2019 INTIMATE PARTNER VIOLENCE COMMUNITY ANALYSIS

LSS CHOICES
For Victims of Domestic Violence

ILLUMINOLOGY | This report was prepared for LSS CHOICES by Illuminology

Report to LSS CHOICES:
Results of Intimate Partner Violence Community Analysis

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A full-service **social science research** firm providing **strategic direction** for clients in the public, non-profit, and private sectors.

INTRODUCTION

In 2017, police departments across Franklin County responded to over 30 domestic violence calls per day, with at least 5 injuries per day due specifically to intimate partner violence (or IPV).[i] These are conservative estimates, as reporting practices vary across law enforcement agencies. Survey estimates suggest that women are as (or more) likely to experience IPV in their lifetimes as they are to be afflicted with any form of cancer or to be injured in an automobile accident.

LSS CHOICES for Victims of Domestic Violence (LSS CHOICES) engaged Illuminology to provide an analysis of Central Ohio's current services related to domestic violence, to identify gaps in the service delivery system, and to provide an estimate of the impact of population growth on that delivery system. Working from a strengths-based perspective, Illuminology and LSS CHOICES engaged a wide variety of organizations that serve survivors of IPV to better understand what is working in our current system, what needs are emerging, and what community assets may be available to fill those needs.

Definitions

The critical first step of this analysis is to define what is meant by domestic violence. The National Domestic Violence Hotline defines domestic violence as "a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship." This includes using physical or sexual violence, emotional abuse, or economic deprivation (or the threat of any of these) to force a partner to behave in ways he or she otherwise wouldn't.[ii] Some researchers and practitioners extend domestic violence to include other control and threat behaviors within a household, such as elder abuse or child abuse. To prevent confusion, we use the term "intimate partner violence" (IPV) to refer to violence or intimidation that occurs between two people who are or have been in an intimate relationship.

Additionally, throughout the report we refer to survivors as women. This is not meant to imply that IPV survivors are only female, but acknowledges that a vast majority of survivors identify as female and so were the focus of this community analysis.

Research Methods

Illuminology collected data for this community analysis from multiple audiences using several techniques. Specifically, Illuminology:

Facilitated the work of community partners to identify services, needs, and gaps in the current system during the 2018 Forum on Intimate Partner Violence, convened by LSS CHOICES.

Conducted literature searches to identify best practices in the coordination of service provision to survivors of IPV and to provide additional guidance in key areas identified as needs in the analysis.

Conducted targeted Internet searches to attempt to identify IPV related organizations in Central Ohio and understand the services provided by those organizations.

Conducted in-depth interviews with national experts on IPV and Community Blueprints Models for providing services to IPV victims.

Circulated online surveys to providers.

Conducted in-depth interviews (IDIs) with local service providers, experts in IPV coordination and collaboration, and representatives of local community organizations with expertise in culturally sensitive service provision.

Conducted a roundtable discussion of women at LSS CHOICES Shelter and circulated an online survey to survivors through providers.

Analyzed census data to identify population trends.

Analyzed data from the National Intimate Partner and Sexual Violence Survey (NISVS), the Ohio Family Health Survey (OFHS), and the Behavioral Risk Factor Surveillance System (BRFSS) survey to identify prevalence rates for IPV in Central Ohio.

Throughout the remainder of the report, we integrate our findings about prevalence of IPV in Central Ohio with a discussion of best practices, risk factors, and protective factors noted in primary and secondary data collection.

Part I of the report focuses on key recommendations based on this research. For each critical need uncovered, the icons above denote which research method highlighted the need.

Part 2 of the report focuses on the rate of IPV in Central Ohio and how emerging demographic trends might increase the demand for services.

Part 3 presents a brief summary of conclusions and includes a Community Asset Inventory which represents the results of our work using discussions with community partners and targeted internet searches to identify the organizations working on IPV in Central Ohio, along with an indication of the services they provide. This should be treated as a starting point for a living document that is constantly updated by providers, along with a periodically released public-facing document so that people in need of services may also reference it.

Additional methodological detail can be found in Appendix A.

Illuminology would like to thank the more than 50 people who participated in the forum, completed a telephone interview or survey, or helped organize a roundtable of survivors for their assistance in this analysis.

PART 1:

Needs Identified from Community Analysis

Across the range of evidence used to gather information about Central Ohio's current status and widely recognized best-practices, five critical underserved needs and four additional underserved needs were identified which are necessary for IPV service providers to improve care for survivors in Central Ohio.

Five critical underserved needs

Critical underserved needs are those that were voiced repeatedly at the community forum and were echoed in subsequent research steps.

Increase the amount of collaboration among partners.

Empower survivors to meet their basic needs.

Provide culturally competent care.

Increase legal aid and improve legal system response to IPV.

Ensure all survivors have equal access.

Four additional underserved needs

These additional needs were identified but were not the highest priority in the forum or were later observed by researchers as they gathered data for this analysis.

Recognize and plan for comorbidity with substance abuse.

Train and retain staff with a passion and aptitude for IPV work.

Identify and track measurable outcomes within organizations.

Identify and track measurable outcomes in the community.

Increase Collaboration Among Partners, Including the Consideration of a One-Stop Shop

The most commonly mentioned theme in the 2018 Forum on IPV was **a need for a "one-stop shop,"** meaning a centralized location in which IPV survivors could access many or all of the services they need. Many forum participants felt strongly that such a space would improve coordination of services, resulting in less stress and trauma for survivors, and could reduce duplication of effort. Follow up in-depth interviews with community partners provided further evidence that this was in the top three needs of IPV survivors in Central Ohio.

Additionally, collaboration is a key feature of trauma informed care (discussed in the next section), allowing providers to avoid re-traumatizing survivors with continuous retelling of their stories.

Community partners envision a shared physical space where providers from most services that a survivor needs to access could work together collaboratively:

- *It would be pretty incredible to have everything in one place. People come here for counseling but have a case manager at another organization and get psychiatric services at a different one - they have to take off work multiple times per week. To me, it would mean having the courts, legal services, case managers, interviewers, everyone together in one location.*
- *It would be more collaborative - people who are doing expert work in their lanes, the best case managers, the best interpreters, legal services with a specialty in DV, trauma counselors. If we silo - one organization is doing it - it's not good. Columbus is very rich in victim's services, but it would be good if we could all rely on one another to provide the expert services we excel at.*
- *We need a center of excellence - a one-stop shop where victims only deal with people who are trained to do this type of work - specialists. All entities coming together in one building so the survivor doesn't have to*

Evidence that increased collaboration would benefit survivors emerged from the following sources:

Community Forum

Interviews with local and national experts

Survivors' Roundtable

Literature Review

State and Federal surveys

Provider and survivor surveys

move around to different appointments, they don't have to re-establish rapport and trust.

- *In a lot of other areas, it's something like a family violence prevention center - local with a multitude of services (providers, child advocacy center, counselors, safety-oriented agencies, children services, child support enforcement), ideally all in one location. Look at the calendar for someone actively trying to leave. They have five court dates, need to get a new job and are trying to find housing - those things aren't even directly related to the abuse. These centers can get things done more efficiently.*
- *Completely mission-driven, victim centered, even when people don't present how you expect them to… A pro-se clinic, legal services, children's services, employment assistance, childcare. All of that should be there.*

Some culturally specific providers approach this idea with caution. They see themselves as already providing wraparound services for the populations they serve in a seamless way. They suggest that a one-stop shop may not be optimal for everyone. However, if this were pursued, they would still want to be at the table throughout the process, co-located there as well—they are full service providers, not just "in existence to advise as a third party.":

- *I don't know what that means in this context. Getting all of their needs met in one place would be very difficult. You need different kinds of services and would require a lot of collaboration.*
- *Some days I think that could benefit us because we wouldn't have to worry about the nuances…. But I don't think this can be done completely. Consider different religious beliefs and their implications for shelter, for instance.*
- *It's a holistic physical place where people would go to begin all services. Everyone would be in that place. In many ways, we are a one-stop shop. Any crime victimization, past or present, things other agencies don't address - crisis intervention, linkages, support groups, education, long term advocacy. We have to partner with others for shelter, but we have most everything else. We serve all 88 counties.*
- *It's an awesome model. On the other hand, right now, we don't need to have multiple agencies involved. It's our intention to be that [one-stop shop] as much as we can. That said, if this happens, we need to be co-located, too.*
- *I think they want to do a one-stop for everyone. That's kind of based on the melting pot theory that everyone would come here and assimilate and assume an identity, but that's not what we have anymore. Immigrants are proud to be Latina or Somali people who LIVE in the U.S. They are learning to navigate the system, but they are bicultural - embracing the U.S. culture but not replacing their old culture with it. People who have been working in the system for many years don't always accept that. It's not possible to give EVERYONE quality services in one place. We exist because the system wasn't working for people we serve.*

- *If they really want to do that, it needs to be inclusive of everyone. We need to be there and leading the case. We're not in existence to advise as a third party… We provide direct services and want to be respected for that.*

Sharing information, and even co-locating staff, can reduce re-traumatization of survivors, who otherwise must re-tell their story and re-establish trust and rapport with each provider they visit. Re-traumatization can also occur when IPV survivors experience service bottlenecks and barriers, for example in the form of untrained staff at security checkpoints or reception desks. One community partner shared the following example: "*I asked several of my assistants/interns to actually go to the courthouse and pretend they were trying to file a protection order against an abusive partner. Not one of them received compassionate responses or guidance when asking for directions when they arrived. Not all of them even found the right place, in the end.*" Another suggested that one of the major tasks of their advocates is helping court staff know that the advocate is aware of the correct identification required for non-US citizens when requesting a protection order. Several clients had encountered staff who refused to accept their passport for this purpose.

In a fully collaborative approach, independent providers **share information as much as possible while still maintaining confidentiality of users**. To this end, providers should strive toward wraparound services, or at least a single advocate trained to take information for multiple providers, so that information only needs to be shared once by the survivor.

Additionally, it is important that any collaboration be approached from the perspective of how that collaboration improves client outcomes or experience. Setting objectives and goals for the collaboration rather than "collaborating for collaboration's sake," as one community partner put it, will be crucial. At least two community partners suggested that while advisory meetings could be useful, they typically devolve into everyone at the table discussing what's happening at their organization rather than discussing higher level issues that impact collaboration. One provider suggested more **carefully tailoring group meeting agendas to the level of the staff in the room,** reserving executive and leadership staff time for bigger picture questions and strategy.

These strategic questions should include how, and with what frequency, progress towards goals will be measured and reported. Working toward shared goals with a clear definition of success is important. Multiple community partners suggested that an **IPV homicide review panel is an example of a task that could help increase collaboration,** and this was also

mentioned as a community need by a provider survey respondent. A multi-disciplinary panel that looked at deaths related to IPV to identify how that outcome *might* have been avoided previously existed but has disbanded. Reviving this effort could help diverse partners come together to work toward a common goal.

Two models are often cited as best practice for communities when considering coordinated response models for providing services to IPV clients: Family Justice Centers and Community Blueprints.

Family Justice Centers

The Family Justice Center (FJC) model was identified by the Department of Justice as a best practice in addressing domestic violence. The FJC model seeks to physically co-locate a minimum of the following full-time partners: domestic violence or sexual assault program staff, law enforcement investigators or detectives, a specialized prosecutor or prosecution unit, and civil legal services. They may also include full-time or part-time shelter staff, community-based victim advocates, city and/or district attorneys, medical professionals, mental health professionals, and other relevant services. This approach grew out of a model for interviewing child sexual abuse survivors which prioritized minimal interviewing. **Reducing the physical separation of these diverse services reduces the number of times a survivor must tell their story, thus reducing re-traumatization**. Physical co-location also reduces barriers to access by reducing the amount of searching and traveling survivors must undertake to find help.

Various organizational structures are possible. Some FJCs are funded by the city or state, supplemented with grant support and fund all or many direct services themselves, funding partner agencies to provide staff at the location. Others primarily function to coordinate the efforts of a diverse group of partners, typically by providing physical space (often rent free) and using memoranda of agreement to specify what services will be provided by which partners and how shared costs will be divided. Some FJCs are located within police departments or within court systems. Others are independent not-for-profits, and at least one is housed within a health department.

Milwaukee, Wisconsin's **Sojourner Family Peace Center** is an FJC that is run by a shelter. They house 18 full-time co-located partners in the center, all of whom contribute operating fees to help with administrative costs. They also have several smaller organizations that

Assets to Address This Need in Franklin County:

Community support for addressing IPV as evidenced by good attendance at the forum.

Community support for the Community Blueprint Model, specifically.

Communities and organizations that have successfully implemented these solutions (e.g. Nashville, Minnesota, San Diego) are open to providing advice.

Potential grant funding opportunities

house advocates there part-time. This FJC was largely the result of the Center (when it was solely a shelter for battered women) gaining "champions" to their cause, then-District Attorney John Chisholm and Children's Hospital of Wisconsin. The three foundational partners agreed that it was not fair to survivors of domestic violence that different services were scattered throughout the city. They proceeded to mount a years-long campaign to bring service providers together, because as their President and CEO, Carmen Pietre said: "*Although fragmentation of services works fine, even well, for providers, it is not fair to the victims seeking help—they desperately need cohesive services. People deserve that.*"

Similarly, **Nashville's Office of Family Safety** just opened one of the largest FJCs (The Family Safety Center) in the country, bringing together at least nine community partners to directly provide services to survivors of DV, sexual violence, child and elder abuse, and human trafficking. Diane Lance, who heads the metro department which houses this center, described a long path to its eventual opening in 2019. Champions within local government – in this case, two different mayors and their wives – were crucial to spearheading efforts to first conduct a full systems analysis and then act on those findings, along with a city history of high rates of IPV and previous efforts to address it with special prosecutors and courts.

"Fragmentation of services works fine, even well, for providers… victims seeking help desperately need cohesive services. People deserve that."

-Carmen Pietre, CEO of Sojourner Family Peace Center

The forerunner to Nashville's Family Safety Center, the **Jean Crowe Advocacy Center**, was (and remains) a space in the courthouse where IPV survivors could wait in a safe, supportive location away from other court waiting areas where offenders or their family may also be present. While waiting, survivors could be connected with a number of services,

meet with their attorneys in private, cozy dens, and even be video conferenced into court to testify. This effort grew into a permanent metro department with more than 20 staff.

Community Blueprint for Safety

The Community Blueprint is an effort growing out of the Duluth Model of a Coordinated Community Response that stresses shared goals and coordination specifically among justice system agencies in an effort to address domestic violence. In the IPV domain, it seeks to create uniform definitions and interrelated, complementary procedures across agencies in order to more nimbly intervene when a survivor of domestic abuse is identified, and to hold the offender accountable. Blueprint communities recognize that domestic violence is not a one-time incident; it requires sustained vigilance on the part of law enforcement and the promise of stiff, unavoidable consequences for offenders.

Blueprint efforts use a set of established practices to assess all the systems that respond to IPV in the community, using interagency collaboration to improve the response in a way that is more victim centered, efficient, and effective. **Such an assessment identifies gaps between what survivors need and how the system as a whole responds.** The broad focus of the work is to identify opportunities for system reform through a detailed review of current operations.

It is our understanding that in late 2018, the Columbus City Attorney's Office spearheaded an effort to bring the Community Blueprint model to Franklin County, including offering to provide three years of contract and staffing costs, professional development, and other plan expenses if Federal funding is secured to assist with this process.[iii] Additionally, at least one community partner was aware of this model and mentioned it specifically:

- *Blueprint for Safety out of Minnesota - Need more big picture planning for more safety especially with law enforcement response becoming more effective. Only a certain population is going to call police. How do we find the others? I think that's one thing the community could really rally around and support.*

Both models seek to better coordinate the community response to domestic violence through increased collaboration. A Family Justice Center is a physical location that attempts to bring together as many public and private services, organizations, and agencies as possible in the same space, in order to reduce the burden and re-traumatization of survivors who would otherwise visit several locations across a city, reliving their story with each

separate request for services. The Community Blueprint produces an internal set of coherent strategies for a community's various branches of the justice system, including specifying what information is needed by which agencies and how it should be shared. In some cases, the implementation of the Community Blueprint Model leads to the development of a Family Justice Center, once the benefits of formal collaboration and community assessment are realized. Nashville followed this process, starting with the Blueprint and growing into a full FJC.

