NATIONAL
Center on
Domestic Violence, Trauma & Mental Health

The Domestic Violence Coalitions' Needs Assessment Survey

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October 2012

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Acknowledgments

Several people played an integral role in the development of the Domestic Violence Coalitions Needs Assessment Survey and report. Carole Warshaw MD, the Director of the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH), guided the overall development of the survey. Samantha Wrona, M.A., NCDVTMH's Research Associate/Information Specialist, provided invaluable help in devising the survey, formatting it for the internet, and in following up with state coalitions to obtain data. Cheryl Howard, the Director of Coalition Programs and Technical Assistance Specialist at the National Network to End Domestic Violence (NNEDV), was integral to the success of this survey. She reviewed survey questions, worked closely with NCDVTMH to distribute the survey to coalition directors, and provided reminders to coalition directors to ensure a high response rate. In addition, Mao Yang of NNDEV; Ann Menard of the National Resource Center on Domestic Violence; and Cris Sullivan, Ph.D., of Michigan State University provided substantial assistance and feedback on survey design. Finally, we would like to thank all of the state and territory coalition directors who took the time, thought, and energy to complete this survey.

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Introduction

Domestic violence (DV) is a pervasive problem that threatens the physical, psychological, emotional, and material safety of women and their children. In the United States each year, millions of women are assaulted by intimate partners. A recent national survey by the U.S. Centers for Disease Control and Prevention found that more than a third of women in the United States have been physically assaulted, sexually assaulted, and/or stalked by intimate partners (Black et al., 2011). Research conducted over the past several decades has shown that many women experience trauma-related mental health and substance use effects from domestic violence (e.g. Bonomi, et al., 2006; El-Bassel, Gilbert, Wu, Go & Hill, 2005; Logan, Shannon, Cole & Walker, 2006; Logan, Walker, Cole & Leukefeld, 2002). In addition, women who have a mental health diagnosis or use substances are at greater risk for abuse (e.g. El-Bassel et al., 2005; Kilpatrick, Acierno, Resnick, Saunders & Best, 1997), due in part to stigma associated with those conditions. Although women may recover relatively quickly if they are able to access resources and support and the abuse is less severe and does not continue over a long period of time (Bonanno, 2004), for others the effects can include longer-term depression, anxiety disorders and PTSD (Coker et al., 2002). In addition, survivors of domestic violence often experience many other types of trauma, including cultural, historical and political trauma as well as childhood abuse and sexual assault (Warshaw, Brashler & Gil, 2009)

All of these factors, in turn, can affect survivors' access to and experience of services. Survivors' reactions to abuse can also affect the people who help and support them. It is not surprising, then, that accessible, welcoming culturally relevant, trauma-informed (TI) domestic violence services and organizations are important. TI *services* are sensitive to the pervasiveness of trauma and its impact on survivors, including how trauma affects a survivor's ability to cope, to access services, and to feel safe both physically and emotionally. Such services are strength-based and non-pathologizing; they take steps to identify potential trauma triggers, reduce retraumatization, and attend to the quality of interactions for both people using services and for staff. TI *organizations* provide an environment and structure that is inclusive, welcoming, destigmatizing, and non-retraumatizing for survivors and staff. TI *organizations* use a variety of strategies to attend to the emotional needs of all staff members, from recognizing vicarious trauma, to addressing self-care in substantive ways, and providing supervision and support so that no one feels alone in doing the work (Warshaw, 2008).

In recent years, service providers across disciplines have increasingly recognized the importance of TI approaches, including domestic violence programs and advocates. In several states, domestic violence coalitions have taken leadership in promoting TI services and organizations, by supporting programs, building interagency collaboration, and promoting TI policy change at the state and local level.

This year, the Family Violence Prevention and Services Program (FVPSA) office asked the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) to conduct a needs assessment with state, territory and Washington D.C. domestic violence coalitions to identify their current exposure and experience with TI approaches, and to help identify supports they would find helpful in working with DV programs and other agencies in their state. This document provides the results of that survey. It is part of a multi-year effort by NCDVTMH to support coalitions in their efforts to enhance the development of accessible, trauma-informed, culturally relevant DV services and organizations. The survey was

conducted in partnership with The National Network to End Domestic Violence (NNEDV), and the state, territory and Washington D.C. DV and DV/SA Coalitions.

How the Survey Was Conducted

In a nationwide effort to identify training and TA priorities, research needs, and to establish baseline information on the state of trauma-informed work at the local program and coalition levels, the Domestic Violence Coalitions Needs Assessment Survey was distributed to 56 state and territory coalition directors. On August 8, 2012, the survey was posted on the National Network to End Domestic Violence (NNEDV) director's listserv. Along with a brief description of the survey's purpose, the posting included a link to the survey, which was housed on a secure and confidential SurveyMonkey page. As participation was voluntary, coalition directors received multiple reminders to encourage survey completion.

Surveys were filled out by coalition directors or their designees in 47 states and territories, yielding an overall completion rate of 84%. Of the 47 surveys completed, 19 (40%) were completed by representatives from coalitions with a dual focus on domestic violence/sexual assault, and 28 (60%) were completed by representatives of coalitions with a primary focus on domestic violence only. The sample is geographically representative and includes states from each region in the United States, including territories. When comparing responders and non-responders, no differences were found in state size, geographic region, or population.

The survey itself consists of 32 questions and covers the following topics:

- Prior training/TA at the state coalition level, covering topic areas and training formats
- Coalition self-assessment of preparedness to provide training/TA to member programs
- Mechanisms for obtaining input from survivors on responsiveness to trauma, mental health, and substance abuse needs
- Coalition staff background in trauma, mental health, or substance abuse
- Coalition responsiveness to the trauma and self-care needs of its staff
- State-level collaborations with multidisciplinary or multi-organizational task forces/working groups
- Relationships with culturally specific organizations
- Barriers faced in influencing state and local policy on trauma, mental health, or substance abuse
- Factors that help coalitions influence state and local policy
- Coalition assessment of how well programs in state are doing in providing services
- Model programs
- Supports coalitions provide to member programs
- Challenges faced
- Preferred formats of future training and TA from NCDVTMH
- Priority of topic areas for future training and TA from NCDVTMH.

Preliminary findings were presented in an initial summary report, which was reviewed by NCDVTMH's

Advisory Board and Research Work Group[1]. The thoughtful input, insights, and suggestions from both the Research Work Group and the Advisory Board have proven instructive and invaluable, and have guided the final analysis and report for the Domestic Violence Coalitions Needs Assessment Survey.

[1] The Research Work Group is a culturally diverse panel of experts in evaluation of DV services outcomes; evidence-based, survivor-defined advocacy interventions; impact and intervention in DV; and DV, trauma, and MH in culturally specific communities. The Advisory Board assists in the steering of NCDVTMH and is a diverse group of experts from all areas of the field, including advocates, researchers, hotline directors, legal experts, coalition directors, and directors of culturally specific organizations.

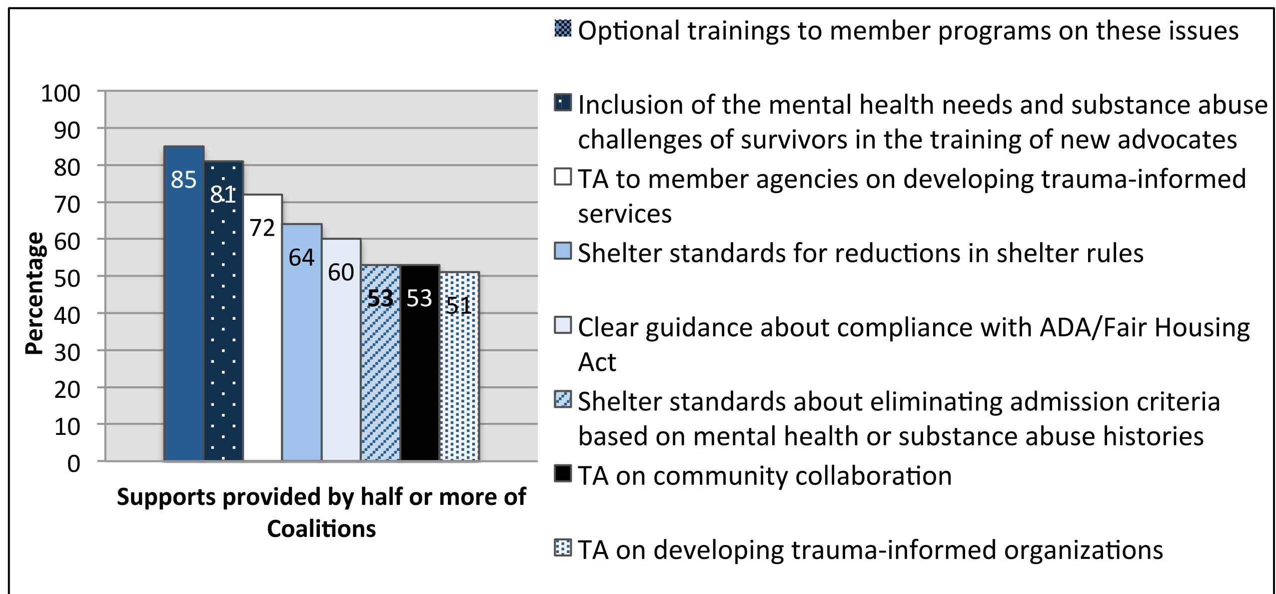
Results

This section highlights the major findings of the Domestic Violence Coalitions Needs Assessment Survey; it includes both quantitative data and substantive qualitative data (responses coalition directors gave in their own words). The complete quantitative data are in table format in Appendix A.

We view this survey and its findings as supportive of the range, depth, and importance of the work being done on behalf of survivors of domestic violence, at both the program and state/territory coalition level. It will help to inform how the NCDVTMH can support the continuing development of accessible, trauma-informed, culturally relevant, and linguistically appropriate domestic violence services and organizations. It is also meant as the basis for an ongoing dialogue among programs, coalitions, the NCDVTMH, NNEDV, and FVPSA on how to support survivors of domestic violence.

Supports to member agencies

Coalitions described supports they provide to member agencies to help them to respond more effectively to women and children experiencing the mental health consequences and substance abuse challenges of DV, using a checklist of 20 possible supports. Respondents also had the opportunity to use their own words to describe other supports, special projects, and other resources for programs in their state. On average, coalitions reported providing around 10 types of supports to member agencies, with a range of 0 to 20 different kinds of supports. The following graph illustrates the supports reported by half or more responding coalitions:



Two of the top supports are related to TA on trauma-informed approaches: 1) 72% of coalitions report providing TA to member agencies on developing trauma-informed *services*, and 2) and 51% of coalitions report providing TA on developing trauma-informed *organizations*. All of the coalitions that provide TA on developing TI organizations *also* provide TA on developing TI services (no coalitions provide TA on developing TI organizations *without providing TA on developing TI services*).

Sixteen Coalitions provided descriptions of supports *in their own words*. Most described materials and training, as in the following examples:

- Preparing a series of Technical Assistance bulletins on these and other topics to be used as "Tip Sheets" by advocacy staff. Creating on-line courses for new advocates on these topics- launch dates of October 1st and January 1st. This also involves updating/revisions to the current Coalition-mandated training standards and tools for programs. Developed and still expanding on-site training sessions (conducted by Coalition staff) for shelter programs on trauma, trauma-informed principles, and creating change. Also, sessions focused on vicarious trauma, compassion fatigue, and burnout. Crafted a Crisis Response Tool Kit for incidents of death or homicide impacting any of our programs. The kit includes model response plans, availability of a state-wide cadre of trauma-informed therapists as resources and TA provided by the Coalition.
- We have incorporated this information into our basic and advanced training and increased the number of those trainings. We are developing BOD training tools that include trauma-informed practice, we are speaking with our state legislature and related committees, and in general are working informally with programs to plant the seeds. Our new strategic plan is focused on the issue of creating trauma-informed organizations. We are in collaboration with a number of groups, especially doing joint training.

