Creating A Safer Texas: Understanding Family Violence Non-Residential Service Use and Impact: Final Report

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Introduction

Non-residential family violence (FV) services[1] are provided to survivors, their children, and families in community-based agencies across the state of Texas. These services are focused on safety, stability and healing and are a crucial component in our societal response to and prevention of family violence. However, the focus of recent research has been primarily on shelter and other on-site housing programs, creating a dearth of empirical evidence describing the activities, goals, and outcomes of non-residential FV services in Texas or around the nation. This represents a missed opportunity as more survivors access non-residential services than shelter-based ones. There is a need for Texas-focused frameworks based in survivor and advocate experiences to support evidence-informed policy making and enhance program evaluation efforts. To address these needs, we embarked on an 18-month, mixed-methods statewide project guided by principles of community based participatory research. The project was conducted in partnership with Texas Council on Family Violence (TCFV) staff, Texas Health, and Human Service Commission Family Violence Program (HHSC FVP) staff, collaborators with specific cultural, practice, and methodological expertise, and FV agency staff and survivors. The project sought to capture survivors' needs and experiences within non-residential services, with attention to the role of racial/ethnic and geographic disparities on service access and engagement. The process, findings, and recommendations stemming from this project are described within this report, which can be used to describe the current picture of non-residential FV services across Texas, inform state program development and policy making, guide enhanced services implementation, and support agencies in effectively and equitably evaluating their non-residential FV services.

[1] For this evaluation, ***non-residential services*** include services delivered in virtual, in-person, and "mobile" modalities, for clients not living on-site (i.e., those not living in emergency shelter and site based transitional or permanent housing) in the FV agency setting.

Background

Texas Survivors & the Family Violence Service Sector

Over 5 million Texans have experienced family violence[2] (FV) in their lifetimes (Busch-Armendariz et al. 2011). Consequences of these experiences reverberate across the lifespan, including long-term ramifications for mental health, physical health, and economic security (Breiding et al., 2014; Lacey et al, 2013; Postmus et al, 2020; Spencer et al, 2019; Stubbs & Szoeke, 2022). Further, with 201 Texans killed by their intimate partners in 2021, FV remains a serious driver of mortality across the state (TCFV, 2022). The impacts of FV are further compounded by racial injustice and health disparities, which put people of color and those with health concerns and disabilities at heightened risk for FV (Bent-Goodley, 2007; Petrosky et al., 2017) and magnifies the impact of violence for survivors who are part of other marginalized groups, including those with LGBTQIA+[3] identities, survivors with disabilities, and survivors who speak languages other than English. Survivors facing multiple types of marginalization have less access to criminal legal supports and formal FV support networks (Lucea et al., 2013) and may have less trust in these services and systems (Robinson et al., 2020).

Texas covers 261,797 square miles in 254 counties, with an estimated population of over 29.52 million residents, over 3 million of whom live in rural communities (US Census, 2021; USDA, 2022). The vast geographic distances covered by some Texas FV agencies, the diversity in Texas communities in size, population, and resources, and the imperative to provide culturally relevant and accessible services to individuals from many backgrounds create unique challenges and opportunities for FV service providers. In Texas, a FV service sector providing a wide range

[2] Throughout this report, the term family violence is used to represent intimate partner violence/domestic violence, including dating violence.
[3] LGBTQIA+ is an inclusive acronym to include Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual and other sexual and gender identities.

of services has been developed to support survivors and their families to increase safety and ameliorate the long-term consequences of violence. Statewide, FV services provide help to nearly 70,000 Texans yearly (HHSC, 2022), with 62,796 clients served by state-funded programs in fiscal year (FY21). On the national domestic violence counts census day in September 2021, over 6100 Texas survivors were served in FV services, over 2200 of whom were served in non-residential services (NNEDV, 2022).

The Texas Family Violence Program (FVP) at the HHSC currently funds 78 full-service FV centers, 8 of which are solely non-residential service centers, which provide life-saving services aimed at individual, family, and community healing, equity, and justice. These services are directed by Chapter 51 of the Texas Human Resource code, which details allowable activities. However, both in Texas and nationally, there is a lack of empirically based evidence about survivor-defined best practices in core FV services. This leaves providers and communities without a comprehensive and inclusive framework for ensuring high quality survivor-centered practices are consistently implemented and sustained. Specifically, non-residential advocacy (sometime referred to as case management[4]) and other non-residential survivor services, with both in-person and virtual service provision, have been omitted from previous evaluative work, despite being some of the core FV services (Goodman & Smyth, 2011; Lyon et al., 2012). Non-residential advocacy encompasses much of the core activities, including intervention services, information provision, and resource linkage, outlined in Chapter 51 of the Texas Human Resource Code (HRC). Chapter 51 guides the funding of FV services by Texas HHSC FVP as it serves to establish the minimum services a FV center/agency must follow to receive funds

[4] While there is much overlap between advocacy and case management, advocacy is client-led support and intervention navigating systems and client needs that is focused on empowerment and rights, while case management refers to the process of assessing, planning, and coordinating services on an individuals' behalf.

through HHSC. These funds include federal sources, such as the Family Violence Prevention and Services Act (FVPSA) as well as state allocations. Non-residential services have become more critical as shelter space and housing vouchers are limited and the need for more "mobile"[5] service provision grows. The COVID-19 pandemic, changing survivor preferences, and the need to reach rural communities has expedited this need for more flexible service provision methods such as mobile advocacy and the use of technology in FV advocacy services.

Service Access

In FY 2021, FV agencies, funded through the Texas HHSC FVP, provided non-residential support to 44,739 survivors and their children (HHSC, 2021). FV agencies aim to enhance survivor social and emotional well-being and safety by addressing mental, physical, and economic challenges created, or exacerbated, by violence experiences (Sullivan, 2018; Wood et al. 2020), however these services are sometimes inaccessible to survivors. As identified in the 2019 TCFV State Plan, in the academic articles and community reports, many identity-specific factors, including race, ethnicity, primary language, sexual orientation, disability status, age and gender identity, effect a survivor's access to helping systems, with marginalized and historically oppressed populations experiencing greater lack of access and/or discrimination or barriers when accessing supports (Brereton et al, 2019; Burse et al 2022; Peitzmeier et al; 2020; Wood et al, 2019). This lack of access compounds societal oppression and higher rates of violence in communities of color and the LGBTQIA+ community to exacerbate barriers to FV service access and service effectiveness for survivors (Brereton et al.,2019; Robinson et al., 2020). Survivors of color often face additional barriers to accessing and engaging with formal services,

[5] Mobile advocacy refers to the provision of advocacy services outside of an office setting and includes court accompaniment, home visits and meeting clients in other community settings. In other words, meeting the client in a place of their preference rather than having the client come to the agency.

and studies show that being white is associated with more formal help-seeking and access (Amstadter et al., 2008; Kim & Hogge, 2015; Waller et al, 2021; Waller et al, 2022).

FV agencies often serve significant numbers of Black/African American survivors and other survivors of color often due to economic stressors and barriers faced at higher rates (Gillum, 2019). Immigrant survivors also face additional barriers such as language access and fears due to immigration status. This leads to the need for more economic supports, investment in language and immigration access supports, and more culturally specific services highlighting the protective strengths of survivors' cultural identities and addressing systemic forms of discrimination (Burman et al., 2004; Gillum, 2009; Ragavan et al, 2018). Culturally rooted services that stress respect and understanding of survivors' cultural background and which are trauma-informed have led to greater well-being for Latina survivors (Serrata, 2019) and greater empowerment, emotion regulation, and lower social withdrawal for LGBTQ survivors (Scheer et al, 2022).

Family Violence Service Impact

There is growing evidence that core advocacy services improve survivor outcomes. Advocacy contributes to changes in survivor well-being, including emotional, social, and physical health and economic and social support (Bennett et al., 2004; Rivas et al, 2016; Sullivan, 2018). Viewing FV services through the lens of Conservation of Resources (COR) theory suggests that after trauma or abuse, survivors face individual, interpersonal, and social resource loss, and that this immediate resource loss can be mitigated, and long-term impacts reduced by gains through informal or formal support (Sullivan, 2018). A FV agency can then support survivors in accessing lost resources by providing information, emotional support, safety planning; resource acquisition; and systems-level advocacy (Constantino et al, 2005; Lyon et al,

2008). Advocacy services are grounded in the perspective that all survivors have rights and deserve access to support to gain resources and improve well-being (Davies & Lyon, 2014; Sullivan & Goodman, 2019). Additionally, research suggests that both access and connection to FV staff leads to greater survivor wellbeing (Wood et al, 2022a). Specifically, advocacy and other FV direct services has also been shown to assist in decreasing negative outcomes such as subsequent experiences of violence and mental health symptoms (Bybee & Sullivan, 2002; Perez et al, 2012; Rivas et al., 2016). Voluntary and low barrier services have been significantly associated with increased survivor autonomy and empowerment (Nnawulezi et al., 2018) and empowerment has also been empirically associated with more positive mental health outcomes (Perez et al., 2012).

A Focus on Non-residential Services

Shelters and housing programs are often seen as the central hub of FV agencies and the gateway to comprehensive services. Most Texas-based and national data focus on service and program outcomes of residential clients (Lyon et al, 2008; Klein et al., 2021; Wood et al, 2022c) or on both non-residential and residential clients (Rivas et al, 2016; Wood et al, 2019). Very little of the research literature on FV services focuses exclusively on survivors accessing non-residential services. The studies focused on residential clients often highlight dynamics unique to the experience of living within a shelter or transitional housing program and their impact on survivors' experiences and service efficacy (Clark et al., 2019; Jategaonkar & Ponic, 2011; Wood et al, 2017; Wood et al, 2022a; Wood et al, 2022b). As such, more is known related to the experiences and outcomes of survivors living in FV housing compared to those accessing non-residential services. Despite this lack of research focus on non-residential services, estimates of between 36% to 71% of service use in FV agencies are provided outside of residential settings

(HHSC, 2021; NNEDV, 2021). Further, survivors frequently request comprehensive services that are not attached to a shelter stay. With rates between 39%-41% of shelter requests being denied due to lack of space in Texas (HHSC, 2021; Wood et al., 2019), there is an even greater need for a focus on access to non-residential service and what the impacts of those services are to address survivor needs.

The COVID-19 pandemic intensified the state and national focus on non-residential services. The pandemic has created and exacerbated safety concerns for FV survivors. There is some indication that there were increased calls to police early in the pandemic (Boserup et al. 2020; Leslie & Wilson, 2020; Piquero et al. 2020) and increased rates of FV in groups including essential workers, those who were pregnant, individuals experiencing economic and housing stressors, individuals living in urban settings, members of marginalized communities and those with toddler age children (Peitzmeier et al, 2022). A 2020 survey found that 74% of 352 FV and sexual assault (SA) staff surveyed, most from Texas, reported decreased survivor safety during the pandemic (Wood et al., 2022e).

During the COVID-19 pandemic, over 50% of the FV workforce rapidly began to offer video conference-based non-residential services to survivors, along with significantly increasing their use of a wide range of virtual platforms for service delivery, such as texting, computer-based chat, email, zoom, web-ex and Skype or FaceTime (Wood et al, 2020). Some FV staff described implementing these virtual services as challenging. Recent research focused on Texas FV staff has demonstrated that FV survivors in these virtual services have had both positive and negative reactions to receiving services in a virtual format (Voth Schrag, et al, 2022; Wood, et al, 2020). Some staff shared that their clients experienced increased feelings of safety, access, and connection due to the ability to access services from their home and the benefits of being able to

receive services without exposing themselves to COVID-19 (Voth Schrag, et al, 2022), while others experienced virtual services as distant, less secure, and ultimately less satisfactory than in-person connection, with particular concern about the ramifications of discussing safety issues virtually while at home with an abusive partner (Voth Schrag, et al., 2022; Wood et al., 2022e).

Impact of Non-residential Services[6]

The largest available national study to date of non-residential FV services surveyed nearly 1500 survivors in four states and found high endorsement of positive FV staff indicators, and a large majority of respondents indicating improvements on nearly every outcome, including getting help with safety, legal supports, custody issues and economic assistance (Lyon et al. 2012). Notably, Black/African American[7], and Asian[8] survivors reported lower rates of perceived staff understanding (Lyons et al, 2012). Common impacts of non-residential FV services are increased safety, economic and housing stability, legal assistance, and improved health. Safety planning is a key component of non-residential advocacy services. Several studies have shown that planning can have promising positive impacts on survivors' safety, especially when focused on individualized needs, empowerment, concrete strategies, linkage to resources, ongoing check ins, strengthening support networks and help with identifying threats to safety when either staying or leaving a relationship and when navigating systems (Davies, 2011; Davies & Lyons, 2014; Johnson et al, 2011; Sabri et al, 2021; Sharps et al, 2016). Safety planning has

[6] The evaluation team reviewed over 50 journal articles, evaluations, and reports on types of non-residential services such as legal advocacy, support groups, counseling, advocacy, and rapid rehousing vouchers. Qualitative and review methodologies were employed to identify themes across these documents, and key individual findings were also assessed and collected. Methodological literature related to language access, translation, and survivor engagement in research was also reviewed at the early stages of the process.

[7] Black/African American is used throughout this report to encompass the diversity of those who represent Black people who have been in the US for many generations or since enslavement as well as those more recently from the Caribbean, Dominican, Haitian, and African sovereign states.

[8] Asian is used throughout this report to encompass the vast diversity of people in the US from the Asian continent and the Pacific Islands, which encompasses more than 40 countries from Far East, Southeast Asia, the Indian subcontinent, and the Pacific Islands.

been shown to have positive impacts when combined with other services. The following summarizes the documented impacts of non-residential FV services.