Implementing these collaborative strategies is not a simple project. Diane Lance partially explained her program's success by a link to Nashville's mayor, who was personally invested due to a violent crime his wife experienced. The Nashville Community Blueprint process took two full years to complete and included periodic large and weekly small group meetings involving more than 100 people from government, not-for-profits, district attorneys, community members, and representatives from all areas within the system that were assessed. Assessment techniques included interviews with everyone from 911 dispatchers to the mayor, document review, ride-alongs, and court observations, and culminated in a lengthy report issued to the community with specific, actionable recommendations. Diane sees the mayor's backing as key to the acceptance of these efforts: "*The Report was upsetting to many leaders. It was a hard message – it would've been a big problem if it had not come from [the] mayor's office… if it came from the prosecutor's office, it would be seen as friendly to legal system, but if it came from a shelter, there might be the sense that you don't understand law enforcement or courts.*"

This sentiment was echoed by Carmen Pietre, of Milwaukee's Sojourner Family Peace Center, and Natalia Aguirre, National Director of the Family Justice Center Alliance: A few critical partners are necessary, ideally one rooted in providing direct services, one in government, and one with strong private or non-profit community ties like a hospital or philanthropic organization. These foundational partners must be willing to spend years "sounding the alarm" until space is found and organizations come together under formal agreements.

One community partner strongly felt this was needed in Central Ohio, but that political will to make it happen was essential. Community activism could help inspire that need: *"It would be very interesting to me if there was a big groundswell of public support, in print and other media, during an election year, to see what happened."*

Undertaking a co-location or coordinated response effort will be expensive, requiring time and **a dedicated organization or staff member who is well-respected and invested to lead the effort.** In fact, this is true of any coordinated response to IPV in a community. As one community partner suggested: "*You need someone whose job it is to coordinate the community response. Who that is and where they are located will vary by community – but they must be well respected with good organizational skills.*" Community partners expressed support for such an effort:

- *Our community has a large number of agencies, and services could be coordinated better. An agency who specializes in serving victims in crisis should take the lead.*
- *We need a hub of some kind. CHOICES has had community advocates. A lot of times all the different parties that service IPV are not acknowledged. For instance, trauma counselors may be the only way we would find some people. Mental health counselors. We need to ensure those people are also aware of the best practices and protocol.*
- *Need coordinated community response - everyone is using the same language - referring to the same services, giving same answers.*
- *Is this person who is an ATOD [alcohol, tobacco, and other drugs] counselor or case manager missing that the primary concern is related to IPV? That survivor would be well served if the counselor knew about the danger of planning and how to make appropriate safety plans.*

Space must be secured, a collaboration of partners must be formed, these partners must dedicate staff to the new endeavor and someone must oversee the collaboration to ensure it operates effectively. There seems to be potential for this kind of investment in Central Ohio – the newly completed LSS CHOICES domestic violence shelter and the recent $20 million dollar grant to Nationwide Children's Center for Family Safety and Healing suggest strong community support. Additionally, the federal government regularly provides grants to communities to facilitate these approaches, which is one avenue our community is already considering.

Improving Collaboration Without a Formal Model

In the absence of full implementation of the Community Blueprint or FJC models, collaboration in Central Ohio could still be increased. In fact, **co-location alone does not ensure that services will be provided in a more efficient or coordinated fashion**. One subject matter expert shared an anecdote about her experience with FJCs. She regularly heard complaints from a prosecuting attorney about how insufficient the reports she

received from them were. This attorney worked only 10 feet down the hallway from the DV investigator who prepared them but had never addressed the need. She concluded, "*Some models are really focused on who will get in the center, rather than on how they work together. You can't just co-locate. That doesn't work.*"

This may require overcoming a history of division or lack of connection between agencies in the community. As one community partner put it:

- *I think it [collaboration] could be improved. I don't know how other communities work together. There seem to be disagreements and in-fighting and I'm not even sure why. Sometimes, I think we lose sight of the end goal. It could also be compassion fatigue or vicarious trauma or burnout. Often people come to this because of their own background. We need to make sure all advocates, case managers, and directors get the support, education, vicarious trauma therapy.*
- *It's a weird network of DV agencies that all fly solo. We need a broad conversation to build clarity amongst providers to better understand who does what. We have a 24/7 help line and get lots of calls and aren't always sure where to route them.*

Providers that focus on culturally specific services may feel especially isolated:

- *We're not getting referrals, not getting respect for the services we provide. We're not invited to the table. It's only when things go south - really bad cases - dealing with the worst of the worst.*
- *Just refer to us. We provide services. We're not in existence to be a third-party agency.*
- *Right now, the experience is, they include us on a task force of coalition style meeting. We all repeat ourselves from the last meeting and rehash a million announcements. Sometimes go to the next level and get a live training from us. Only a few go to the next level and actually call us when they should.*

Some community partners see bright spots where collaborations are happening and note the good turnout at the first forum at the beginning of this community analysis project:

- *There is some collaboration happening. ODVN has several committees - CHOICES sit on some of them with us. Those are usually at the leader or director level. It improves communication. It would be great to provide support for them - provide training and education to one another, just increase collaboration and connection.*
- *There was a good turnout. There are a lot of people who care about this and CHOICES having more access (with the new shelter) is also going to help.*

- *There was a good turnout at that forum. A lot of good people are working on this.*

Improving this collaboration will require first acknowledging and attempting to mend differences between providers, then consistently following through on promises.

- *I'm not sure I even understand enough to know [how to improve collaboration]. A good first step is just trying to be open in the communications and acknowledge the elephant in the room. It's not clear to me how you'd get the right people to the table, though.*
- *What partnerships should we have but don't? What ones do we only have on paper? How can that be fixed? Admitting wrong is a big part of that.*
- *Overcoming bad blood takes extra effort. Show an extra effort and mean it.*

Better networking to understand the full landscape of services offered by others seems essential:

- *Need to consider reaching out to other community partners. What do you do? What could you do? How could it be better on both sides?*
- *It's more people playing in the sandbox together. Not an expectation that just because we work together, we can give you information. You know, deputies call me because people won't tell them that the victim is in shelter. But the shelter is not supposed to disclose that information to anyone.*
- *Look at current partners - how is that going? Are you able to draw on that to connect to others? "You also partnered with x agency – I think that would really help our clients… can you bridge for me?" Even if it's the advocate-to-advocate level connection.*
- *Just a better understanding of who's serving who - how do we connect people from specific populations with the services that are right for them?*
- *There needs to better partnerships with organizations that serve specific populations. Reach out through the lens of "We need you, you don't need us."*

To this end, we have produced a draft community asset inventory (see Part III). Starting with this list will naturally lead to expansions as collaborations develop. This inventory should be constantly updated and reviewed by those included on it; intimate and accurate knowledge of the services offered by other organizations is vital to smooth collaboration and referral

processes. Warm handoffs, which were seen as a necessity by several community partners, should be emphasized:

- *We have to have community partnerships. People should be saying "We're not the best resource but let me tell you about this agency."*
- *Improved communication and "warm handoffs" with referrals.*

One community partner suggested that to do this effectively, it may be necessary to be sensitive to insecurities about how such collaboration can impact funding, "*There can sometimes be competition for clients. This is MY client. They are worried about numbers for funders. Focus on getting clients the help they need."*

Additionally, providers should make clear, to potential clients and to other providers, the requirements (and "deal-breakers") for receiving services from their organization. If requirements to receiving service are not made clear up front, women in need of help may feel like they are "given the runaround" and feel discouraged from seeking further services if allowed to get their hopes up, only to be turned away after beginning the process with a provider. At least one community partner indicated members of her staff have felt badly burned by providers who did not accept their clients into programs but did not provide a reason that made sense to them. This represents a break of trust, both to the provider and to the woman in crisis. This is particularly true of providers with crisis hotlines, which are often viewed as gateways to *all* services, not just those associated with the hotline itself.

Finally, at least one community partner noted that some case managers and advocates are already doing this and cited the Advocate Coalition of Franklin County as an asset in this regard, suggesting it: "… does a lot of good middle work - they connect victim advocates to court advocates; for example, which allows them to say, 'I have a case where X is happening… does that sound right?'"

Recommendations:

- ✓ Coordinate with current efforts to implement the **Community Blueprint Model**
- ✓ **Consider** creating a "mini-Family Justice Center" in the courthouse
- ✓ Consider **visiting communities with one-stop models** in place
- ✓ Find ways for providers to connect with and learn about one another. Suggestions include **reviving the IPV homicide review panel** and beginning to **acknowledge (and repair) fractured local relationships**

Empower Survivors to Meet Their Basic Needs

The Centers for Disease Control and Prevention (CDC) suggests that **addressing socioeconomic factors holds great potential for preventing IPV.** Financial security can go a long way toward enabling IPV survivors to escape from their situations; the CDC cites a two-year microfinancing and gender norms training program in South Africa that reduced IPV from 11.4% to 5.9%. Similar success has been shown in Ecuador.[iv] These microfinancing opportunities can take a range of forms, such as cash vouchers, low- or no-interest loans for business startups, or person-to-person or communal borrowing. Locally, responses from the 2005 BRFSS support this: **More than one-in-four of Franklin County women in households earning under $20,000 per year reported experiencing physical or sexual IPV in the past year, while fewer than 4% of women in households earning $20,000 or more report this.** An academic study of services used by women in the Midwest who have suffered domestic violence demonstrated that 8 of the top 10 most helpful services were financially empowering (e.g., subsidized day care, subsidized housing, welfare assistance, educational support).[v] Other ways of improving financial security (like improving paid leave policies) provide additional assurances that, if crisis strikes, a survivor can still be assured their job will be there for them when they are able to return. Even more critical, **finding shelter and long-term housing is vital to ensuring feelings of safety and stability.**

The need for financial empowerment was strongly endorsed by attendees to the Community Forum: Shelter and housing was the need third-most often identified as a critical need in Central Ohio, followed immediately by the need for money, financial literacy, and material things like clothes. This theme also came through strongly in our roundtable discussion with survivors of IPV at LSS CHOICES. The women there expressed frustration with their inability to **locate and maintain living wage employment** and see this as a community-wide problem. Community partners cited financial control and abuse as a key factor in IPV relationships and a barrier to women leaving dangerous situations. This is especially true when children are involved. As one woman in the

Evidence that we must empower survivors to meet their basic needs emerged from the following sources:

Community Forum

Interviews with community partners &

Survivors' Roundtable

Literature Review

Provider and survivor surveys

roundtable said, "*I don't just have to take care of me. I have to take care of me and my kids and I can't have us in a rundown apartment in a bad neighborhood*."

The need for living wage employment was also mentioned by a provider in the survey as a key future demand. This provider indicated that a job needed to both sustain a family but also offer hours that parents could work. Another survey respondent noted a need for job training and employment assistance.

Because of her history of violence and being controlled, it can be uniquely difficult for a survivor of IPV to find and maintain employment.

Several complicating factors make finding employment difficult, according to survivors. They suggested that a **lack of employment history, lack of education and job skills, transportation** (including a shortage of bus passes at some times), and **the need for affordable, safe child care** all made it harder for them to find and maintain any job, let alone one that would support them and their families. Community partners also voiced these concerns as did two provider survey respondents:

- *Transportation is always an overwhelming need.*
- *Transportation is a big barrier in Franklin County, for everything.*
- *It would be good to have bus passes more readily available - maybe a free pass when you get your second check, maybe like an incentive (currently the passes stop after the first paycheck, according to survivors at LSS CHOICES).*
- *Need childcare, especially after age 12.*
- *Need affordable childcare.*
- *Childcare is another area. JOIN used to have some respite services. They would take the kids for up to three days quarterly, connect them with medical and dental exams. I know that was used by many survivors who were starting a new job.*

A critical **shortage of affordable housing** was also a major theme of the community analysis. Again, it was a finding from the survivor's roundtable, and was echoed by various community partners in the provider survey and in interviews:

- *Lack of residential options is a huge problem. Financial control is actually more common than physical violence. The population seeking shelter doesn't have enough options.*
- *Housing is a big issue in our community.*
- *Housing is the biggest need.*

This is not a new problem. Franklin County has a severe shortage in affordable housing. The monthly Fair Market Rate (FMR) set by the federal Department of Housing and Urban Development (HUD) in 2018 was $910.[vi] At this rate, **a household must earn $36,400 to afford a two-bedroom apartment. However, the mean renter income in Franklin County is less than $34,500** and many in the county (including many IPV survivors) have extremely low incomes. The Affordable Housing Alliance of Central Ohio estimates that 54,000 low-income households in Franklin County spend more than half their income on housing.[vii]

The **shortage of affordable homes is most severe for the lowest-income households**. Using data from 2010-2014, the Urban Institute estimated that for every 100 extremely low-income (ELI) renter households in Franklin County, only 45 units are adequate, affordable, and available, including units subsidized by HUD.[viii] Franklin County's ratio of 45 units for every 100 households compares unfavorably with Cuyahoga (Cleveland), Allegheny (Pittsburgh), and Hamilton (Cincinnati) counties, which have ratios of 50, 53, and 54 respectively. Without HUD subsidies, only 23 units would be available for every 100 ELI renter households in Franklin County.

A decent, affordable home is the foundation of a family's social and economic security. Education, health, and economic mobility outcomes are all at risk if children are living in unaffordable homes.[ix] The availability of affordable housing also depends on where you live and is particularly restricted in areas with substantial minority populations: one in four Black families and one in six Hispanic or Latino families live in areas of concentrated poverty, compared to only one in 13 white families.[x]

The Mayor of Columbus has taken some steps towards addressing the need, including allocating 50 million dollars for affordable housing in a bond package that Columbus residents will vote on in 2019. Franklin County commissioners have discussed doubling conveyance fees on property sale prices, from $2 per $1,000 to $4.[xi] Dollars raised through conveyance fees are split evenly between the Affordable Housing Trust and Community Shelter Board; if fees were doubled, around $28 million would be generated annually. Taken together, these two funding sources would not nearly fill the need for affordable housing units but would demonstrate political will to build momentum on this issue.

Assets to Address This Need in Franklin County:

Political will to address affordable housing in Central Ohio, including recent proposed bond allocations from Mayor Ginther.

Community investment and support for new Shelter construction.

Expansion of transitional housing services by Huckleberry House, Catholic Social Services, and LSS CHOICES.

Engaging with local policymakers and other key players to ensure that IPV survivors in shelter or transitional housing are given priority for new decent, affordable units outside of the area they used to reside in may be a promising strategy. This would not necessarily entail financial assistance, but an advanced position on waiting lists for available units. One survivor said she had been on the HUD waiting list for 15 months and had no idea when this housing assistance would be available to her. Variation by area in the quality of schools, transportation, presence of crime, healthy food stores, and recreational facilities for children also make it difficult to find affordable housing that is adequate for a family's needs.

Not only do these women have difficulties finding housing they can afford, but finding such housing and being able to secure leases are two critically different things. Sadly, obstacles to taking these critical steps often result directly from the cycle of abuse and control survivors have endured. Survivors shared their challenges in this arena including a **lack of credit history or poor credit, a lack of rental history and references, and a history of evictions** which may make landlords hesitant to rent to them. Additionally, getting away from the area in which they previously resided can be crucial for survivors' safety and wellbeing But high rents can make such a move difficult. **Thus, while addressing basic needs such as housing and transportation are barriers for nearly all clients who are engaged with social service programs, they may be central to the abuse suffered by IPV survivors, making the problem doubly complex and important to address.**

Transitional housing, which seeks to help IPV survivors exit shelter or abusive situations and provides a supportive environment to move toward independence, may help fill some of this gap as well, as noted by at least one community partner and one provider survey respondent. LSS CHOICES offers transitional housing to families with four or more children and to survivors who speak English as a second language, two populations that have been shown to have longer shelter stays. Huckleberry House also provides transitional housing - in 2015, they

grew their program to 10 units specifically serving survivors of IPV. Clearly, however, there is room (and need) for growth.

Finally, drawing on the literature from best practices in combatting homelessness can be instructive here. Case managers who focus on finding and maintaining stable housing for families on the brink of homelessness suggest that personal connections with landlords can be a promising way to ease the path of survivors into independent housing. These case managers make it a point to personally network with local landlords to help them understand their financial assistance program, encourage landlords to contact case managers when problems arise, and help landlords understand the unique needs facing their population.[xii] At least one community partner mentioned such a relationship with a local apartment complex – the manager regularly contacts them as vacancies arise. Such networking may help women overcome the stigma attached to moving from shelter and case managers can also help provide a safety net while survivors establish their household.

Psychologically Empower Survivors

Beyond economic empowerment, an "empowerment approach" also requires that **survivors of intimate partner violence be treated as their own agents of change,** providing them with access to information, education, support, and tools they need to create the change in their lives that they want and need.[xiii]

Empowerment is one of the core values of the Ohio Domestic Violence Network

Service providers should recognize that violence against women is rooted in patriarchal societal norms, and seek to enhance the independence of women. To this end, no program should be mandatory or contingent upon completion of other services; women should instead be recognized as the "primary planners of their own goals and objectives."[xiv] Women should also be encouraged to view themselves as the masters of their own future. Their history of violence has been taken this away from them, and service providers must seek to reinstate it.

