The Member Programs' Survey: Initial Summary of Key Results

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In recent years, state and territory domestic violence/sexual assault (DV/SA) coalitions have promoted trauma-informed (TI) DV/SA services by providing support and training to their member programs, building interagency collaborations, and working to advance TI policies at the state and local level. The Member Programs' Survey (MPS) was developed by NCDVTMH for use by state/territory DV/SA coalitions to measure changes in their member programs' capacity for engaging in work from a TI perspective. While the MPS's were tailored to each coalition's individual needs, it included the following core sections across all states: organizational approaches to becoming more TI; availability of trauma- specific, culturally specific, and TI services; challenges and strengths in responding to the trauma-related needs of survivors; and supports available for program staff members, including trainings on TI approaches. The MPS was available to all state and territory DV/SA coalitions. Baseline data were collected between August 2013 and September 2015. All participating DV/SA coalitions received an individualized summary of results upon the completion of data collection.

This summary provides baseline results from the MPS's core sections. It represents responses from 211 programs in 10 states. Respondents include: executive directors from 104 programs, program managers from 37 programs, advocates and other frontline staff from 18 programs, mental health clinicians from 9 programs, administrative staff from 2 programs, along with program staff who either represent other positions (from 25 programs) or did not provide their occupation (from 16 programs). These data represent: 66 stand-alone dual DV/SA programs, 61 stand-alone DV-only programs, 35 dual DV/SA programs that are part of a larger agency, 18 DV-only programs that are part of a larger agency, 5 mental health agencies primarily serving DV survivors, 5 DV or DV/SA programs based within hospitals, and 17 "other" types of programs. Four programs did not provide information on their type. Of the 211 DV programs in this sample, 153 have shelters and 55 do not have shelters; 3 programs did not specify whether or not they have a shelter.

Approaches to Becoming A More Trauma-Informed Organization

Respondents rated the extent to which their programs' policies, procedures, and organizational culture incorporate principles of TI practice, using a scale from 1 (Not Well-Incorporated) to 10 (Well-Incorporated). Overall, respondents reported that their programs have thoroughly incorporated TI principles into their policies, procedures, and organizational culture (overall mean = 8.26). On average, programs rated themselves the highest on incorporating a commitment to supporting survivor self-determination and choice into their policies, procedures, and organizational culture (mean = 8.94). The overall lowest mean is for having a formal organizational commitment to trauma-informed approaches and services (mean = 7.57). The complete data are included in the table below.

To what extent do your agency's policies, procedures, and organizational culture incorporate:	
Item	**N (Mean)**
A commitment to supporting survivor self-determination and choice	156 (8.94)
A commitment to providing fully accessible services	183 (8.79)
An understanding of the mental health effects of DV/SA and other trauma	160 (8.38)
A recognition of the pervasiveness of multiple types of trauma in the lives of survivors	187 (8.31)
A commitment to reducing retraumatization and promoting healing and recovery	180 (7.99)
A commitment to providing culturally relevant trauma-informed services	187 (7.81)
A formal organizational commitment to trauma-informed approaches and services	113 (7.57)

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A subset of programs were asked about rules for curfew, chores, group attendance, and watching one's own children while in shelter. While group attendance was considered optional for the majority of these programs (56%), this was not the case for curfew (14%), chores (14%), or watching one's own children while in shelter (3%). Less than 40 programs answered these questions, so the sample size is likely too small for the results to be representative of DV programs in general.

Does your shelter program have rules regarding:					
Item	**Yes- mandatory**	**Yes- unless prearranged**	**Determined case-by-case**	**Optional**	**N**
Curfew	10 (27%)	15 (40%)	7 (19%)	5 (14%)	37
Chores	15 (40%)	11 (30%)	6 (16%)	5 (14%)	37
Group attendance	2 (5%)	8 (22%)	6 (17%)	20 (56%)	36
Watching one's own kids while in shelter	18 (50%)	16 (44%)	1 (3%)	1 (3%)	36

Another subset of programs were asked about ways that their organization's physical environment is responsive to the needs of survivors and their children. Overall, 98% of these programs strongly agree or agree that their physical spaces consider the privacy of survivors. Ninety-one percent have child-friendly areas for children to play. Again, a limited number of DV programs answered these questions, so these results may not be representative of DV programs in general.

How strongly do you agree that the following practices occur?					
Item	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**N**
Survivors have access to private, locked spaces for their belongings.	20 (51%)	12 (31%)	6 (15%)	1 (2%)	39
The program has private spaces for staff and survivors to discuss personal issues.	31 (65%)	16 (33%)	1 (2%)	0 (0%)	48
Staff members refrain from talking about survivors in common spaces.	19 (45%)	19 (45%)	4 (10%)	0 (0%)	42
The program provides a child-friendly space for children to play	28 (62%)	13 (29%)	4 (9%)	0 (0%)	45

Trauma-Informed, Trauma-Specific, and Culturally Specific Services

The MPS asked respondents to indicate whether certain trauma-specific services are available within their programs. Programs offer access to a range of trauma-specific services. Over three-quarters of programs reported having access to community and peer support services to address trauma-, mental health-, and/or substance abuse-related needs. While alternative and/or mindfulness-based healing activities are the least prevalent trauma-specific service, they are still available in 30% of responding programs.