Economics

Assisting survivors in addressing economic barriers and poverty are vital parts of non-residential services, aiding safety and stability. Direct financial and cash assistance is one of the most impactful forms of support that FV agencies can provide (Free From, 2022; Wood et al, 2019). Free From, a California based non-profit, provided small grants up to $250 to 2,163 survivors across the United States in November of 2020. Survivors spent their grants to purchase food (53.5%), pay household utility bills (35.9%), and purchase needed household items (29.7%) (Free From, 2022). Financial supports have been one of the most helpful interventions in improving survivors' safety (Wood et al, 2022b), with 73% of survivors identifying flexible cash assistance as their top need (Free From, 2022). There has also been growing evidence that programs focused on increasing survivors' financial capabilities, asset building, and financial literacy, if done in flexible and low-barrier ways, can have positive impacts on both survivors and the FV staff implementing the programs (Silva-Martinez et al, 2016; Tlapek et al, 2022).

Housing

Housing beyond shelter or on-site housing is a primary need of non-residential FV clients. Housing supports offered to non-residential clients may include help with rental assistance, voucher programs, and financial support to address housing related debts. Much of the research on the impact of housing vouchers is on the broader unhoused population; however, there is growing evidence that rapid rehousing programs specifically for FV survivors focused on advocacy, flexible engagement, trauma-informed practices, and community resources can lead to greater wellbeing, safety, and quality of life (Nnawulezi et al, 2018; Sullivan & Olsen, 2016).

Some studies have found that FV programs are successful in helping survivors retain their housing up to 18 to 24 months after receiving a housing voucher, as well as enhance their long-term economic security and safety (Mbilinyi, 2015; Sullivan et al., 2019). Other housing voucher studies have shown the need for more virtual and mobile services where advocates meet with the client in their home or in the community to maximize the impact and access of these services and to decrease survivors' isolation (Sullivan & Olsen, 2016; Wood et al, 2022d). Another critical component of FV housing voucher services is to address the structural, systemic, and oppression-based barriers for survivors when using housing vouchers and trying to find permanent housing, such as discriminatory housing practices, unsafe housing conditions, racial housing segregation, and gender discrimination (Holliday et al., 2021; Wood et al, 2022d).

Legal

Legal advocacy and legal representation are other areas that have been shown to be of great importance for survivors in Texas (Wood et al, 2019). In criminal legal system settings, when focused on legal rights and choices, legal advocacy can lead to increases in survivor wellbeing (Cattaneo & Goodman, 2010). There is some evidence that civil legal representation including aid with protective orders, are connected to decreases in reported physical, emotion/verbal, and stalking behaviors and increases in economic self-sufficiency (Hartley & Renner, 2016; Hartley & Renner, 2018; McFarlane et al, 2014; Renner & Hartley, 2021). Notably, there is need for caution about the potential negative impacts to FV survivors, especially those from marginalized communities, when FV services focus too much on criminal legal responses rather than looking at family violence as a broader human rights and civil rights issue (Mehrotra et al, 2016).

Health

A recent systematic review of 27 studies concluded that most interventions for FV survivors lead to some improvements in areas of increased social support and/or mental health outcomes; however, did not lead to increased use of healthcare resources (Ogbe et al, 2020). A substantial literature has established the efficacy of mental health counseling interventions including Prolonged Exposure, Eye Movement Desensitization and Reprocessing (EMDR) therapy, and Cognitive Processing Therapy for addressing trauma symptoms with survivors of interpersonal violence (Arroyo et al, 2017; Forbes et al., 2020; Johnson et al, 2011). In a recent systematic review of studies on psychological therapies for survivors of FV, there is evidence of some reduction in depression, increases in emotional health and short-term reduction of anxiety; however, there is not enough evidence to show an impact on PTSD, self-efficacy and re-exposure to harm and violence (Hameed et al, 2020). There is a growing body of research exploring the positive impact of peer support groups leading to a greater sense of connection and belonging and reduction of distress (Sullivan, 2012) and, when developed for specific cultural groups such as Hispanic/Latinx[9], leading to a greater sense of community, self-advocacy, and empowerment (Page et al, 2021). Another study has shown that to improve health outcomes for those who are the most vulnerable, innovative practices such as co-locating FV advocacy services within HIV medical providers can positively impact health for a very vulnerable population of survivors (Wingood et al, 2013). A small shelter-based study found that survivors receiving a social support intervention utilized fewer healthcare resources over the follow up period, hypothesizing that increased social support could lead to reduced health care need (Constantio et al, 2009). Overall, there is growing evidence that various non-residential interventions can lead to some reduction in family violence, increase safety, reduce depression

[9] Throughout this report, Hispanic/Latinx represents the diversity of people who identified as being of Spanish speaking or Latin American descent, representing Cuba, Central and South America, Mexico, and Puerto Rico.

and PTSD symptoms, increase financial resource obtainment and greater social support. However, more evidence on non-residential FV services is needed, especially to understand survivor needs and articulate the core service approach with a plan for further evaluation. Given the primacy of non-residential services for survivors in Texas, the focus, delivery, and quality of these services should be a priority for a statewide response to violence prevention and intervention.

A Survivor-Centered Evaluation for Texas

To address the lack of knowledge about non-residential FV services, researchers from the University of Texas Medical Branch (UTMB) Center for Violence Prevention (CVP), the University of Texas at Arlington School of Social Work, TCFV and HHSC FVP partnered to 1). conduct a statewide assessment of non-residential FV services and 2). Build and pilot a survivor-centered, equity focused evaluation of non-residential services for programmatic and planning use. This report details the evaluation approach, summary findings, and recommendations of this work.

Evaluation Method

Approach

The evaluation team from UTMB and UTA partnered with TCFV, HHSC and Texas FV agencies to use community-based participatory research approaches to conduct an exploratory, sequential mixed methods evaluation of non-residential FV services across the state of Texas. The project's community-based and equity-focused participatory approach meant that choices related to the focus of the project, including engagement methods, data collection approaches, and interpretation of findings were made in collaboration between the research team and community partners, including staff from TCFV and HHSC FVP. Drs. Josie Serrata and Melissa

Torres provided expert consultation in cultural adaptation and community-based participatory methods, along with content expertise on data collection and measurement with diverse populations. A participatory approach also centers the voices and perspectives of survivors and staff when making recommendations about programming and quality. Further, this approach involved project tasks that had an overarching emphasis on engaging diverse survivor voices; consulting with scholar-experts to enhance team understanding; interviewing an inclusive sample of practitioners representing the diversity of Texas; and considering language access and culturally responsive practices across project phases *and* products. This approach facilitates high quality and rigorous research while remaining flexible to address emerging community needs (Goodman et al, 2018). To enhance our participatory model, TCFV staff, all with previous direct service experience, participated in data collection[10]. The team at TCFV engaged in training with the evaluation team on trauma-informed data collection and human subjects' safety. By employing this approach, the project strived to maximize the benefits of community-researcher partnerships and limiting the possibility that research findings have unintended negative consequences (Goodman et al, 2018).

For this study, a definition of non-residential services was developed in collaboration with TCFV and HHSC staff. Non-residential services are defined as **any services (virtual, phone or in person) provided outside of shelter or onsite housing**. Non-residential services may include services such as advocacy, case management, economic aid, counseling, parenting support, housing advocacy, legal advocacy, and legal representation. The project aimed to build a picture of non-residential services being provided in a variety of formats to diverse communities across Texas, and to support agencies and advocates seeking to assess the impact

[10] TCFV staff only interviewed survivor participants, to reduce the chance of staff discomfort due to the training and support roles of the coalition with agency staff.

and effectiveness of these services for all Texan survivors. The overarching research questions guiding the evaluation were:

1. *What do survivors need and want from non-residential advocacy?*
1. *What is effective in their view?*

To address these questions, the project had the following specific aims:

Aim 1: Understand survivor experience, needs, and recommendations related to non-residential advocacy in diverse Texas family violence program settings, including the impact of racial, ethnic, and geographic disparities on services access and engagement, with the goal of improved practice and policy making, e.g., a review of Chapter 51 of the Texas Human Resource Code.

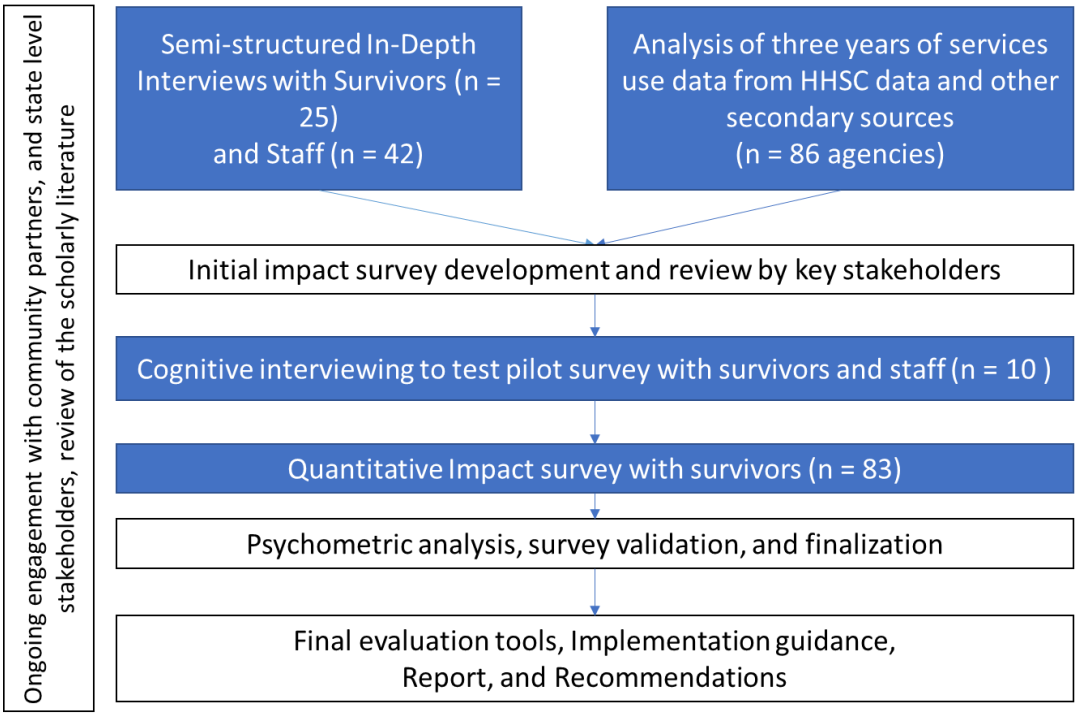
Aim 2: Create a program logic model based on survivor and advocate input.

Aim 3: Assess initial efficacy of both virtual and in-person non-residential advocacy on key survivor and advocate-identified outcomes.

Aim 4: Develop psychometrically sound, survivor-centered, and easy to implement evaluative tools for key non-residential advocacy program outcomes for statewide dissemination.

The project design and associated activities recognize the diverse lived experiences and needs of survivors and FV staff across the state, as well as the limitations of any single data stream or narrative to fully capture non-residential services access and quality. For the exploratory mixed methods approach, key streams of data were collected, and steps taken to facilitate the integration of data and the prominence of survivor and community voices are outlined in Figure 1 and described below.

Figure 1. Exploratory Sequential Mixed Methods Design



Project Activities

Analysis of HHSC FV Program Service Data

The evaluation team built a secondary dataset of information gathered via open records requests sent to HHSC's Family Violence Program and granted through the Texas Public Information Act. The dataset was created based on feedback and support from TCFV staff who are experts in statewide FV program data management, as well as HHSC staff who collect and use these data. We analyzed data for the three most recent state fiscal years (FY19, FY20, and FY21) on: family violence program hotline calls by agency, month, and call type; FV agency level demographic data for non-residential clients by service-type, including gender, age, and race/ethnicity; and total statewide unduplicated and total service contacts for non-residential clients by age, race/ethnicity, gender, and language. These data were combined, as appropriate, for analyses and merged with publicly available data from the U.S. Census (U.S. Census, 2022)

(including county level racial demographics, and % urban) and the Eviction Lab project (including poverty and eviction rate at the county level) to build a picture of the type of services currently being accessed and their context (Hepburn et al, 2020). This resulted in a set of data with secondary data reflecting current trends in Texas FV services as indicated in Table 1.

Table 1: Secondary Data Sources

	Hotline Calls by Month Per Agency	**Service Data by Agency**	**Service Data Statewide**	**Eviction Lab & Census.gov**
Data Source	HHSC Family Violence Program	HHSC Family Violence Program	HHSC Family Violence Program	Evictionlab.org Data.census.gov
Time Period Covered	Monthly Counts for FY19 – FY21 (3 total records)	Monthly counts by agency for FY19 - FY21 (duplicated & unduplicated)	Yearly Total Counts by agency for FY19 (duplicated & unduplicated)	2016 & 2010 matched census and eviction data
Number of Records	Between 81 & 86 agencies per month	82 agencies in FY19, 87 agencies in FYs 20 & 21	82 agencies in FY19, 87 agencies in FYs 20 & 21	Per County with an included FV agency
Variables	Agency Name (String) Type of Call (Counts per month)	Duplicated & Unduplicated: Non-residential service type Ender Age Race/Ethnicity by service mode (face to face, virtual, phone)	Duplicated & Unduplicated: Age Non-residential Service type Ender Age Race/Ethnicity Language	Poverty Rate Population Race/Ethnicity Demographics Eviction Rate % Urban

The analyses of these data included in this report are intended to provide insight into who is receiving services, what services they are accessing, and what gaps might exist.[11] As such, we sought to combine and analyze these data from FY19-FY21 to:

1. Capture trends in FV hotlines calls,

[11] These service and hotline data only reflect the services documented by staff in HHSC-funded FV agencies during those fiscal years using the service codes that were requested to be documented by HHSC and are not a complete picture of services provided or needed, nor do they indicate whether services provided were high quality or in alignment with the service model outlined in this report.

2. Identify service type counts for services both required in Texas Human Resource Code Chapter 51 and offered through HHSC's Exceptional Item Funding (EIF)[12] services.
3. Explore the demographics of survivors and their children who are receiving services reflected in these data, including differences by service category, age, gender, language, and race/ethnicity.
4. Better understand changes in mode of service delivery (phone, virtual, face to face) as reflected in these data[13].
5. Explore the context of non-residential FV services by evaluating county level demographic data alongside program data.