Some described collaborative efforts, for example:

- [Name] grant to address DV/IVP with people who have disabilities; developing collaboration with CCS on supporting "go to" clinical staff who have special knowledge and expertise in addressing DV/IVP using a trauma-informed approach; providing expertise on state's mental health transformation grant, and serving on Trauma-Informed Care conference [which] will include DV/IVP advocates.
- We collaborated on a training curriculum and were also involved in the multi-issue Unserved/ Underserved Access Project (which included, among other things, TAT on mental health/ substance abuse/trauma-informed issues)

Others described changes in program standards, as in the following:

- We are in the process of revising our standards and will be including language on TIC. We have very heavy empowerment language in the standards that often gets interpreted here as something that looks close to TIC. We do have standards about limiting rules in shelter and imposing no conditions on entry. Coalition staff do extensive training on all federal protections that require programs to serve persons with mental health and substance abuse issues. This training is part of the required basic 40-hour training which we are currently updating to include more information on TIC.
- Developed statewide project on Shelter rules; published nationally distributed manual for project replication

Some have developed manuals, for example:

- Trauma-Informed Care manual that was written by [Coalition] staff in collaboration with local programs. TIC manual is available on [Coalition's] website with accompanying webinar… [Coalition] offers a training on AOD [alcohol and other drugs] and DV which has been offered statewide multiple times over the last 7 years and has also been provided onsite for local

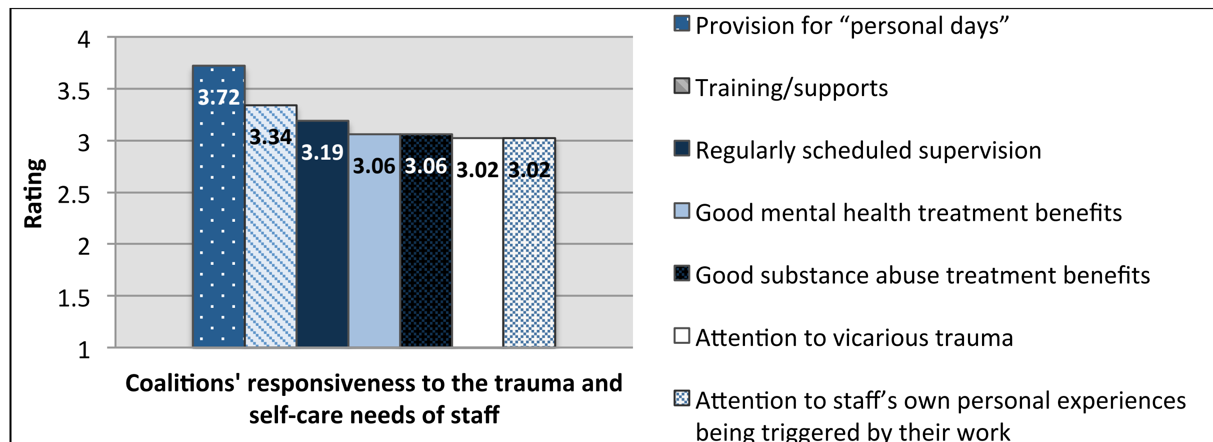
programs for their staff only. Currently, coalition does not have funding to designate a trainer for these issues specifically and does not have sufficient staff to do this work.

Other approaches were also described, as in the following:

- We don't provide "basic orientation training for new advocates," but have woven some of this content through the sample advocate curriculum we developed. Similarly, we don't set "shelter standards" per se, but have provided a number of opportunities for shelters to access TA and peer learning/support regarding these issues… We've found our local member programs are most receptive to this information on a voluntary basis and hence, we've created a number of opportunities for peer-to-peer training, sharing and discussions (i.e., our monthly Shelter Managers' Peer Conference Call, etc.).
- Currently developing learning communities for Executive Directors, advocates, and counselors. As part of these learning communities Coalition staff will be providing training on trauma-informed services and will include agency self-assessments, readiness assessments of all participants, and skill practice

Coalition support for the trauma and self-care needs of staff

Coalitions described the extent to which they respond to the trauma and self-care needs of their own staff. Respondents rated coalition attention to staff self-care needs across 11 topics, using a four-point scale ranging from 1 (not at all), 2 (a little bit), 3 (somewhat), 4 (very much). Overall and across all topics, coalitions reported that they respond "somewhat" to the trauma and self-care needs of their staff, with individual coalition responses ranging from "not at all" to "very much." Across all coalitions, "provision for 'personal days'" had the highest average rating, and "support and resources for staff sobriety" had the lowest average rating. The graph below shows, on average, the top seven ways that coalitions address the trauma and self-care needs of staff members.



Seven coalitions gave additional information on ways that the trauma and self-care needs of staff are addressed. The following four responses provide additional detail:

- Due to the number of staff sensitized to issues of trauma, we have several folks who are especially attuned to recognizing signs of vicarious trauma, compassion fatigue and/or burnout in each other. They are frequently our best resources for helping another staff member. But this takes place on an informal basis and sometimes outside the worksite.
- Staff can use 4 hours per week for wellness activities such as exercise, yoga, etc.

- We have recently formed a wellness committee that is working on promotion of staff wellness opportunities.
- We actively supervise using a reflective model that explores finding work/life balance.

Culturally specific organizations, resources, and services

Coalitions were asked to provide information on culturally specific DV/SA programs, connections with culturally specific organizations, and the availability of culturally relevant resources in their states. 28 coalitions (61%) reported that they have relationships/connections with state or local culturally specific organizations to work on issues concerning the relationship between DV/SA and mental health, substance abuse, and trauma. 27 coalitions provided additional information in their own words.

Some named collaborations with generic state agencies, for example:

- We collaborate with Alliance Child Maltreatment Prevention.
- We work with the territory mental health division
- [Coalition] partners in a rural grant with [State] DHHS, which involves child welfare services and policy-level initiatives including health and trauma-informed initiatives. This work involves collaboration with the [State] Office for Multicultural services. [State] partners with other culturally specific organizations where issues of health, substance abuse and/or trauma are addressed in the work, but are not the specific topic focus of the work.

Others named agencies with a particular focus:

- LGBTQ task force, Immigrant Victims Network
- 3 DV/SA programs in [State] are culturally specific organizations, including Latina-specific, native, and GLBTQ. Two of the three have been involved in the trauma-informed work that the Coalition has been doing.
- We are trying to outreach to the Puerto Rican, Dominican Republican and Haitian populations. The last two are our newest immigrants. There are few organized groups.
- We work with some of the Tribal organizations in the state. This has mostly been sharing information and training and not on-going projects.
- Yes, we work with [Organization] which works with the LGBTQI population and several community-based organizations that work with immigrant/refugee populations, and [Organization] which works with the Deaf and Hard of Hearing survivors. Currently, we do not think any of them are working on issues specifically related to mental health, substance abuse or trauma.

Others described cross-cultural collaboration as a consistent approach:

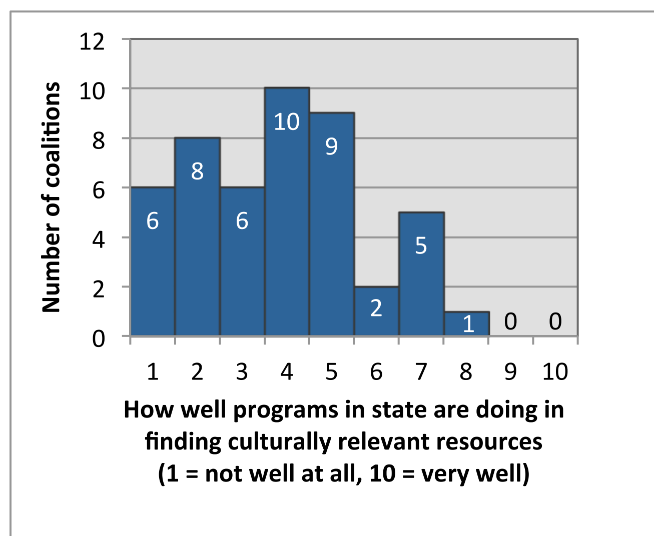
- [Coalition] ensures that underserved communities and their unique needs are consistently incorporated into all collaborative endeavors.
- [Coalition's] Women of Color Coalition considers these issues and brings recommendations to us. We work closely with Latino Community Development Agency.

A total of 17 coalitions (40%) reported that there are culturally specific DV/SA programs within their state that address mental health, substance abuse, and/or trauma. Eleven provided further information

in their own words. The following are the responses with the clearest descriptions; several also illustrate funding strains:

- [Coalition] has task forces that address special needs of women of color, also LGBTQ. [Coalition] is also working on a project addressing DV/IVP with people with disabilities.
- [Organization] is a culturally specific program targeting members of the Orthodox Jewish community that has as one of its target group victims with mental illness. In addition, the agency is the host agency in partnership with the local battered women's shelter, which is a program for children exposed to domestic violence. The overwhelming majority of the clients in this program are from the Latino community, many undocumented. There is a significant amount of trauma work that goes on with these clients and their mothers.
- The Asian Pacific Islander [Organization] provides counseling services for victims. [Name], a domestic violence program in [City's] Jewish community, also provides counseling services. [Organization] provides counseling and other services to Hispanic victims.

Coalitions also reported on how well programs in their state are doing in finding culturally relevant resources to address mental health, substance abuse, or trauma-related needs. This question explicitly included the needs of LGBTQI survivors. On a range from 1 to 10, with 1 being “not well at all” and 10 being “very well,” coalitions on average gave their state a rating of 4. Individual coalition responses ranged from 1 to 8, with no coalitions giving their state a rating of 9 or 10 for this question. The graph to the left shows the range of responses for how well programs in state are doing in finding culturally relevant resources to address the mental health, substance abuse, or trauma-related needs of survivors.



Seventeen coalitions provided further information in their own words. Limited resources, particularly in rural areas, was the most prominent theme in these comments, as in the following examples:

- Funding cuts are significant barrier. Comprehensive, long-term services are seen as "extra" in this economic environment. Acute care is currently the focus.
- Our state is, in general, very conservative. It can be difficult to find resources (including funding) for culturally relevant services. It is particularly difficult in the rural areas of the state. Additionally, in many areas there is not much acknowledgement of the LGBTQI community including survivors who identify as LGBTQI.
- The programs do very well with what they have - many of our programs are in areas that have little or no resources addressing substance abuse, mental health or trauma-informed care. And with those that do, the waiting period for response to referrals is ineffective. So they are incredibly creative and resourceful in very sparse locations.
- [Coalition] is currently working on a statewide initiative called Safe Zone. The purpose of this project is to train all staff and one board member of the DV program on the unique issues facing the LGBTQI community, including different forms of oppression and how it can impact the

individual survivor as well as the community… There are no culturally specific mental health, substance abuse or trauma agencies for individuals from marginalized communities to have access. What community mental health services are available are not able to meet the needs of the general public much less specific needs of different cultural groups.

- It's so hard to generalize because we have several local programs who are doing outstanding work in these areas, most are somewhere in the middle, and a few are very concerning. Our programs experienced a 3-year unserved/underserved access TAT project recently, addressing intersections w/ DV, people with disabilities, people experiencing mental health/substance abuse issues, and LGBTQ survivors. In many ways, they were inundated with access to training, resources, best/promising practices and policy recommendations in these areas. Some adopted these practices, but many were hampered by their own budget/resource issues and competing priorities. In addition, even when they were able/willing, their ability to partner with local service providers (disability, MH/SA, LGBTQ) has also been severely hampered by budget cuts throughout our state…

When asked how pressing a challenge the lack of culturally specific services is in their states, 40 coalitions (87%) stated that it is "a big problem."