Services available to address the trauma-related needs of survivors and their children:	
Item	**Yes (%)**
Access to community and peer support services to address trauma-, mental health- and/or substance abuse-related needs	160 (76%)
Services on supporting the parent-child relationship within the context of DV	132 (63%)
Services addressing the traumatic effects of DV are available onsite for children and adolescents	107 (51%)
Clinical staff or consultants provide trauma-specific services for survivors onsite	90 (43%)
Evidence-based services addressing the effects of trauma are available onsite for survivors	65 (31%)
Alternative and/or mindfulness-based healing activities or approaches	64 (30%)

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Programs also provided information on how often they use a range of TI approaches in working with survivors and their children. This item utilized the following scale: Always = 1, Usually = 2, Sometimes = 3, and Never = 4. Across all items, respondents reported a high frequency of use of TI approaches in their programs (overall mean = 1.68, or between "Always" and "Usually"). The complete results are below.

How often does your program currently use the following approaches in providing services?					
Item	**Always**	**Usually**	**Some-times**	**Never**	**N (Mean)**
Staff members help survivors to obtain/maintain access to their medications, as needed.	112 (68%)	35 (21%)	14 (9%)	4 (2%)	165 (1.45)
Staff members talk with survivors about ways that perpetrators use mental health- and substance abuse- related needs to control their partners, in the context of advocacy and/or safety planning.	94 (54%)	59 (33%)	21 (12%)	1 (1%)	175 (1.59)
Staff members provide survivors with information about common responses to trauma, including the ways DV and other experiences of trauma can affect mental health and well-being.	87 (49%)	75 (43%)	12 (7%)	2 (1%)	176 (1.60)
Staff members incorporate an understanding of trauma into their interactions with survivors.	78 (44%)	84 (47%)	15 (8%)	1 (1%)	178 (1.66)
Staff members provide information to survivors to help them to understand the impact of trauma and DV on their children.	88 (50%)	63 (35%)	25 (14%)	1 (1%)	177 (1.66)
Shelter staff apply knowledge of trauma in addressing the stresses that arise in communal living situations.	62 (44%)	56 (39%)	21 (15%)	3 (2%)	142 (1.75)
Staff members support survivors in identifying common emotional triggers.	71 (40%)	80 (45%)	25 (14%)	1 (1%)	177 (1.75)
Staff members incorporate an understanding of the effects of trauma on development into their interactions with children of survivors.	67 (39%)	75 (44%)	28 (16%)	2 (1%)	172 (1.80)
Staff members approach parenting support with a focus on enhancing resilience through strengthening the bonds between survivors and their children.	60 (35%)	82 (48%)	23 (14%)	6 (3%)	171 (1.85)

In addition, programs from all 10 states were asked if they provide **culturally specific services** (e.g., services based on culture, language, ability, or identity) to address the traumatic effects of DV. Of the 142 programs that responded to this question, 52 (37%) said yes and 90 (63%) said no.

Programs' Current Capacity to Respond to the Trauma-Related Needs of Survivors

Programs rated their confidence in their ability to meet the trauma-related needs of survivors, either onsite or in their communities, using a scale from 1 (Very Limited) to 10 (Excellent). Overall and across all items, programs were moderately confident in their ability to meet survivors' trauma-related needs (overall mean = 6.92). They had the least confidence in their capacity to meet the needs of survivors experiencing immigration-related trauma (mean = 6.08). Programs had the most confidence in their capacity to support survivors experiencing the traumatic effects of DV/SA and other lifetime trauma (mean = 7.94). The complete results are below.

Overall, how confident are you in your program's current ability to support survivors with a range of trauma-related needs, either onsite or through services in the community?											
Item	**Scale: 1 = Very limited, 10 = Excellent**										**N (Mean)**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Survivors experiencing the traumatic effects of DV/SA and other lifetime trauma	3	1	1	4	12	15	15	41	43	38	173 (7.94)

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Overall, how confident are you in your program's current ability to support survivors with a range of trauma-related needs, either onsite or through services in the community?											
Item	Scale: 1 = Very limited, 10 = Excellent										N (Mean)
	1	2	3	4	5	6	7	8	9	10	
The parent-child relationship within the context of DV	6	3	6	3	19	12	23	36	40	26	174 (7.34)
Survivors experiencing trauma stemming from legal policies and procedures	2	5	9	9	21	7	22	38	36	24	173 (7.19)
Children who have experienced the traumatic effects of exposure to DV/SA, child abuse, or neglect; or who have other mental health-related needs	7	4	9	6	17	16	23	35	37	18	172 (6.98)
Survivors with a range of mental health needs	3	6	11	8	18	15	27	44	28	14	174 (6.86)
Survivors with a range of substance abuse-related needs	5	7	10	11	17	14	34	41	22	13	174 (6.64)
Survivors experiencing the ongoing effects of cultural, political, and/or historical trauma	8	4	13	12	25	17	32	29	23	10	173 (6.32)
Survivors experiencing immigration-related trauma	9	9	17	11	24	13	28	34	20	9	174 (6.08)

The MPS also assessed the extent to which staff members face challenges in responding to the trauma-related needs of survivors and their children, using a scale from 1 (Not at All) to 10 (Very Much). Overall, programs reported that staff members face some challenges in working with survivors experiencing the traumatic effects of abuse (overall mean = 4.62). Programs indicated that staff members are most challenged by concerns about how mental health symptoms or substance use may affect the physical and emotional safety of other program participants (mean = 5.34). Programs reported having the fewest challenges related to limited staff knowledge, experience, and/or comfort in addressing the trauma-related effects of DV/SA (mean = 3.96). The complete results are in the table below.