Interviews with Staff Providing Non-Residential Services

Between September 2021 and April 2022, the research team interviewed forty-two (42) staff, who provide non-residential services to survivors of FV, from fifteen (15) Texas FV agencies from across the state, covering North, South, Central, East and West Texas. The interview guide was developed through an iterative process of collaboration between the study team, TCFV staff, and community collaborators. Staff were eligible for interviews if they provided or supervised some type of non-residential services at a Texas FV agency in the previous year. Staff interviews focused on the breadth and depth of non-residential FV services, staff perception of survivor needs, perceived non-residential service impact, service approach

[12] In Texas, prior to each Legislative session, state agencies can request funding, above their base funding amount, through a Legislative Appropriations Request to the Legislative Budget Board, to either enhance services or increase the effectiveness of agency operations. At the time of this report, HHSC Family Violence Program has exceptional item funding for legal services, economic, housing and mental health needs of survivors

[13] Note: HHSC did not request data from FV agencies on virtual service provision in all of the included FYs, as they begun funding such services in FY20 at the outset of the coronavirus pandemic. Because of this, the substantial increase in virtual services seen in these data from 2019-2020-2021 is likely exaggerated by the fact that prior to FY20, there was not a way to report virtual services to HHSC.

with diverse populations and staff experiences during the COVID-19 pandemic. The evaluation team, in partnership with TCFV, first identified and recruited seven FV agencies that were representative of the diversity of Texas programs (including culturally specific programs) to request project interviews. Following site specific outreach, a promotional message was sent on TCFV statewide listservs to recruit additional staff across the state. Promotional materials for the confidential and voluntary interviews were shared with staff, who contacted the evaluation team if interested. The staff interviews, conducted over zoom, phone or in person, during staff work hours, involved open-ended questions, and lasted no more than an hour. Onsite interviews were conducted at two agencies. See Appendix F for the interview guide. The plurality of staff interviewed identified as female, White, non-Hispanic and under the age of 45 years old. The majority had more than 5 years' experience working with survivors of FV and over 60% identified their primary role as an advocate, case manager, hotline advocate or crisis worker, with many of these staff also having additional roles as legal advocates, liaisons to Department of Family and Protective Services (DFPS), high risk team members, bilingual advocates, volunteer coordinators and child advocates.

Table 2: Staff Interview Participants

	Staff Interviewed	
	=*n*	%
Gender Identity		
Female	39	92.9%
All Other Genders	3	7.1%
Age		
23-34	15	35.7%
35-44	16	38.1%
45-54	4	9.5%
55+	7	16.7%
Race/Ethnicity		
White, Non-Hispanic	20	47.6%
Hispanic, Latinx	17	40.5%
Additional (AAPI, American Indian or Alaska Native, Black/African American, Multiracial/Multiethnic[14])	5	11.9%
Years in the Field		
1 year or less	8	19.1%
2-4 years	9	21.4%
5-9 years	16	38.1%
10 years or more	9	21.4%
Job/Role		
Advocate/case manager	26	61.9%
Counselor/therapist	6	14.3%
Director/coordinator	10	23.8%

Interviews with Survivors using Non-Residential Services

Between January 2022 and April 2022, 25 survivors who had used FV non-residential services at six FV agencies in Texas were interviewed, 8 of which were cognitive interviews focused on review of a survey tool (see survey development section). Survivors were eligible to be interviewed if they were receiving non-residential services and were not currently living in

[14] In this report, if someone identified themselves as multiracial or if they chose more than one race or ethnic group, they were reported in these results as multiracial/multiethnic. Additionally, because so few Black/AA or AAPI staff responded to the interview opportunity, they are combined into the "other" category.

shelter or any on-site housing programs. The purpose of the interviews with survivors in non-residential services was to learn about survivors' needs, and experiences in, and the impact of non-residential FV services. To achieve these goals, the interview guide was reviewed by the study team, TCFV staff, and community partners and consultants to ensure questions were relevant, culturally sensitive, minimally burdensome, and were appropriate to non-residential settings. Participants were asked about their background, experiences accessing non-residential services, service experiences, needs both met and not met, including economic, housing, safety, legal, parenting and children's needs, interactions with social services and government services, and recommendations for service providers and systems.

The evaluation team, in partnership with TCFV, emailed promotional materials to the seven evaluation sites who participated in staff interviews. Staff at each agency were asked to send the promotional materials to non-residential clients who then contacted the study team if interested. The research team conducted confidential and voluntary interviews over zoom, phone or in person. Interviews were conducted in English and Spanish, and participants received a $30 electronic gift card. For both survivor and staff interviews, conversations were conducted in the language of the participants choice (English/Spanish). Spanish translations of the interview guide were developed through an iterative process including initial translation by certified translators and then additional checking and review by bilingual interpersonal violence scholars who provided consultation on this project (Dr. Melissa I.M. Torres and Dr. Josephine V. Serrata). Spanish language interviews were conducted via phone or video conference by Dr. Torres. Fourteen (14) of the 25 survivors interviewed had children under 18 years old and another eight (8) had adult children. Thirteen (13) of the survivors interviewed had been in FV services two years or less and several participants (5) had been in services for more than six years. See table 3

for an overview of survivor interview participants.

Table 3: Survivor Interview Participants

	=*n*	%
Age		
25-34	4	16%
35-44	7	28%
45-54	9	36%
55+	2	8%
Unknown[15]	3	12%
Race/Ethnicity		
White, non-Hispanic	2	8%
Black or African American	2	8%
Hispanic or Latinx	14	56%
Asian American/Pacific Inlander	4	16%
Multiracial/Multiethnic/Other/Unknown	3	12%
Language		
Spanish	2	8%
English	23	92%
Years Receiving Services		
Less than a year	5	20%
1-2 years	8	32%
3-5 years	3	12%
6-9 years	2	8%
10 + years	3	12%
Unknown	4	16%

Pilot of "Texas Community Support Survey" (TCSS) of Non-residential FV Clients

Information from the interviews, HHSC data analysis, and literature review was used to develop a pilot survey to assess non-residential service outcomes. The pilot survey was based on previously validated and reliable measures in the FV field that have been found to minimize

[15] In the cognitive interviews, not all demographic questions were asked which led to several unknowns in some of the demographic categories.

opportunities for distress and discomfort. Validated scales were combined with both established study-team made and augmented key fidelity indicators, and insight from community engagement with collaborators and consultants including TCFV staff, FV program staff, survivors, and leaders, and Dr. Josie Serrata and Dr. Melissa Torres, both of whom are experts in culturally relevant survey construction for survivors of family violence. Key domains were identified through qualitative interviewing and literature review, including survivor demographics, perceptions, and outcomes of non-residential IPV services, indicators of non-residential service model fidelity, and health and safety variables. A measurement chart detailing the survey domains can be found in Appendix E.

Survey Review. The pilot survey, The Texas Community Support Survey (TCSS) was initially reviewed by cultural adaptation and FV service experts, along with TCFV staff. The draft was then refined to reflect team feedback. Then, the team embarked on a round of additional survey validation and testing using a technique known as cognitive interviewing. This is an evidence-based qualitative data collection method and survey testing technique which stems from fields including cognitive and social psychology and emphasizes capturing the voices and experiences of survey takers in the testing and development process. Cognitive interviewing seeks to understand how a survey (both as a whole and individual items) fulfills its intended purpose with individuals from within the community of focus (in this case, survivors who have used non-residential family violence services in Texas) (Willis & Boeije, 2013). For this project, cognitive interviews were conducted with survivors and frontline agency staff (n = 10). Interviewers reviewed a draft TCSS with survivors, asking them to answer the questions, and also to share their feedback on clarity, understanding, depth of experience, distress, and accessibility. Cognitive interviewing results indicated questions did not evoke distress, and with

minimal changes, the surveying approach would offer a way for participants to engage in evaluation with minimal safety concerns. After cognitive interviewing, changes were made to the TCSS reflecting feedback. A few examples of changes made to the Texas Community Support Survey based on the results of cognitive interviewing include 1). separating out items related to legal support for divorce from legal support for custody and child visitation issues; 2). updating language related to key agency staff (e.g., advocate, case manager) to better reflect survivors' own language, 3). adding an item about a participant's comfort asking for services as a potential reason not to engage, and 4). shifts to how we talk about safety in the context of data collection. As a result of cognitive interviewing, the study team also changed the survey name from the "Texas Community Safety Survey" to "Texas Community Support Survey" to increase the safety of participants still in contact with partners using violence. After finalizing the Texas Community Support Survey, it was programed into the secure Qualtrics survey platform and distributed to FV agencies across the state. Participants received a $25 gift card for participation[16]

Survey fielding. The final web-based survey developed based on staff, survivors, and collaborator input, was shared via email, social media[17], and in meetings and phone calls with partner non-residential FV agencies across Texas. All survey questions were voluntary, and the survey was advertised as a confidential opportunity to

Eligible survey participants:

- Were at least 18 years of age
- Had started non-residential services at a Texas FV agency in the past 12 months
- Had been out of shelter for at least 1 month

[16] A measurement chart listing key domains and measurement approaches within the TCSS will be available in Appendix E of this report. For more information about the survey tool, email the authors of this technical report.
[17] A direct link to the survey was not shared on social media. The study team's email address was shared via social media to contact to learn more about how to take the survey.

provide feedback to an external research team. FV agencies were asked to promote the survey to eligible participants

These eligibility criteria were selected with attention to participant re-call, the focus on non-residential services, and provide an understanding of the shorter-term impact of services. The survey was open for three months in the spring and summer of 2022 (May-August). A total of 83 eligible participants completed the survey. Participant demographics are summarized in Table 4. Survey participants were 35.27 years old on average (SD: 9.16, Range 18-70), and most identified as female (92.8%). A plurality of participants identified as Hispanic/Latinx (36%), with substantial representation from Black/African American (23%), White (17%), and Asian (14%) survivors as well. Participants worked with FV agencies from across the state, with a slight majority working with FV agencies in the Houston Metro area. Most (77.9%) participants had children under the age of 18 at home, and they had a wide range of educational backgrounds. Over 15% of participants chose to complete the survey in Spanish.

Table 4. Survey Participant Demographics

	=*n*	%
Race/Ethnicity		
White, non-Hispanic	14	16.9%
Black or African American	19	22.9%
Hispanic or Latinx	30	36.1%
Asian American/Pacific Islander (AAPI)	12	14.5%
Multiracial/Multiethnic[18]	7	8.4%
Survey Language Choice		
Spanish	13	15.7%
English	71	84.3%
Gender Identity		
Female	77	92.8%
Other Gender Identities	6	7.2%
Sexual Orientation		
Bisexual/Pansexual	10	12.4%
Heterosexual/Straight	68	90.0%
Other	3	3.7%
Age		
18-29	22	26.5%
30-39	35	42.2%
40-49	21	25.3%
50+	5	6.0%
Number of Children Under 18		
0	17	22.1%
1	24	31.2%
2-3	28	36.4%
4+	8	10.4%
Highest Level of Education		
8th Grade or Less	4	4.8%
Any High School	6	7.2%
High School Graduate/GED	14	16.9%
Some College	27	32.5%
Associates Degree	5	6.0%
Bachelor's Degree	18	21.7%
Advanced Degree	9	10.8%

[18] The survey included an option of American Indian/Alaska Native, which was not selected by any survey taker

The sample represents a highly diverse collection of survivors with a range of service durations and interactions, all of which helps to validate the functioning and efficacy of these tools for a range of programs and settings across the state (See Table 5).

Table 5. Survey Participant Service Frequency and Duration

	= *n*	%
How Long Have You Been Receiving Services?		
Less than a Month	8	9.6%
1 Month	5	6.02%
2-3 Months	19	22.9%
4-6 Months	24	28.9%
7-9 Months	9	10.8%
10-12 Months	18	21.7%
How often have you met with staff from this agency since starting services?		
1-2 times	21	28%
3-5 times	12	16%
6-8 times	13	17.3%
9-11 times	8	10.7%
12+ times	21	28%
Texas Region		
North Central (DFW)	18	21.4%
Central (Austin/SA)	11	13.3%
Southeast	5	6%
West	6	8%
Houston Metro	43	51.8%

Logic Model Creation and Review

Information analyzed via literature review, secondary data, staff, and survivor interviews, the TCSS and expert review were used by the evaluation team to create and verify a logic model of non-residential FV services. Concepts from the logic model were explored in staff and survivor interviews, including a focus on service impacts and activities. TCFV, HHSC and community partners reviewed the logic model and provided feedback, which was incorporated at various stages in the development and accompanying measurement approach. The survivor-

centered non-residential family violence services logic model, created with staff and survivor voice, can be found in Appendix B, and is discussed at length in the findings.

Safety and Confidentiality

Throughout this evaluation, safety protocols were implemented that aligned with standard human subjects' protections and the World Health Organization (WHO) guidance on family violence and COVID-19 (WHO, 2020). The study was reviewed and approved by UTMB's Institutional Review Board (IRB # 21-0116) with reliance from UTA. Analysis of HHSC data included no individually identifiable indicators. All members of the data collection team had experience working with the survivors of violence. The consent form for all data collection activities, interviews and survey outlined the study, including confidentiality protections, potential risks, and benefits. Major exceptions to confidentiality were detailed in writing and verbally and included child maltreatment and vulnerable adult abuse disclosure as outlined in Texas state law.

For interviews, participants were asked to share safe and preferred contact methods and asked if it was safe to receive emails or texts about the interview. All interviews were conducted by evaluation team members approved by the IRB, trained in trauma-informed interview techniques and with experience working with FV survivors. Evaluation team members also referred to the study broadly, as the "Evaluation of Non-Residential Services" when reaching out to potential interviewees as a further safety precaution. A resource sheet was available to give to interview participants, upon request if needs arose in the context of the interview.

For surveys, the study was advertised as a community support survey rather than a family violence survey to reduce the risks for survivors who may still have safety concerns. An internet safety message and community resources were provided on the first and last screen of the online

survey. Participants were encouraged to take the survey or do interviews alone, apart from others in their house. All questions were voluntary, and participants could skip survey or interview questions without penalty. Surveys were monitored for signs of distress. There was no evidence that data collection for this project compromised participant safety and/or caused distress. Several participants expressed benefits from participating.