Model programs

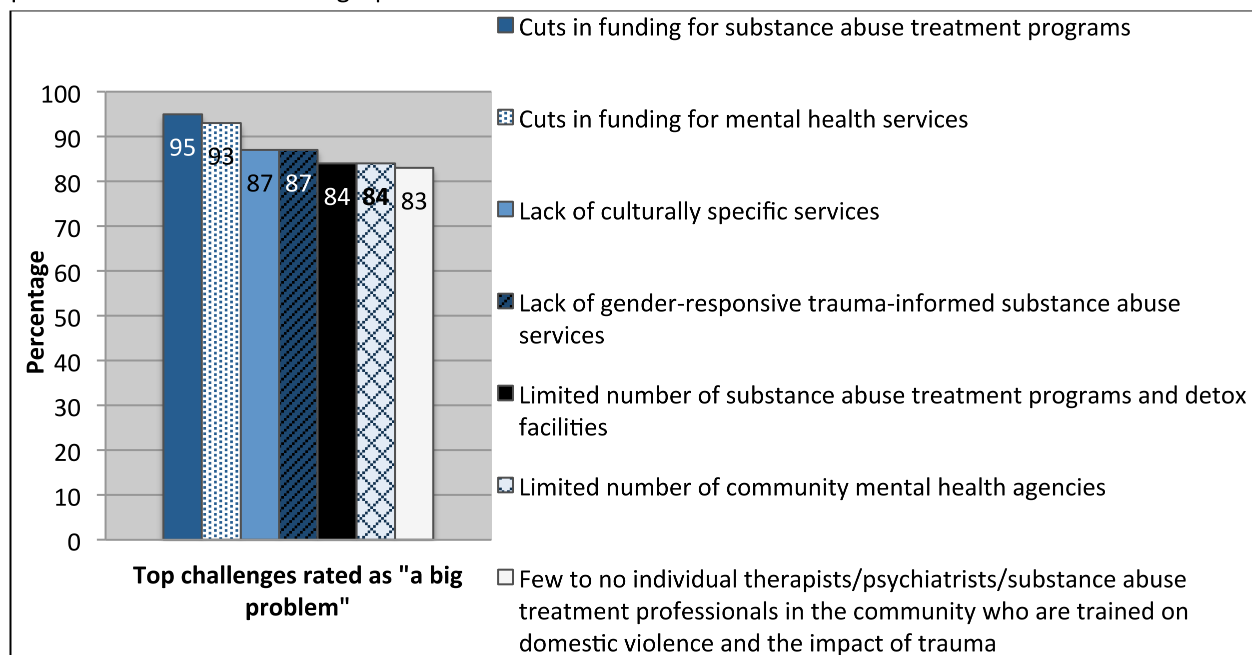
Coalitions reported on model or promising programs in their state that address mental health, substance abuse, and/or trauma especially well. In total, 25 coalitions (57%) reported that there are model programs within their state that address mental health, substance abuse, and/or trauma especially well. 21 coalitions responded to the survey request for additional information. Some simply named a program(s) or provided general descriptions. The following examples reflect the range of program activities and collaborations that coalition respondents considered model or promising:

- The Office of Attorney General Victim Services Unit has undertaken a training initiative to address Trauma issues. The local programs are very responsive because this is the state administration for certification and funding. We follow behind providing technical assistance and support with implementation.
- [Name] is working closely with the [Coalition] to support on-site clinicians who will be "go to" people for help with clients in DV/IVP situations. [Name] is a statewide mental health and substance abuse treatment agency, serving 2,000+ clients each year.
- I would say that we have a program in [City], [program name], who has a director who has been using TIC for many years. She trains her staff and provides peer training. She has a background in mental health work and understands the principles and implements them in daily work.
- From member programs: [Name] programs for children and their non offending parent. The model in [Name] County of collaboration between [Names—DV, sexual assault] and the Mental Health Association has been effective in improving mutual understanding, streamlining the process and conducting cross training. Progress in this area is being made even without funding, although more progress could be made more quickly with funding. [Organization] has a continuum of care to address mental health and substance abuse and we incorporate trauma treatment into all of our work using the ARC model, (attachment, self-regulation, and Competency.) We also have gender-specific substance abuse programs. [Name] Jewish Family Services is a full service licensed mental health center with clinicians that are trained in both domestic violence and treatment of trauma and other mental health issues.

- We are part of an OVW project supporting women who have experienced DV/SA and have mental health issues and/or developmental disabilities. It is the beginning of our work in these intersections. We have developed an introductory cross training for staff titled Survivor Centered Advocacy, as well as a 9 week training on healthy relationships and healthy sexuality for women with mental health issues and/or developmental disabilities.
- [Organization] is a licensed mental health facility as well as a DV shelter
- There are a few programs in the state that have been/are currently demonstration sites for the HHS Open Doors to Safety Grant and/or Children Exposed to Violence Grant that are doing good work in these areas. Additionally there are a couple other programs in the state that have been addressing mental health, substance abuse, and trauma for years and participated in the counselor training and monthly consultation calls for the Children Exposed to Violence Grant.

Challenges faced by coalitions

The survey also asked coalitions about challenges faced in providing DV/SA services. It provided a list of 13 possible challenges and requested that respondents categorize them as a "big problem," "small problem," or "no problem." On average, coalitions rated the overall challenges faced in providing DV/SA services as being "big problems." The seven challenges that coalitions most frequently rated as "a big problem" are shown in the graph below.

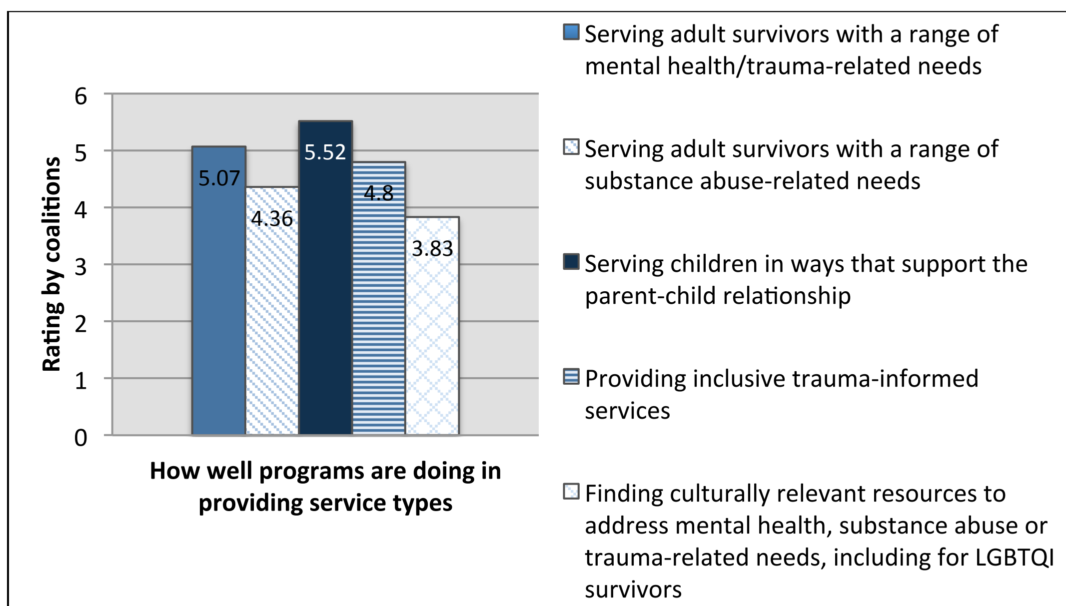


Four coalitions also provided further information. These two addressed the question directly:

- [State] is experiencing significant across the board cuts to all social services. DV has not yet been directly cut but the funding has been stagnant and sustained minor cuts making all but daily status quo impossible.
- We have only 11 [Name] programs for children across the state. Each has a wait list and only serves children ages 3 to 12. Lack of immigration services in [Name] County; limited public transportation available in the large counties of [Names]; lack of child care; lack of low income housing and lack of a homeless shelter in either county. Services vary by county. Some counties have a dearth of community mental health centers and/or long waiting lists.

Estimates of how well programs are delivering services

Coalition members were asked to rate, on average, how well programs are providing services within their states, understanding that individual programs are likely to vary. On a scale from 1 (not well at all) to 10 (very well), on average, coalitions gave programs within their state a rating of 5. Coalitions provided the highest rating (average = 5.5) on how well programs are doing in serving children in ways that support the parent-child relationship. The area with the lowest overall rating (average = 3.8), pertained to how well programs are doing in finding culturally relevant resources in their state to address mental health, substance abuse, or trauma-related needs (including for LGBTQI survivors). Below is a graph showing the average rating of how well programs are doing in delivering services, by topic.



Status of state-wide collaborations and policy work

The survey assessed state-wide efforts made by coalitions to influence policy and practice. Thirty coalitions (64%) reported being a part of multidisciplinary or multi-organizational state level task forces/organizations/working groups addressing issues related to mental health, substance abuse, and/or trauma. All coalitions provided additional descriptions, ranging from collaborations with a single named state-wide agency to extensive, multiple task forces, work groups, and commissions (although one noted that extensive collaboration had diminished because of funding). The following examples illustrate the range of state-wide collaborative work described. These examples are more extensive because they illustrate that many coalitions are involved to an impressive degree.

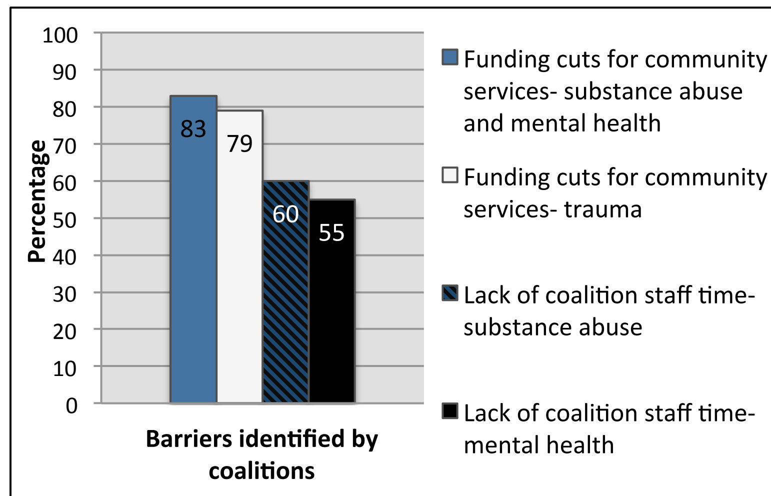
- The Coalition has been part of a state-level Cross Systems Collaboration made up of representatives from our sister sexual assault coalition, the disability community, mental health, peer support groups, substance abuse, Deaf services, and others for almost 10 years. The group's mission is to address violence in the lives of people with disabilities and those with a range of mental health needs.

- Statewide epidemiological work group convened by substance abuse prevention and treatment agency.
- Trauma-informed Advocacy Work Group
- We work on a commission that attends to the trauma, mental health and substance abuse needs of incarcerated women. Some local agencies also participate on task forces or organizations.
- We have a staff member on the [State] Prevent Child Abuse board working on developing curricula for home visitors on understanding the intersections of substance abuse, mental health and domestic violence.
- We are the host for the meetings and have been a part of the Continuum of Care on homelessness, whose agencies deal with these populations in our communities. I attend sessions, such as a recent SAMSHA training on trauma-informed care and substance abuse with the Department of Health.
- DHHR Behavioral Health Advisory Board, Child Advocacy Centers' Mental Health Committee, Governor's Advisory Council on Substance Abuse, Supreme Court Improvement Program Subcommittee on Children's Mental Health
- Ongoing relationship with statewide trauma-informed care group. Ongoing relationship with statewide faith organizations, this at times has included a focus on mental health and trauma. Ongoing relationships with organizations that support children & families.
- Our Prevention Programs Director works with the [State] Department of Mental Health and [State] Department of Alcohol and Drug Services on prevention issues and the conversations often include discussions on trauma. Our Prevention Programs Director with the [State] Adolescent Partnership, the group is focused solely on trauma, mental health or substance abuse but there is an understanding of the issue and it interwoven into the discussions. Our Family Systems Advocacy Director is working with the [State] Department of Job and Family Services, as well as local child protective service agencies to increase understanding of the impact DV has on children and the non-offending parent, using the Safe and Together model.
- [State] Change Initiate (OVW Disability Grant - working with the State Independent Living Council); [State] Coordinated Response to Sexual and Domestic Violence works on issues related to sexual and domestic violence and includes the associated trauma; have attended behavioral health task forces with Department of Health and Welfare
- [Coalition] ED chairs the Homicide Review Panel "Health Recommendations Task Group." [Coalition] sits on the [State] Women's Health Council. [Coalition] has established a Health Advisory Council that includes health/DV stakeholder. [Coalition] sits on the Child Death Panel, which includes review of health related components. [Coalition] participated in the [State] Integration Task Force, which was related to integration of mental health and substance abuse initially, and then on integration of behavioral health with physical health services. [Coalition] participated in Project Connect over the last three years. [Coalition] has an ongoing relationship with [State] CDC, including the injury prevention group and [Name], a multi-disciplinary, health/DV task force. [Coalition] partners in a rural grant with [State] DHHS, which involves child welfare services and policy level initiatives including health and trauma-informed initiatives.
- The Domestic Violence Action Team of the [State] Department of Services has a committee dedicated to cross-agency collaboration related to behavioral health concerns. The Governor's Advisory Board on Domestic Violence Prevention and Response has a subcommittee focused on underserved populations, which currently focuses on older adults and those with disabilities, including mental health and substance abuse related disabilities. We are part of both of these groups. Neither is particularly trauma-informed!!!