Shelters, in particular, should strive to avoid recreating the cycle of power that survivors are attempting to avoid.[xv] But this, too, should be approached with caution. In some cases, providing too many choices for a survivor who has been subject to control by her partner can be difficult for survivors. There is a delicate, individually determined balance to be found here, based on each survivor's personal history; there will be no one-size-fits-all model. Being in tune with this issue and responsive to clients' needs is important.

Practice Trauma-Informed Care

In addition to empowerment, ODVN and the National Advisory Committee on Violence Against Women suggest that **a trauma-informed approach is critical to appropriately serving women in need.**[xvi,xvii] This should extend to *all* employees and representatives of

Evidence that we must psychologically empower survivors emerged from the following sources:

Community Forum

Interviews with community partners

Survivors' Roundtable

Literature Review

organizations, not only those in "sensitive" roles. Repeated negative interactions with a rude kitchen worker or someone on the janitorial staff may be just as consequential and off-putting for someone seeking services as discomfort with an advocate.

This theme surfaced strongly in interviews with community partners:

- *The community in general and providers in particular need to understand the neurobiology of trauma - it can contribute to victims staying and can impact if and how they use services.*
- *Trauma-informed care and trauma responsive care are critical. Are you serving people who need services? Are you asking people what they need? If the average stay is less than three days in shelter, for example (either generally or amongst some subgroups), that is a problem. Are people upset and leaving at 3am? They are not going to do your survey and you will not know what they needed.*
- *Everyone should be trained and good at trauma-informed and trauma responsive care. For example, the hotline. It's essential that everyone who answers the hotline is not just knowledgeable about TIC but should be pretty excellent at trauma-informed care. Realistically, they cannot connect them to any resources right away. They need to adequately assess for needs and provide the person with all the tools and resources you realistically can. Otherwise people will feel badly and they will never call again. And they will tell all of their friends to never call.*
- *From the top down, everyone must be knowledgeable about IPV and trauma, throughout the agencies.*
- *We need to understand the complexities and trauma clients have faced coming here, especially if coming as a refugee.*

The Substance Abuse and Mental Health Services Administration describe trauma-informed care (TIC) as follows: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."[xviii] Trauma-informed organizations must ensure that people working at all levels of the organization have an understanding of what trauma is and how it can impact the thoughts, feelings and behaviors of clients. Training and assessment should help staff identify symptoms of trauma both in the clients they work with and in their coworkers - self-care and dealing with the effects of secondary trauma are crucial to a trauma-informed approach.

Above all, **trauma-informed approaches are strengths-based and recognize the impacts of trauma**. In the context of IPV, TIC recognizes that IPV is a unique form of violence characterized by long-term, repeated coercion and abuse by someone the person trusts and loves; that many of the behaviors and reactions expressed by a survivor are normal responses to their specific history of traumatic experiences; and that service providers must strive to avoid re-traumatization. Current systems that seek to address IPV, especially shelter care, often focus first and foremost on the physical safety of survivors, which is a necessary minimum component. However, if survivors are to move forward from an abusive relationship, in some cases breaking generational cycles of abuse and dysfunctions, TIC is necessary and may not always be present. As one survivor put, "This is a place where I'm safe, or at least safer. This is not a place where I can heal." A provider echoed this sentiment, "The women who come to us come because of a very traumatic relationship event, but that's just a small part of all the trauma they have experienced." Thus, shelter and meeting basic needs are a necessary, but insufficient, step in caring for IPV survivors.

Recommendations:

- ✓ Engage with local policy makers to ensure **IPV survivors are considered in housing planning**
- ✓ Continue attempts to **expand transitional housing**
- ✓ **Engage with local landlords and employers** to increase understanding of dynamics of IPV and encourage cooperation with renters and case managers
- ✓ Train all staff in as many organizations as possible on the principles of **trauma-informed care** (TIC) framework to ensure psychological empowerment
- ✓ Hold organizations **accountable** for TIC practices

Provide Culturally Competent Care

A critical implication of the need for an individualized, trauma-informed approach is that providers must be culturally competent, as culture has a massive impact on how women interpret their experiences and expect to be treated**. The need for culturally competent care was the second most often cited critical gap in the IPV forum** and was mentioned by many community partners. Additionally, two service providers noted they had seen increases in the numbers of immigrants served in the last five years. In-depth interviews with service providers who focus on specific cultural populations in Central Ohio were conducted to better understand the needs in this area.

To explore this idea, community partners were asked to define what cultural sensitivity or cultural humility meant to them. Overwhelmingly, community partners identified this idea as **being open-minded and understanding what you don't know about the experience of others.** This includes their cultural, religious and sexual identity. But it's more than just memorizing a set of facts about a culture, learning rudimentary phrases in another language, or taking a one-time training. Cultural sensitivity means working to better **understand the full identity of each individual** survivor you encounter:

- *Integrity, dignity, it's not knowing everything about the culture, but understanding that there are differences and variation in what you expect. It's really just about unconditional support and acceptance for what the person in front of you needs.*
- *Cultural humility is always being open to what people say they need.*
- *Just ask, "Is there anything I can do to make you more comfortable?"*
- *It's not just trying to understand people when they have a need and communicate with them. It's about where they came from, the universe. Each community has its own universe and we try to make all our programs sensitive to that.*
- *This will look different for different populations - deaf, LGBTQ, different cultures.*
- *The more cases you see, and the more open-minded you are, the better you will do.*
-

Evidence that culturally competent care would benefit survivors emerged from the following sources:

Community Forum

Interviews with community partners

Literature Review

Provider and survivor surveys

- *Humility means you know you don't know. But you're going to show up and keep trying. Listening to what the deaf person says he or she needs, not what you think he or she needs or what the training said.*
- *People have to talk about cultural humility and cultural awareness, have to learn about other cultures. I'm still learning every day and people working with these populations have to be open to that.*

Importantly, culture is more than simply immigration status or the language survivors speak. For instance, some providers might overlook the important dynamic that may face African American women entering a system that is primarily staffed by white women. In fact, at least one community partner suggested that African American women may be most underserved when it comes to accessing services designed with them in mind: "*I know where to send Hispanic women or Somali women. I don't have anywhere that I can say for sure is designed to be optimal for African Americans.*"

In some cases, culture or identity plays into abuse dynamics in specific ways:

- *A lot of people are very kind… but don't understand the cultural context of abuse. In the South Asian community, there can be multiple perpetrators (father, father-in-law, mother-in-law, son-in-law). Many live in joint families and victim and the abuse is embedded in this context. Sometimes the husband is a passive bystander who is unwilling to move out of the home. It's a complex and multi-level issue. We can't treat someone based solely on culture. We can't say all individual women are unable to navigate the system. You have to be nonjudgmental, without preconceived notions.*
- *It is important to understand the history of different cultures - in some cultures, women may not be able to show any of their body. In others IPV might be more normal.*
- *Recognize that services to victims and batterers are typically with white male perpetrator and white female survivor in mind. That's the prototype. It might not work for people of color. It doesn't resonate in the Somali community where some have been taught that beating your wife is part of being a good husband.*
- *Goes out the window in queer relationships, too.*
- *May be harder to speak to White Appalachian or Black communities with different levels of cultural acceptance and expectations. It's less stark for them.*
- *How it presents in the LGBTQ community and the barriers will be different. Abuse tactics are more specialized in this community - threat of being outed, lack of legal protections, especially when it comes to child custody.*
- *[In the LGBTQ community, there] are stereotypes about who can or can't be the abuser or the abused.*
- *I think a lot of people aren't aware of how pervasive it is in the [LGBTQ] community - they don't*

Assets to Address This Need in Franklin County:

Africentric Personal Development Shop

ASHA Ray of Hope Asian American Community Services

Buckeye Region Anti-Violence Organization

Community Refugee & Immigration Services

Deaf World Against Violence Everywhere

Ethiopian Tewahedo Social Services

Ohio Hispanic Association

have an understanding of the why or the history, including intergenerational trauma.

Several community partners said that cultural sensitivity must become ingrained in the IPV world. One said it best: *"One of the reasons we are still having this conversation is that we haven't made this sensitivity a part of our culture. It has to be in our heads, all the time. Just like we talk about asking victims 'Are you in a safe space?' being second nature in DV, this has to be that way, too."*

Something as simple as learning to correctly pronounce a person's name is a concrete example of cultural sensitivity (or the lack thereof). As one community partner noted: *"It's hard to pronounce names from other cultures, I get that. But it's their NAME. You have to learn it. It's important. Ask them to repeat it. Make the effort."*

It is important to note that **some culturally specific providers would prefer to serve clients within their organizations** rather than further integrating into the larger system. They believe that members of their community are better served in-house and would prefer to grow their services rather than refer outside of their own organization.

"I think there is enough capacity within specialized communities. Otherwise, if it's not going to work then we need to build capacity within the community if it's not there. We're professional, we know the context, and we know how to identify leaders within the communities and reach out and train them. We're tired of trying to change the mainstream system so we're building our own capacity instead, without even depending on the system. We've been doing this for 18 years and we haven't seen any changes."

In addition to providing culturally humble or culturally specific services, another piece of cultural competency is providing services that are necessary for specific subpopulations to access the various systems involved in a response to IPV. Three additional key areas were identified – a need for translation services, shelter-specific concerns, and a need for legal assistance specific to immigration law.

Need for Translation Services

Language barriers are a specific issue that was mentioned by many community partners and two provider survey respondents. The **need for good translators (who are part of or in some way tied to) the communities they serve** cannot be overstated. Additionally, **specific training on IPV** for these interpreters is crucial.

- *Always a need for interpreters, especially with ongoing service. If you do get it, you get it only for intake.*
- *Lack of interpreting services is a huge problem. It costs a lot. It has to be in person but that's even more expensive. The translator should ideally be part of the community - if there aren't enough people in the culture who are serving as interpreters, then we need to train and educate them.*
- *Can't be via computer - it's too impersonal.*
- *We try to hire good interpreters and train them on DV. We need to have very long conversations [with survivors], and even with clients who can speak English, we want to introduce those discussions with someone who ideally shares the language. It's easier to recount history in your native language. So even with English speaking clients we should be asking if they need an interpreter.*
- *Interpreters from the community will understand some of the cultural issues intuitively. For instance, in a recent case we were trying to figure out a child's birthday. We ended up dating it with a holiday through the interpreter, but it was two years later than we thought. Not everything translates directly.*
- *Need for unbiased interpreters from community - we had a Somali woman come in and through our interpreter [knowledgeable about IPV], told us things that led us to believe she was being trafficked. We notified The Salvation Army who brought in someone from the [Somali] community, and she blew it off and gave a completely different story.*

Finally, **interpreting is necessary at all stages of service**, not only at intake. It is essential for clients in shelter, for example, to understand how the shelter works and what to expect. Similarly, good interpreters who can counsel or counselors who will allow translators are sorely needed.

- *Without access to language, they can usually get basic needs met, but they are isolated otherwise. We need to be… giving them check-ins about what to expect.*
- *I worked with one Deaf woman and one Azerbaijani who spoke Russian, they (LSS CHOICES) offered interpreters and a relay service, but there was a lot of negativity around them using those resources. Interpreters are a NEED to serve people and help them stay safe. It seems like there is only limited contact - they can only communicate when the translator is there.*

The language barrier is never starker then when serving survivors who are members of the Deaf culture. Community partners described a cultural difference between Deaf and hearing people, one rooted in a history of oppression. Deaf people are often perceived to be less intelligent, which is based primarily on an information gap that results from less access to incidental learning that occurs when exposed to spoken language, media and other sources. This, in turn, can create an inherent power dynamic whereby both hearing and Deaf people may assume that hearing people have more information, leading to choices being restricted, or made for Deaf people:

- *Recognizing that the intelligence is there but the fund of information isn't and that means you have to explain more about how the system works and the roles that people play. Explaining what's a lawyer vs. an advocate vs. a victim witness.*
- *Literacy level is often significantly lower - haven't had access to English. Can be really confusing with court documents - instructions on forms, intake forms. You need someone who understands the system, and the forms, AND Deaf culture.*

Translation services for Deaf people are difficult to locate and can be expensive. Though Central Ohio has the highest concentration of translators in the state, there are still not enough. Service providers should not assume that written materials or family members (especially minor children) can substitute for well-trained translators.

Shelter Specific Concerns

Community partners suggested that providing culturally competent care might be most difficult in a shelter situation. This is not a new issue, according to at least one community partner who said it was being discussed ten years ago when she worked at a shelter. The difficulties in this arena are multiplied for survivors in shelter when they lack access to interpreters as just described. For some clients, it may be directly tied to their past experiences, either with specific shelters or other similar environments:

- *Even if a client goes to shelter, she may not be able to stay there. It's traumatic for many refugees, especially if they don't have someone to tell them in their native language about what's happening at the shelter and how things work. It feels chaotic, like a refugee camp. Many concerns for their children in terms of bullying etc. They are an easy target - who will they tell with language barriers? It can be too big a cultural shift for some.*
- *A lot of IPV shelters are very… it would be difficult to be transgender and be in a shelter. Services are definitely designed for people who identify and present as female. They are female centered places.*

- *Not a lot [of LGBTQ community members] enter shelter. There is a fear that other residents or staff will not be supportive. Outreach to let them know it is a safe space would be good, but only if educated staff can actually provide that safe space.*

One specific area mentioned often with regard to shelter had to do with cooking and dietary restrictions:

- *There are a lot of levels. Some simple things get overlooked by direct service providers. In the shelter - do they have something they can eat? Are they allowed to cook?*
- *Need to have protocols and policies in place to enable the system to deal with dietary restrictions, religious restrictions.*

One community partner felt some progress had been made in this area for her clients:

- *We have really increased our partnership with them to help clients be successful in shelter until we can get their immigrant status settled.*
- *Once I took a client to shelter who had had food restricted by her abuser. She got dinner and it was chicken nuggets and salad. That's when she started crying and I almost did, too. We are making incremental changes. We now have spices.*

Immigration Cases and Legal Concerns

A significant theme within this larger concern emerged in interviews with community partners, the community forum and surveys with providers: working with immigrant populations brings additional legal hurdles to the forefront. Again, in this area, the issue intersects with abuse and control dynamics in the relationship, especially for undocumented immigrants. In abusive relationships where the survivor is undocumented, the abuser may threaten to have the survivor deported:

- *Without documents, they are afraid to do anything. Abuser will hold kids, threaten to call immigration and have her deported and keep the kids.*

Even for immigrants with legal residency, complicated legal issues can emerge. In some instances, the immigrant may have their abuser listed as their sponsor, the person who has legally accepted responsibility for a person. In those cases, leaving may be impossible, a fact that abusers can take advantage of:

- *I used to believe that if you're an undocumented or an immigrant survivor, the first thing you need to do is get out. But if the person is the sponsor, that might not even be possible.*

In extreme cases this can lead to sense of entitlement or ownership that intensifies the abusive dynamics:

- *In some countries, you may be paired with someone, agree to marry, meet for first time and have to marry within 90 days. [You would then] get a conditional 2-year green card and at the end have to reapply to get conditions removed. That translates to "I've paid for you to come here and be my wife... you belong to me."*

Abusers can withhold documents, provide false information and threaten immigrants with a call to immigration authorities.

- *Most get all of their information from their sponsor, which may be incorrect. He controls whether she can go to ESL [English as a second language classes] or get a driver's license. He may tell her those things aren't possible.*
- *There are so many layers they have to work through to feel safe. The abuser keeps their passport, doesn't let them learn English, their children are often citizens and they are not. Each one of those is another layer.*
- *One of my clients, who stayed at CHOICES, was told by her sponsor that her citizenship could be revoked. It wasn't true, but she didn't know that. "Because I brought you here, all I have to do is call immigration." Even if they think he's lying, because children are often involved, they don't want to test the theory. What if he has her deported and keeps the kids? If from a rural or war-torn area, if they could keep their kids with them, if he has them deported, what do they return to?*

Additionally, some new immigrants may not have a frame of reference for social services or individual rights:

- *Most new immigrants don't know the rights of an individual. They are not familiar with the social services system. They feel indebted.*
- *Often coming from countries or communities where social services don't exist or were completely inaccessible. It's not part of their experience or concept.*

These concerns may be especially potent for some groups at this time. Mexicans, Puerto Ricans, and other immigrants from Spanish speaking countries may be particularly wary of interacting with any government system under the current administration. One provider who works with these populations said they have had to change their programming:

- *We've had to adjust programming because of the political persecution of Latinos in this country. In the past, when we did outreach, we would bring 20 - 25 people in to a class. With the political climate now - they won't come to large group classes because they are afraid immigration would see and try to target those events. We actually agree that that could*

happen, that they may be right. We didn't want to have that happen. So now we do smaller classes, not openly advertising on social media so they don't feel we're exposing them.