Data Analysis

Qualitative data were analyzed by the study team using thematic analysis methods (Braun & Clarke, 2021) for staff and survivor interviews and content analysis (Braun & Clarke, 2020) for cognitive interviews. Survey data were reviewed in Qualtrics for duplicate and repeated ("bot") entries, with all confirmed or suspected duplications removed from analysis. Quantitative data (secondary and survey data) were analyzed using descriptive and bivariate methods including analysis of frequencies, means, chi-square, analysis of variance and Pearson correlations. Further, selected quantitative scales were analyzed for their psychometric properties and functioning overall and across racial/ethnic groups within the sample through assessment of Cronbach's alpha, interitem correlation coefficients, and factor structure (Illowsky & Dean, 2022). Integration of qualitative and quantitative data occurred at the mid-point of data collection (for secondary data and initial qualitative interviews) and in the process of developing themes and recommendations from the project as a whole. Strategies such as pattern matching, scholarly reflexivity, and causal process tracing supported the team in drawing connections across data sets and building mixed-methods inferences resulting in final study conclusions and recommendations (Tashakkori et al, 2021).

Results

The collaborative evaluation team sought to understand non-residential family violence service use, to explore the needs of survivors in Texas seeking non-residential services, to articulate the approach used by staff to address those needs, and to examine the efficacy of these services from staff and survivor perspective. We approached the project aims through collaborative quantitative and qualitative data collection. Below, we present the integrated findings of our data collection activities in three sections: 1). Understanding Survivor Service Use; 2). Articulating the Family Violence Service Model and 3). Assessing FV Program Impact. Additionally, the research team created vignettes developed from qualitative interviews to bring rich narrative and exemplify key findings. These vignettes are included throughout the report, and in Appendix C with discussion questions for use in training and educational applications. While these vignettes are fictional, they represent a composite from data collection across the state for this project and include quotes and scenarios from people we interviewed for this project.[19]

Section 1: Understanding Survivor Service Use

Texas Human Resource Code, Chapter 51

To examine non-residential service provision in FV agencies in Texas, it is critical to first understand the underlying statutory framework, Chapter 51 of the Texas Human Resource Code. Chapter 51 provides the Texas statutory framework for the funding of family violence services in Texas and outlines the services that FV centers/agencies are required to provide (Texas Human

[19] The case vignettes were prepared solely for training and educational discussions. They are not intended to suggest either effective or ineffective service provision, nor the experiences of any one specific survivor, advocate, or agency. Rather, these vignettes are compilations based on qualitative interviews with survivors and staff providing non-residential services in a wide range of agencies conducted for *Creating A Safer Texas: Understanding Family Violence Non-Residential Service Use and Impact: Final Report*. All names and certain facts have been disguised to protect confidentiality. Quotations in each vignette are directly from survivors and staff, but no vignette relies on quotations solely from one individual or agency. The authors wish to thank the survivors and staff who participated in this research for their contributions.

Resource Code, §51). Further, Chapter 379 of the Texas Administrative Code[20] sets forth rules for HHSC-funded FV agencies about how family violence services should be implemented (Texas Administrative Code, §379). While FV agencies work from a range of service models, the 2010 update to the Family Violence Prevention and Services Act (FVPSA) clarified that family violence services (called domestic violence services in other states) that receive federal funding must be available to service users on a voluntary basis and must abide by strict confidentiality guidelines (FVPSA, U.S.C.). The voluntary service model, as outlined by FVPSA, centers survivor autonomy and allows room for individualization based on each person's personal circumstances and goals (Missouri Coalition Against Domestic & Sexual Violence, 2012; Wood et al, 2020b). Chapter 51 includes 12 service categories that are required for FV agencies to provide as part of receiving HHSC funding.[21] FV staff collect and input data about service provision and report data to HHSC (See Appendix D for a list of HHSC FVP's service definitions for data collection). In Texas, victim-advocate privilege guidelines are also codified in Chapter 93 of the Texas Family Code (Texas Family Code, §93). Thus, FV agencies in Texas who receive federal and state funding from HHSC FVP must provide services included in HRC §51, adhere to the regulations detailed in TAC §379 and TFC §93 (state privilege), and use a voluntary service model.

Evaluation data analysis from multiple sources (secondary data, interviews, TCSS) indicate that FV agencies are consistently providing the services articulated in Chapter 51, as

[20] Chapter 379 of the Texas Administrative Code can be found online at: https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=1&pt=15&ch=379

[21] The 12 required services codified in Texas Human Resource Code, Chapter 51 are: 24-hour-a-day shelter, 24-hour-a day crisis hotline, access to emergency medical services, intervention services, access to emergency transportation, legal assistance in the civil and criminal justice systems, information about educational arrangements for children, information about training for and seeking employment, cooperation with criminal justice officials, community education, a referral system to existing community services, & a volunteer recruitment and training program. Chapter 51 can be found online here: https://statutes.capitol.texas.gov/Docs/HR/htm/HR.51.htm

they are bound by their HHSC contracts to do so. Secondary data analysis of HHSC data and staff interviews reveal that among the categories of services tracked by HHSC, several categories are used most frequently to capture service provision by staff. The category "intervention services" broadly captures many direct services being provided by FV agencies, such as advocacy and case management tasks, which Chapter 51 describes as referrals, safety planning, understanding and support and other resource assistance. Staff interviews reveal the category of "intervention services" is interpreted broadly, with activities that are not clearly represented in other aspects of Chapter 51 (see below), but potentially allowed under service definitions falling under this umbrella. Some staff expressed that the current services detailed in Chapter 51, and in the Chapter 379 of the Texas Administrative Code, become more of a checklist, rather than an approach to service provision and that the categories are too restrictive and too prescriptive. One staff stated, "*it ends up just being a check box on a grant versus the individual needs of that community*" (Staff 30). Staff shared a strong desire not to have additional service documentation or systems to manage which would burden those already stretched thin. One staff explained:

> my struggle with that is that I know—our staff already has to do so much. Every single advocate here already has six jobs. In adding things, it would just add more jobs for each one of us. It wouldn't necessarily add another person who can do those things and who's actually trained to do those things. (Staff 12).

Chapter 51 represents many activities staff use routinely to address the needs of non-residential FV survivors, but is not inclusive of the breadth, depth and specificity of services being provided on a regular basis.

HHSC Funded Non-Residential FV Services Provided in Texas, 2019-2021[22]?

[22] All services in this section are defined by HHSC for FV service providers and definitions are provided to FV agencies for data collection purposes. TCFV provides technical assistance on these definitions and HHSC data collection.

HHSC-funded FV agencies[23]reported serving 46,293 individual survivors & children through non-residential services in fiscal year (FY) 2019, 44,449 individual survivors and children through non-residential services in FY20, and 44,189[24] individual survivors and children through non-residential services in FY21. Staff members engaged in 480,266 individual non-residential service activities[25] in FY19, 488,843 individual service activities in FY20, and 543,085 individual service activities in FY21. On average, an individual survivor in non-residential services received 10.4 separate service interactions (separately coded instances of service provision) in FY19, 11 separate service interactions in FY20, and 12.3 separate service interactions in FY21, suggesting that the number of services provided per survivor increased slightly over the three-year period. This can be compared to an average of 23 separate service interactions for survivors using FV shelter. In all three FYs, the service categories of "intervention services,[26]" "information & referral," and "orientation" comprised the largest service categories provided under Chapter 51 (see table 6). While some variation in service counts by year was observed, they were generally consistent among the three examined FYs. Most notably, there was sizeable increase in endorsement of the service categories "emergency orientation," "intervention services," and "information and referral to community services" from 2019 to 2021. Conversely, there was a sizeable reduction in endorsement of "child services," "child recreation," "support group," and "transportation." Further, the increase seen from FY20 (16,456) to FY21 (18,549) in the "orientation" category, which is used generally with each client

[23] We are only able to offer a report of services currently collected by HHSC. Services that do not fit in those categories are likely placed in services with broad descriptions such as 'Intervention' or 'Information and Referral.'
[24] This is slightly lower than the 44,739 survivors and children indicated in the 2021 Statewide records request data gathered by TCFV. This is likely due to differences in the framing of the requests, as the data provided in the current report comes from aggregating individual agency reports.
[25] i.e., duplicated non-residential service counts
[26] In this section, all service categories in quotation marks are HHSC required and tracked services. Any service described without quotations describes a summary of related services.

only once at the time-of-service engagement, could suggest an increase in new/first time survivors served in FY21, compared to FY20. These data reflect a 12.7% increase in survivors who received a service coded as "orientation" in FY21, compared to FY20. However, it is important to keep in mind that these numbers only reflect the funded services[27], and are not a complete picture of services provided or needed.

Table 6. Unduplicated Service Counts[28] by Fiscal Year

	2019	2020	2021
Family Violence Option	1069	1012	969
Emergency Orientation	431	780	968
Educational Arrangement for Children	238	397	210
Child Services	4692	4215	3506
Child Recreation	2761	1472	541
Transportation	1346	1135	826
Medical Care	901	1047	1058
Medical Accompaniment	481	497	477
Intervention Services	28720	30604	32206
Information & Referral-Community Services	21229	21566	22767
Information & Referral-Employment	3384	3683	3629
Legal Assistance	12489	12795	12231
Support Group	8825	6622	5782
Orientation	17726	16456	18549
Counseling/Therapy	12898	12114	12112

Twenty-five FV agencies received Exceptional Item Funding (EIF) in both FY 2020 and 2021. EIF services comprised a substantial portion of innovative FV services (see table 6). In FY 2020, 1642 unduplicated clients were provided services under EIF and in FY 2021,[29] 3520

[27] By 'funded services' we mean that these figures reflect how individuals across the state chose to record what happens in services for the purpose of reporting to HHSC- a single interaction may include a wide variety of 'services' (e.g., intervention services, information and referral, and child focused support) all in a single session, and different folks across the state may choose to report information on that session differently. As such, viewing data and findings with caution in terms of how much they can say about services across the state is warranted.

[28] In this analysis, unduplicated means each survivor is counted one time for each service they receive (so a survivor who received "intervention services" and "transportation" and "EIF-economic stability-other" is counted 3 times). A survivor who received "intervention services" on 8 separate occasions during the FY only counts as '1' in this analysis. Because we did not have access to client level data, these unduplicated numbers 1) cannot account for any overlap due to clients being served more than one year (because all clients are counted as new at the beginning of each fiscal year), 2) cannot distinguish shelter clients from non-residential clients (because some clients may receive both residential and non-residential services within the same year) or 3) cannot account for any clients who were served by more than one FV agency (because identifiable client level data is not reported to HHSC).

[29] EIF funding was not available for FY19. EIF funded for FY20 started mid-fiscal year in March 2020 & only represents half of a year of service provision. FY21 represents a full year of service provision.

unduplicated clients were provided services under EIF. These services were provided face-to-face or virtual (phone or virtual platform) and were in three categories of services – legal services/representation (for protective orders, divorce, child custody, visitation, child support, immigration, housing, financial), economic stability (including financial assistance for housing, employment, childcare, education) and mental health (counseling).

Table 7. Exceptional Item Funding (EIF) FY20-FY21

	FY19	FY20	FY21
EIF-Legal Services-Protective Orders	0	96	159
EIF-Legal Services-Divorce	0	138	252
EIF-Legal Services-Child Custody	0	103	217
EIF-Legal Services-Child Support	0	110	108
EIF-Legal Services-Child Visitation	0	73	121
EIF-Legal Services-Child Protective Services	0	14	16
EIF-Legal Services-Immigration	0	221	607
EIF-Legal Services-Housing	0	31	46
EIF-Legal Services-Financial	0	7	9
EIF-Legal Services-Other	0	104	109
EIF-Economic Stability-Housing Assistance	0	250	634
EIF-Economic Stability-Educational Assistance	0	63	126
EIF-Economic Stability-Employment Assistance	0	46	99
EIF-Economic Stability-Childcare/Ancillary Support	0	97	128
EIF-Economic Stability-Other	0	176	613
EIF-Mental Health-Counseling	0	90	203
EIF-Mental Health-Other	0	23	73

Who is Engaging in Non-Residential Family Violence Services?

Trends in Service Use Considering Race and Ethnicity. Texas is a diverse state, serving family violence survivors from a broad range of racial and ethnic groups. Census population estimates for the state of Texas for July 1, 2021, include the following estimates of the racial and ethnic demographics of the state: White alone, not Hispanic/Latinx: 41.2%; Hispanic/Latinx: 39.7%; Black/African American: 12.9%; American Indian/Alaska Native: 1%; Asian alone: 5.2%; two or more races: 2.1% (US Census, 2022). Given systemic barriers, as well

as disparities in rates of exposure and service access, service engagement rates that are similar to overall state demographics should not necessarily be assumed to indicate equitable service access and engagement. Existing data suggests that people of color experience more interpersonal violence, including family violence, and as such should arguably be more present in services compared to the demographics of the state overall. As such, analysis related to race has been performed on both unduplicated survivors (including children) (e.g., each survivor in services is equal to 1) and duplicated services (e.g., each service interaction with a survivor is equal to 1) (see Table 8).

Family violence service rates, for the most part, are similar to Census data representation of racial and ethnic groups in the general Texas population, with some notable exceptions. As seen in table 8, Hispanic/Latinx survivors made up the largest group served by FV agencies in all three years. White survivors were the next largest group in all three years, and Black/African American survivors were third in all three years. There was a substantial increase in the 'unknown race' category in 2020 compared to 2019. The higher representation of Hispanic/Latinx survivors in the duplicated counts compared to the unduplicated counts is noteworthy, as it indicates that these survivors are receiving a greater number of services per survivor on average than other participants. Notably, Asian individuals represent 5% of the Texas population, and only 1.3- 2.4% of people coming to Texas family violence services across FY19-21, and American Indian/Alaska Native individuals comprise 1% of the Texas population and .5 to .6% of those coming to Texas family violence services. Additionally, Black/African American survivors appear slightly more frequently in the unduplicated counts than the duplicated counts, suggesting they have slightly less engagement over time (e.g., a lower number

of service encounters) compared to others. In other words, Black/African American survivors, on average, may not be receiving non-residential services for as long as other groups.

