes a resource page, include LGBTQ+ resources at both a local and national level.
- If chat services with program staff are available on the agency website, ensure the staff member uses gender-inclusive language and mirrors language used by the survivor if they are unsure of the meaning.
- If posting on social media platforms as a part of awareness related activity (Domestic Violence Awareness Month, Teen Dating Violence Awareness Month, Sexual Assault Awareness Month, Pride Month/June), include information and resources for LGBTQ+ audience members.
- LGBTQ+ outreach and awareness activities should be done year-round and not only during June/Pride Month.

Promotional Material

- As with language on webpages and social media, any informational material about the agency should prioritize the use of gender-inclusive language
- If the agency is providing a written list of local and national resources, include LGBTQ+ specific agencies, and ensure the resources cover all age ranges (youth, adult, elder)
- If the agency posts material in community spaces, visual content should be representative of all communities receiving services, including LGBTQ+ survivors.

Building Relationships with the LGBTQ+ Community

60 Gender-inclusive stock photos: https://genderphotos.vice.com/
To increase support for the survivor and knowledge of staff in the agency, connections with agencies offering support in multiple capacities to LGBTQ+ individuals is essential. Collaboration increases the number of safe places for survivors and identifies allies throughout the survivor’s local community.

- Relationships should be pursued with agencies both at a local and state level. Familiarity with established national organizations is also encouraged.
- Reach out to LGBTQ+ movements in the communities the agency is servicing, to establish a relationship and learn what services they offer, as well as other agencies with which they have relationships.
- Seek input from the LGBTQ+ community regarding programming and outreach initiatives.
Tips for programs on what it means to be gender-affirming

Gender-affirming

Gender affirmation is a framework that recognizes and honors a trans and/or nonbinary person’s experience with their own gender identity. Programs can practice gender affirmation through the language they use (for example, name and pronouns), the gender-affirming products they provide (chest binders and gaffs), the education they provide on accessing gender-affirming medical care if desired (such as hormone replacement therapy or gender-affirming surgeries), and ultimately by understanding that gender affirmation is unique to each person and is not a one-size-fits-all approach. Gender affirmation is similar to a survivor-centered framework in that it recognizes the importance of supporting a survivor’s bodily autonomy and decision-making abilities, and providing participants with choices for what gender affirmation looks and feels like for them. Much of the gender affirmation process is based on what is personally affirming to a trans and/or nonbinary person, what feels safe to pursue, and what is available and accessible.

Resources for gender-affirming medical care

One element of gender affirmation is medical transition. Medical transition is an optional form of medical care for trans and/or nonbinary folks and its purpose is to allow trans and/or nonbinary people the autonomy to make decisions regarding their bodies in order to feel more congruent with their gender identity and comfortable within their bodies. While transition-related medical care is critical and even life-saving for many trans people, it is not a requirement of being a trans person and is an element of transition that many trans and/or nonbinary people may choose not to pursue.

Medical transition-related care looks different for each trans and/or nonbinary person. When providing medical transition-related referrals, it is important for programs to vet the medical care providers as the process of receiving any form of medical care as a trans and/or nonbinary person can be traumatizing and/or triggering and transphobia is a pervasive issue in the medical field. Gender-affirming medical procedures can include:

- hair growth or removal treatments
- hormone replacement therapy
- various gender affirming surgeries to make one's face, chest, and/or anatomy more in line with one's gender identity

Resources for gender-affirming legal needs

Some trans and/or nonbinary people may choose to change their legal name and/or gender marker. This requires trans and/or nonbinary people to navigate the costly process of changing their legal documents, including but not limited to a person’s:

- birth certificate;
- passport;
- social security card;
- driver’s license;
- banking information;
- bills;
- paychecks and other employment related documents; and
- academic records, diplomas, and certifications.

Programs can provide gender-affirming support to trans and/or nonbinary participants by supporting participants in navigating legal name and gender marker changes. Programs should consider providing flexible financial assistance to trans and/or nonbinary participants interested in making these gender-affirming legal changes. Programs should also consider building community partnerships with legal aid organizations who can provide these services to trans and/or nonbinary participants at low- or no-cost.

**When a person is transitioning while in a program**

Gender transition looks different for every person. Coming out as trans and/or nonbinary is a brave and bold decision in a world where transphobia and violence against trans people is normalized. Supporting a person in the beginning stages of their transition journey, whatever that journey looks like for that particular individual, includes providing much of the same validation, support, and advocacy that victim service providers are already trained and accustomed to providing. An especially important and supportive role victim service providers can play in practicing gender affirmation with trans and/or nonbinary participants is by asking how they can support that person’s transition process. A few additional tangible ways service providers can help include:

- Being supportive
- Listening
- Removing judgment
- Asking about pronouns (for example, she/he/they/ze) and their name at the same time (refer to the inclusive language charts)
- Updating their name and pronouns in agency documents
- Safety planning around the changes that may occur with medical care, legal documents, and with friends and loved ones
- Informing staff in a way that is supportive of the person transitioning

Additionally, programs can provide gender-affirming supplies and request gender-affirming supplies during donation drives. Gender-affirming supplies might include:

- Chest binders (compression undergarment to compress breast/chest tissue) in a variety of shades and sizes
- Tuck kits/gaff (tucking hides external genitals by providing a smooth appearance)
- Shapewear in different shades and sizes
- Packer/packer straps (packing is wearing padding or a phallic object in the front of the pants or underwear to give the appearance of having a penis)
- Breast forms
- Clothing in extended sizes, up to and including 6XL
- Shoe size inclusivity
  - Have diverse shoes styles in extended sizes, up to and including size 15
- Wigs of varied shapes, lengths, styles, textures and colors
- Gender neutral personal hygiene products
- Look for items in a range of colors and patterns. If choices are limited, select the most gender-inclusive (or gender neutral) option.
  - Menstruation products
  - Soaps/body wash
  - Shampoo and conditioners
  - Shaving items and creams
  - Hair clippers
  - Make-up and nail polish
Medical Trigger Disclosure Cards

Please be patient with me; medical settings and procedures can be triggering for me.
1. Please thoroughly explain what you'll be doing before you start and continue to explain with each new step.
2. Please check in before changing the positions of your hands/equipment/etc. and give me time to truly answer.
3. The best way to help me if I am triggered is to:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

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