- *There is a decrease in services for undocumented people - they are afraid to seek assistance right now. It's also hard to serve them - they can't get government assistance; they can't get a job.*

Finally, several providers perceived a lack of sensitivity from various organizations in the legal system, ranging from police departments to court clerks to judges:

- *Some don't have formal identification. They may have a passport. They have to provide a photo ID to file a protection order. The people at the court are sometimes very difficult to work with - won't let them fill out the protective order form.*
- *About five to seven years ago we had someone with an El Salvador passport. We got the required papers, an advocate helped them fill them out, and we provided ID. The court worker called immigration and told the victim not to leave. The advocate had to call the supervisor and the Attorney General - this traumatized the victim. Lots of people the victim knew heard about that experience and won't reach out again.*
- *We tell people to call the police. But then they get there, they don't speak Spanish, the report is not accurate. The report says no one spoke English so we didn't investigate. Or the victim doesn't speak English and the abuser does and the police officer listens to the abuser.*

Recommendations:

- ✓ Coordinate with **local agencies** that focus on specific cultures
- ✓ Continue to source (and seek grant support for) **translation** services
- ✓ Continue to attempt to **increase diversity in staff** at all levels

Need for Additional Legal Services and Education for Legal Partners

A third strong need emerged in our interviews with community partners and survivors. Specifically, although nearly everyone involved in the research acknowledged the good work done by Ohio Legal Aid and Capital University, and this was the most commonly cited service provided by respondents to the provider survey, both survivors in the round table and community partners acknowledged a need for **more or faster access to legal assistance**. This may be especially true for middle class women who may make too much money to qualify for legal aid but not enough money to hire an attorney with expertise in IPV:

- *Need help for people who are middle class - Capital and Legal Aid are doing a lot… those who make 35,000 to 40,000 can't get Legal Aid, but also can't afford an attorney who specializes in or understands DV. ODVN gets funding to provide some but it always runs out in the first 6 - 8 months.*

Of note, two providers reported seeing more women of middle and higher socio-economic status seeking services from their program over time and two providers noted that legal services are a key future need.

Survivors face challenges at every step of the process when it comes to taking legal action against their abusers. Survivors shared their experiences with far more financially well-equipped and legally savvy partners who were much better prepared to appear in court. Some reported police officers who did not take their concerns seriously or suggested they were at fault for the situation. The Lethality Assessment Program – which coordinates the detection of IPV by local police and sheriff's departments and guarantees access to shelter care for survivors

"There is a long wait for the legal clinic. They do great work, but I can't get in." -Survivor

Evidence that more legal services and education for legal partners is needed emerged from the following sources:

Community Forum

Interviews with community partners

Survivors' Roundtable

Literature Review

Provider and survivor surveys

Assets to Address This Need in Franklin County:

Buckeye Ranch

Capital University Law Clinic

Lethality Assessment Protocol

Ohio Legal Aid

Ohio Domestic Violence Network

identified by these law enforcement officials – was cited by many community partners as a positive step in the right direction, though at least one survivor and one community partner suggested that refinements may be necessary to be sure the correct party was identified as the abuser.

Additionally, there seems to be a need for **additional training around the dynamics of IPV specifically as it operates in the legal system.** From the court clerks who take applications for protective orders to the judges who make bail and child custody decisions, understanding how IPV plays out in the legal system is critical. This can be seen in two major areas: child custody cases and the experience of survivors who do press charges or seek out protection orders.

Child Custody Cases

Community partners see **children being used as pawns** in situations that allow abusers to continue to exert control over their partners. They may request (and be granted) shared custody only to use threats to hurt or not return the children as a weapon. Abusers are often savvy and know how to appear to be the partner who should have custody.

- *Abusers are trying to take kids and the court system is not educated about this dynamic. The abuser is in control and looks more sane. More education for judges would be helpful to help them understand the dynamics of IPV.*
- *There is a myth that if mom petitions for custody, she almost always gets it, but the stats don't bear that out. If you look at this state, when men ask for full or partial custody, they almost always get it. They get shared custody but don't take the kids or use the kids to continue abusive control tactics.*
- *Child custody is a huge issue. If she is staying in a shelter how can she convince a judge or lawyer, she can still have or even see her children?*

Additionally, **children must still visit with abusers**, sometimes in unsupervised contexts. One community partner noted that courts

sometimes **mandate family therapy** a survivor must attend with her abuser.

- *IPV is dangerous. People are dying. This should have more influence in court - kids are visiting with offenders so mom has to see the offender. They are being forced by the court to do family counseling with the offender. There is parental alienation. The courts need to step in and keep people from being re-victimized over and over.*
- *The courts suck. They will sometimes give abusers full access to kids. I know women who have waited to get services until they knew the oldest child could protect the youngest…. It's re-traumatizing women.*
- *When I train law enforcement, I ask them to consider her perspective. In your mind, you think, "Is she overreacting?" when she is calling you because he's 10 minutes late dropping the kids off. But what he's told her is that he's going to kill or hurt or take her children. It's a power dynamic. She's not believed, and it's not documented because these visitations aren't court monitored or supervised.*

Buckeye Ranch was seen as a key asset in this regard. As one community partner put it, the supervision program at Buckeye Ranch, "*is doing amazing work for families. They are able to help kids visit with abusers in a safe space. This is both a positive [in our community] and a need because there is still a need for that.* "

Currently, survivors must visit at least three separate places to secure civil and criminal protection orders and, if pressing criminal charges, must attend court hearings and sit in waiting areas where the abuser and his family also wait. This creates a **dangerous and traumatizing situation for survivors:**

- *Right now, in most criminal cases, the victim ends up using the same elevator and sitting in the same hallways as the perpetrator. It's not victim centered at all.*
- *It's not safe to go to misdemeanor court. They have the potential to be harmed at every step of the way.*
- *A victim is looking at 3 - 4 visits for an ex-parte order; they have to be there all day.*
- *Biggest problem is right now, cops come to the house and take the abuser to jail. The victim wants a protective order, so he can't come home. Need to be able to link them to people who can help them. Court files paperwork and moves on - they don't refer, educate or serve the victim. Need to acknowledge that filing for these protective orders is different from filing for a dog license or a business license. It's so hard for victims to make that decision. If we make them go to three different offices to get a piece of paper, have we really served that person? Do you know how scary, how traumatic it is to reach out to us? The current response is insufficient.*

If a one-stop shop (which would help solve these issues) is not feasible, something akin to the Jean Crowe Advocacy Center in Nashville, in the form of a **separate area in the courthouse where survivors can safely wait** and make the most of their waiting time by

learning about (or possibly utilizing) services available to them is desperately needed in Franklin County. This could also serve as a springboard to a larger effort. As one community partner put it, "*At a minimum, we need a place where they (survivors) can be safe during the proceedings if we can't have all the services in the same place.*"

Recommendations:

- ✓ Continue to source (and seek grant support for) **legal assistance**
- ✓ Develop or **find training resources for legal system partners**
- ✓ **Revisit LAP trainings** to ensure new officers are trained and officers know how to properly identify the primary aggressor
- ✓ Publicize and enhance existing **waiting areas in courthouses** for victims to wait, away from abusers.

Ensure All Survivors Have Equal Access

Community partners noted the need to be certain that all survivors can access services within the IPV system with the least effort possible:

- *It's really about access more broadly… Need to consider are you serving the entire community? Are we posting flyers in Linden like we are on the Capital Law campus? Are peer support groups close to people who need them?*
- *Knowledge and access are critical pieces for whatever that would look like - hotline, access to information about safety, resources, transportation.*
- *There is a big conversation right now in DV about the criminal justice intervention model. Primarily because it has a disproportionate impact on women of color and other marginal groups. One of the principles of the Blueprint is to encourage people to consider the disproportionate impact on people of color. Who is affected by the response and in what ways?*

Certainly, some of the recommendations already suggested will move Central Ohio toward this goal, most notably providing trauma-informed care and increasing collaboration within the network. Significant access issues can be related to communication barriers, which could be alleviated with better staff training and improved communication within agencies:

- *We recently had interns call every shelter in Ohio. We had personally trained and partnered with 1/2 of those agencies. 100% of the line staff had no idea if there were translation services available. None of our clients would have been able to access help. These are partners with policies and funding line items. It must be consistently communicated.*

One community partner noted that after adding a Spanish-speaking advocate to the organization's staff in early 2018, the number of Hispanic and Spanish-speaking clients grew rapidly. Outreach to different populations within communities (and the providers who serve

Evidence that we must ensure ALL survivors have equal access emerged from the following sources:

Community Forum

Interviews with community partners

Literature Review

them) is an important first step, but it can take a long time to see the results:

- *Identify groups in Columbus to reach out. Reach out to the leaders and just ask, "What can we do for you? What do you need us to do for you?" Follow their lead, let them tell you. You may not ever get the outcomes you anticipated, or it may take several years, but eventually you will see more of them seeking help.*
- *It's a different lens. You really need a full-time outreach person to better understand these different populations. Look at the data about who comes in for service (and who doesn't.) It's not rocket science.*

Trust amongst providers and with victims is needed to ensure access. Again, this is an issue that is especially crucial in the IPV context. Survivors are hesitant to trust given their past experiences and a lack of trust that partner agencies will deliver on promises can look like an unwillingness to cooperate in some instances:

- *We're protective of our clients. Some of our partner agencies want us to tell [our clients] about them right away. We do that if and when we think they can handle it. We can't refer to them if they aren't willing to do it well. We can't break that trust.*
- *We don't say, "Go to XYZ place and they will do it right." We tell them what to expect and let them decide. We would love to be able to be in a place where we could confidently refer but for most we just can't.*
- *It's part of a larger plan - serving all of the community. You need to convince the community they can trust you, they're taking a chance on you.*

Finally, although this community analysis has focused primarily on the needs of female survivors of IPV, it is important to note that access may be restricted for other groups of people who are experiencing other forms of domestic violence or have been survivors of sex trafficking. This theme was mentioned by several community partners and was noted by one provider in the survey:

- *There is a need for shelter and services for family violence and elder abuse - lots of parents being abused by adult kids and the homeless shelter environment isn't serving their needs.*
- *[Redacted] has never accepted males or other specific subgroups. They are always referred to [other shelters outside Central Ohio] but can't be transported there. What are the odds they make it there? If you are going to say, categorically, "No we can't," then you need a backup.*
- *Human trafficking - We had a case where a US citizen went to Colombia, met the woman, married her, brought her back and promised to send money to her family. Then he locked her in the house with no phone, no Internet access. The police officer saw it as human trafficking,*

said she should get immediate housing, but the shelter said she wasn't DV, and the human trafficking people said she wasn't trafficked.

One provider noted a particular need for counseling for children who have witnessed domestic violence in the survey.

Recommendations:

- ✓ Review internal data to **identify populations** with less successful outcomes
- ✓ Ensure outreach is **broad** and all providers within the system understand what other providers offer
- ✓ **Review and revise hotline protocols** to be sure basic safety planning always occurs, that staff are aware of resources and referrals available and ensure follow up occurs.
- ✓ Practice **warm handoffs**
- ✓ Be clear and transparent about **exclusionary criteria** for all programs
- ✓ Ensure purpose of hotline is clear and work with partners to identify a **central access point** for survivors.
- ✓ Consider working with partners to begin **an ER advocacy program**

Additional Needs Identified

In addition to the needs most strongly evidenced in our analysis, several additional needs were clear but did not rise to the top for all audiences or were important needs noted by researchers as they completed quantitative analysis.

Recognize and Plan for Comorbidity with Substance Abuse

Substance abuse is a known risk factor for experiencing IPV. It has been found to be more common both among women who use drugs or alcohol and among women whose partners use drugs or alcohol.[xix] One study suggests that two thirds of women seeking treatment for substance abuse had experienced physical IPV in the past six months[xx] and a study at a methadone clinic found that 90 percent of women receiving treatment there had experienced IPV in their lifetime.[xxi]

This connection may exist due to trauma experienced by IPV survivors (before they experienced IPV) or as a coping mechanism in response to their IPV experience. At least two community partners noted this is an issue in their experience and may present particular problems for those who need shelter:

- *There is a lot of connection between addiction and trauma. We have very long waiting lists for people to get into treatment.*
- *Intersectionality with the opioid crisis is escalating. If they are addicted and have a place to stay but need help, there is nowhere for them to go. No shelter for those with addiction issues.*

With Ohio at the forefront of the opioid crisis, and a tendency for Central Ohio women to drink slightly more than women in other areas of the state[xxii], this could be particularly problematic in Franklin County.

Hire, Train and Retain Staff with a Passion and Aptitude for IPV Work

Throughout our interviews with community partners and survivors, it was clear what a critical difference the training and perspective of an advocate or case manager can make. Those on the front lines providing services must understand the dynamics of IPV and be steeped in the principles of trauma-informed care. They should be invested with a sense of mission and

encouraged to care for themselves and deal with signs of primary and secondary trauma just as they do with their clients. One community partner said her organization is "baking this into [their] DNA": "We have a secondary trauma group. We're building informed care into our infrastructure. It's not if you are impacted, it's when."

Importantly, care must be taken to recruit staff, especially advocates, who resemble the populations with which they work, though community partners admit this is no easy task:

- *It helps when service providers look like you and share an identity. Diversity is super important on my team, but white women are the majority who apply for clinical positions. Everyone wants more diversity. So how do you recruit within communities to get them into the pipeline? How do we reach small communities to recruit from them?*
- *One of my clinicians is talking to social work classes, but how do we let more people know there is a need? High school outreach?*
- *66 percent of our clients are white women. Why is that? Because our providers are also white?*
- *Women of color have worked at [redacted] but that does not mean that the work environment was well suited. The lack of representation among advocates is a huge issue for this type of agency and needs to be reviewed.*
- *Recruit the best advocates. We're always looking for multi-lingual people. Need to be able to build rapport with clients and an affinity to culture or some connection really helps that.*
- *Hire people from the communities, people who look like the people they serve. If you're serving immigrants and refugees, do you have one on staff? Maybe not in an advocate role, but in some other role. If not, you should be partnering with someone who does have them on staff.*

Hand in hand with recruiting, training, and hiring staff is holding them accountable when things go badly. One community partner shared a story about an IPV advocate who violated a client's confidentiality by going to the client's place of work and requesting a discount, seemingly without consequences. As she put it, "*Proper training and education, yes, but also accountability for employing that training / education.*"

Identify and Track Measurable Outcomes Within Organizations

As discussed in the collaboration section, it is essential that IPV service providers track outcomes to determine program efficacy and improvement over time.

Intervention methods must be assessed, and assessment requires measurable outcomes. **Service providers should set intervals for periodic evaluation of their efforts**. This was

strongly recommended by service providers in other communities who were identified as leaders in the area of IPV. To be sure your organization is doing the best job it can in helping those who need it, you must evaluate and adjust services based on feedback and pre-determined metrics. You should expect to see improvement in metrics as a result of any change you plan to make. What metrics would those be? Are survivors' subjective experiences improving as a result of a change? Are shelter stays shortening as a result of increased transitions to long term housing, or as a result of women dropping out of the system? How can these things be demonstrated? Importantly, measurable outcomes should be identified and tracked over time, not only *after* changes are made, so that baseline, pre-change measurements are available as comparison points.

A more concrete example that may be actionable using existing records would be to analyze hotline calls for patterns that could reveal important information about the community. What is the average number of calls an individual makes to the hotline? If this number is high, it may suggest that hotline protocols are not working, creating repeat callers. What is the average call duration? This number probably *should* be high, as there is no simple call. One community expert, for example, suggested that no hotline call should ever be under 20 minutes (unless that becomes unsafe for the caller, obviously), because anybody who calls a hotline should be receiving assistance in safety planning, at a bare minimum.

Collect and Discuss Community-Wide Data Across Organizations

As Part 2 of this report suggests, measurement of the prevalence of IPV in Central Ohio, specifically, is *very* scarce, with only one source of information available that is able to provide insight at the community or county level. The Behavioral Risk Factor Surveillance System (BRFSS) is a brief national survey administered annually by each state. In addition to the brief national measure, each state may ask additional questions of its own residents, with the full dataset eventually released to the public. Ohio included several questions measuring IPV in 2005, but has not done so since. The researchers strongly recommend that providers come together to submit a request to re-introduce those questions in forthcoming BRFSS administration(s).[1] **This presents a tremendous opportunity to receive an updated**

[1] Details can be found at https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/behavioral-risk-factor-surveillance-system/welcome/ Illuminology would also be happy to assist with making this request.

measure of IPV prevalence in Central Ohio and to measure change in prevalence over time.