Table 8. Percentage of Survivors Served By Race/Ethnicity in FYs 19-21 (Unduplicated & Duplicated)

	FY19 Unduplicated	FY19 Duplicated	FY20 Unduplicated	FY20 Duplicated	FY21 Unduplicated	FY21 Duplicated
Black/ African American	13.2%	12.7%	12.8%	12.4%	13.6%	13.7%
Hispanic/ Latinx	44.3%	49.6%	41.5%	46.7%	44.8%	49.4%
White	32.6%	30.1%	29.8%	29.6%	27.6%	26.9%
Asian American Pacific Islander - AAPI	1.3%	1.2%	2.0%	2.0%	2.4%	2.2%
American Indian/ Alaskan Native	0.5%	0.6%	0.5%	0.5%	0.5%	0.5%
Multiracial	3.0%	3.1%	3.2%	3.0%	2.9%	2.8%
Other	1.5%	1.0%	2.2%	1.5%	2.4%	1.9%
Unknown	3.3%	1.6%	7.8%	4.3%	5.7%	2.4%
Refused	0.0%	0.0%	0.00%	0.0%	0.00%	0.1%

Additional analyses were conducted to understand the percentage of survivors who identify as Black/African American, Hispanic/Latinx, White, and other racial identities across each of the key family violence service categories in FY19-21. Tables 9, 10, and 11 provide the percentage of survivors of each racial/ethnic group represented in each of the 15 service categories across the state. In FY19, Black/African American survivors have more representation in service categories for “information and referral”, while they are less represented in services including “legal” and “counseling” services. Hispanic/Latinx survivors are more represented in categories related to services for children, “transportation,” “medical care,” “legal assistance,” and “support group,” while they are less represented in “orientation services,” “medical accompaniment,” and “information and referral for employment.” White survivors are more represented in “orientation” categories, “medical accompaniment,” “information & referral for employment,” and “counseling,” but less represented in child focused categories,” medical care,” “transportation” and support groups.” Survivors in additional race/ethnicity categories are highly represented in child services, but less represented in “information and referral for employment.”

Table 9. FY19 Service Categories Percentage by Racial/Ethnic Group

	Black/ AA (13.2%)	**Hispanic/ Latinx (44.3%)**	**White (32.6%)**	**Other (9.6%)**	**% of total services coded as this category in FY19**
Family Violence Option	17%	41%	32%	10%	1%
Emergency Orientation	12%	25%	56%	7%	>1%
Educational Arrangement for Children	11%	68%	12%	9%	>1%
Child Services	15%	54%	16%	15%	4%
Child Recreation	11%	69%	14%	7%	2%
Transportation	17%	58%	19%	6%	1%
Medical Care	13%	63%	18%	6%	>1%
Medical Accompaniment	14%	25%	50%	11%	>1%
Intervention Services	17%	42%	34%	7%	25%
Information & Referral- Community Services	18%	41%	34%	6%	18%
Information & Referral- Employment	24%	33%	38%	4%	3%
Legal Assistance	9%	54%	30%	7%	11%
Support Group	10%	59%	22%	9%	8%
Orientation	14%	37%	39%	11%	15%
Counseling	7%	44%	39%	9%	11%

As described in table 10, in FY20, Black/African American survivors comprise 12.8% of service recipients, Hispanic/Latinx survivors comprise 41.5% of service recipients, White survivors comprise 29.8% of service recipients, and survivors with other racial identities represent 15.7% of other service recipients. In FY20, Black/African American survivors are more highly represented in service categories “transportation” and “information and referral” support, and less represented in categories including “medical care”, “legal assistance”, and “counseling.” Hispanic/Latinx survivors are more highly represented in child focused categories, “medical care,” and “support group,” and are less represented in orientation focused categories and “medical accompaniment.” White survivors are highly represented in “medical accompaniment,” “orientation,” “information and referral,” and “counseling” categories, while they are less represented in child focused, “transportation,” and “medical care.’ Survivors in

other race/ethnicity categories are more represented in “child services” and less represented in “information and referral services.”

Table 10. FY20 Service Categories Percentage by Racial/Ethnic Group

	Black/ AA (12.8)	**Hispanic/ Latinx (41.5)**	**White (29.8)**	**Other (15.7)**	**% of total services coded as this category in FY 2020**
Family Violence Option	17%	44%	23%	17%	>1%
Emergency Orientation	13%	31%	48%	8%	>1%
Educational Arrangement for Children	14%	68%	9%	8%	>1%
Child Services	14%	52%	14%	20%	4%
Child Recreation	13%	62%	17%	8%	1%
Transportation	19%	49%	19%	12%	1%
Medical Care	9%	64%	19%	8%	>1%
Medical Accompaniment	15%	30%	44%	11%	>1%
Intervention Services	15%	46%	29%	10%	27%
Information & Referral-Community Services	17%	42%	33%	7%	19%
Information & Referral-Employment	18%	40%	36%	6%	3%
Legal Assistance	9%	45%	31%	15%	11%
Support Group	11%	56%	21%	12%	6%
Orientation	13%	33%	36%	17%	14%
Counseling	7%	42%	34%	16%	11%

As described in table 11, in FY21, Black/African American survivors comprised 13.6% of service recipients, Hispanic/Latinx survivors comprise 44.8% of service recipients, White survivors comprise 27.6% of service recipients, and survivors with other racial identities represent 13.9% of other service recipients. Black/African American survivors are more represented in service categories for “child recreation,” “transportation” and “information and referral” support, and less represented in categories including “medical care,” “legal assistance”, and “counseling”. Hispanic/Latinx survivors are more highly represented in “child services,” “transportation,” “medical care,” and “support group,” and are less represented in orientation focused categories and “child recreation.” White survivors are highly represented in “medical

accompaniment," "orientation," "information and referral," and "counseling" categories, while they are less represented in "child services," "transportation," and "medical care." Survivors in other race/ethnicity categories are highly represented in "child recreation," and less represented in "medical care," "intervention services," and "information and referral" categories.

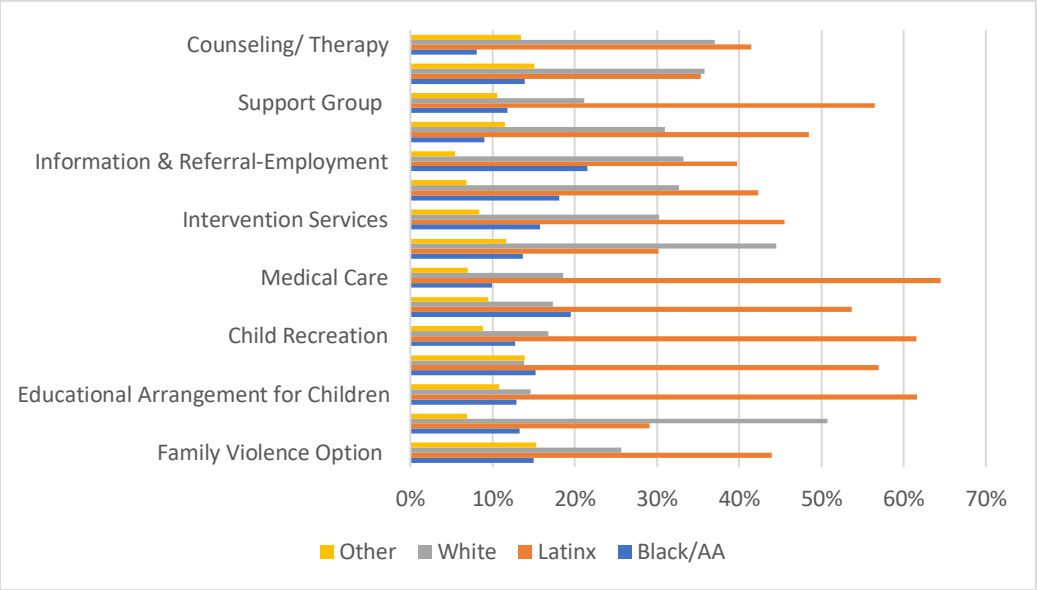
Table 11. FY21 Service Categories Percentage by Racial/Ethnic Group

	Black/AA (13.6)	Hispanic/ Latinx (44.8)	White (27.6)	Other (13.9)	**% of total services coded as this category in FY 2021**
Family Violence Option	13%	46%	23%	18%	>1%
Emergency Orientation	14%	29%	50%	6%	>1%
Educational Arrangement for Children	12%	49%	23%	16%	>1%
Child Services	17%	64%	12%	8%	3%
Child Recreation	21%	28%	30%	21%	>1%
Transportation	23%	53%	13%	11%	>1%
Medical Care	9%	66%	18%	7%	1%
Medical Accompaniment	13%	36%	39%	13%	>1%
Intervention Services	16%	48%	28%	8%	28%
Information & Referral-Community Services	19%	44%	31%	7%	20%
Information & Referral-Employment	24%	46%	24%	6%	3%
Legal Assistance	10%	47%	32%	11%	11%
Support Group	15%	53%	21%	11%	5%
Orientation	14%	36%	32%	17%	16%
Counseling	9%	38%	37%	15%	10%

Figure 2 (below) illustrates the percentage of service recipients for each service category by race/ethnicity using data from all three years. It underscores that the trends witnessed in the year-on-year data are generally stable, with Hispanic/Latinx survivors comprising the plurality of all service recipients, including the highest percentage of recipients in all categories except "orientation," "emergency orientation", and "medical accompaniment." White survivors are over-represented as a portion of their service use in both orientation categories. Compared to the other service categories, Black/African American survivors receive

a higher percentage of information and referral and transportation services compared to their overall service use percentage, while Black/African American survivors receive a lower percentage of "counseling" and "legal assistance."

Figure 2. Total (3 Year) Service Categories Percentage by Race/Ethnicity



Trends in Service Use Considering Gender. Clients (adults and children) who identified as female received the vast majority of all FV services in all three FYs (see table 12). Over 80% of services are provided to female identified clients across the three years, with just over fifteen percent provided to clients identified as male, and less than 1% identified as 'additional' in this dataset. Only 28 agencies in FY20 (out of 84) reported serving any survivors with an 'additional' gender identity. The number of services provided to male identified clients decreased slightly from FY19-21. These numbers are inclusive of all ages served, and include children, who likely make up a significant portion of males served.

Table 12. Unduplicated Non-residential Clients by FY and Reported Gender

Gender: Unduplicated Non-residential Clients	FY19		FY20		FY21	
	n	%	n	%	n	%
Female	38134	82%	36990	83%	37104	84%
Male	7873	17%	7188	16%	6914	16%
Additional	84		90		84	
Refused	9		10		9	
Unknown	193		171		78	

Trends in Service Use Considering Language. In FYs 2019-2021, residential and non-residential services were provided to survivors in all 14 languages indicate by HHSC, and a range of languages categories in this dataset as 'other.' The largest percentage of survivors were provided services in English (80.4%) and Spanish (15.4%). See table 13 for complete language counts by year. Importantly, the category 'other' comprised the third most frequently endorsed language in all three years, suggesting the need for additional categories to capture the diversity of languages.

Table 13: Residential and Non-residential Clients Served by Language

Language: Unduplicated Residential and Non-residential Clients	FY19	FY20	FY21
American Sign Language	54	56	38
Arabic	120	159	186
Cantonese	0	2	3
Chinese	54	43	45
English	57884	51606	50565
French	33	50	52
German	4	3	6
Italian	1	0	1
Korean	21	16	14
Russian	20	26	25
Spanish	10704	9766	10151
Tagalog	3	5	8
Urdu	32	107	114
Vietnamese	55	59	44
Other	2755	2730	1544

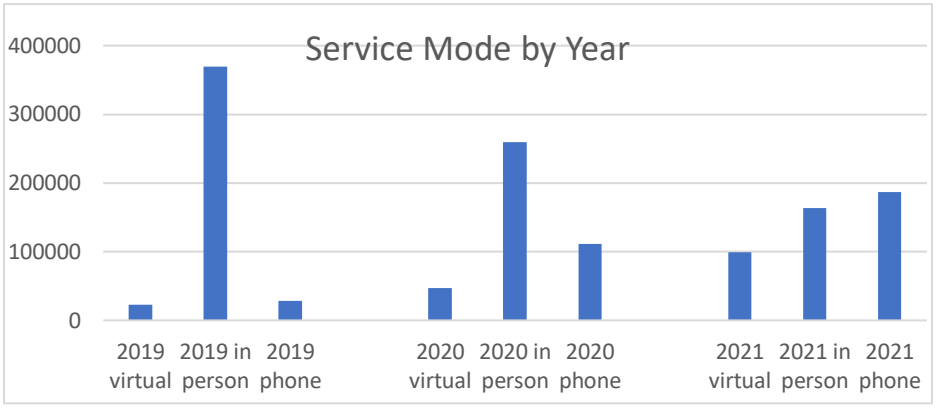
Trends in Service Use Considering Age. Adults between 18 & 64 comprise the largest group of non-residential service recipients (71.4%), with children 0-17 comprising 26.0% and adults aged 65+ comprising 1.4%. In FY19, youth aged 0-17 made up 28% of unduplicated services, while that dropped to 25.7% and 23.8% in FY20 and FY21. Adults aged 18-64 made up 69.6% (FY19), 70.8% (FY20), and 73.8% (FY21) of clients over the three years, with those over 65 making up 1.4% (FY19), 1.5% (FY20), and 1.4% (FY21) of clients over the three-year period. For comparison, adults 65 and over comprise 12.5% of Texans based on U.S. Census data, indicating that this group is underrepresented in services as a portion of the Texas population (U.S. Census, 2022). See table 14 for more information. There has also been a significant drop in children served by FV agencies, with a decrease in the number of individuals under 18 served from 13,170 in FY19 to 10,529 in FY21.

Table 14. **Non-residential Services by Client** *Age*

Age: Unduplicated Non-residential Clients	FY19	FY20	FY21
Age: 0-17	13170	11428	10529
Age: 18-64	32239	31459	32623
Age 65+	670	670	635
Refused	9	20	19
Unknown	115	593	233
Unknown Child	14	25	25
Unknown Adult	76	254	125

Trends in Service Use Considering Service Delivery Modality. The pandemic brought on a significant shift in service provision, as well as changes in availability of funding for virtual and phone services. Data demonstrate a substantial shift in services toward virtual, and phone-based services in FY20 and FY21, though the FY19 virtual data service provision is likely undercounted because it was an unfunded service modality at the time. See figure 3, which represents a count of each service type by modality by year.