In addition, coalitions described how well these collaborations are working, using a scale ranging from 1 ("not very well at all") to 10 ("very well"). On average, coalitions rated these collaborations with a score of 6.

Barriers to influencing state-level policies

Respondents identified a number of barriers faced in influencing state or local policies related to mental health, substance abuse, and trauma in the context of DV/SA. Out of 18 possible barriers, coalitions on average identified 8 major barriers to influencing policies. The graph to the left details the top four barriers that coalitions most frequently cited.



Eight coalitions provided further descriptions of barriers. In general, these barriers relate to a lack of awareness among state agencies and program staff, and the impact of funding limitations. The following examples illustrate these patterns:

- Several of our relationships at the state level are in flux due to the tightening dollars. Without someone in some of these key positions who takes a specific interest in DV, maintaining a consistent profile with each entity is no easy task. "Trauma" seems to be on everyone's agenda lately so it is one of in-roads to these conversations.
- Outside of coalition staff there is no discussion of this in our state. We have only recently, in the last year or so, begun to discuss it with our programs. It appears to be a concept they have never heard of and to which they are resistant. Many of the programs here still adhere to a very grassroots model based in the work of the 70's and 80's and they vilify any interactions with mental health or substance abuse agencies. They see them as victim-blaming. We are treading very lightly in introducing the concept and helping them get concrete information about how to implement specific strategies.
- Attitudinal barriers within some state agencies
- Everything is centered on the DSM 9 (very pathology-based). Also, DV "treatment" includes batterer Intervention and services for victims and children. Department of Children and Family Services oversees it all with very blurred boundaries.

For about half of the coalitions, policy work in mental health (average = 49%), substance abuse (average = 45%), and trauma (average = 47%) is not currently a priority.

Factors that help to influence state-level policies

In describing factors that help coalitions influence state or local policies related to mental health, substance abuse, and trauma in the context of DV/SA, respondents could choose up to 5 options. On average, coalitions identified 3 factors that are helpful in influencing policy. The top three factors that help to influence state-level policies are listed below, in rank order:

- Skilled Coalition staff (66%)
- History of good working relationships with key people (62%)
- "Champions" in key state agencies (53%)

Past training and TA

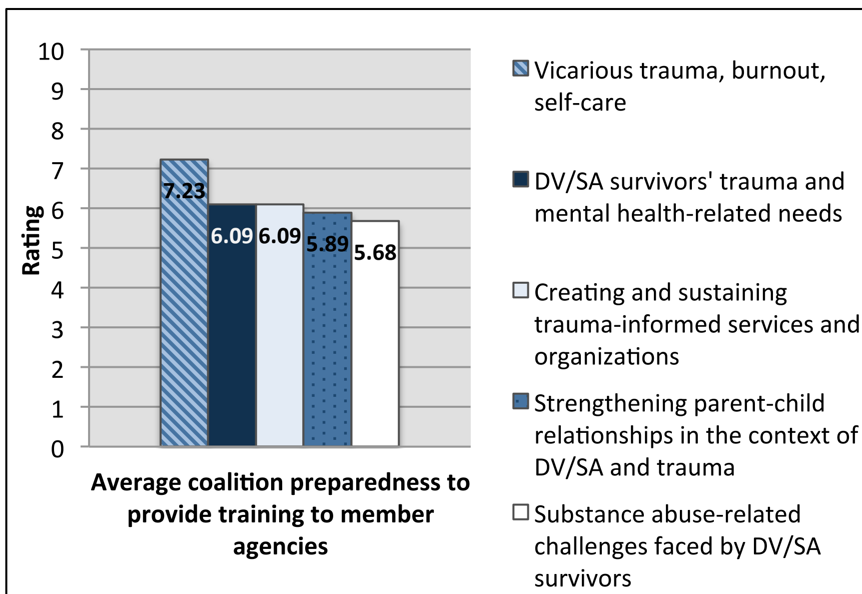
Coalition Directors reported the percentage of staff members who have received training on mental health, substance abuse, strengthening parent-child relationships, vicarious trauma/burnout/self-care, and trauma-informed services. Across all topics, and on average, coalitions reported that 11%-25% of staff members have received training, with a range from 1-10% and over 75%. Below is a list of all of the training topics, in rank order of the average percentage of staff who received the training.

- The trauma and mental health needs of DV/SA survivors (average = 26%-50%)
- Vicarious trauma, burnout, and/or self-care (average = 26%-50%)
- Trauma-informed services and organizations (average = 11%-25%)
- The substance abuse challenges faced by DV/SA survivors (average = 11%-25%)
- Strengthening parent-child relationships in the context of DV/SA and trauma (average = 11%-25%)

Training was delivered by a variety of methods, including webinars, in-person trainings, and ongoing consultation. Below is a list of all of the training delivery methods, in rank order of the average percentage of staff who received the training. This encompasses all training topics (e.g. mental health, substance abuse, etc.)

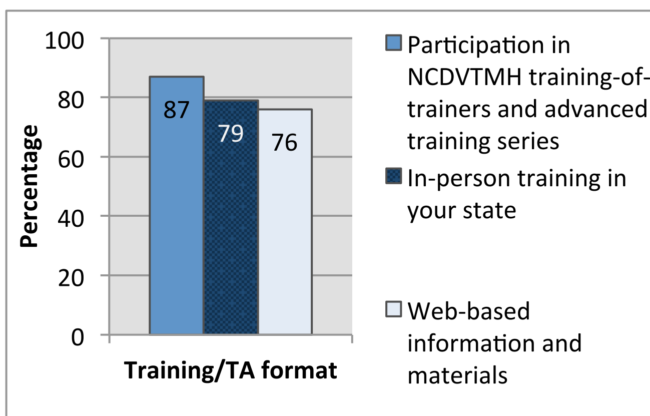
- In-person training (average = 26%-50%)
- Training delivered by consultants (average = 11%-25%)
- Training delivered by webinar (average = 11%-25%)
- Training delivered through NCDVTMH materials and/or staff (average = 11%-25%)

In addition to training received, coalitions were asked to rate how prepared their own staff are to provide training and TA to member programs. On a scale from 1 to 10, where 1 is "not prepared at all" and 10 is "very well prepared," on average, coalitions reported a score of 6. The graph below shows, on average, coalitions reports of how well-prepared they are to provide TA and training to member agencies. The top five topic areas are depicted.



Training needs: usefulness of formats and priority of topics

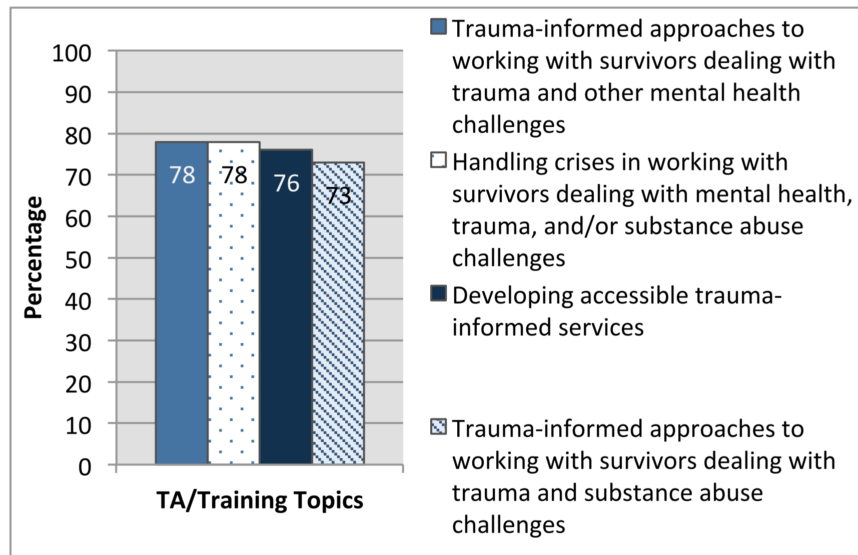
In order to help plan future training and TA initiatives, coalition members were asked to provide feedback on the formats for training and TA delivery that are the most useful and accessible. For each format provided, the possible responses were "very," "somewhat," and "not at all." The graph to the left shows the three formats that were most frequently rated as "very useful."



The list below shows the remaining formats, based on the percentage of coalition respondents who ranked them as "very useful."

- In-person symposiums for coalitions (72%)
- Follow-up web meetings with state coalitions to discuss implementation and to highlight promising approaches (71%)
- Webinar series on core elements of trauma-informed advocacy with accompanying conversation guides (71%)
- Webinar series on key elements of developing/building enhanced services with accompanying conversation guides (71%)
- Follow-up web meetings with state coalitions to discuss implementation and to highlight promising practices (71%)
- Online trainings (e-trainings, online courses, with CEU's) (69%)
- Broadcast messages, alerts (36%)
- Social media, such as Facebook, Twitter, others (29%)

Coalitions also provided feedback on the priority (high, medium, low, or no need) of training and TA topics. Survey respondents described the priority level of each topic as "high," "medium," "low," or "no need." The graph to the left depicts the four training/TA topics that were most frequently rated as being a high priority.



All of the remaining topics are listed below, in rank order. Percentages show how often coalition members described each topic as being a "high priority".

- Building coalition capacity to support programs in issues around accreditation policies, model policies, incorporation into basic training curricula (71%)
- Trauma-informed approaches to working with children and their non-abusive caregivers (65%)
- Safety planning with survivors dealing with trauma, mental health, and/or substance abuse challenges (64%)
- Creating trauma-informed organizations (includes reflective practice and supervision, personnel policies, addressing vicarious trauma) (64%)
- Creating safe environments so that adult survivors and children feel able to talk with staff about trauma, mental health, and/or substance abuse in conversations and service planning (64%)
- Developing culturally specific, trauma-informed services in partnership with culturally specific organizations, including responses to historical trauma (60%)
- Building coalition capacity to support trauma-informed practice dealing with special situations (e.g., community crises involving DV or SA, use of new technologies for delivering services) (60%)
- Developing culturally specific trauma-informed services in partnership with culturally specific organizations, including responses to immigration-related trauma (56%)
- Legal issues related to trauma, mental health, and substance abuse (e.g., custody and immigration issues) (52%)
- Developing outcome measures to evaluate the effectiveness of trauma-informed services (51%)
- The impact of trauma on child development (50%)
- Reducing retraumatization in the legal process (both civil and criminal) (48%)
- Building collaboration with state and local mental health providers (43%)
- Building collaboration with state and local child treatment/advocacy/protection organizations (43%)
- Building collaboration with state and local substance abuse service treatment providers (35%)

- Medication issues related to working with survivors dealing with mental health, trauma, and/or substance abuse challenges (34%)
- Building collaboration with state and local mutual and peer support organizations (28%)

Discussion, Limitations, Implications

These survey results clearly show that some states have made substantial progress in enhancing trauma-informed approaches, while others have not yet made these efforts a priority. Over the next four years, advocates, survivors, community members, coalition staff and board members, the NCDVTMH, NNEDV and FVPSA will work together on ways coalitions can further develop their capacity to support member programs. This section of the report presents some secondary findings from the survey, and discusses some implications of the data. This discussion identifies areas for ongoing attention, needs, and opportunities for capacity building, and is grounded recognition of the work that advocates, programs, and coalitions do to both support survivors and to challenge social systems that enable domestic violence to continue.

One important outcome of this survey is an understanding of the impact of prior training/TA on a variety of issues. Coalitions with higher levels of overall training/TA on the specified topics show significantly higher scores for: overall support to member programs; overall responsiveness to the trauma and self-care needs of coalition staff; and coalitions' perceptions of how well member programs serve survivors, across all domains. Notably, there were no significant differences in the overall total number of challenges faced by states, or in the overall total number of barriers coalitions reported facing in influencing policy.