In addition to the large-scale survey approach provided by the BRFSS, community organizers should also seek police records related to IPV. Despite mandatory reporting laws (e.g., Ohio Revised Code §3113.32), not all agencies regularly release their statistics to the public: **Over 130 Ohio law enforcement agencies missed at least one monthly DV statistics report in 2017, and 18 counties were missing one or more reports from one-third or more of their law enforcement agencies.**[xxiii] In Franklin County, one quarter of law enforcement agencies missed at least one month of reporting. Organizations engaged with IPV should demand more thorough reporting by law enforcement, consistent with Ohio law.

Central Ohio IPV service providers should also seek to reinstate a policy of systematically reviewing IPV-related fatalities. This would provide valuable insight, as well as a concrete goal around which providers could gather, furthering communication and collaboration between organizations and law enforcement agencies.

Additional Recommendations:

- ✓ Identify potential **substance abuse treatment providers** who have experience with IPV and vice-versa
- ✓ Create a **certification program or better utilize ODVN's training program** to create a sense of identity and mission for the work
- ✓ Apply for grants to improve retention **through higher salaries or work benefits**
- ✓ Encourage staff to pay attention to signs of **compassion fatigue and secondary trauma** – applying the same trauma-informed care lens to themselves as to their clients
- ✓ Work with the **Advocate Coalition of Franklin County** to increase connections between individual advocates
- ✓ Work to **recruit within communities that are being served**
- ✓ **Set and track measurable outcomes** within agencies
- ✓ **Apply to have the IPV module re-introduced on the Ohio BRFSS** to allow tracking of community level indicators over time
- ✓ Encourage law enforcement agencies to **honor mandatory reporting laws** that require reporting IPV statistics and to share those reports
- ✓ Systematically review **IPV-related fatalities**

PART 2:

IPV Prevalence in Central Ohio

Estimates of IPV prevalence are notoriously difficult, inconsistent across measure, and generally sparse. The best data available for Central Ohio, despite being over a decade old, reveal troubling patterns.

More than 1 in 4 women in central Ohio will experience **physical IPV** in their lifetime.

Nearly 1 in 10 will experience it in the next year.

1 in 3 women will experience physical or sexual assault in their lifetime, which is about as high as their risk for contacting any form of cancer.

5X Women in Franklin County are five times more likely to have experienced IPV in the past year, compared to Cuyahoga and Hamilton counties.

3X Women who are not black or white are more than 3 times as likely to have experienced IPV in the past year, compared to white and black women.

40% If current population and incidence trends hold, the number of survivors who may need services will increase by 40% by 2040

Defining and Measuring the Prevalence of IPV

Prevalence rates of intimate partner violence are difficult to assess. Because there is no strong consensus on its definition, different efforts to measure it use different questions, resulting in different estimates of prevalence. An assessment focusing on the survivor's subjective experience, for example, may include questions like whether a partner has ever "acted very angry towards you in a way that seemed dangerous" or measures of coercion and control, while an assessment from a criminal justice perspective would focus more on actual, physical violence or explicit threat of violence that would constitute a criminal act regardless of relationship between survivor and assailant.

Even when intimate partner violence is explicitly defined, there is no consistently used measurement instrument over time, whether due to improved understanding of the complex phenomenon of IPV and its antecedents and consequences, or the need to reduce survey administration costs due to changes in research funding.

A woman's lifetime risk of experiencing physical IPV is the same as her risk for developing any form of cancer

In this report, we rely on three large-scale surveys of thousands of individuals each. These studies provide statistics for the state of Ohio:

- National Intimate Partner and Sexual Violence Survey (NISVS) with data collected between 2010-2012 and state-by-state estimates released in 2017
- Ohio Family Health Survey (OFHS) with data collected between 2008-2010
- Behavioral Risk Factor Surveillance System (BRFSS) with data collected in 2005, which provides the best estimate for Central Ohio, specifically

We first examine two kinds of prevalence rates – lifetime prevalence of IPV, which tells us, in stark terms, the number of women who will experience IPV at least once in their lives, and annual prevalence, which is most helpful in projecting demand for services.

Estimating Prevalence for Ohio Women

Lifetime Prevalence Rates for Ohio Women Compared to the U.S.

The National Intimate Partner and Sexual Violence Survey (NISVS) uses a battery of 30 questions to measure the prevalence of various forms of IPV. The NISVS found that **one out of three women have experienced physical violence** from an intimate partner at some

point in their life, or **39 million victims across the United States.** Broadening the definition to include sexual violence, physical violence, and/or stalking by an intimate partner results in a startling estimate of 37.3% lifetime prevalence rate. This is essentially equal to the American Cancer Society's lifetime risk for women developing any form of cancer (37.7%).[xxiv] The statistics for psychological aggression are no less grim. Approximately 47% of female respondents experienced it in their lifetime, or almost 57 million women.

Lifetime Prevalence Rates – National Intimate Partner and Sexual Violence Survey (NISVS), 2010-2012

	U.S. Estimate	Ohio Estimate
Physical IPV	32.4%	34.5%
Any contact sexual violence, physical violence, and/or stalking by an intimate partner	37.3%	38.0%
Any psychological aggression by an intimate partner	47.1%	46.8%

In Ohio, the lifetime prevalence of physical IPV among women according to the NISVS, is **34.5%,** somewhat higher than the national rate of 32.4%. However, we do not want to overstate this difference, as the national 95% confidence interval is entirely within the Ohio confidence interval, which suggests that statistically, these rates are equivalent. When broadening the definition of IPV to include any sexual violence, physical violence, and/or stalking by an intimate partner, Ohio's lifetime prevalence rate is 38.0%. The lifetime prevalence rate of psychological aggression within Ohio respondents is also comparable to the national average, at 46.8%.

Lifetime Prevalence Rates for Ohio Women from Ohio-Specific Surveys

The Ohio Family Health Survey (OFHS) included a single item in 2008 and 2010 to measure IPV: "Has an intimate partner ever used physical violence against you? This includes hitting, slapping, pushing, kicking, or hurting you in any way." For purely methodological reasons, this survey might find lower prevalence rates than the NISVS, which had far more nuanced conceptualizations of violence across its 30 questions. The results confirm this expectation: **The lifetime prevalence rate of IPV for women in the OFHS was 18.4%.**

The Ohio Behavioral Risk Factor Surveillance System (BRFSS) is a middle ground in complexity between the NISVS and the OFHS. It asked five questions to measure whether

the following four things ever occurred: threats of physical violence, attempted physical violence, actual physical violence, unwanted sex; and whether, in the past 12 months, the respondent had experienced physical violence or unwanted sex with an intimate partner. It revealed an estimated **26.4% prevalence of lifetime physical IPV among Ohio women.**

In the 2005 BRFSS, 26% of women in Ohio reported experiencing physical IPV at some point in their lifetime.

Estimating Prevalence in Central Ohio

The NISVS and the OFHS report statistics for all of Ohio, but Ohio-wide estimates are only good proxies for our local area if there is evidence that Central Ohio does not differ from Ohio as a whole in any meaningful ways. For example, if Central Ohio has more Black or African American residents than the Ohio average, we must examine whether IPV prevalence rates are higher, lower, or roughly the same, among Black or African American respondents as they are among other demographic groups. As demonstrated in Appendix A, **Franklin County has consistently been home to higher proportions of non-White residents** than the state as a whole (a trend that is increasing over time), and this difference is consequential for IPV service provision: National trends (from the NISVS and elsewhere) suggest that reports of lifetime prevalence of IPV are higher among Black or African American women and women of other races/ethnicities than among White women.[2]

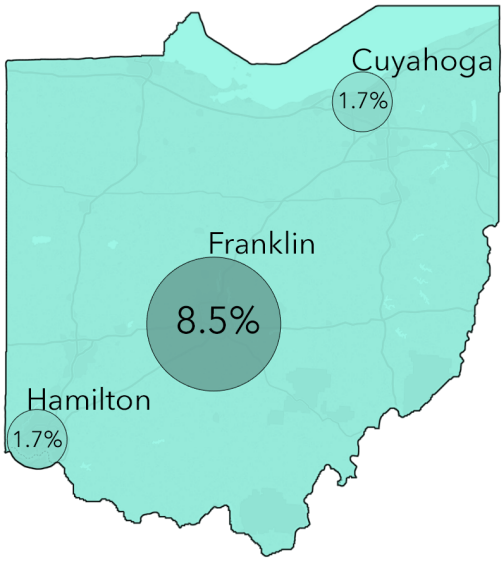
Therefore, for local estimates of the prevalence of IPV in Franklin County, we rely on estimates based on our own analysis of the 2005 BRFSS dataset released by the CDC moving forward. Despite being slightly older than other reports, this dataset allows estimates most specific to Central Ohio.

[2] It is beyond the scope of this report to delve into the causes of racial disparities in IPV, but it should be noted, of course, that these unfortunate differences are likely the results of a chorus of social and economic inequities. For instance, White women may have greater access to services and community supports, allowing earlier, informal interventions and escape opportunities before "becoming a statistic" and entering the system of official service providers.

Twelve Month Prevalence

Understanding the likelihood of a woman experiencing IPV in her lifetime, and therefore EVER needing services, is useful and helps us better understand overall trends and subgroup differences. However, to better coordinate service provision and plan for future needs, it's imperative to understand how many women are likely to need services across a specific time period.

12 Month IPV Prevalence in Ohio's Most Populous Counties



Twelve-month prevalence estimates are useful for this purpose and may reveal patterns that are otherwise not apparent in lifetime rates. For instance, the counties housing the three largest Ohio cities all show lifetime prevalence rates for women between 24% and 30%. However, their 12-month prevalence rates tell a different story—one that should concern us here in Central Ohio.

Despite the approximate parity in terms of lifetime IPV between Franklin, Hamilton, and Cuyahoga counties, **when asked in the BRFSS whether physical or sexual assault had occurred at the hands of an intimate partner in the past 12 months, 8.5% of Franklin County women said it had**. This is worse than the state average of 5.9% and is *five times* greater than for women in Hamilton or Cuyahoga counties (both only 1.7%). Assuming that rate has remained relatively stable, that would mean that **over 50 thousand women in Franklin County have been physically or sexually assaulted by an intimate partner in the past 12 months.**

When considering 12-month prevalence across different races, a striking trend for Central Ohio is observed - **1 in 5 women who do not identify as just Black/African-American or White reported experiencing intimate partner violence in the past 12 months, over double the national average, and triple the rate of White and Black women in Franklin County.**

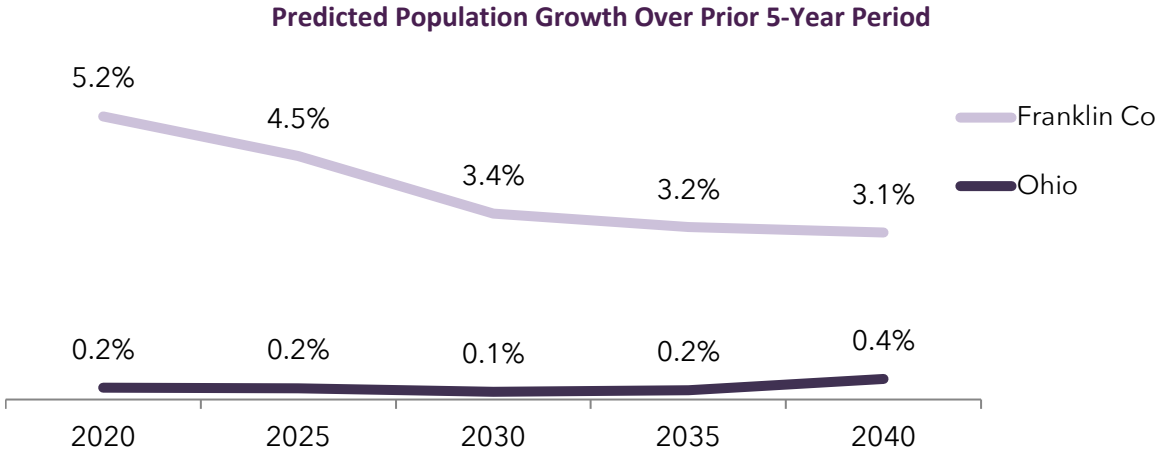
12-Month Prevalence of Intimate Partner Violence, by Race/Ethnicity		
	2005 BRFSS Franklin County[3]	2010-2012 NISVS National[4]
White only, non-Hispanic	6.5%	5.7%
Black only, non-Hispanic	6.1%	9.4%
Other	20.1%	9.0%

The estimates suggest that it is important to consider race when projecting potential prevalence of IPV services in Central Ohio. In order to make these estimates we must also consider general population trends observed in Ohio.

Projecting Future Demand in Central Ohio

Demographic Trends in Central Ohio

Central Ohio is growing at an increasingly fast pace. From 2010 through 2017, annual population growth in Franklin County increased from about 1.1% to 1.7% despite Ohio's growth rate remaining relatively stable during that duration. According to predictions by Ohio's Development Services Agency (DSA), Ohio's state affiliate of the U.S. Census Bureau, the pattern of Franklin County's growth is expected to continue, albeit at a slowing rate.



The change in Franklin County's population has been driven largely by increasing

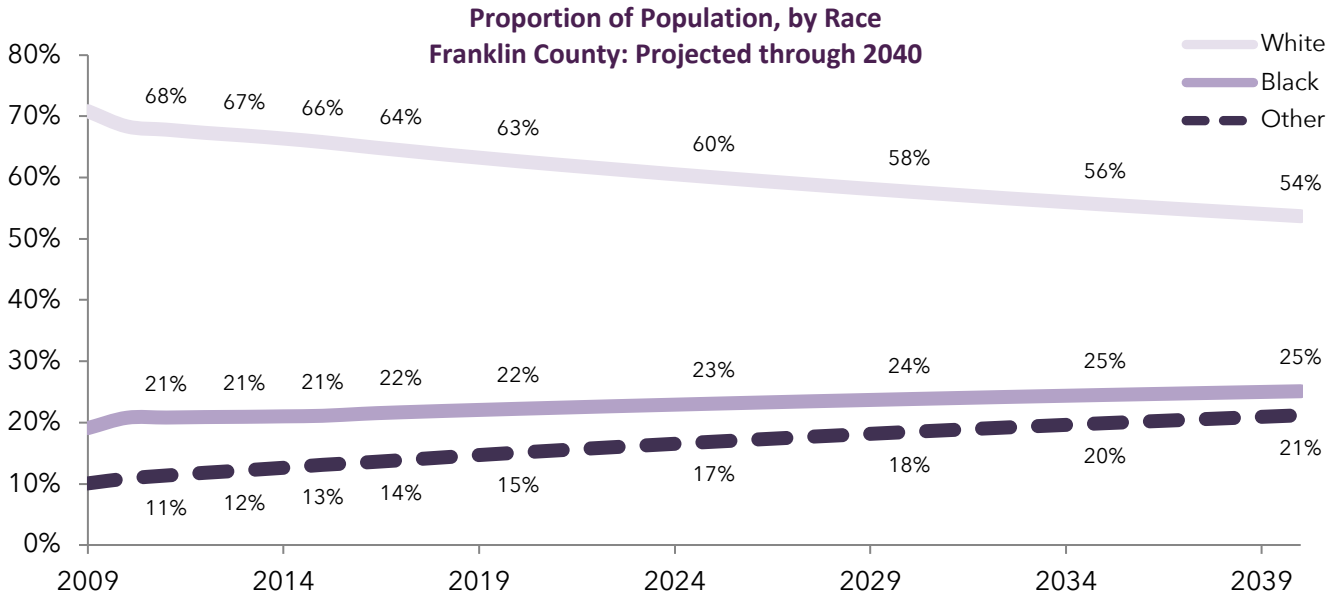
[3] BRFSS includes 12-month exposure to physical and/or sexual violence by an intimate partner

[4] NISVS includes sexual violence, physical violence, and/or stalking by an intimate partner

proportions of non-White residents: The White proportion of Franklin County's population dropped from 67.5% to 63.4% from 2010 - 2017 while shares of the county's population that were Black, Asian, Hispanic, and multiracial increased.

Predicting further change in the years to come, the proportion of children under the age of 18 who are White shrank from 55.5% to 50.3% between 2010 and 2017. Hispanic and multi-racial children saw the greatest rate of growth during that time, with 2.0% and 1.7% increases, respectively.

To estimate future demographic composition of Central Ohio, we created a model of demographic change in Franklin County using the population growth of each racial group from 2009-2017 to project growth into the years 2020-2040. These growth rates were then multiplied by the total population estimates provided by the DSA (which incorporated birth rates, death rates, and migration patterns into a complex model of total population change, but did not do so by racial subgroups), to produce projected population trends for each year as displayed in the next chart. Because groups other than Black and White Franklin County residents have historically been so small, projections are made only for White, Black, and all other races combined.