Figure 3. Service Mode by Year[30]



Hotline Service Use Trends. Hotline represents a critical access point for FV services in Texas. Hotline data for HHSC-funded FV agencies were analyzed for FY19, 20, and 21. Categories of hotline calls and mean number of calls per month per agency over the three included years are found in table 15.

Table 15. Hotline Call Categories[31]

Shelter Denial Focused Calls Categories (Reason for Denial or Referral)	Mean Calls Per Agency Per Month Across FY19-21
Hotline Call - Seeking Shelter: Denied due to lack of space	17.21
Hotline Call - Seeking Shelter: Denied for other reasons	10.69
Hotline Call - Seeking Shelter: Referrals to another FV shelter	5.64
Hotline Call - Seeking Shelter: Referrals to temporary shelter due to lack of space	10.28
Family Violence Focused Calls Category	Mean Calls Per Agency Per Month Across FY19-21
Calls About Family Violence[32]	194.69

Figure 4 depicts changes over time for calls focused on shelter denials and on giving referrals to shelters elsewhere in FY19, 20 and 21. Data reflect the combined monthly totals for all calls in categories beginning with Hotline Call – Seeking Shelter: Denials or Referrals to other shelters. Trends in calls seeking shelter (denials and referrals to other shelters) over three

[30] In these data, a survivor receiving intervention services and counseling in person in one year is counted twice as 'in person' that year
[31] These are the categories that are currently tracked by HHSC-funded FV agencies for HHSC reporting purposes. These categories do not reflect any referrals given or focus on non-residential services.
[32] If a hotline caller is accepted into shelter, those calls are categorized under "calls about family violence."

years demonstrate increases in these calls during summer months with the highest level of these calls coming in late summer 2019, with an average of 57 calls per agency in September of 2019. In other words, in summer months, shelters had to turn away more families, most likely due to capacity issues. A precipitous drop in calls resulting in a denial or a referral to another shelter occurred at the outset of the COVID-19 pandemic, with these calls not reaching previous highs through the end of the data range (August 2021), meaning that shelters were not facing capacity issues at the beginning of COVID during lockdowns. See figure 4 for the mean (average) number of calls related to shelter denials and to referrals to other shelter per month over the three-year reporting window.

Figure 4. Average Seeking Shelter: Denials and Referrals to other shelters Hotline Calls per Program FY19 – FY21

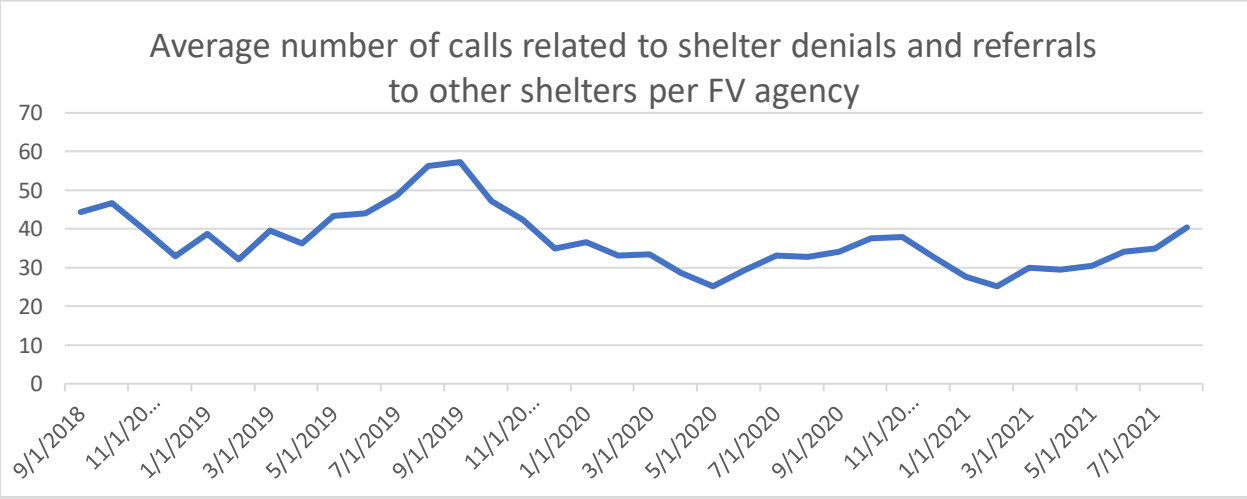
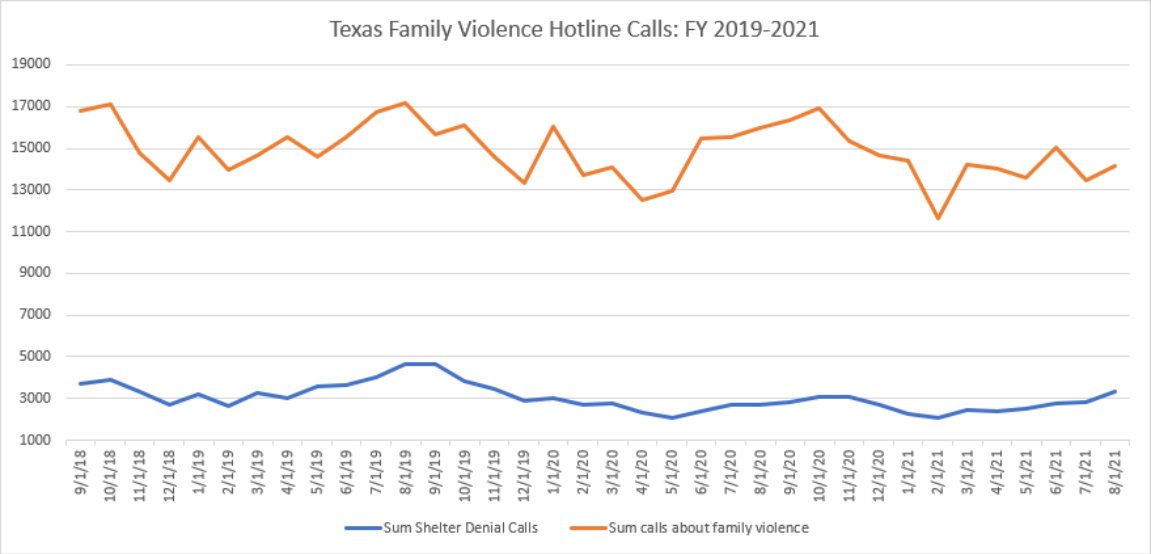


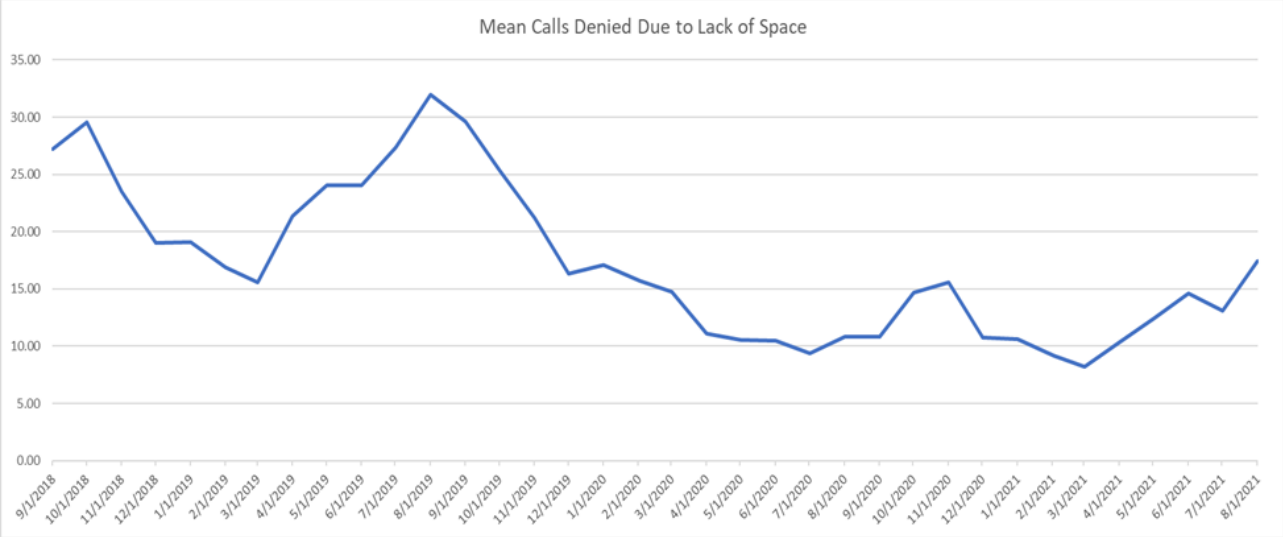
Figure 5 depicts the total calls per month for shelter denial or referral to other shelters compared to other family violence related calls (which includes those accepted into shelter).

Figure 5. Total Texas Family Violence Hotline Calls Per Month FY19-FY21



Finally, Figure 6 illustrates the mean number of calls specifically categorized as being hotline calls that were focused on seeking shelter and were denied due to lack of space. In the window of time under investigation (FY19 – FY21), there were more calls that were categorized as denied due to lack of space in the period before March 2020 than after, with the largest mean number of calls in this category being in September (mean = 27.2) and October (mean = 29.6) of 2018 and July (mean = 27.4), August (mean = 32) and September (mean = 29.6) of 2019.

Figure 6. Mean Calls Denied Due to Lack of Space Per Month FY19-FY21



For the vast majority of survivors using non-residential services, hotline is the first service interaction they will have with a local agency. One staff member shared the important role of hotline for non-residential clients: "*...we receive a lot of <hotline> calls of clients that for many reasons are not ready for shelter services, but definitely they are a good fit for our program*, "she went on to say, *"Then we refer them to our non-residential facility that they can come during business hours just to apply, explore*." (Staff 19). Interview participants reported that the interaction on the hotline, especially when warm and welcoming, established initial comfort with the agency and provided an orientation to service availability and access. Hotline as the "front door" of services means that staff working in these FV agencies often interact with clients and assess their needs, referring them to programs within an agency that may help them. In the vignette below, the critical role of hotline work is shared through the story of Lori.

Staff Vignette 1: The Central Role of Hotline Services.
Lori (she, her) has been working as a hotline advocate at the front desk of Safe Center's outreach office for about one year. While she is 25 and new to domestic violence work, she has worked other places with people who have experienced trauma and domestic violence -- as a receptionist at private therapist office and a case aide in a juvenile detention center. She has always enjoyed helping people.
Lori loves the high paced juggle of her work. She loves the challenge of going from general phones calls, like people wanting to donate clothing and furniture, to crisis phone calls from survivors needing immediate safety planning, and then again to someone who just wants to talk which "*is really tricky, because it's like when someone is calling and they just wanna talk, you just wanna listen to them.*" At work, she handles a constant stream of other needs, including greeting those coming in for counseling and advocacy appointments and helping walk-in clients. Luckily, if a caller is "*suicidal or they're in a really, really unsafe situation"* she can send them directly to the counselor on call. She is also in charge of checking the crisis emails that people send through their agency's website and messages that people post on the Center's Facebook page. She sends those messages to one of the non-residential advocates for follow up. She speaks a little Spanish but can transfer Spanish-speaking callers to a bilingual advocate if she needs back up. She has used the Language Line a couple of times for other languages, but some callers had hung up before she could get the Language Line on the phone. At night, on the weekends and when she is on her lunch break, the hotline is routed to their shelter.
Lori feels a lot of responsibility in her job, and that can be hard sometimes. "*I control the traffic of all of that because I take in all of the phone calls, and I direct people to where they need to go. I also am the first face that clients see when they come in.*" She knows that she is the gatekeeper – that first connection for someone reaching out for help. Young people who call often ask if she can text them a resource or information; but unfortunately, they do not have that capability at her agency yet. Lori hopes they can do that in the future, but also knows that she is already juggling a lot of tasks and responsibilities already. About half of their calls from survivors are people looking for shelter, and half are needing other supports, like counseling, safety planning, or other housing options. Housing is the hardest because in her community there are very few housing resources. Shelter and counseling often have waiting lists – so she is constantly providing referrals to other organizations that may or may not be able to help survivors in her community. Lori keeps an ever-changing binder full of community resources, constantly updating them based on feedback that callers and other advocates give her. Sometimes things change faster than she can keep up with. Occasionally, callers can be really frustrated when referrals that Lori provides don't work out. As the first person at the agency that folks talk with, people sometimes unload a lot of frustration and hurt on her. That can be painful for Lori, but it helps to be able to check in with her supervisor when they meet every week. Lori reflects on her challenging; but rewarding job, "*I feel like my purpose is to make them feel welcome, make them feel brave enough to take that step, give them options, let them know. I mean, even if not here, there are other places you can go."*

The Context of Non-residential FV Services in Texas

To understand the local contexts of agencies included in the HHSC service use data, the team compiled county-level[33] indicators for the 85 agencies included in the HHSC data. These county-level indicators from the U.S. Census and Eviction Lab were merged with agency level participant and service use indicators to gain greater perspective on the context of non-residential

[33] For agencies with offices in multiple counties, the county in which the agency is headquartered was used.

family violence services in Texas. Across the four racial/ethnic groups that the study is powered to examine[34], higher numbers of survivors served in local agencies was moderately to strongly correlated with the percentage of county residents in that racial/ethnic group (Black/African American, r = .33, p =.00; Hispanic/Latinx, r = .51, p =.00; White r =.22, p =.04; Asian r = .38, p = .00), providing some initial evidence that agencies are serving a survivor population that reflects the counties they serve.[35] To look at services availability across setting and levels of economic need, correlations between county indicators for percentage of the county counted as urban and percentage of county residents living at or below the federal poverty level, were run with counts of survivors receiving services under each of the HHSC service codes. There were no significant correlations observed between the number of survivors served by agencies in each of the service categories and the percentage of individuals in the agency headquarters' county living in poverty. In other words, the extent of poverty in communities is not linked to the number of survivors receiving any specific type of service. Two significant correlations were observed between number of survivors receiving certain services and the percent of an agency's home county that is classified as urban. Both support group services (r = 26, p = .02) and counseling services (r = .31, p = .00) were positively correlated with county percent urban. This means that as counties are more urban, there are more survivors receiving counseling and support group services.