Analyses also examined the relationship between training/TA provided by NCDVTMH. The sample was divided into two categories: coalitions who have received significant training/TA from NCDVTMH, and coalitions who have not yet received significant training/TA from NCDVTMH. Coalitions who had received substantial training/TA from NCDVTMH had significantly higher scores for:

- Rating of how well member programs are doing in providing services, across all domains
- Supports coalitions provide to member agencies, largely focused on support and TA on trauma-informed services and practices (TA on developing trauma-informed services; TA on developing trauma-informed organizations; TA on providing reflective supervision; model policies for trauma-informed services; having a designated coalition staff member to provide TA on child trauma and parenting; support with trauma-informed agency self-assessments or outcome evaluations; and statewide initiatives to address DV; trauma, and mental health)
- How prepared coalition staff are to provide training/TA to member programs, across all domains
- Membership in a multi-disciplinary or multi-organizational state-level organization/task force/working group for working on issues related to mental health, substance abuse, and/or trauma

As was true for the findings about training/TA from any source, no significant differences were found between coalitions who had received a higher level of training/TA from NCDVTMH and coalitions who have not yet received significant training/TA from NCDVTMH on challenges faced by coalitions, across all topics. Although there were no differences in reported challenges, training was associated with enhanced coalition capacity to provide support.

These data suggest that coalitions with higher levels of training are better equipped to provide training to their member programs on implementing TI services and practices, and feel more confident in their

ability to provide training/TA on a range of topics. Coalitions with more training also perceive the programs in their state as doing a better job in providing services across all domains. For programs with more NCDVTMH training/TA, this includes finding culturally relevant resources to address the mental health, substance abuse, and trauma-related needs of survivors. As there are no significant differences in challenges faced by coalitions, these data suggest that coalitions with higher levels of training, and especially from NCDVTMH, may have enhanced capacity to support the implementation of trauma-informed practices in their state.

While these results highlight how trainings and TA can support programs and coalitions, they are also instructive in identifying areas for ongoing attention. For example, the results show than an average of just 11%-25% of coalition staff members received any training/TA on the trauma-related topics listed. The survey also examined rates of training/TA by specific topic. Areas of relative strength include training/TA on the trauma and mental health needs of DV/SA survivors, along with vicarious trauma, burnout, and/or self-care (average = 26%-50% of coalition staff). However, on average only 11%-25% of coalition staff have received training/TA on trauma-informed services and organizations, the substance abuse challenges faced by DV/SA survivors, and strengthening parent-child relationships in the context of DV/SA and trauma. Given the prevalence of substance abuse for survivors of domestic violence, along with the impact of domestic violence on children, this identifies areas where additional training/TA could be helpful.

These data also highlight needs concerning the development of trauma-informed services and organizations. When coalitions rated the priority of future training/TA topics, four of the top five topics most frequently described as a "high priority" related to trauma-informed approaches and services. Both the receipt of training and the capacity to deliver training/TA on trauma-informed approaches may have a direct impact on work done at the program level. This survey found that coalitions with a designated person on staff to provide TA on TI advocacy were significantly more likely than others to perceive member programs as doing a good job in providing inclusive trauma-informed services. Taken together, these data suggest two levels of need regarding training/TA on developing trauma-informed approaches and services: 1) at the coalition level, and 2) at the program level, optimally delivered by a trained, designated coalition staff member.

The results also describe an important need for culturally specific services that address the mental health, substance abuse, and trauma-related needs of survivors. Sixty-one percent of coalitions reported that they have some kind of relationship/connection with state or local culturally specific organizations to work on issues concerning the relationship between DV/SA and mental health, substance abuse, and trauma. While this figure shows the frequency of such relationships, it does not describe the quality of the relationships or the types of programs or services. The qualitative data are helpful in this regard, with coalitions describing collaborations with generic state agencies (e.g., state offices for multicultural services), agencies with a particular focus (e.g., Latinas, immigrants and refugees, LGBTQI), or collaborations as a consistent approach (e.g., the inclusion of underserved communities into all collaborative endeavors). This figure also implies that 39% of coalitions lack connections with culturally specific programs, or that such programs do not exist. In fact, 87% of coalitions report that the lack of culturally specific services in their state is "a big problem." Coalitions

were asked how well programs in their state are doing in finding culturally relevant resources (including for LGBTQI survivors) to address survivors' mental health, substance abuse or trauma related needs. Using a scale from 1 ("not well at all") to 10 ("very well"), coalitions on average gave their state a rating of 4, with no coalitions rating their state with a score of 9 or 10. Clearly, this marks a significant area of need.

This survey's data indicate a relationship between training/TA and connections with culturally specific organizations. The coalitions that have connections with culturally specific organizations also have a significantly higher percentage of staff members who have received training/TA in general, delivered either in-person or through a consultant. In addition, coalitions with connections to culturally specific organizations have significantly more staff members who have received training/TA on trauma and mental health in the context of DV/SA; on parent-child relationships in the context of DV/trauma; on vicarious trauma, burnout, and/or self-care; and on trauma-informed services and organizations. In addition, coalitions with a designated staff member for providing TA on TI advocacy are significantly more likely to have a connection with a culturally specific organization. These relationships are important, although the data cannot tell us about what *causes* them. For example, it is not clear whether coalitions with higher levels of staff training also have more resources or connections in general, or if the training makes them more aware of the importance of having relationships with culturally specific organizations, or if coalitions that have more connections have become more aware of the importance of making TI approaches a priority.

Nonetheless, when asked about the relative priority of a variety of training/TA topics, only 60% of coalitions listed developing culturally specific trauma-informed services in partnership with culturally specific organizations, *including historical trauma* as a "high priority." Furthermore, only 52% of coalitions ranked developing culturally specific trauma-informed services in partnership with culturally specific organizations, *including immigration-related trauma* as "a high priority." The data suggest that this may well be related to the availability of and connections to culturally specific organizations. Coalitions with connections to culturally specific organizations were more likely than those without connections to prioritize training/TA on developing culturally specific TI services in partnership with culturally specific organizations, including historical trauma (this approached statistical significance). There was no difference for immigration-related trauma, and this may mark an area for ongoing attention. Also, coalitions not connected to culturally specific organizations were more likely to see the lack of culturally specific services as a big problem. Being trauma-informed means, in part, being inclusive and culturally relevant. Support to coalitions and programs in identifying and advocating for culturally specific agencies and services will be an important aspect of enhancing trauma-informed approaches.

Finally, the survey results show clearly that training and TA on the topics associated broadly with trauma-informed services are high priorities for coalitions. Many specific topics were grouped into six categories, and the average priority rating (ranging from 1 for "no need" to 4 for "high priority") was calculated for each category. "Trauma-informed approaches" led the list of categories, with an average rating of 3.57. It was followed by "mental health needs of DV survivors," substance abuse challenges of DV survivors," and "culturally specific approaches" – all with ratings averaging 3.5 or over. The

remaining two categories, “working with children in the context of DV/SA” and “building collaborations” both averaged over 3.0 (“medium priority”). Coalitions have provided clear support for further training and TA in the areas addressed in the survey.

Limitations

While the results of this survey are instructive and provide a basis for ongoing discussions on expanding inclusive, culturally relevant TI services and organizations, they are limited by several factors. First, because the purpose of this survey is to assess the status of training/TA, ongoing priorities, and capacity for implementing TI services and organizations on the state level, it was designed with Coalition Directors as the primary source of data. Advocates, survivors of domestic violence, community members, and state-level stakeholders were not contacted to complete this survey. While coalition directors and their representatives provided rich, thoughtful, and important information, input from other individuals within the domestic violence movement may have provided additional perspectives and nuance. Also, coalitions vary in their membership criteria and standards, along with the extent to which local domestic violence programs choose to be coalition members. This means that reporting on local programs may be affected by varying knowledge and awareness of local programs, and differences in connections with local programs that provide DV services. In appreciation of the many roles that coalition directors play, and in consideration of their often limited time, this survey was designed to be both as comprehensive and as brief as possible. Because of this, some items may have benefitted from additional questions or options. For example, while the survey assesses whether coalitions have relationships with culturally specific programs with a focus on mental health, substance abuse, and/or trauma, the survey does not allow for a quantitative measurement of the quality of those relationships. Additionally, while the survey assesses the percentage of coalition staff members who have received training on a variety of topics and formats, it does not ask for a rating of the overall quality of those trainings/TA. The results of this survey should be seen within the context of these limitations.

Moving Forward

It is our hope that the information contained in this report provides useful data for individual states and territories, as well as acting as a baseline for measuring change over the next four years. We also hope that it encourages a coordinated, collaborative, and multifaceted approach to identify training and TA priorities, moving forward. Ultimately, we hope that this information will be helpful to coalitions and programs in their efforts to enhance what they have already been doing to build capacity to implement accessible, inclusive, culturally specific and linguistically appropriate trauma-informed services for survivors of domestic violence.

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Appendix A

In this section, you will find data on each survey item, along with aggregate variables that were made for the purpose of statistical analysis. Please note that the full survey questions accompany each table found in this section. Depending on the type of question, some tables will show information about:

- **Total.** The total number of responses is designated by the symbol *N*. 47 respondents completed this survey. For many items, the *N* will equal 47. If a respondent (or respondents) did not answer a question, then the *N* will be less than 47.
- **Percentage (%).** This is used to show the percentage of respondents who selected a given option for a survey question.
- **Checked/Not checked.** Some items allow respondents to choose a number of options through using check boxes. For example, there is an item in the survey that asks respondents about the supports their coalitions provide to member programs. If a support is checked, then it means that the coalition provides it to its member programs.
- **Mean.** This is the average score for an item.
- **Standard deviation.** The standard deviation (in this report, abbreviated as *SD*) gives us information about the spread (or distribution) of responses for any given item. A smaller standard deviation tells us that the scores tend to be clustered close to the mean. A higher standard deviation tells us that scores tend to be more spread out from the mean.
- **Range.** This shows us the lowest and highest individual response for any given item.
- **Options and values for responses.**
    - For many questions in this survey, the options for responses are given using words (e.g., not a problem, small problem, big problem). For the purposes of statistical analysis, we assign numerical values to these words, so that, for example, "not a problem" equals 1, "small problem" equals 2, and "big problem" equals 3. Where appropriate and possible, you will find a combination of word-based and numerical values in the header row (e.g., not a problem- 1, small problem- 2, big problem- 3).

Tables

Fig. 1: Type of coalition: Domestic violence only or dual domestic violence/sexual assault coalition

Type of coalition	Total *N (%)*
DV only	28 (60%)
Dual DV/SA	19 (40%)

Fig. 2: Does your coalition have any mechanism (e.g., advisory group, workgroup, other regular feedback strategy) to obtain input from survivors about how responsive you are to trauma, mental health & substance abuse needs?

Mechanism for input from survivors	Total *N (%)*
Yes	14 (30%)
No	33 (70%)

Fig. 3a: Does your coalition have anyone on staff who has a background (specialized training, extensive experience, license/credential) in trauma, mental health or substance abuse?

Staff member with background in trauma, mental health or substance abuse	Total *N (%)*
Yes	33 (72%)
No	13 (28%)

Fig. 3b: If you answered "Yes" to the item above, is that person in a position at least partly dedicated to working on trauma, mental health or substance abuse?

Staff with background working on trauma, mental health or substance abuse	Total *N (%)*
Yes	26 (72%)
No	10 (28%)

Fig. 4: Do you have any relationships/connections with state or local culturally specific organizations to work on issues regarding the relationship between DV/SA and mental health, substance abuse and/or trauma?

Connections with culturally specific organizations	Total *N (%)*
Yes	28 (61%)
No	18 (39%)

Fig. 5: Are there culturally specific DV/SA programs in your state that address mental health, substance abuse and/or trauma?

Culturally specific DV/SA programs in state that address mental health, substance abuse and/or trauma	Total *N (%)*
Yes	17 (40%)
No	25 (58%)
Don't know	1 (2%)

Fig. 6: Are there model or promising programs in your state for addressing mental health, substance abuse and/or trauma that address these concerns especially well?

Model programs in state	Total *N (%)*
Yes	25 (57%)
No	18 (41%)
Don't know	1 (2%)

Supports Coalitions provide to member agencies

Fig. 7a: Which of the following supports are you currently providing to your member agencies to help them respond more effectively to women and children experiencing the mental health consequences of abuse or substance abuse challenges? (Check all that apply.)