To what extent do staff experience the following challenges in working with survivors who are dealing with the traumatic effects of abuse?											
Item	Scale: 1 = Not at all, 10 = Very much										N (Mean)
	1	2	3	4	5	6	7	8	9	10	
Concerns about how mental health symptoms or substance use may affect the physical and emotional safety of other program participants	14	20	24	12	15	20	24	17	10	15	171 (5.34)
Concerns that survivors experiencing mental health- or trauma related symptoms may not be able to make the best use of the program's services	13	14	30	14	24	22	20	10	15	8	170 (5.14)
Difficulties in responding effectively in interactions with survivors that trigger their own responses to trauma	16	37	38	12	25	15	11	10	6	1	171 (4.02)
Limited staff knowledge, experience, and/or comfort in addressing the trauma-related effects of DV/SA	19	33	40	16	20	12	17	10	3	1	171 (3.96)

Ways That Programs Support Staff Members

Respondents shared information about how their programs support the self-care and trauma-related needs of staff members, which is an important aspect of trauma-informed practice. On a scale of 1 (Not at All) to 4 (Very Much), programs reported that they respond "somewhat" to the self-care and trauma-related needs of staff members (mean = 3.04). Overall, programs were least likely to provide wellness programs for staff (mean = 2.40) and most likely to provide personal days for staff self-care (mean = 3.43). The complete results are in the following table.

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To what extent does your program respond to the self-care and trauma-related needs to staff?					
Item	**Not at all**	**A little**	**Some-what**	**Very much**	**N (Mean)**
Provision for "personal days"	8	20	35	112	175 (3.43)
Support of staff self-awareness, personal development, and self-care	6	15	61	92	174 (3.37)
Attention to staff members' own personal experiences being triggered by their work	8	24	62	82	176 (3.24)
Careful attention to work load management	10	23	61	81	175 (3.22)
Regularly scheduled supportive supervision incorporating a reflective practice approach.	20	28	63	65	176 (2.98)
Attention to vicarious or secondary trauma	20	27	56	62	165 (2.97)
Staff access to clinical supervision or guidance	32	19	53	70	174 (2.93)
Mental health and substance abuse treatment benefits	32	29	59	54	174 (2.78)
Wellness programs for staff	58	29	39	43	169 (2.40)

Programs provided information on the percentage of current paid staff members who have received training on a variety of trauma-related topics. The scale for this question is as follows: 1 = 0% of staff members, 2 = 1-25% of staff members, 3 = 26-50% of staff members, 4 = 51-75% of staff members, 5 = 76-99% of staff members, and 6 = 100% of staff members. Across all programs, 51-75% of current paid program staff members received training on trauma-related topics. The results are in the table below.

Training Topic	**N (Mean)**
Ways batterers use mental health and substance abuse concerns against survivors	173 (4.50)
Strategies and tools to support survivors' resilience, healing, and well-being	170 (4.48)
Collaborating with mental health and substance abuse treatment providers and systems	173 (4.48)
Trauma-informed approaches to working with survivors	133 (4.41)
Vicarious or secondary trauma	172 (4.34)
How to support survivors experiencing mental health & substance abuse-related effects of trauma and DV/SA	172 (4.26)
The impact of DV and trauma on children's development	171 (4.21)
How various forms of oppression can affect a person's experience of DV/SA and other lifetime trauma, including access to supports, resources, and opportunities for safety	173 (4.15)
Trauma-specific interventions for adult survivors	133 (4.08)
How staff members' own background, culture, or status can create risk for inadvertent use of power and control	173 (3.89)
Trauma-informed approaches to supporting the parent- child bond	133 (3.70)
Trauma-specific interventions for children and adolescents	129 (3.57)
The impact of historical trauma on survivors, their families, and communities	171 (3.57)
Culturally specific approaches to healing relevant to the community being served	131 (3.53)
The impact of immigration-related trauma on survivors, their families, and communities	172 (3.42)

Conclusion

Overall, these results show the remarkable range, depth, and diversity of TI practices being employed by DV and DV/SA programs across 10 states. However, these results represent baseline measures of DV programs' capacity to provide TI services. Many of the DV/SA coalitions who have utilized the MPS are or will be conducting TI initiatives involving training, technical assistance, and consultation to strengthen and support their member programs' capacity in working with survivors with trauma-related needs. The MPS will be re-administered in 2016 to document changes in DV programs' capacity to provide TI services. A final report showing changes in DV programs' work in providing TI services will be available upon the completion of data collection.

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