[34] Black/African American, Hispanic/Latinx, White/Non-Hispanic, Asian
[35] This should be seen as a global measure, speaking to service providers across Texas as a whole, rather than reflecting realities in any specific agency.

Section 2: The Family Violence Service Model

The Needs of Survivors

To build on a picture of statewide trends from HHSC data, the evaluation team used a variety of data sources to understand Texas survivor-expressed needs when engaging in non-residential services. These needs provided the basis for a survivor-centered model of services for FV agencies. From interviews and surveys, several domains of needs were developed, including economic, health, legal and regulatory, child-related, and environmental.

Economic

Most survivors using FV services have economic needs related to financial forms of IPV, experiences of poverty, and lack of community resources, living wages, affordable housing, and education/training options. Survivors who participated in the TCSS shared their current housing and economic situations (see table 16). Over 80% of survey participants are making under $2000 a month. For reference, the federal poverty guideline for a family of four is $27,750 (ASPE, 2022), or $2,312.50 a month, indicating high levels of economic needs. Interview and survey participants expanded on economic conditions, describing needs related to job training, employment options, childcare, securing government benefits, and direct financial support. Virtually all staff and survivors who participated in interviews and survey expressed that survivors need access to tools for financial stability. For example, one survey participant shared they needed "*financial help to get a job to make money for my family*." Transportation was also an economic need for non-residential survivors, with 26% of participants indicating insecure transportation access. A staff member shared a common economic problem for survivors is a "...*lack of transportation for sure, especially in these rural areas. We don't even have Uber. You just don't have it*." One survey participant summarized their main need as "*funds for gas or gas gift cards.*"

The most frequent economic need, along with direct financial assistance, was housing. Most survey and interview participants needed help with housing, including keeping existing housing, and staff interviewed overwhelmingly ranked it as a top need.

> Yeah, I feel like mostly housing and rental assistance is probably the biggest strike because they've either left their abuser or they're in the home and the abuser is out of the home, but they have one income and or maybe they don't have any income at all. Maybe they haven't worked in years and they've been a stay-at-home mom. So, or maybe, you know, they've been isolated, so they haven't been able to work or have that education to start a job, right? So definitely, housing, and rental assistance is the biggest one. (Staff 5).

While some non-residential clients may have stable housing, many are experiencing housing insecurity and homelessness. One survivor described this need.

> My main needs right now is to find a place. I'm strugglin' with that right now because everything is so expensive and to move into a new place you gotta have the rent, you gotta have a deposit. There're so many extra fees and so that's the kicker right now. I'm getting' ready to pick up a second job to try to help make that happen pretty quick 'cause I want that to happen quick and so—so I can just get back to myself, get back on track. I'm pickin' up an extra job to get the finances to do it. (Survivor 26).

Another survivor shared how her financial situation might keep her from safer housing. "*Well, I'm just tryin' to get out. Again, I work at McDonald's, and I'm a provider. I'm probably gonna lose that provider job, but I don't know if McDonald's is gonna be enough to pay for water, gas, and rent."* (Survivor 9). Economic needs were interwoven with addressing safety and health concerns for survivors, making them among the most pressing issues for non-residential FV clients.

Table 16. Economic Demographics of TCSS Participants

Economic Demographics	**N**	**%**
What best describes your current housing situation?		
Home/apartment/condo owned by myself	11	13%
Home/apartment/condo rented by myself	39	48%
Home/apartment/condo using a housing voucher	6	7%
Staying/living with a friend or family member	19	23%
Other	7	8%

What is your current employment status?	N	%
Employed full time (about 40 hours)	16	20%
Employed, seasonally/occasionally	4	5%
Employed working less than 40 hours	16	20%
Employed working more than 40 hours	10	12%
Not employed, caregiving	5	6%
Not employed, looking for work	23	28%
Other (Retired, not looking)	2	2%
Waiting on permission to work	6	7%
What is your current monthly income from all sources		
Less than $500	23	28%
$501-1000	21	26%
1001-2000	22	27%
2001-3000	5	6%
3001-4000	5	6%
4001-5000	3	4%
5000 or more	2	2%
Thinking about where you currently live, do you have your own reliable transportation or have access to reliable transportation to get where you need to go?		
Always	47	57%
Frequently	15	18%
Sometimes	10	12%
Rarely	3	4%
Never	8	10%

Health

Impacts from abuse and trauma contributed to significant health needs for survivors, which has been compounded by isolation due to FV and a lack of access to care. One survivor shared their need for support to address mental health issues. "*I needed someone to talk to, to get out of that. Sometimes I needed support. Other times I was having severe anxiety. Other times I was a complete mess, and I just needed someone to advise me on the directions to take*." (Survivor 11). Survivors reported a range of mental and physical health issues, including sleep problems, chronic pain, diabetes, depression, anxiety, gynecological issues, heart conditions and

cancer. Table 17 displays TCSS participants self-reported health related needs. Nearly 20% of participants do not have access to affordable food they like in their neighborhoods, and nearly half do not currently have health insurance (46%), with only 30% reporting being regularly able to pay for needed prescription medications. TCSS participants also completed a set of validated mental health assessments, including the PHQ-15 (Kroenke et al, 2002), which assesses somatic symptoms related to depression, the PHQ-9 (Kroenke, 2001) which assesses depression symptomology, and the PCL-5 (Prins et al, 2015) which screens for PTSD symptomology. Eighty-eight percent (88%) of participants had at least mild somatic symptoms as measured by the PHQ-15, with over 40% meeting the previously established threshold for severe somatic symptoms. Sixty-nine percent (69%) of participants had at least mild depression symptoms, with 22% meeting the pre-established threshold for severe depression. Finally, 54% of participants endorsed 4 or 5 items on the PCL, indicating a positive screen for probable PTSD. These results indicate a high likelihood of mental health care needs, which many participants shared are inaccessible in their area.

Interview participants further described the lack of access to counseling services, especially in rural areas where significant geographic distance and transportation insecurity threatened healthcare access.

> There's a big need in the rural areas for, you know, more mental health that's readily available. So, where they don't have to be picked up by a bus that says, you know, MHMR on the side. And also, substance abuse, that is a big, big challenge in the rural areas that we have. (Staff 9).

Even when mental health services exist, staff report it is lacking in the ability to meet survivor needs. "*Oftentimes, if they're needing that mental health agency, they need something more than just our counselor. That mental health agency currently doesn't have a counselor. All they're doing is medication*." (Staff 12). Overwhelmingly survivors want support with physical and

mental health issues related to family violence, but lack the support, information, and finances to access these services. See table 17 for more information about health impacts.

Table 17. Participant Self-Reported Health Impacts

Health Indicators		%
Do you have regular access to affordable food you like to eat in your neighborhood?	Yes	81%
	No	19%
Do you currently have health insurance?	Yes	54%
	No	46%
Are you able to comfortably pay for prescription medications you need for your health?	Yes	30%
	Sometimes	34%
	No	36%
Have you been diagnosed with any disability, impairment, or mental health condition?	Yes	34%
	No	66%

Legal and Regulatory Systems

Staff and survivors expressed a range of legal needs related to family violence, including civil legal remedies like custody, divorce, protective orders, and eviction-related proceedings, as well as criminal-related needs such as support with representation for a pending case. Additionally, many survivors are engaged in the child welfare system, often related to FV experiences, and need support to understand their rights and to comply with Child Protective Services (CPS)-related requirements. Staff accompanied survivors to CPS court cases, provide classes to meet CPS requirements, assist survivors in meeting the requirements of their CPS service plans and help them navigate that system (Wood et al, 2021). As one survivor shared, "g*etting somebody to talk to, to handle the CPS nonsense* [was] *essential."* (Survivor 3). For survivors coming from other countries and cultural backgrounds, needs include information on U.S. immigration and legal systems.

> I'm Asian. Me coming here is because of my spouse. I am co-dependent my spouse. I didn't know anything about it because this is the first time I've been to the United States. Everything is new. When I have gone through the things which I have gone through, it was like I was very helpless. I don't have any options. (Survivor 10).

Some participants had tried to access other legal services before reaching out to FV agencies and experienced significant obstacles.

> When you're in that position, and you're having to contact other organizations, it's not really easy 'cause you're already in a lot of stress and a lot of pressure coming out of it. I don't know. All of us have different feelings when we're out of the situation like that. You wouldn't be as comfortable to talk to too many people to explain your situation 'cause when you approach them, even for legally, they do ask you many questions about how you were in that position. You have to go over and over with that, explaining your story and all that. It's emotionally really traumatizing at that point because you're just out of the situation, and you're having to tell that over and over to people, explaining that. (Survivor 15).

Legal needs, especially related to children and immigration, were primary concerns for survivors, but even in communities with legal aid and other low-income civil legal services, program accessibility and wait times remain a pressing issue.

Child-related Needs

Many non-residential FV clients have minor or adult children with needs related to violence, abuse, and harm. For minor children, survivors shared the need for youth counseling to address trauma symptoms and behavior concerns, and development activities, and family recreation to promote growth and joy. One survivor shared her experience trying to get counseling for her child, "*Well, I asked for the therapy* <for my child>. *When I asked, they say, "It's only for you."* (Survivor 14). The most frequently shared child related need is childcare, which in many communities is unaffordable, inaccessible, or even unavailable. One survey participant shared their main need was "*Childcare services are the urgent need for the mom who is already suffering emotionally and physically.*" Staff also shared in interviews about the need for emergency and onsite childcare for non-residential clients to access FV services, be able to

go to health and social service appointments, and to pursue job opportunities. Staff expanded about the lack of available childcare in their communities:

> There's one small daycare that sometimes can take kids, but most of our clients have had to find private individuals that will take a couple of kids in their home or a family member that will take care of their kids. Some of them have had to quit their jobs or change their schedule, take less hours, because they had to be home for their kids. (Staff 15).

Child-related needs, especially for those with minor children in need of care, interlaced with economic and legal needs for many survivors accessing non-residential services. Survivors consistently reported that addressing the needs of their children is a top priority when seeking non-residential services.

Inclusive and Safe Environment

Finally, survivors and staff also emphasized the need for low-barrier access to an inclusive environment when coming to FV services. An inclusive environment means that initial access to services is welcoming, timely, and focused on addressing immediate needs. Some participants noted the lack of counseling and legal services on evenings and weekends made it difficult for them to participate in services. Many survivors reported needing help outside of the criminal justice system or CPS, viewing FV services as safer and less judgmental space for support. Waiting lists for services like legal representation and counseling create barriers to an inclusive environment. Service availability in the language of choice and modality (in-person, virtual, phone) also signals safety and inclusion. Access to consistent bilingual (English and Spanish) services is a significant need for many FV non-residential programs. One staff member noted: "*we have seen a need these last few years, and we're having a hard time meeting it, is bilingual services, even if they're nearby or another service, free counseling services that are bilingual*," they explained the access issues, "*we're seeing a real need for, or either the parent's*

bilingual and the kid or the parent speaks Spanish, but the child speaks English, that we would update the parent or talk to them. Right?" (Staff 26). In the case vignette below, the needs and barriers of inaccessible and not-inclusive services are highlighted through Xochitl's story.

Survivor Vignette 1: The Need for Culturally Inclusive Services

Xochitl (she/her) knew she needed to talk to someone about the stomach aches, headaches, and nightmares she was experiencing after years of abuse. Two years ago, she left her ex-husband, Raul; but after recently being evicted when she lost her job, she decided to move back in with their 16-year-old son, Matías, to Raul's apartment and get back together with Raul. Soon though the verbal abuse from Raul and his controlling behavior, like not letting her get a job, escalated again and she was not sure if she could stay. Matías pleaded with her to try to make it work, "*If you leave, it's just gonna mess up everything. Everyone's gonna be upset. We're not gonna manage. Don't worry about it. We can get you counselling, and you'll be fine*."

She had tried to reach out to a couple of resources, but she was just put on hold for long periods of time at the places she called. She wondered if it was because she spoke in Spanish when she called. Finally, a friend told her that Hope Services, was a place where she could talk to someone, and she decided to walk in there to get help. When she walked in, the person at the front only knew a few words in Spanish; however, Xochitl could speak a little English, so she asked about counseling. She was told they didn't have a Spanish speaking counselor available but did have a counseling opening with an English-speaking therapist. She was scared at first, but she tried to make it work. It was hard. She felt like there were cultural barriers on top of the language ones – like the therapist minimizing the abuse she experienced as a product of her culture's machismo. Xochitl was frustrated with this and vented to her friend, *"When they don't get that* [our culture] *or don't speak our language, it makes it more difficult for both of us. We need to be understood in more ways than one."* She also felt that her therapist sometimes blamed her Catholic religion and Mexican culture for the abuse and didn't see the strength that her religion and culture provided her – "*I don't feel that the religion is the problem*!"

At first Xochitl's therapist kept talking with her about how she needed to plan to leave her relationship; when Xochitl explained she was not wanting to leave, the therapist seemed to shut down and not really offer much help. "*I remember her telling me,* '*We can't do anything about those issues. You can't get a job. You can't do this. You can't do that. Just try focusing on other things.' What I needed her to do was help me with those things that I can't do. That is what I need help.*" She felt alone both at home and when getting counseling. Once, when Xochitl was waiting for an appointment with her therapist, she started talking to another survivor at Hope Services. Maria also spoke Spanish, and they had a lot in common. Maria told Xochitl about an immigration lawyer who was really good with U-Visa cases, and immediately understood all the ways Xochitl was working to keep her family safe. That conversation meant so much to Xochitl, she often wishes she could have that kind of connection with other women in her same situation more often and wishes that Hope Services offered some sort of way to do that. She also wished there were a counselor who understood her culture and spoke her language.