Overall mean for all supports combined = 9.50 supports. Range of supports = 0 to 20.

Item	Total *N*	Checked *N (%)*	Not Checked *N (%)*
Inclusion of these issues in basic orientation training for new advocates	47	38 (81%)	9 (19%)
Required training for member programs on these issues	47	10 (21%)	37 (79%)
Optional training for member programs on these issues	47	40 (85%)	7 (15%)
Technical assistance (TA) on developing trauma-informed services	47	34 (72%)	13 (28%)
TA on developing trauma-informed organizations (policies, practices, supervision, and organizational culture that support staff in being trauma-informed)	47	24 (51%)	23 (49%)
TA on providing reflective supervision	47	10 (21%)	37 (79%)
Incorporation into accreditation standards for programs	47	10 (21%)	37 (79%)
TA on community collaboration	47	25 (53%)	22 (47%)
Shelter standards for reductions in shelter rules	47	30 (64%)	17 (36%)
Shelter standards about eliminating admission criteria based on mental health or substance abuse histories	47	25 (53%)	22 (47%)
Clear guidance about compliance with ADA/Fair Housing Act	47	28 (60%)	19 (40%)
Shelter standards about reducing/eliminating admission criteria based on prescription medications	47	23 (49%)	24 (51%)

Item	**Total** *N*	**Checked** *N (%)*	**Not Checked** *N (%)*
Model policies for trauma-informed services (e.g., practice guidelines, guidelines for responding to community trauma)	47	18 (38%)	29 (62%)
Trained designated person on coalition staff to provide training or TA on responding to survivors' mental health-related needs	47	18 (38%)	29 (62%)
Trained designated person on coalition staff to provide training or TA on responding to survivors' substance abuse-related needs	47	16 (34%)	31 (66%)
Trained designated person on coalition staff to provide training and TA on trauma-informed advocacy	47	21 (45%)	26 (55%)
Trained designated person on coalition staff or under contract to provide training and TA on child trauma and parenting supports	47	19 (40%)	28 (60%)
Support with trauma-informed agency self-assessments or outcome evaluations	47	9 (19%)	38 (81%)
Statewide initiative to address DV, trauma and mental health	47	16 (34%)	31 (66%)
Statewide initiatives to address DV and substance abuse	47	9 (19%)	38 (81%)
Special projects (specify)	47	9 (19%)	38 (81%)
Other resources for programs (specify)	47	7 (15%)	40 (85%)
Other collaborative activities (specify)	47	5 (11%)	42 (89%)

Fig. 7b: Comparison of two supports coalitions provide to member agencies: *Technical assistance (TA) on developing trauma-informed services*, and *TA on developing trauma-informed organizations (policies, practices, supervision, and organizational culture that support staff in being trauma-informed).*

Item	**Total** *N (%)*
Does not provide TA on developing TI services, does not provide TA on developing TI organizations	13 (28%)
Provides TA on developing TI services, but does not provide TA on developing TI organizations	10 (21%)
Provides TA on developing TI organizations, but does not provide TA on developing TI services	0 (0%)
Provides TA on both developing TI services and developing TI organizations	24 (51%)

Coalition responsiveness to the trauma and self-care needs of staff

Fig. 8: To what extent does the Coalition respond to the trauma and self-care needs of staff?

Overall mean for Coalition responsiveness to staff trauma and self-care needs = 3.02, SD = .71.

Item	**Total** *N*	**Not at all- 1** *N (%)*	**A little bit- 2** *N (%)*	**Somewhat- 3** *N (%)*	**Very much- 4** *N (%)*	**M (*SD*)**
Attention to vicarious trauma	47	4 (9%)	10 (21%)	14 (30%)	19 (40%)	3.02 *(.99)*
Attention to staff's own personal experiences being triggered by their work	47	4 (9%)	8 (17%)	18 (38%)	17 (36%)	3.02 *(.94)*
Good mental health treatment benefits	47	5 (11%)	4 (8%)	21 (45%)	17 (36%)	3.06 *(.94)*
Good substance abuse treatment benefits	47	5 (11%)	4 (8%)	21 (45%)	17 (36%)	3.06 *(.94)*
Training/supports	47	1 (2%)	7 (15%)	14 (30%)	25 (53%)	3.34 *(.82)*
Regularly scheduled supervision	47	4 (8%)	5 (11%)	16 (34%)	22 (47%)	3.19 *(.95)*
Topics related to self-care addressed in staff meetings	46	8 (17%)	10 (22%)	13 (28%)	15 (33%)	2.76 *(1.10)*
Support & resources for staff sobriety	46	13 (28%)	6 (13%)	18 (39%)	9 (20%)	2.50 *(1.11)*
Provision for "personal days"	46	0 (0%)	5 (11%)	3 (6%)	38 (83%)	3.72 *(.66)*
Careful management of work load	47	6 (13%)	2 (4%)	28 (60%)	11 (23%)	2.94 *(.90)*
Promotion of activities that support staff well-being (yoga, exercise, outside consultation, etc.)	46	9 (19%)	11 (24%)	15 (33%)	11 (24%)	2.61 *(1.06)*
Other (please describe)	6	4 (66%)	1 (17%)	0 (0%)	1 (17%)	1.67 *(1.21)*

Challenges faced by Coalitions

Fig. 9: How pressing are the following challenges in your state?

Overall mean for how pressing challenges are in state = 2.79, SD = .19.

Item	**Total** *N*	**Not a problem- 1** *N (%)*	**Small problem- 2** *N (%)*	**Big problem- 3** *N (%)*	**Mean (*SD*)**
Cuts in DV funding for programs	47	3 (6%)	8 (17%)	36 (77%)	2.70 *(.59)*
Cuts in funding for the Coalition	47	4 (9%)	12 (26%)	31 (66%)	2.57 *(.65)*
Cuts in funding for mental health services	44	1 (2%)	2 (5%)	41 (93%)	2.91 *(.36)*
Cuts in funding for substance abuse treatment services	43	0 (0%)	2 (5%)	41 (95%)	2.95 *(.21)*

Item	Total *N*	Not a problem- 1 *N (%)*	Small problem- 2 *N (%)*	Big problem- 3 *N (%)*	Mean (*SD*)
Limited number of community mental health agencies	44	1 (2%)	6 (14%)	37 (84%)	2.82 *(.45)*
Waiting lists prohibit timely access to services in the available mental health programs	44	1 (2%)	7 (16%)	36 (82%)	2.80 *(.46)*
Limited number of substance abuse treatment programs and detox facilities	44	0 (0%)	7 (16%)	37 (84%)	2.84 *(.37)*
Lack of gender-responsive trauma-informed substance abuse programs	45	0 (0%)	6 (13%)	39 (87%)	2.87 *(.34)*
Concerns about confidentiality in rural areas	45	4 (9%)	18 (40%)	23 (51%)	2.42 *(.66)*
Limited number of children's services that address issues related to trauma and DV	45	1 (2%)	7 (16%)	37 (82%)	2.80 *(.46)*
Few to no individual therapists/psychiatrists/ substance abuse treatment professionals in the community who are trained on domestic violence and the impact of trauma	46	0 (0%)	8 (17%)	38 (83%)	2.83 *(.38)*
Lack of culturally specific services	46	1 (2%)	5 (11%)	40 (87%)	2.85 *(.42)*
Others (please describe)	2	0 (0%)	0 (0%)	2 (100%)	3.00 *(.00)*

How well programs in state are doing

Overall mean for how programs in state are doing, across all topics = 4.71, SD = 1.74. Overall range of responses = 1 to 9.

Fig. 10a: Understanding that there may be large differences across individual programs, how well do you think programs in your state, in general, are doing in serving *adult victim/survivors with a range of mental health/trauma-related needs?* (Please select one number)

Total	Not well at all			→			→			Very Well	Mean (*SD*)
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
45	2 (4%)	1 (2%)	5 (11%)	8 (18%)	14 (31%)	5 (11%)	3 (7%)	7 (16%)	0 (0%)	0 (0%)	5.07 *(1.84)*

Fig. 10b: Understanding that there may be large differences across individual programs, how well do you think programs in your state, in general, are doing in serving *adult victim/survivors with a range of substance abuse-related needs?* (Please select one number)

Total	**Not well at all**			**→**			**→**			**Very Well**	**Mean (*SD*)**
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
45	3 (7%)	5 (11%)	9 (20%)	5 (11%)	13 (29%)	3 (7%)	4 (9%)	2 (4%)	1 (2%)	0 (0%)	4.36 *(1.96)*

Fig. 10c: Understanding that there may be large differences across individual programs, how well do you think programs in your state, in general, are doing in *serving children in ways that support the parent-child relationship?* (Please select one number)

Total	**Not well at all**			**→**			**→**			**Very Well**	**Mean (*SD*)**
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
46	2 (4%)	2 (4%)	4 (9%)	4 (9%)	8 (17%)	10 (22%)	9 (20%)	6 (13%)	1 (2%)	0 (0%)	5.52 *(1.96)*

Fig. 10d: Understanding that there may be large differences across individual programs, how well do you think programs in your state, in general, are doing in *providing inclusive trauma-informed services?* (Please select one number)

Total	**Not well at all**			**→**			**→**			**Very Well**	**Mean (*SD*)**
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
44	2 (4%)	6 (14%)	5 (11%)	6 (14%)	9 (21%)	4 (9%)	8 (18%)	3 (7%)	1 (2%)	0 (0%)	4.80 *(2.10)*

Fig. 10e: Understanding that there may be large differences across individual programs, how well do you think programs in your state, in general, are doing *finding culturally relevant resources* to address mental health, substance abuse or trauma-related needs, including for LGBTQI survivors? (Please select one number)

Total	**Not well at all**			**→**			**→**			**Very Well**	**Mean (*SD*)**
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
47	6 (13%)	8 (17%)	6 (13%)	10 (21%)	9 (19%)	2 (4%)	5 (11%)	1 (2%)	0 (0%)	0 (0%)	3.83 *(1.92)*

Multidisciplinary and multi-organizational state level task forces

Fig. 11a: Are you part (i.e., are "at the table") of any multidisciplinary or multi-organizational state level organizations/task forces/working groups for working on issues related to mental health, substance abuse and/or trauma?

Part of any state level collaboration	Total *N (%)*
Yes	30 (64%)
No	17 (36%)

If yes, on a scale from 1 to 10, how well would you say these collaborations are working?

Overall mean for how well collaborations are working = 5.83, SD = 2.12. Range of responses = 1 to 10.

Fig. 11b: Trauma/mental health

Total	Not well at all			→			→			Very Well	Mean (SD)
N	1 *N (%)*	2 *N (%)*	3 *N (%)*	4 *N (%)*	5 *N (%)*	6 *N (%)*	7 *N (%)*	8 *N (%)*	9 *N (%)*	10 *N (%)*	
29	1 (3%)	1 (3%)	1 (3%)	4 (14%)	4 (14%)	5 (17%)	5 (17%)	2 (7%)	4 (14%)	2 (8%)	6.17 *(2.32)*

Fig. 11c: Substance abuse

Total	Not well at all			→			→			Very Well	Mean (*SD*)
N	1 *N (%)*	2 *N (%)*	3 *N (%)*	4 *N (%)*	5 *N (%)*	6 *N (%)*	7 *N (%)*	8 *N (%)*	9 *N (%)*	10 *N (%)*	
26	2 (8%)	2 (8%)	2 (8%)	5 (19%)	6 (23%)	3 (11%)	0 (0%)	2 (8%)	3 (11%)	1 (4%)	5.12 *(2.50)*

Fig. 11d: Child trauma/parenting

Total	Not well at all			→			→			Very Well	Mean (*SD*)
N	1 *N (%)*	2 *N (%)*	3 *N (%)*	4 *N (%)*	5 *N (%)*	6 *N (%)*	7 *N (%)*	8 *N (%)*	9 *N (%)*	10 *N (%)*	
28	2 (7%)	2 (7%)	5 (18%)	2 (7%)	2 (7%)	2 (7%)	2 (7%)	6 (21%)	2 (7%)	3 (11%)	5.75 *(2.90)*

Barriers faced in influencing policy

What are the major barriers you face in influencing state or local policies related to mental health, substance abuse and trauma in the context of DV/SA? Please check all that apply for each option.