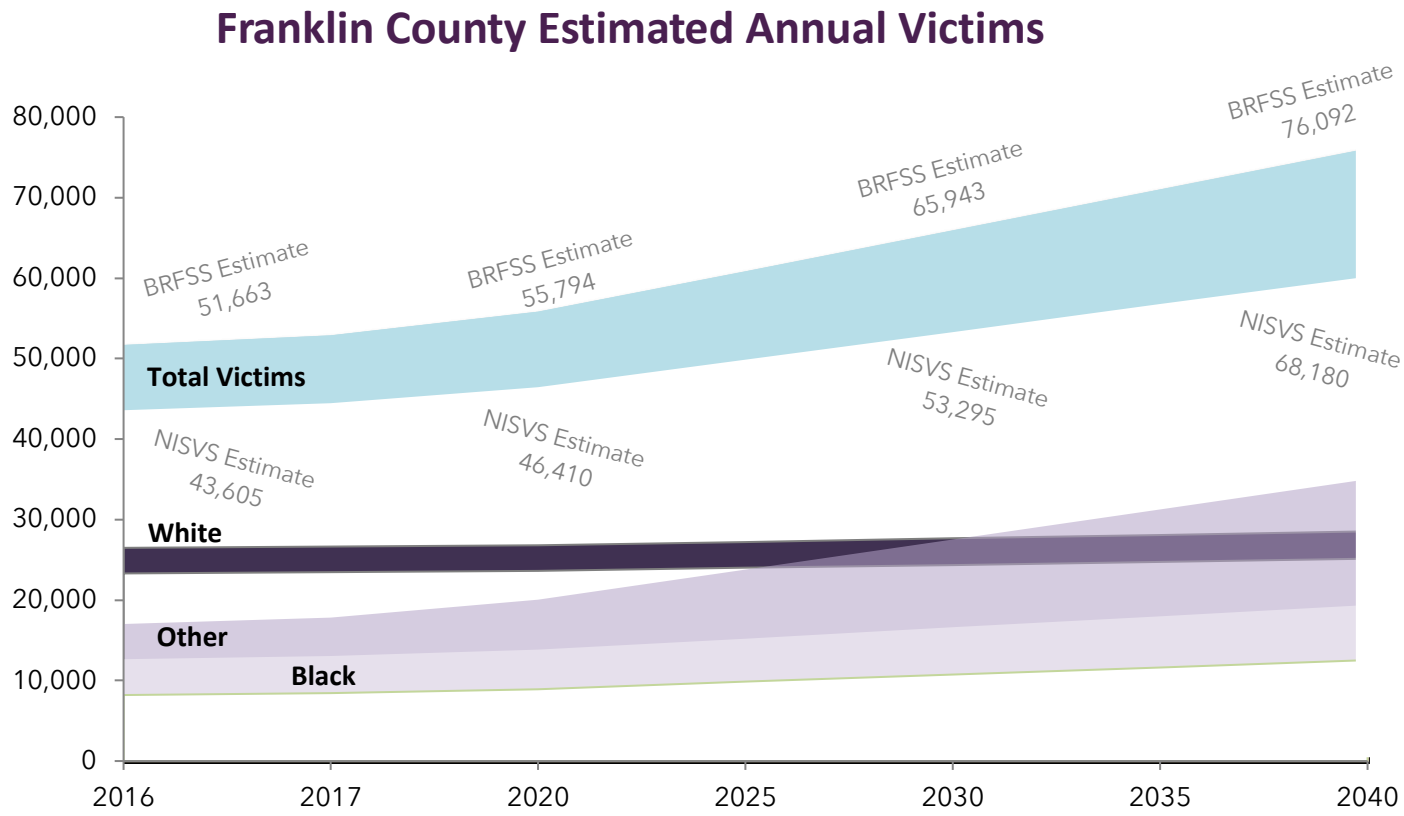


Projecting Prevalence of IPV in Central Ohio

Next, the estimated twelve-month prevalence rates for IPV were combined with population trends discussed above to generate the total number of women per year that are predicted

to be victims of IPV through 2040, assuming that current population trends continue.[5]

The graph below shows a range of anticipated victim counts per year. The lower boundary of each range conveys a conservative estimate, based on NISVS estimates of Ohio's statewide prevalence rates in 2010-2012. The upper boundary of each estimate is a more community-specific (but less reliable, because of its smaller sample) estimate based on analysis of BRFSS data from Franklin County in 2005. Based on these projections, the number of women impacted by IPV (and therefore services that are needed) is expected to increase steadily from somewhere between 43,000 and 52,000 in 2016 to somewhere between 68,000 and 76,000 in 2040, **an increase of 35% to 44%.** If the proportion of the population that seeks services hold steady over time, demand for services should see a similar increase.



It is unlikely these projections will surprise IPV providers. As the table below shows, of the ten providers who answered a question about trends in demand for services, seven have

[5] These projections also rely on the conservative assumption that the Franklin County population will remain at 51% women, 49% men. During the years 2010 through 2017, that proportion has fluctuated from a high of 51.35% female in 2010 to a low of 51.16% women in 2016. Because of the slight downward trend, we settle on the conservative estimate of 51% for all projections.

seen an increase over time and no providers reported a decrease. In one interview, a provider noted that while they started serving three to four clients ten years ago, they have increased the load to more than 400. She concluded with "*I think we are just scratching the surface*."

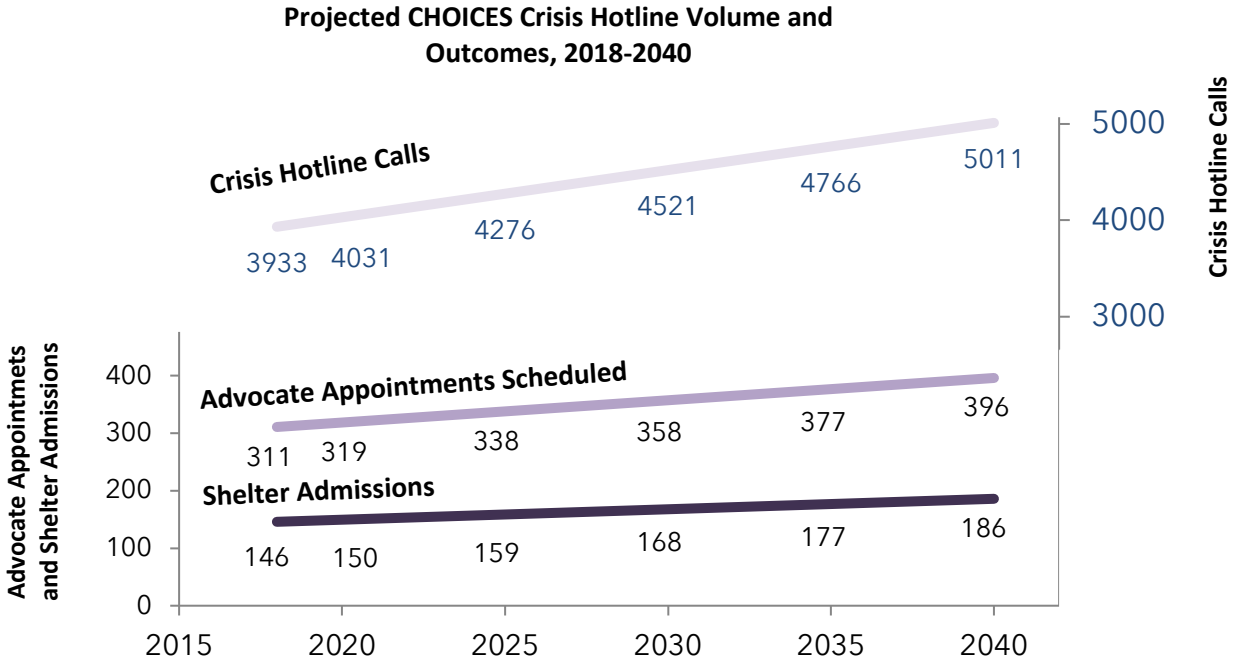
Over the last five years, has the number of people seeking services from your organization:	
Increased	70%
Decreased	0%
Remained Stable	10%
Not Sure	20%
N	10

Projecting Minimum Demand for Shelter and Community Advocacy

In Central Ohio, one piece of the IPV response which has changed over time is the use of the Lethality Assessment Protocol (LAP). First implemented in Franklin County in 2015, this protocol consists of a standard set of questions that police officers can administer when responding to a suspected DV situation. Based on the pattern of answers, police officers can better determine which victims are likely to be in a fatally dangerous IPV situation and immediately connect victims with LSS CHOICES. Should victims agree to talk with someone at the LSS CHOICES hotline, they are guaranteed a placement at the LSS CHOICES shelter (if necessary) or connected with supportive services through LSS CHOICES or other agencies.

Breakdown of Calls to LSS CHOICES Hotline in 2018			
Call Type	**Number**	**Percent of all calls**	**Percent LAP calls**
Did not originate from LAP assessment	2,271	57.7%	N/A
Originated from LAP assessment	1,662	See below	N/A
Declined to speak with the hotline	278	7.1%	16.7%
Spoke to the hotline	927	23.6%	55.8%
Entered Shelter	146	3.7%	8.8%
Scheduled an appointment with a community advocate	311	7.9%	18.7%
Total	3,933	100%	100%

Using the rates of crisis hotline calls (3.11 per 1,000 Franklin Co residents), the rate of calls resulting in shelter entry (1.16 per 10,000 residents), and calls resulting in appointments with an advocate (2.46 per 10,000 residents) in 2018, we can create rough estimates of how many calls, shelter admissions due to those calls, and advocate appointments due to those calls might occur through 2040, using the projected populations described previously. In the following graph, the top line demonstrates the expected increase in calls to the hotline, growing to over 5,000 per year in 2040 if rates of usage remain at 2018 levels. The second line represents the number of appointments scheduled with community advocates as a result of calls to the crisis hotline, growing to almost 400 per year in 2040. The bottom line represents the number of women who are projected to call the crisis hotline and end up being admitted to the shelter, which could grow to almost 200 per year by 2040.



It is important to note that these estimates assume that everything about the LAP remains constant. Should refinement of the LAP lead to the identification of more women in need of assistance, or if broader system collaboration and outreach leads to more victims being open to receiving services, these numbers may underestimate the annual volume of calls and call dispositions.

PART 3:

Conclusions

Intimate partner violence is startlingly common across the nation, with a third of women suffering from physical IPV and almost half suffering from psychological IPV at some point in their lives. Central Ohio is no better: **Over 30% of women here report experiencing physical and/or sexual IPV at some point in their life, and over 8 percent report experiencing it in the past 12 months.**

After gathering feedback from many community partners, from providers, and from subject matter experts, we suggest the local IPV response system consider the following identified needs:

1) Increase collaboration among partners, including the consideration of a one-stop shop
2) Empower survivors, both economically, to meet their basic needs, and psychologically, to gain a sense of control over their own lives. This includes practicing trauma-informed care among ***all*** employees/representatives of organizations
3) Provide culturally competent care
4) Increase access to legal services and better educate legal partners
5) Ensure all survivors have equal access
6) Recognize and plan for comorbidity with substance abuse
7) Hire, train, and retain staff with a passion and aptitude for IPV work
8) Identify and track measurable outcomes within organizations
9) Collect and discuss community-wide data across organizations

Considering annual prevalence projections, demand for IPV services in Central Ohio is forecast to grow over time, with the number of annual survivors increasing to somewhere in the range of 68 to 76 thousand annual survivors by 2040, from a current average of roughly 50 thousand. This represents an estimated growth of approximately 40% in the number of IPV survivors who may require services over this period.

It is imperative that Central Ohio providers be prepared for this growth. There is widespread openness and support for increased collaboration among community partners, suggesting that our community can meet this challenge. The Community Asset Inventory, beginning on the next page, represents a first step at cataloging the organizations in Central Ohio who exist to specifically serve IPV victims.

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ACTION OHIO Coalition for Battered Women

Contact:

https://www.actionohio.org
614.825.0551

Location:

Worthington

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

Action Ohio's mission is to promote quality programs, services, and resources to survivors of domestic violence. Our goal is to ensure equal rights and empowerment for all individuals as we work toward the eradication of family violence in our society.

Africentric Personal Development Shop (APDS)

Contact:

https://apdsinc.org
614-253-4448

Location:

Columbus

Geographic Coverage:

Franklin County

Services Offered:

Batterer services
Services for substance abuse

Brief Mission Description, from Website:

The Africentric Personal Development Shop (APDS), is an innovative behavioral healthcare center specializing in Cognitive Behavioral Therapy (CBT) for the prevention, treatment of, and recovery from addictions. Our agency also provides educational classes for the intervention and prevention of domestic violence.

ASHA Ray of Hope

Contact:

http://asharayofhope.org
614.326.2121

Services specialized for:

South Asian women

Location:

Columbus

Geographic Coverage:

Central Ohio (main focus)
Also receive calls from outside of Ohio through sister agencies

Services Offered:

Assistance locating housing
Access to legal services
Access to childcare
Services for victims who choose to remain in the household
Outreach, public awareness, education, prevention
Direct financial assistance
Transportation

Brief Mission Description, from Website:

Each woman that Asha serves is unique. The women have diverse backgrounds including age, religion, ethnic origin, economic and educational background, language spoken, and immigration status. Asha Ray of Hope molds services to meet each client's specific needs and exists to create a safe place that provides culturally-sensitive support, services, and advocacy for South Asian women facing domestic abuse, and we work to educate, engage, and mobilize the South Asian community to eradicate violence against women.

Asian American Community Services

Contact:

http://www.aacsohio.org
614.220.4023 ext. 236

Services specialized for:

Asian American and Pacific Islander (AAPI)

Location:

Upper Arlington

Geographic Coverage:

Central Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Family Support Program (FSP) seeks to foster healthy families and healthy personal relationships within the Asian immigrant/Asian-American community and beyond. One of our most important goals is to educate and empower individuals, families, and community members (particularly immigrants and new Americans), so that they have the right tools to have a fulfilling life in the United States while also being able to honor and celebrate their heritage.

Be The One Ohio

Contact:

http://icanbetheone.com
888.886.8388

Services specialized for:

Younger people (12/13-24)

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

Be the One Ohio is an initiative led by the Ohio Alliance to End Sexual Violence (OAESV) focused on preventing sexual violence and relationship violence among pre-teens and teens in Ohio.

Buckeye Region Anti-Violence Organization

Contact:

http://www.bravo-ohio.org
614.294.7867

Services specialized for:

LGBTQI

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Access to legal services
Access to counseling
Services for victims who choose to remain in the household
Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

BRAVO works to eliminate violence perpetrated on the basis of sexual orientation and/or gender identification, domestic violence, and sexual assault through prevention, education, advocacy, violence documentation, and survivor services, both within and on behalf of the Lesbian, Gay, Bisexual, and Transgender communities.

Catholic Social Services

Contact:

https://www.colscss.org
614.221.5891

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Transitional/long term housing opportunities
Assistance locating housing
Access to counseling
Services for children
Mental health
Direct financial assistance
Transportation

Brief Mission Description, from Website:

Through our Intensive Family Services, we provide mental health counseling and intensive case management. These services help clients understand and address the underlying issues that contribute to their lack of economic security, resilience, and overall well-being; and help them take tangible steps toward family stability, economic security, resilience, and greater overall well-being.

Center for Family Safety & Healing

Contact:

http://familysafetyandhealing.org
614.722.8200

Location:

Columbus

Geographic Coverage:

Uncertain

Services Offered:

Assistance locating housing
Access to legal services
Access to counseling
Services for children
Outreach, public awareness, education, prevention
Direct financial assistance

Brief Mission Description, from Website:

The Center for Family Safety and Healing fully addresses all aspects of family violence, including child abuse and neglect, teen dating abuse, domestic violence and elder abuse, thanks to an impressive combination of public and private resources.

LSS CHOICES

Contact:

https://lssnetworkofhope.org/choices/
614.224.6617

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Respite/short term housing services for victims of IPV
Assistance locating housing
Access to legal services
Access to childcare
Access to counseling
Services for children
Outreach, public awareness, education, prevention
Direct financial assistance
Transportation

Brief Mission Description, from Website:

Domestic violence is a terrible and increasingly pervasive problem that tears apart families and communities. Victims and their children who are living with an abuser need a safe place to go to break the cycle of violence and begin the healing process. CHOICES has been the sole resource for victims to seek shelter from domestic violence in Franklin County for four decades.

City of Columbus Attorney's Office, Domestic Violence and Stalking Unity

Contact:

http://www.columbuscityattorney.org/dv.aspx
614-645-0314

Location:

Columbus

Geographic Coverage:

Columbus

Services Offered:

Access to legal services
Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Domestic Violence Unit has four specially trained prosecutors that are assigned to handle only domestic violence cases. These specialized prosecutors handle cases that include, but are not limited to, repeat assaults, egregious acts of violence, and victims that are high risk (including the elderly, children, and the disabled). Additionally, the Unit has several courtroom advocates who work in tandem with various community liaisons to provide a variety of services to domestic violence victims. In cooperation with community organizations like CHOICES for Victims of Domestic Violence, Southeast Mental Health Service, Legal Aid, and Franklin County Children's Services, the City Attorney's Office provides a centralized resource and support system within the Unit.