Average number of barriers faced = 8. Range of number of barriers faced = 0 to 18.

Fig. 12a: Barriers related to mental health

Item	**Total** *N*	**Checked** *N (%)*	**Not checked** *N (%)*
Lack of Coalition staff time	47	26 (55%)	21 (45%)
Lack of awareness of the importance of the role DV/SA programs can play	47	18 (38%)	29 (62%)
Funding cutbacks for community services	47	39 (83%)	8 (17%)
Disinterested state agencies	47	19 (40%)	28 (60%)
Lack of connections with key people/leaders	47	12 (26%)	35 (74%)
Policy work in this area is not a current priority	47	23 (49%)	24 (51%)
Others (Please describe)	47	3 (6%)	44 (94%)

Fig. 12b: Barriers related to substance abuse

Item	**Total** *N*	**Checked** *N (%)*	**Not checked** *N (%)*
Lack of Coalition staff time	47	28 (60%)	19 (40%)
Lack of awareness of the importance of the role DV/SA programs can play	47	20 (43%)	27 (57%)
Funding cutbacks for community services	47	39 (83%)	8 (17%)
Disinterested state agencies	47	15 (32%)	32 (68%)
Lack of connections with key people/leaders	47	12 (26%)	35 (74%)
Policy work in this area is not a current priority	47	21 (45%)	26 (55%)
Others (Please describe)	47	2 (4%)	45 (96%)

Fig. 12c: Barriers related to trauma

Item	**Total** *N*	**Checked** *N (%)*	**Not checked** *N (%)*
Lack of Coalition staff time	47	25 (53%)	22 (47%)
Lack of awareness of the importance of the role DV/SA programs can play	47	16 (34%)	31 (66%)
Funding cutbacks for community services	47	37 (79%)	10 (21%)
Disinterested state agencies	47	12 (26%)	35 (74%)
Lack of connections with key people/leaders	47	9 (19%)	38 (81%)
Policy work in this area is not a current priority	47	22 (47%)	25 (53%)
Others (Please describe)	47	1 (2%)	46 (98%)

Factors that are helpful in influencing policy

Fig. 13: If you have worked in this area, what are the major factors that help you influence state or local policies related to mental health, substance abuse and trauma in the context of DV/SA? (Check all that apply)

Overall mean of factors that help in influencing policy = 2.62. Range of factors = 0 to 5.

Item	Total *N*	Checked *N (%)*	Not checked *N (%)*
History of good working relationships with key people	47	29 (62%)	18 (38%)
Skilled Coalition staff	47	31 (66%)	16 (34%)
Funds available to focus staff time on this effort	47	23 (49%)	24 (51%)
"Champions" in key state agencies	47	25 (53%)	22 (47%)
Sympathetic legislature	47	15 (32%)	32 (68%)
Have not worked in this area	47	7 (15%)	40 (85%)
Other (Please describe)	47	2 (4%)	45 (96%)

Training received by Coalitions

The percentage of coalition staff who have received training was measured by both format (webinar, in-person training, etc.) and by topic (vicarious trauma/burnout/self-care, trauma and mental health-related needs of DV/SA victim/survivors). The overall average score for the receipt of training (over all topics and including all formats) = 2.84, which corresponds to "11-25%" of Coalition members. The range of scores is from 1.17 to 5.55, which corresponds to "1-10%" to ">75%" of Coalition members receiving training.

Fig. 14a: About what percent of current coalition staff members have received each of the following types of training (by topic)?

Format	Total *N*	0% *N (%)*	1-10% *N (%)*	11-25% *N (%)*	26-50% *N (%)*	51-75% *N (%)*	>75% *N (%)*	Mean *(SD)*
Trauma and mental health-related needs of DV/SA victim/survivors	45	0 (0%)	9 (20%)	10 (22%)	11 (25%)	11 (25%)	4 (8%)	3.16 *(1.28)*
Substance abuse-related challenges experienced by DV/SA victim/survivors	46	0 (0%)	15 (33%)	13 (28%)	9 (19%)	6 (13%)	3 (7%)	*2.76* *(1.20)*
Strengthening parent-child relationships in the context of DV/SA and trauma	47	0 (0%)	17 (36%)	15 (32%)	8 (18%)	3 (6%)	4 (8%)	*2.54* *(1.28)*
Vicarious trauma/burnout/self-care	47	0 (0%)	8 (17%)	17 (36%)	11 (24%)	7 (15%)	4 (8%)	*3.06* *(1.28)*
Trauma-informed services and organizations	44	0 (0%)	15 (34%)	12 (27%)	8 (18%)	5 (12%)	4 (9%)	*2.81* *(1.28)*

<u>Key:</u> 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%",
4.00-4.99 = "51-75%", 5.00-6.00 = ">75%"

Fig. 14b: About what percent of current coalition staff members have received each of the following types of training (by format)?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean** ***(SD)***
Webinar (offered by NCDVTMH or another source)	47	0 (0%)	14 (30%)	14 (30%)	10 (21%)	6 (13%)	3 (6%)	*2.67 (1.18)*
In-person training (offered by NCDVTMH or another source)	47	0 (0%)	7 (15%)	16 (34%)	15 (32%)	5 (11%)	4 (8%)	*3.07 (1.08)*
On-going consultation offered by staff person (either NCDVTMH or another source) with expertise in these issues	45	0 (0%)	23 (50%)	11 (24%)	6 (14%)	3 (6%)	3 (6%)	*2.86 (1.48)*
Any type of training delivered through NCDVTMH materials or staff members	46	0 (0%)	16 (36%)	5 (11%)	15 (33%)	5 (11%)	4 (9%)	*2.36 (1.22)*
Other (Please describe)	22	0 (0%)	14 (64%)	4 (18%)	2 (9%)	0 (0%)	9 (9%)	*1.90 (1.53)*

Key: 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%", 4.00-4.99 = "51-75%", 5.00-6.00 = ">75%".

Fig. 14c: About what percent of current coalition staff members have received each of the following types of training on the trauma and mental health-related needs of DV/SA victim survivors?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean** ***(SD)***
Webinar offered by NCDVTMH	43	9 (21%)	9 (21%)	10 (23%)	8 (18%)	5 (12%)	2 (5%)	2.93 *(1.47)*
Webinar offered by other source	42	9 (21%)	5 (12%)	6 (14%)	12 (29%)	4 (10%)	6 (14%)	3.36 *(1.69)*
In-person training offered by NCDVTMH	42	13 (31%)	7 (17%)	5 (11%)	7 (17%)	7 (17%)	3 (7%)	2.93 *(1.72)*
In-person training offered by other source	43	6 (14%)	6 (14%)	11 (25%)	9 (21%)	2 (5%)	9 (21%)	3.51 *(1.67)*
On-going consultation offered by Coalition staff person with expertise in these issues	41	10 (24%)	6 (15%)	6 (15%)	3 (7%)	10 (24%)	6 (15%)	3.37 *(1.85)*
On-going consultation offered by outside consultant with expertise in these issues	41	14 (34%)	7 (17%)	7 (17%)	3 (7%)	6 (15%)	4 (10%)	2.80 *(1.76)*
Other (Please describe)*	15	11 (73%)	0 (0%)	3 (20%)	1 (7%)	0 (0%)	0 (0%)	1.60 *(1.06)*

Key for Mean score: 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%", 4.00-4.99 = "51-75%", 5.00-6.00 = ">75%"

*Other formats described include: conferences, an online tutorial, implementing a mental health work *group within the coalition, a general presentation, and occasional consultation and research.*

Fig. 14d: About what percent of current coalition staff members have received each of the following types of training on substance abuse-related challenges experienced by DV/SA victim/survivors?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean (*SD*)**
Webinar offered by NCDVTMH	42	17 (41%)	10 (24%)	5 (12%)	9 (21%)	0 (0%)	1 (2%)	2.24 *(1.32)*
Webinar offered by other source	42	9 (21%)	10 (24%)	7 (17%)	11 (26%)	2 (5%)	3 (7%)	2.90 *(1.50)*
In-person training offered by NCDVTMH	44	19 (43%)	8 (18%)	6 (14%)	8 (18%)	2 (5%)	1 (2%)	2.30 *(1.42)*
In-person training offered by other source	44	8 (18%)	7 (16%)	7 (16%)	6 (14%)	6 (14%)	10 (22%)	3.57 *(1.84)*
On-going consultation offered by Coalition staff person with expertise in these issues	40	16 (40%)	6 (15%)	4 (10%)	4 (10%)	6 (15%)	4 (10%)	2.75 *(1.84)*
On-going consultation offered by outside consultant with expertise in these issues	40	14 (35%)	11 (28%)	5 (13%)	3 (7%)	4 (10%)	3 (7%)	2.53 *(1.63)*
Other (Please describe)*	16	14 (88%)	1 (6%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	1.19 *(.54)*

Key for Mean score: 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%", 4.00-4.99 = "51-75%", 5.00-6.00 = ">75%"

*Other formats described include: having substance abuse experts on staff, including staff who provide trainings/webinars.

Fig. 14e: About what percent of current coalition staff members have received each of the following types of training on strengthening parent-child relationships in the context of DV/SA and trauma?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean (*SD*)**
Webinar offered by NCDVTMH	43	21 (49%)	12 (28%)	4 (9%)	4 (9%)	2 (5%)	0 (0%)	1.93 *(1.18)*
Webinar offered by other source	44	13 (30%)	14 (32%)	4 (9%)	8 (18%)	0 (0%)	5 (11%)	2.61 *(1.62)*
In-person training offered by NCDVTMH	43	27 (63%)	7 (16%)	5 (12%)	0 (0%)	3 (7%)	1 (2%)	1.79 *(1.32)*
In-person training offered by other source	45	10 (22%)	8 (18%)	7 (15%)	8 (18%)	3 (7%)	9 (20%)	3.29 *(1.82)*
On-going consultation offered by Coalition staff person with expertise in these issues	42	16 (39%)	6 (14%)	6 (14%)	3 (7%)	5 (12%)	6 (14%)	2.83 *(1.89)*
On-going consultation offered by outside consultant with expertise in these issues	42	17 (41%)	8 (19%)	6 (14%)	6 (14%)	1 (2%)	4 (10%)	2.48 *(1.64)*
Other (Please describe)*	16	12 (75%)	2 (13%)	1 (6%)	0 (0%)	0 (0%)	1 (6%)	1.56 *(1.32)*

Key for Mean score: 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%", 4.00-4.99 = "51-75%", 5.00-6.00 = ">75%"

*Other formats described include: the coalition providing and/or coordinating trainings and a conference in this area.

Fig. 14f: About what percent of current coalition staff members have received each of the following types of training on vicarious trauma/burnout/self-care?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean** **(*SD*)**
Webinar offered by NCDVTMH	43	23 (53%)	5 (12%)	7 (16%)	8 (19%)	0 (0%)	0 (0%)	2.00 *(1.22)*
Webinar offered by other source	45	7 (15%)	8 (18%)	8 (18%)	13 (29%)	5 (11%)	4 (9%)	3.29 *(1.52)*
In-person training offered by NCDVTMH	44	26 (59%)	5 (11%)	6 (14%)	6 (14%)	0 (0%)	1 (2%)	1.91 *(1.30)*
In-person training offered by other source	47	1 (2%)	3 (7%)	6 (13%)	11 (23%)	11 (23%)	15 (32%)	4.55 *(1.35)*
On-going consultation offered by Coalition staff person with expertise in these issues	43	13 (30%)	5 (12%)	7 (16%)	2 (5%)	7 (16%)	9 (21%)	3.28 *(1.98)*
On-going consultation offered by outside consultant with expertise in these issues	41	16 (39%)	9 (22%)	4 (10%)	4 (10%)	5 (12%)	3 (7%)	2.56 *(1.70)*
Other (Please describe)*	15	13 (86%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)	1 (7%)	1.47 *(1.36)*

<u>Key for Mean score:</u> 1.00 = "0%", 1.01-1.99 = "1=10%", 2.00-2.99 = "11-25%", 3.00-3.99 = "26-50%", 4.00-4.99 = "51-75%", 5.00-6.00 = ">75%"

*Other formats described include: a coalition-coordinated training, a staff retreat.

Fig. 14g: About what percent of current coalition staff members have received each of the following types of training on trauma-informed services and organizations?