Community Refugee and Immigration Services (CRIS)

Contact:

https://www.crisohio.org
614.235.5747

Services specialized for:

Refugee and immigrant communities

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Access to legal services
Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

Community Refugee & Immigration Services (CRIS) is an independent non-profit organization that serves the growing refugee and immigrant populations in Central Ohio. We have over 60 staff members that hail from more than 15 countries with many languages represented. CRIS is a refugee resettlement agency, meaning we have a contract with the Department of State to directly receive and place refugees in our community. In partnership with Church World Service we resettled individuals and families from all over the world.

Deaf World Against Violence Everywhere (DWAVE)

Contact:

https://www.dwaveohio.org
614.678.5476 (video phone)

Services specialized for:

Deaf, DeafBlind, Hard of Hearing and DeafDisabled communities

Location:

Worthington

Geographic Coverage:

Unclear

Services Offered:

Access to legal services
Access to childcare
Access to counseling
Services for children
Services for substance abuse
Outreach, public awareness, education, prevention
Mental health
Direct financial assistance
Transportation

Brief Mission Description, from Website:

To promote the empowerment of and equality for Ohio's diverse Deaf, DeafBlind, and Hard of Hearing communities by offering culturally affirmative advocacy and education, while inspiring community accountability, in response to oppression and relationship and sexual violence.

Ethiopian Tewahedo Social Services (ETSS)

Contact:

https://www.ethiotss.org/home.html
614.252.5362 x202

Services specialized for:

Immigrants and refugees

Location:

Columbus

Geographic Coverage:

Columbus

Services Offered:

Access to legal services
Services for children
Services for victims who choose to remain in the household
Outreach, public awareness, education, prevention
Direct financial assistance
Transportation

Brief Mission Description, from Website:

ETSS is a community based 501(c)(3) organization that helps new arrivals from all countries establish roots and gain self-sufficiency in Columbus through programs and services that encourage community integration, sustained employment, education, health, and strong families. We provide services to both adults and children through employment assistance, ESL courses, After School programs, Summer camps, and advocates for victims of domestic violence.

Family and Community Services, Inc.

Contact:

https://fcsserves.org
330.297.7027

Location:

Ravenna

Geographic Coverage:

Twenty-one counties and two states: Ohio and Michigan

Services Offered:

Respite/short term housing services for victims of IPV
Transitional/long term housing opportunities
Access to legal services

Brief Mission Description, from Website:

Family & Community Services, Inc. will effectively respond to community needs by advocating for social awareness and social action in four primary areas: Engaging and Empowering Communities; Strengthening and Supporting Individuals and Families; Focusing on the Futures of Children, Dependents and Youth; and Providing Tools for Healthier Lives. Action outcomes include striving towards achieving a high level of dignity and satisfaction for our clients, developing innovative partnerships, promoting volunteerism, and maintaining a strong financial position.

FCS' Place of Peace provides a safe environment to conduct supervised visitations and safe exchanges for families impacted by domestic violence, sexual assault, stalking, child abuse or conflict during exchanges.

Family and Youth Law Center at Capital University Law School

Contact:

http://www.familyyouthlaw.org
614.236.6779

Location:

Bexley

Geographic Coverage:

Uncertain

Services Offered:

Access to legal services

Brief Mission Description, from Website:

The Family and Youth Law Center at Capital University Law School (FYLaw) works within child welfare, adoption, and juvenile justice systems to support positive outcomes for children, youth, and families. This includes the OHIO IPV Collaborative, a partnership of the Ohio Department of Job & Family Services, the Supreme Court of Ohio, the Family and Youth Law Center (FYLaw) at Capital University Law School, The Safe and Together Institute, and other key stakeholders dedicated to addressing IPV in child welfare cases in Ohio by providing technical assistance and Safe and Together trainings for children services agencies and community partners.

Family Violence Prevention Center (Office of Criminal Justice Services)

Contact:

https://www.ocjs.ohio.gov/family_violence.stm
888.448.4842

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Center serves as an information clearinghouse for public and private organizations providing assistance to victims. The Center also offers a variety of services such as providing victim advocacy, resources and referrals, organizing workshops, giving presentations and conducting research on family violence and its impact on communities.

Franklin County Prosecutor's Office, Special Victims Unit and Victim Witness Assistance Unit

Franklin County Prosecuting Attorney

Contact:

www.prosecutor@franklincountyohio.gov
614.525.3555

Location:

Columbus

Geographic Coverage:

Franklin County

Services Offered:

Access to legal services
Access to victim services

Brief Mission Description, from Website:

The Special Victims Unit has seven specially trained prosecutors who are assigned to handle the most serious cases of interpersonal violence, including sexual assaults, child abuse, domestic and child homicides, online exploitation of minors, and human trafficking. They use vertical prosecution to limit the additional trauma to victims, allowing one prosecutor to work with the victim from the very beginning of the case to the very end.

The Victim Witness Assistance Unit has ten advocates who assist victims of domestic violence, child abuse, sexual assault, stalking, and homicides. Advocates are in the criminal division, juvenile division, and The Center for Family Safety & Healing. They work closely with the SVU prosecutors and assist victims as they navigate the criminal justice system by providing courtroom accompaniment, resources and referrals, victim rights information, notification of court dates, and more.

Huckleberry House

Contact:

http://huckhouse.org
614.294.8097

Services specialized for:

Youth aged 12-24

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Respite/short term housing services for victims of IPV
Transitional/long term housing opportunities
Assistance locating housing
Access to counseling
Services for children
Outreach, public awareness, education, prevention
Mental health
Direct financial assistance
Transportation

Brief Mission Description, from Website:

Huckleberry House works with Central Ohio's youth and families who are dealing with some of the most difficult problems imaginable. Issues like abuse, violence, neglect, poverty, and homelessness. No matter how hopeless the situation may seem, we offer proven programs and committed people who know how to help young people and families take control of their lives. So they can move past the circumstances they're in, and move toward the future they want.

Legal Aid Society of Columbus

Contact:

https://www.columbuslegalaid.org
614.824.2612

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Access to legal services

Brief Mission Description, from Website:

The Legal Aid Society of Columbus is Central Ohio's oldest and largest general civil legal services organization. Since 1954, Legal Aid lawyers have been pursuing justice and changing lives.

Mental Health America of Franklin County

Contact:

https://mhafc.org
614.221.1441

Location:

Columbus

Geographic Coverage:

Franklin County

Services Offered:

Access to legal services
Access to counseling
Services for substance abuse
Outreach, public awareness, education, prevention
Mental health

Brief Mission Description, from Website:

Mental Health America of Franklin County (MHAFC) is an affiliate of Mental Health America, the country's leading organization dedicated to helping all people live mentally healthier lives. We support the Central Ohio community by guiding people to mental health services that may not otherwise be accessible. We believe in inclusivity and work with ALL individuals and their families through each step on the path to wellness, from making initial referrals, to providing free mental health services, to helping maintain stability and productivity once they are achieved.

Mid-Ohio Psychological Services

Contact:

http://mopsohio.com
614.751.0042

Locations:

Eastland, Delaware, Lancaster, Newark, Chillicothe

Geographic Coverage:

Central Ohio

Services Offered:

Access to legal services
Mental health

Brief Mission Description, from Website:

Mid-Ohio Psychological Services, Inc. provides high-quality, cost-effective, culturally-sensitive, socially-responsible, mental health, substance abuse, and support services to individuals and community organizations, while offering professional development to its staff and other professionals in the field.

Mount Carmel Crime & Trauma Assistance Program

Contact:

https://www.mountcarmelhealth.com/about-us/community-benefit/outreach-programs/crime-and-trauma-assistance-program-ctap
614.234.5900

Locations:

Columbus, Canal Winchester, Grove City, Hilliard, Lewis Center, New Albany, Westerville

Geographic Coverage:

Central Ohio

Services Offered:

Mental health

Brief Mission Description, from Website:

Violent crime and traumatic events can be devastating. The trauma experienced by victims and their loved ones can be physical, emotional, social and spiritual. Fortunately, recovery is possible, but it can require specialized professional assistance. That's where Mount Carmel's Crime & Trauma Assistance Program (CTAP) comes in and helps with a single step toward healing. CTAP was developed to facilitate the healing and recovery process for child and adult victims, survivors and co-survivors through education, empowerment, and therapeutic intervention.

Nemeth Counseling

Contact:

https://www.nemethcounseling.com
(614) 849-8204

Locations:

Hilliard, Westerville

Geographic Coverage:

Franklin County

Services Offered:

Access to counseling
Services for children
Mental health

Brief Mission Description, from Website:

At Nemeth Counseling and Consultation, we provide a research-based approach to mental health counseling, using only methods of treatment that have been proven to be effective. Our team of highly-trained clinicians will provide a comfortable and confidential setting for counseling, right in your own community. We believe in building great relationships with our clients, beginning with the first contact through successful completion of treatment.

Ohio Alliance to End Sexual Violence

Contact:

https://oaesv.org/
216.658.1381

Location:

Independence

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention
Provider training and technical assistance
Public policy implementation

Brief Mission Description, from Website:

As Ohio's statewide coalition, OAESV advocates for comprehensive responses and rape crisis services for survivors and empowers communities to prevent sexual violence.

Ohio Department of Health - Sexual Assault & Domestic Violence Prevention Program (SADVPP)

Contact:

https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/sexual-assault-and-domestic-violence-prevention-program/welcome-sexual-assault-domestic-violence-prevention2
614.466.9543

Services specialized for:

Seven projects focused on underserved/inadequately served sexual assault survivors from the African/African American; Asian/Asian American; and LatinX/Hispanic/Spanish-speaking populations in Ohio

Location:

Columbus

Geographic Coverage:

Ohio - local district is Franklin County Public Health

Services Offered:

Access to legal services
Services for children
Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Ohio Department of Health (ODH) Sexual Assault and Domestic Violence Prevention Program (SADVPP) seeks to improve the health status of Ohio women by identifying issues that affect women's health and developing programs to address those issues. These programs include those that address sexual assault and domestic violence prevention and services.

Ohio Domestic Violence Network

Contact:

http://www.odvn.org
800.934.9840

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention
Provider training and technical assistance
Public policy implementation

Brief Mission Description, from Website:

The Ohio Domestic Violence Network advances the principles that all people have the right to an oppression and violence free life; fosters changes in our economic, social and political systems; and brings leadership, expertise and best practices to community programs.

Ohio Hispanic Coalition

Contact:

http://ohiohispaniccoalition.org
614.840.9934

Services specialized for:

Hispanic/Latina women, men and families

Location:

Columbus, Franklin County, Central Ohio

Geographic Coverage:

Ohio

Services Offered:

Bilingual/bi-cultural case management
Court companionship
Safety planning
Legal/medical advocacy
Access to resources (legal services, counseling, etc.)
Support groups
Crisis intervention
Community empowerment groups
Outreach

Brief Mission Description, from Website:

The Ohio Hispanic Coalition's Soy Latina program mission is to create a safe place where Latino/Hispanic victims of domestic violence, sexual assault, and other victims of crime have access to information, advocacy, support, and quality services that are culturally and linguistically understanding of Latino communities

Ohio Intimate Partner Violence Collaborative

Contact:

http://www.ohiochildlaw.org/ohio-intimate-partner-violence-collaborative/
614.236.6539

Location:

Bexley

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Ohio Intimate Partner Violence (IPV) Collaborative is a partnership of the Ohio Department of Job & Family Services, the Supreme Court of Ohio, the Family and Youth Law Center (FYLaw) at Capital University Law School, The Safe and Together Institute, and other key stakeholders dedicated to addressing IPV in Ohio child welfare cases by providing public children services agencies and community partners with technical assistance and Safe and Together trainings that focus on perpetrators' patterns of behaviors, non-offending parents' protective capacities, and the impact of domestic violence on children.

Ohio Legal Aid

Contact:
https://www.ohiolegalaid.org
614.715.8560

Location:
Columbus

Geographic Coverage:
Ohio

Services Offered:
Access to legal services

Brief Mission Description, from Website:

Ohio Legal Aid is comprised of nine legal aid organizations that serve Ohioans struggling to make ends meet by providing high quality legal help and problem solving throughout Ohio's 88 counties. Each of these organizations provide legal counsel – at no cost to the client – to help Ohioans achieve justice for themselves and their families.

Ohio Men's Action Network

Contact:

https://ohman-ohio.org
(614) 781-9651

Services specialized for:

Information aimed at prevention specifically for men and boys

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Ohio Men's Action Network (OHMAN) is a network of men and women, as individuals and as representatives of local and state organizations, working to engage men and boys in efforts to prevent sexual violence; sexual exploitation; domestic, intimate partner, family and relationship violence and to promote equitable, nonviolent relationships and a culture free of oppression. We seek to create and support communities where all people can live free of violence within their relationships, and share in their commitment to respect, safety, and equality.

Ohio Victim Witness Association

Contact:

www.ovwa.org
614-787-9000

Services specialized for:

Victims of Crime
Advocates and Allied Professionals who work with Victims of Crime
Ohio Communities
Registered Advocates in Ohio
Organizations and programs that serve victims of crime

Locations:

90 Northwoods Blvd, Suite B6
Columbus, Oh 43235

Geographic Coverage:

Ohio

Services Offered:

Training
Technical Assistance
Best Practices
Public Policy
Victim Support, Service Connection, and Referrals

Brief Mission Description, from Website:

To promote access to safety, healing, justice, and financial recovery for Ohio crime victims through meaningful rights and quality services.

OhioGuidestone

Contact:

https://ohioguidestone.org
800.639.4974

Locations:

Columbus, Lancaster

Geographic Coverage:

Ohio

Services Offered:

Respite/short term housing services for victims of IPV
Access to counseling
Services for children
Mental health

Brief Mission Description, from Website:

OhioGuidestone works for every person and family to reach happiness. With our family services, we lead children, parents, and individuals towards ways to change their situations for the better.

OhioHealth Sexual Assault Response Network of Central Ohio (SARNCO)

Contact:

https://www.ohiohealth.com/services/neuroscience/our-programs/behavioral-and-mental-health/sarnco
614.788.8860 (corporate offices of OhioHealth)

Location:

Columbus

Geographic Coverage:

Central Ohio

Services Offered:

Access to legal services
Access to counseling
Outreach, public awareness, education, prevention
Transportation

Brief Mission Description, from Website:

The OhioHealth Sexual Assault Response Network of Central Ohio (SARNCO) is a rape crisis intervention and prevention program. It provides advocacy and emotional support services in conjunction with medical and social services at OhioHealth Emergency Departments and other local facilities in central Ohio. SARNCO's mission is to empower all survivors and end sexual violence. Our vision is to live in a world without oppression, where all people are safe to live authentic, freely chosen lives and to pursue their full potential.

OSU Student Wellness Center

Contact:

https://swc.osu.edu/
614.292.4527

THE OHIO STATE UNIVERSITY
OFFICE OF STUDENT LIFE

Location:

Columbus

Geographic Coverage:

Local to OSU

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Student Wellness Center at The Ohio State University empowers students to strive for balance and wellness. Wellness is an active, ongoing process which involves becoming aware of and taking steps toward a healthier, happier, more successful life.

Somali Community Association of Ohio (SCAO)

Contact:

http://www.somaliohio.org
614.262.4068

Services specialized for:

The Somali community

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Access to counseling

Brief Mission Description, from Website:

We advocate and promote self-sufficiency for families through employment, education, cultural and social support and economic empowerment. We serve elders, working adults, teens and children at no charge. Special support and attention goes to recent immigrants who seek to create new lives in the United States.

Southeast Healthcare Services

Contact:

http://southeastinc.com/index.php
614.225.0980

Location:

Several - HQ in Columbus

Geographic Coverage:

Ohio

Services Offered:

Access to legal services
Access to counseling
Services for children
Services for substance abuse
Services for victims who choose to remain in the household
Outreach, public awareness, education, prevention
Mental health

Brief Mission Description, from Website:

Southeast, Inc. is a comprehensive provider of mental health, chemical dependency, healthcare, and homeless services assisting diverse populations regardless of their economic status. With the belief that all people have the capacity to grow and change, we provide our services to people of all ages, cultures, races, religious preferences, genders, and sexual orientations in order to enhance wellness and recovery, thereby improving families, workplaces, and communities.

Supreme Court of Ohio - Advisory Committee on Domestic Violence

Contact:

https://supremecourt.ohio.gov/Boards/ACDV/Default.asp
614.387.9408

Location:

Columbus

Geographic Coverage:

Ohio

Services Offered:

Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Advisory Committee on Domestic Violence provides ongoing advice to the Supreme Court of Ohio regarding statewide rules and uniform standards concerning the establishment and operation of domestic violence programs, development and delivery of services on matters involving domestic violence, and any other issues deemed necessary to support Ohio courts' response to domestic violence and related offenses.