Format	**Total** *N*	**0%** *N (%)*	**1-10%** *N (%)*	**11-25%** *N (%)*	**26-50%** *N (%)*	**51-75%** *N (%)*	**>75%** *N (%)*	**Mean** **(*SD*)**
Webinar offered by NCDVTMH	40	15 (37%)	9 (23%)	8 (20%)	4 (10%)	3 (8%)	1 (2%)	2.35 *(1.41)*
Webinar offered by other source	42	13 (31%)	8 (19%)	9 (21%)	6 (14%)	4 (10%)	2 (5%)	2.67 *(1.53)*
In-person training offered by NCDVTMH	40	15 (37%)	8 (20%)	8 (20%)	4 (10%)	3 (8%)	2 (5%)	2.45 *(1.52)*
In-person training offered by other source	44	7 (16%)	6 (14%)	9 (20%)	7 (16%)	8 (18%)	7 (16%)	3.55 *(1.70)*
On-going consultation offered by Coalition staff person with expertise in these issues	40	14 (35%)	2 (5%)	6 (15%)	6 (15%)	9 (22%)	3 (8%)	3.08 *(1.80)*
On-going consultation offered by outside consultant with expertise in these issues	39	16 (41%)	10 (25%)	5 (13%)	2 (5%)	3 (8%)	3 (8%)	2.36 *(1.60)*
Other (Please describe)*	15	13 (86%)	1 (7%)	1 (7%)	0 (0%)	0 (0%)	0 (0%)	1.20 *(.56)*

Key for Mean score: 1.00 = “0%”, 1.01-1.99 = “1=10%”, 2.00-2.99 = “11-25%”, 3.00-3.99 = “26-50%”, 4.00-4.99 = “51-75%”, 5.00-6.00 = “>75%”

*Other formats described include: coordinating a round table on the topic, extensive reading, participation in a trauma institute, occasional consultation and research from another organization, and participating in the sanctuary institute.

Coalition preparedness to provide training/TA to member programs

Fig. 15a: In your opinion, how prepared are your Coalition staff to provide training/TA to your member programs on DV/SA victim survivors’ *trauma and mental health-related needs?*

Total *N*	**Not prepared at all → → Very well prepared**										**Mean (*SD*)**
	1 *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
47	2 (4%)	6 (13%)	5 (11%)	3 (6%)	2 (4%)	5 (11%)	4 (8%)	8 (17%)	7 (15%)	5 (11%)	6.09 *(2.89)*

Fig. 15b: How prepared are your Coalition staff to provide training/TA to your member programs on *substance abuse-related challenges* faced by DV/SA victim/survivors

Total *N*	**Not prepared at all → → Very well prepared**										**Mean (*SD*)**
	1 *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
47	2 (4%)	7 (15%)	5 (11%)	5 (11%)	3 (6%)	2 (4%)	8 (17%)	6 (13%)	5 (11%)	4 (8%)	5.68 *(2.82)*

Fig. 15c: How prepared are your Coalition staff to provide training/TA to your member programs on *strengthening parent-child relationships in the context of DV/SA and trauma?* (Please select one number)

Total *N*	**Not prepared at all → → Very well prepared**										**Mean (SD)**
	1 *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	
47	4 (9%)	3 (6%)	7 (15%)	3 (6%)	3 (6%)	6 (13%)	2 (4%)	8 (17%)	5 (11%)	6 (13%)	5.89 *(2.95)*

Fig. 15d: How prepared are your Coalition staff to provide training/TA to your member programs on vicarious trauma/burnout/self-care? (Please select one number)

Total	**Not prepared at all → → Very well prepared**	**Mean (*SD*)**

N	1 *N (%)*	2 *N (%)*	3 *N (%)*	4 *N (%)*	5 *N (%)*	6 *N (%)*	7 *N (%)*	8 *N (%)*	9 *N (%)*	10 *N (%)*	
47	0 (0%)	1 (2%)	2 (4%)	6 (13%)	4 (8%)	2 (4%)	6 (13%)	7 (15%)	12 (26%)	7 (15%)	7.23 *(2.31)*

Fig. 15e: How prepared are your Coalition staff to provide training/TA to your member programs on creating and sustaining *trauma-informed services and organizations*? (Please select one number)

Total	**Not prepared at all**			**→**			**→**		**Very well prepared**		**Mean**
N	**1** *N (%)*	**2** *N (%)*	**3** *N (%)*	**4** *N (%)*	**5** *N (%)*	**6** *N (%)*	**7** *N (%)*	**8** *N (%)*	**9** *N (%)*	**10** *N (%)*	**(*SD*)**
46	3 (6%)	5 (11%)	3 (6%)	4 (9%)	3 (6%)	5 (11%)	6 (13%)	5 (11%)	5 (11%)	7 (16%)	6.09 *(2.92)*

Future TA/training priorities

Fig. 16a: Which of the following formats for training and TA would be most helpful and accessible to you?

Item	**Total** *N*	**Not useful at all- 1** *N (%)*	**Somewhat useful- 2** *N (%)*	**Very useful- 3** *N (%)*	**Mean (*SD*)**
Web-based information and materials	46	1 (2%)	10 (22%)	35 (76%)	2.74 *(.49)*
Webinar series on core elements of trauma-informed advocacy with accompanying conversation guides	45	1 (2%)	12 (27%)	32 (71%)	2.69 *(.51)*
Follow-up web meetings with state coalitions to discuss implementation and to highlight promising approaches	45	2 (4%)	12 (27%)	31 (69%)	2.64 *(.57)*
Webinar series on key elements of developing/building enhanced services with accompanying conversation guides	45	3 (7%)	10 (22%)	32 (71%)	2.64 *(.61)*
Follow-up web meetings with state coalitions to discuss implementation and to highlight promising practices	45	2 (4%)	11 (25%)	32 (71%)	2.67 *(.56)*
Online trainings (e-trainings, online courses, with CEUs)	45	2 (4%)	12 (27%)	31 (69%)	2.64 *(.57)*
In-person symposium for coalitions	43	2 (5%)	10 (23%)	31 (72%)	2.67 *(.57)*
Participation in NCDVTMH training-of-trainers and advanced training series	46	1 (2%)	5 (11%)	40 (87%)	2.85 *(.42)*
In-person training in your state	47	1 (2%)	9 (19%)	37 (79%)	2.77 *(.48)*
Broadcast messages/alerts	42	11 (26%)	16 (38%)	15 (36%)	2.10 *(.79)*
Social media, such as Facebook, Twitter, others	42	14 (33%)	16 (38%)	12 (29%)	1.95 *(.80)*

Fig. 16b: Please rate the priority of the following training and TA topic areas for your state: Overall categories

(NOTE: After reviewing individual survey items for overall themes, the categories shown in the following table were created. Fig. 16b shows responses to the individual survey items on the priority of training and TA topic areas for respondents' states/territories.)

Category	**Total** *N*	**Minimum**	**Maximum**	**Mean (*SD*)**
Trauma-informed approaches (10 items)	46	2.60	4.00	3.57 *(.42)*
Working with children in the context of DV/SA (3 items)	46	1.67	4.00	3.42 *(.59)*
Mental health-related needs of DV survivors (6 items)	46	2.50	4.00	3.53 *(.42)*
Substance abuse-related challenges of DV survivors (6 items)	46	2.50	4.00	3.51 *(.42)*
Building collaborations (4 items)	44	2.00	4.00	3.16 *(.64)*
Culturally specific approaches (2 items)	45	2.00	4.00	3.50 *(.60)*

Key: 1 = No need, 2 = Low priority, 3 = Medium priority, 4 = High priority

16c: Please rate the priority of the following training and TA topic areas for your state: Individual items.

Item	**Total** *N*	**No need- 1** *N (%)*	**Low priority- 2** *N (%)*	**Medium priority- 3** *N (%)*	**High priority- 4** *N (%)*	**Mean (*SD*)**
Other (Please describe)*	3	0 (0%)	0 (0%)	0 (0%)	3 (100%)	4.00 *(.00)*
Trauma-informed approaches to working with survivors dealing with trauma and other mental health challenges	45	0 (0%)	0 (0%)	10 (22%)	35 (78%)	3.78 (.42)
Handling crises in working with survivors dealing with mental health, trauma and/or substance abuse challenges	45	0 (0%)	1 (2%)	9 (20%)	35 (78%)	3.76 *(.48)*
Trauma-informed approaches to working with survivors dealing with trauma and substance abuse challenges	45	0 (0%)	0 (0%)	12 (27%)	33 (73%)	3.73 (.45)
Developing accessible trauma-informed services	46	1 (2%)	0 (0%)	10 (22%)	35 (76%)	3.72 *(.58)*
Building coalition capacity to support programs in the areas listed above (e.g., accreditations policies, model policies, incorporation into basic training curricula)	45	1 (2%)	2 (5%)	10 (22%)	32 (71%)	3.62 *(.68)*

Item	Total *N*	No need- 1 *N (%)*	Low priority- 2 *N (%)*	Medium priority- 3 *N (%)*	High priority- 4 *N (%)*	Mean (*SD*)
Trauma-informed approaches to working with children and their non-abusive caregivers	46	0 (0%)	3 (7%)	13 (28%)	30 (65%)	3.59 *(.62)*
Safety planning with survivors dealing with trauma, mental health and/or substance abuse challenges	45	0 (0%)	3 (7%)	13 (29%)	29 (64%)	3.58 *(.62)*
Developing culturally specific trauma-informed services in partnership with culturally specific organizations, including responses to historical trauma	45	0 (0%)	2 (4%)	16 (36%)	27 (60%)	3.56 *(.59)*
Creating safe environments so that adult survivors and children feel able to talk with staff about trauma, mental health and/or substance abuse in conversations and service planning	42	0 (0%)	4 (10%)	11 (26%)	27 (64%)	3.55 *(.67)*
Creating trauma-informed organizations (includes reflective practice & supervision, personnel policies, addressing vicarious trauma)	45	1 (2%)	5 (11%)	10 (22%)	29 (65%)	3.49 *(.79)*
Developing culturally specific trauma-informed services in partnership with culturally specific organizations, including responses to immigration-related trauma	45	0 (0%)	5 (11%)	15 (33%)	25 (56%)	3.44 *(.69)*
Building coalition capacity to support trauma-informed practice dealing with special situations (e.g., community crises involving DV or SA, use of new technologies for delivering services)	45	0 (0%)	7 (16%)	11 (24%)	27 (60%)	3.44 *(.76)*
The impact of trauma on child development	46	1 (2%)	4 (9%)	18 (39%)	23 (50%)	3.37 *(.74)*
Developing outcome measures to evaluate the effectiveness of trauma-informed services	43	1 (2%)	6 (14%)	14 (33%)	22 (51%)	3.33 *(.81)*
Legal issues related to trauma, mental health, and substance abuse (e.g., custody and immigration issues)	44	0 (0%)	9 (21%)	12 (27%)	23 (52%)	3.32 *(.80)*
Reducing re-traumatization in the legal process (civil and criminal)	44	0 (0%)	8 (18%)	15 (34%)	21 (48%)	3.30 *(.77)*
Building collaboration with state and local mental health providers	42	0 (0%)	6 (14%)	18 (43%)	18 (43%)	3.29 *(.71)*
Building collaboration with state and local child treatment/advocacy/protection organizations	44	1 (2%)	5 (12%)	19 (43%)	19 (43%)	3.27 *(.76)*
Building collaboration with state and local substance abuse treatment providers	43	0 (0%)	7 (16%)	21 (49%)	15 (35%)	3.19 *(.70)*
Medication issues related to working with survivors dealing with mental health, trauma and/or substance abuse challenges	44	0 (0%)	10 (23%)	19 (43%)	15 (34%)	3.11 *(.75)*
Building collaboration with state and local mutual and peer support organizations (e.g., 12-step, consumer and peer support recovery)	43	0 (0%)	16 (37%)	15 (35%)	12 (28%)	2.91 *(.81)*

**Other responses include: Understanding trauma-informed practice through the lens of empowerment-based/survivor-defined services; the provision of high quality, free or low-cost trainings on mental*

health, substance abuse, and/or parent-child relationships; engaging member program staff on trauma informed practices; impacting local (as opposed to state-wide) policy on drugs and substance abuse.