The Center for New Beginnings at The Woodlands

Contact:

http://www.thewoodland.org/center-for-new-beginnings/
740-349-7066

Location:

Newark

Geographic Coverage:

Central Ohio

Services Offered:

Access to legal services
Access to counseling
Services for children
Services for victims who choose to remain in the household
Outreach, public awareness, education, prevention

Brief Mission Description, from Website:

The Center for New Beginnings is a program offering free, confidential emergency shelter and services to community members who are victims of a domestic violence situation and need help with a New Beginning. Established in 1983, New Beginnings believes that violence of any type is unacceptable for resolving difficulties. Domestic violence affects all family members, genders and all socioeconomic levels and victims should not be blamed for the violence of their partners.

Turning Point

Contact:

http://www.turningpoint6.org
740.382.8988

Locations:

Marion, Delaware (DV shelter coming soon)

Geographic Coverage:

Delaware County, Marion County, Crawford County, Morrow County, Union County, Wyandot County

Services Offered:

Respite/short term housing services for victims of IPV
Transitional/long term housing opportunities

Brief Mission Description, from Website:

Turning Point has the social responsibility to respond to the needs of domestic violence victims by providing shelter, counseling, advocacy and general support services and to identify and confront the causes of domestic violence. All of Turning Point's services are free of charge and confidential. Services are available to any victim regardless of race, color, religion, gender, sexual orientation, national origin, age, disability, marital status, amnesty or status as a covered veteran in accordance with applicable federal, state and local laws, including victims of federal crimes. Turning Point is committed to being a Safe Zone, part of the visible network of LGBTQI allies. LEP/Deaf/Hard of Hearing Services are available.

US Together

Contact:
http://ustogether.us
614.437.9941

Services specialized for:
Generally refugee populations

Locations:
Columbus, Cleveland, Toledo

Geographic Coverage:
Ohio

Services Offered:
Access to legal services

Brief Mission Description, from Website:

The Victims of Crime Program at US Together understands that victims suffer personal loss, experience stress and trauma, and will need guidance in the aftermath of a crime. Services are free and will provide the aid and information to support victims of crime during the recovery period. The professionals at US Together will provide intensive case management for victims of crime to help them reclaim their lives.

APPENDIX A:
RESEARCH METHODS & ADDITIONAL DATA ON RACE AND IPV

In this appendix, more detail about the research methods employed is provided.

2018 IPV forum

On October 18, 2018, LSS Choices convened a gathering of more than 45 community leaders attended, representing more than 30 organizations (as shown in the next table). Illuminology used a combination of small and large group facilitation methods to help participants identified the needs of IPV survivors in Central Ohio, the resources available to assist IPV survivors in Central Ohio and the most critical gaps between the needs and services.

Organization Name
Ohio Hispanic Coalition
Ohio Victim Witness Association
Action Ohio Coalition
Afrocentric Personal Development Shop
Asha Ray of Hope
Asian American Community Services
Capital University Law Clinic
Center for Family Safety and Healing
City Prosecutor's Office, Office DV and Stalking Unit
Columbus City Attorney's Office
Columbus Police Department
Community Shelter Board
Deaf World Against Violence Everywhere
Ethiopian Tewahedo Social Services
Franklin County Children Services
Franklin County Municipal Court
Franklin County Probation Department
Franklin County Sheriff's Office
Jewish Family Services

Organization Name
LSS Choices
Mayor Ginther's Office
Mt Carmel Health Systems
Nationwide Center for Family Safety & Healing
Office of Criminal Justice Services
Office of Franklin County Prosecutor
Ohio Domestic Violence Network
Ohio Health - Sexual Assault Response Network of Central Ohio
Ohio Health Sexual Assault Nurse Examiner Program
Ohio Legal Aid
Southeast Inc.
YMCA
YWCA
YWCA Family Center

During this forum, brainstorming of needs and services occurred in rotating groups of 4 – 8 people and were then shared to the larger group and posted. Using a dot voting exercise, respondents identified the three most critically underserved needs of IPV survivors in Central Ohio. Materials used to conduct the 2018 Forum can be found at the end of this appendix in the materials archive. The full report of the results of this forum can be found in Appendix B.

In-depth interviews

Following the forum, in-depth telephone interviews were completed with representatives from two groups of organizations:

1) Organizations who were not represented at the forum
2) Organizations with special expertise in the areas identified as the greatest areas of need during the forum (culturally sensitive care and one-stop shop).

Community Partners

The next table shows a list of people and organizations who participated in these in-depth interviews.

Interviewee Name	Organization Name
Melissa Pierson	Franklin County Board of Commissioners, Justice Policy and Programs
Lorie McCaughan	Capital University Law Clinic
Sgt. Rick Ketcham	Columbus Police Department
Rebecca Walter Stephanie Day	Deaf World Against Violence Everywhere
Josue Vicente	Ohio Hispanic Coalition
Amy Hummel Harcar	Ethiopian Social Services
Shantha Balswamy	Asha Ray of Hope
Carly Mesnick	Mount Carmel Health Crime & Trauma Assistance Program
Lee Ann Barber	Mount Carmel Health Forensic Nursing
Michael Daniels	Franklin County Board of Commissioners, Justice Policy and Programs
Janet Doolan	Ohio Victim Witness Association

Interviewee Name	Organization Name
Michelle Grizzle	Ohio Health Sexual Assault Response Network of Central Ohio
Angela Stoller-Zervas Lillian Howard	LSS Choices
Sandy Huntzinger	Ohio Attorney General's Office
Callie Query Kara Penniman	Nationwide Center for Family Safety & Healing
Stephanie Smith	Huckleberry House

In these interviews, researchers asked representatives from organizations who were not represented at the forum basic questions about their perceptions of the greatest needs facing IPV survivors in the community, community resources available for addressing those needs, and their understanding of needs related to the cultural sensitivity and the one-stop shop concepts.

Representatives from organizations perceived to be expert in providing culturally competent are were asked briefer versions of the basic questions and more detailed questions about their experience providing culturally competent care, their understanding of the barriers to providing this care, and their perception of the perceived need for a one-stop shop.

Subject Matter Experts

Representatives from organizations and communities with expertise in the one-stop shop model were asked to provide the "story" of their organization, and to provide advice to communities considering this model, along with questions to better understand the barriers to implementing such a program.

Interviewee Name	Organization Name
Carmen Pietre	Sojourner Family Peace Center (Milwaukee, WI)
Natalia Aguirre Rylie Shore	Family Justice Center Alliance
Yvette Lopez-Cooper	San Diego Family Justice Center
Diane Lance	Office of Family Safety (Nashville, TN)
Denise Eng	Praxis International (St. Paul, MN)

All interviewees were asked to provide referrals to other people who might assist the researchers in gathering more information about the topic of their interview. In total in-depth interviews were conducted with 24 people. In-depth interview guides can be found at the end of this appendix in the materials archive.

Provider Survey

Provider surveys were distributed to a total of 19 organizations, identified in consultation with LSS Choices and from referrals from other providers and 12 completed surveys were collected. Representatives from each organization were sent a link to a survey that asked them to indicate the types of services provided, the number of families or individuals assisted with each service and to solicit their feedback about changes they are seeing in people needing assistance over time, as well as their advice on the best ways to collaborate with other organizations invested in IPV.

Because the number of completed surveys is relatively small, the results are considered qualitative in nature and are described as such in the report. Survey materials can be found at the end of this appendix in the materials archive.

Client Survey & Roundtable

Client surveys were distributed through providers described above who were asked to circulate the link to any client who could safely complete it or to provide paper copies that could be returned to Illuminology. Very few completed client surveys were received so Illuminology supplemented this data collection effort with a roundtable discussion held with clients of Choices on January 29, 2019. In total, information was collected from 21 clients via survey or roundtable discussion.

Because the number of completed surveys is relatively small, the results are considered qualitative in nature and are described as such in the report. Survey materials can be found at the end of this appendix in the materials archive.

Literature Searches for Best Practices in IPV

Google Scholar and Web of Science were used for a search of the academic literature regarding IPV best practices for service providers. To accomplish this, the following terms were used, with all iterations of phrase 1, phrases 1+2, and phrases 1+2+3. In addition, when an article found in this search cited relevant information in another article, that article was also located. An article was considered relevant if it referred to or identified best practices for provider of non-medical services to victims of IPV. This process resulted in over 20 articles, many of which were consulted in drafting this report.

Term/Phrase 1	Term/Phrase 2 (if used)	Term/Phrase 3 (if used)
Intimate partner violence	best practices	service provider
IPV	evidence-based	collaboration
Domestic violence		

Internet Search for IPV-Related Organizations in Central Ohio

In addition to the list provided by LSS CHOICES and "snowball" efforts of always asking with which other agencies/organizations survey respondents or in-depth interviewees collaborated and whether they could think of other Central Ohio service providers that we should contact, we also conducted an Internet search of related terms in order to identify additional service providers relevant to IPV. To the credit of Central Ohio's network of providers, the Google searches did not result in the discovery of any new providers. This suggests that, regardless of levels of collaboration, there is a good level of mutual awareness among service providers in Central Ohio.

Term/Phrase 1	Term/Phrase 2 (if used)	Term/Phrase 3 (if used)
Intimate partner violence	services	Central Ohio
IPV	assistance	Franklin County, Ohio
Domestic violence	help	Columbus, Ohio

Analysis of Quantitative Survey Data

Information about Data Sources

The United States Census' "American Fact Finder" was used to obtain historical population, demographic, and financial trends for Franklin County and Ohio. Specifically, table B03002 for years 2009-2017 was used to obtain demographic and population information, and table S1901 was used to obtain Franklin County household income. In addition, population projections for Ohio and Franklin County were obtained from Ohio's Development Services Agency (https://development.ohio.gov/reports/reports_pop_proj_map.htm).

Several large-scale surveys were consulted in the search for reliable prevalence estimates for Central Ohio. The National Intimate Partner and Sexual Violence 2010-2012 (NISVS) survey, the Ohio Family Health Survey (OFHS), and the Behavioral Risk Factor Surveillance Survey (BRFSS) were chosen as the most relevant and reliable measures of IPV prevalence in Central Ohio. They will be explained in detail after explaining why other, seemingly good candidates, were not selected.

The National Violence Against Women Survey (NVAWS), and the National Criminal Victimization Survey (NCVS), and the NISVS 2015 were considered but were excluded from this report for the following reasons. The NVAWS was conducted in 1995-1995, so the data are already almost 25 years old. In addition, it only summarized its findings at the national level, so any important differences between Ohio and other states would be lost or distorted when adjusting down to the state level. The NCVS is an annual study, so its findings are constantly updated, but it focuses only on ***criminal*** activity, with IPV simply one potential form thereof. Although it does ask about reported and unreported incidents, its focus and language is still on criminal activity, and because many victims of intimate partner violence may not consider IPV criminal in nature, there is a very good chance that this severely underestimates the prevalence of IPV. Additionally, it only summarizes its findings at the "regional" level, so rather than obtaining Ohio-level statistics, we would be limited to obtaining Midwestern statistics. Finally, the NISVS 2015 was not reported in this document because it did not summarize its findings at the state level, and because of the methodological change (drastically reducing its number of questions) over its 2010-2012 iteration. This reduction in the number of questions creates an illusion of reduced IPV that simply cannot be interpreted as a change of prevalence, as the instrument itself changed over time. To reduce confusion, we selected the iteration of the 2010-2012 NISVS which (1) used the more comprehensive instrument and (2) that collected enough data to enable reporting at the state level, despite being 3-5 years older.

The 2010-2012 NISVS was selected because it used a comprehensive definition of IPV, with 30 questions to assess history of IPV, including **physical violence** (i.e., slapping, pushing or shoving, hit with something hard, kicked, hurt by pulling hair, slammed against something, tried to hurt by choking or suffocating, beaten, burned on purpose, used a knife or gun), **contact sexual violence** (i.e., rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact, all which could be through force, inability to consent, or coercion), **psychological violence** (i.e., acting angrily in a way that seemed dangerous; told you were a loser, failure, or not good enough; called you names like ugly, fat, crazy, or stupid; insulted, humiliated, or made fun of you in front of others; or told you that no *one else would want you)*, **and stalking** (i.e., watched or followed you from a distance, or spied on you with a listening device, camera, or GPS; approached you or showed up in places, such as your home, workplace, or school when you didn't want them to be there; left strange or potentially threatening items for you to find; sneaked into your home or car and did things to scare you by letting you know they had been there; left you unwanted messages[.] This includes text or voice messages; made unwanted phone calls to you[.] This includes hang-up calls; sent you unwanted emails, instant messages, or sent messages through websites like MySpace or Facebook; left you cards, letters, flowers, or presents when they knew you didn't want them to).

It also collected contained enough observations (over 22,000 women completed it) to provide summaries of most of its comprehensive findings by state, enabling a picture of Central Ohio, in particular, to begin to emerge.

The 2008-2010 OFHS is reported because it was a study conducted specifically by Ohio researchers, and so provides statistics for the State of Ohio, rather than national-level trends like the surveys described above. However, studying IPV was only one of several purposes of the survey, so it was not as comprehensive a measure. In fact, IPV was assessed using only one question: "Has an intimate partner ever used physical violence against you? This includes hitting, slapping, pushing, kicking, or hurting you in any way." This single item means that far fewer people would be likely to endorse experiencing IPV, as it is not nearly as comprehensive as asking about 30 different actions. In addition, that measure changed slightly; the question above was used in 2010, but in 2008, the instrument asked first about physical violence in the past year, then about whether an intimate partner was the/a person who used the violence. Although its IPV assessment instrument is weak, the OFHS was a massive study, with responses from over 58,000 adults in Ohio, so to the extent that the

single item captures the concept of physical IPV, it provides a statistically reliable estimate based on a large sample.

Finally, the 2005 Ohio BRFSS included an optional module assessing IPV. Falling between the exhaustive NISVS instrument and the limited OFHS single item, the BRFSS asked whether the following four things ever occurred at the hands of a current or former intimate partner: threats of physical violence, attempted physical violence, actual physical violence, unwanted sex; and whether, in the past 12 months, the respondent had experienced physical violence or unwanted sex with an intimate partner. This was asked of 7,498 Ohio residents, with responses from over 5,000 to at least one of the items. Roughly 1,700 of these respondents were residents of Franklin County, providing a healthy number of people from which to form overall conclusions. However, the women of this sample were largely White (79.4%) and Black (10.8%), making estimates and predictions for other racial/ethnic groups impossible; there simply were not enough responses from those groups to draw any conclusions.

Projected demographics of Franklin County and Ohio

The next table, which uses data from the U.S. Census, demonstrates that the racial and ethnic makeup of Ohio is changing, requiring this to be considered when making projections. Because people who report races and ethnicities other than White and Black make up relatively small proportions of Franklin County and Ohio, they have been collapsed into an "Other" category which includes Hispanic, Asian and Pacific Islander, American Indian and Alaska Native, Multiracial and other races.

Demographics in Franklin County and Ohio, 2009-2017						
	Franklin County			Ohio		
	White	Black	Other	White	Black	Other
2009	70.8%	19.1%	10.1%	82.5%	11.6%	5.9%
2010	68.4%	20.8%	10.9%	81.6%	12.0%	6.4%
2011	67.8%	20.8%	11.3%	81.4%	12.0%	6.7%
2012	67.3%	20.9%	11.8%	81.1%	12.0%	6.9%
2013	66.9%	20.9%	12.2%	80.8%	12.0%	7.2%
2014	66.4%	21.0%	12.6%	80.5%	12.0%	7.4%
2015	65.8%	21.1%	13.1%	80.3%	12.0%	7.7%
2016	65.1%	21.4%	13.4%	80.0%	12.1%	7.9%
2017	64.5%	21.7%	13.9%	79.6%	12.1%	8.3%

Lifetime Prevalence of IPV by Race

The table below, which uses NISVIS lifetime prevalence data, demonstrates that IPV rates differ for women with different racial and ethnic identities. Again, this suggests that this factor is important to consider when projecting future IPV prevalence.

Prevalence of Contact Sexual Violence, Physical Violence, and/or Stalking by an Intimate Partner, by Race/Ethnicity NISVS 2010-2012		
	Lifetime Prevalence	95% Confidence Interval
White	37.3%	(36.2, 38.5)
Black	45.1%	(42.2, 48.1)
Hispanic	34.4%	(31.3, 37.6)
Asian or Pacific Islander	18.3%	(13.8, 23.8)
American Indian / Alaska Native	47.5%	(38.9, 56.3)
Multiracial	56.6%	(50.5, 62.5)