Building a Non-Residential Service Model for Texas Family Violence Programs

Based on our understanding of the current landscape of services, and the needs of survivors, we assessed the existing Chapter 51 framework for elements that were missing, incomplete or lacking attention to adaptation and diversity. Below, missing elements of 51 are outlined.

Services Missing from Chapter 51

While program staff did not want additional data management burdens, staff interview participants shared several services frequently provided by FV agencies that are not clearly represented in Chapter 51. These services are outlined below.

Safety Planning. Safety planning is a discrete skillset that staff use for program goals that was perceived to be one of the most important services offered; but one that is minimized in the current definitions of services under Chapter 51. Staff interview participants report safety planning is typically captured under "hotline" or "intervention service" data indicators and is defined as a specific type of "intervention services" in Chapter 51. Staff expressed that a large portion of their work is related to safety planning and mitigating safety risks, including risks when engaging with legal and regulatory systems such as legal, CPS, child support, and public benefits. Safety planning is especially central to hotline, where "*the main goal is to ensure safety in that moment."* (Staff 19). However, in the current framework, there is not enough focus on safety planning in Chapter 51 relative to its central role. One staff shared, "*I think it might be helpful for* <funders> *to know the amount of time that is spent addressing the safety in a crisis*." (Staff 15). Staff emphasized safety planning work needs to become broader and more inclusive of the diversity of situations survivors are in-it is not as easy as "just leave." There is an underlining assumption through many programs that the ultimate goal is for the survivor in non-

residential services to leave that relationship and potentially come into their housing/shelter services. The emphasis on leaving as the ultimate safety plan reduces the potential impact of services on survivors who remain with their partner. Staff shared survivors need more options to stay safer - whether that is staying safer in their current home or making the choice to seek other housing options. The depth and breadth of effective safety planning is currently underrepresented in Chapter 51 services.

Advocacy within Community Systems. While Chapter 51 includes community education, cooperation with DFPS and law enforcement, and resource referral, it does not have clear indicators for activities like advocating within those systems or in the greater community on behalf of individual survivors towards system-level change. Advocacy in partnership with individual survivors and systems advocacy for broader policy and practice changes in such systems as the criminal and civil legal systems, CPS, TANF/Medicaid, child support, schools, are vital activities that program staff reported in interviews doing frequently to help meet survivor needs and potential safety risks. The requirement to have "coordination" and "cooperation" with criminal legal systems is clearly outlined in Chapter 51, and several staff members shared important examples of how they work as advocates to enhance the safety of survivors as they interact with law enforcement. One staff member shared how they worked with law enforcement after a report of a negative experience from a survivor.

> I know the head of the division. I just, and fortunately we were having a meeting with the police chief and (name) was there & I said '(name), I need your help.' 'What happened here?' but 'this, this thing, I need to make sure my, my client is safe and her, her son was taken from her,' 'I need to help you with, with this,' and voila! That's systems level, policy level advocacy. (Staff 2).

Staff discussed the challenges and tensions of cooperating with systems while also needing to advocate for change and accountability in systems– both of which are needed to serve survivors.

This can lead to conflicting situations for advocates and survivors when these systems do not always seem safe for survivors to access. For example, one staff described this challenge,

> Even having coordination with law enforcement, local agencies, I mean, that can be really hard because even within a single department, there's not always a lot of communication from the top down. And so, you know, patrol officers kind of are very reactive and they have to be... And, you know, law enforcement isn't trauma informed, law enforcement isn't victim centered, law enforcement doesn't handle domestic violence great, even with the improvements that there's been. I completely understand when victims are like, I can't call 9-1-1. I'm not going to tell 'em you have to, you know, because they do get arrested when they're the true victim, they do tell them that they've clearly been assaulted and no arrest is made. You know, you can't guarantee what the outcomes are going to be. (Staff 26).

As this quote illustrates, there are times when encouraging cooperation with criminal justice officials can lead to detrimental outcomes for survivors and when barriers and challenges in that system need to be addressed.

Counseling. Counseling to address trauma and mental health needs, including both crisis, peer-led support, and clinical therapeutic supports, is a frequent service provided by FV agencies and one of the most requested services by survivors. Despite this, currently Chapter 51 does not include counseling at all except for in a broad subcategory of "understanding and support" as a part of intervention services. Most agencies had licensed counselors on staff or on contract, however there was high demand for these services and often a waitlist. As one staff member shared, "*I do have a wait list so that is a barrier."* (Staff 9). While there is the need to include counseling services in Chapter 51, it must be done with a focus on trauma-informed and culturally centered healing.

Economic/Financial Support. One of the most frequently mentioned omissions in the current Chapter 51 was flexible funding for survivor basic and financial needs, clothing, utility assistance, and medical needs. Especially for non-residential service users, financial support is

one the most powerful tools staff have to increase survivor safety and stability. As one survivor shared,

> They helped with a gift card also for gas. Recently, actually just last week I believe, or two weeks ago, they just enrolled me to help me with the bills for the next I believe three months, I wanna say, three or four months. That's a huge relief as well right now. (Survivor 12).

While Exceptional Item Funding (EIF) may incorporate some financial elements to FV services, the work to secure and distribute economic support, especially food, is lacking in Chapter 51. One survivor shared the importance of food access:

> they call me if I, you know, if they got food in, saying, do you need anything? Come and pick it up. Or them calling me about this. They check on me periodically if they haven't heard me, from me, for a while. They wanna make sure I'm okay. (Survivor 2).

One staff articulated this need, "*we need to have that unrestricted funding so that we can provide our survivors with all the, you know, needs that arises just when they leave the situation*." (Staff 2). Flexible funding is a key service component that is missing in Chapter 51 currently that addressed survivors expressed needs.

Housing Support. Housing offers both safety and stability to family violence survivors and is one of the most requested services. In the 2019, TCFV State Plan, the most unmet service need documented for survivors was more help looking for housing (Wood et al, 2019). Housing can be precarious for non-residential clients due to ongoing economic disparities, violence and harm and staff are constantly assisting with those concerns. For example, one staff described,

> we still see that huge need in our non-residential clients that, yes, they may have an apartment, but they need to move because the individual stalking them or the individual still attacking them in that place of living. And so, we do have other resources that can help them move or transition from that place of living. (Staff 8).

Housing support includes emergency shelter, housing vouchers, transitional housing, permanent supportive housing, and rental assistance. Housing supports, beyond emergency shelter, are

currently included as an EIF service; but are not directly mentioned in Chapter 51. Staff report that a large portion of the work with non-residential clients is to help them find or maintain their housing, whether that is a one-time rental assistance or a longer-term housing voucher. Providing a survivor with tools to get safer in a current home is a critical part of housing advocacy work, such as a doorbell camera to enhance security and safety. There is a need for more housing resources, beyond emergency shelter, for survivors accessing non-residential services at FV agencies and an acknowledgement in Chapter 51 of its importance and centrality to the work would better reflect the needs of survivors.

Health Services. Survivors present to non-residential services with a wide array of health needs, including disability, chronic pain, and traumatic brain injury (TBI). Many lack consistent access to high quality medical care. FV agencies may lack the expertise and infrastructure to provide this care directly and choose to focus on referrals and community collaborations. These efforts, despite being a central part of direct service work, are not articulated in the current service landscape. In Chapter 51, "access to emergency medical care" is listed; but this term does not translate clearly in non-residential settings. Furthermore, in non-residential settings, staff did not understand this requirement with one staff articulating, "*what do they mean by emergency medical care? Do they mean that we are to provide medical care*?" (Staff 5). The health-related support that is being provided and what is needed is much broader than access to emergency medical care and that needs to be articulated in the service framework.

Culturally Relevant and Culturally Grounded Services. Chapter 51 does not detail the need for culturally rooted and relevant services that was routinely expressed by staff and survivors interviewed for this study as critical to having inclusive and supportive survivor services. Culturally grounded service models are ones where survivors from those communities

felt understood, received language justice[36], and had their needs met in a way that was rooted in their cultural identity. While some Texas FV agencies focus on culturally specific programming for targeted populations, virtually all agencies benefit from a focus on inclusive and relevant services. One staff shared that "*We need to talk about the cultural responsiveness and incorporate it in all the services."* (Staff 2). Staff discussed the need to reflect on

> "Who are we missing?" "Who are we missing, who is not represented here?" right? Then, "Where are they, and how can we find them, and how can we get them the information that they need?" and that's through the collaborative model that we have on our team—which is very diverse. (Staff 30).

Chapter 51 should address and support this need for services and programs that are culturally rooted and responsive.

The Need for a Service Model

Chapter 51 does not detail a specific service approach or model, but instead is more of an inventory of specific services that must be provided by FV agencies. This absence of an overarching service model can lead to confusion and inconsistency within FV agencies and services related to Chapter 51. Our findings indicate staff and survivors' needs would be better met if Chapter 51 were to be revised to include as a guiding document that articulates a service approach framework for the funding of services, outlining broad service domains that are survivor-centered and high impact. The service model-focused approach would be grounded in promising and evidence-based practices and center Texan survivors' expressed needs. It also must be paired with measurable constructs to evaluate quality and efficacy. This service approach needs to identify domains of services in broad terms without being overly prescriptive,

[36] The American Bar Association defines language justice as "an evolving framework based on the notion of respecting every individual's fundamental language rights—to be able to communicate, understand, and be understood in the language in which they prefer and feel most articulate and powerful." https://www.americanbar.org/groups/young_lawyers/projects/disaster-legal-services/language-justice-during-covid-19/#:~:text=What%20is%20language%20justice%3F,feel%20most%20articulate%20and%20powerful

allowing for variation across geographic, demographic, and survivor specific needs and preferences.

Principles and Service Domains for a Non-Residential Service Model

Based in findings from this project that Chapter 51 lacks a service model guidance, data from this project and previous projects, along with best practices from the family violence field were used to create principles of the overall service approach to inform the creation of the non-residential service logic model. Many of these are tenets that family violence services have been grounded in since their inception and most have been codified into state and federal laws and administrative rules. In table 18, we list six defining principles of a Texas best practice non-residential FV service model as identified through project activities.

Table 18: Overarching Service Approach: Principles of Texas best practice FV service model

Key Principles	Brief Definition
1. Survivor-centered	*Survivor-centered* refers to the principle that all survivors should be able to make their own decisions and exert control over their life choices.
2. Focused on Dismantling Systemic Oppression	*Dismantling systemic oppression* through practices and policy advocacy that create healthy and safe communities and reduce the burden of the intersection of violence and abuse with all other forms of oppression, including racism, classism, sexism, heterosexism, xenophobia, transphobia.
3. Low barrier (accessible)	*Low-barrier* services are accessible with minimal wait and across modalities (phone, virtual, in person, mobile) and regardless of relationship status.
4. Culturally Responsive	Texas is diverse and survivors' needs can vary based on their access to resources and access to power connected to their culture, language, gender, sexuality, abilities, their personal circumstances, and intersectional identities. Equitable responses strive to tailor responses based on this diversity of needs and create culturally responsive services and programs comprised of staff from those diverse cultures to meet these needs.
5. Trauma-Informed	A *trauma-informed* approach moves away from a punitive pathology model to one that is aware of the impact of traumatic life events. The Center for Disease Control and Substance Abuse and Mental Health Services Administration (SAMHSA)'s defines trauma-informed as having six principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment voice and choice and addressing cultural, historical and gender issues (CDC, 2020).
6. Confidential	*Confidentiality* is paramount to survivors' and codified in federal law (FVPSA, U.S.C.). In Texas, interactions between advocates and survivors are further codified as privileged (Texas Family Code, § 93).
7. Voluntary	Self-determination and autonomy are fundamental principles in service provision for survivors and are actualized through choice and the voluntary nature of FV services. *Voluntary services* are codified in federal law (FVPSA, U.S.C.) which states that survivors cannot be required to participate in any FV service.

Core Service Domains. From project activities, the team developed a complementary list of core services based in a voluntary, low-barrier, survivor-centered, trauma-informed, equity-focused, and confidential service approach. A service domain represents a collection of skills addressing survivor needs. See table 19 for an outline of core service domains.

Table 19: Core Service Domains

Service Domain	Brief Definition
Individual and System Advocacy	Individual and community support and crisis services that help survivors navigate systems, build support, and find needed resources for all aspects of their lives, includes working in macro and mezzo systems to address the survivor-defined needs.
Hotline Service	Emergency services provided over the phone or online chat, by FV staff or volunteers, and are accessible 24 hours a day, 365 days a year. Hotline support includes immediate access to empathetic support, crisis intervention, referrals, and resources.
Legal Assistance	Legal advocacy, to help survivors understand and navigate the complex criminal and civil legal systems and to assist in reaching outcomes that promote survivor safety and autonomy in those systems. Legal assistance including legal representation, when available, for survivors from a licensed attorney.
Economic Support	Flexible assistance to address a diversity of economic needs such as groceries, clothing, school supplies, utility bills, childcare, car repairs, and immigration legal fees.
Housing Support	Assistance and advocacy with obtaining and maintaining safe, permanent housing, including one-time or ongoing rental assistance or deposits, help obtaining housing vouchers, assistance with such housing costs as utility deposits, advocacy with landlords or connection to housing attorneys.
Peer and social connections	Peer-led (survivor-led) support groups, hiring survivors as staff, linking survivors with new and previously ruptured social contacts, and setting up opportunities for survivors to support and mentor each other with a goal of reducing isolation and increasing positive social networks.
Health and Mental Health Support	Support for survivors' physical health needs through education, services, resources, and referrals. Counseling, both peer support and clinical therapy; somatic healing; alternative healing modalities such as yoga, mindfulness; trauma-focused techniques; connection to psychiatric care and more traditional talk therapies. Clinical therapy with licensed counselors, social workers, and psychologists.
Prevention	Actions and services striving to end violence or future acts of violence on several levels, the tertiary level (improving service impact), secondary level (helping prevent more violence from occurring), primary level (improving conditions to stop violence from happening in the first place). This may include school and community-based classes.
Child Advocacy	Advocacy to address the needs of survivors' children, including emotional support and counseling, after school activities, support enrolling in children in school, help with childcare, and advocacy around children's' safety and academic needs.
Safety Planning and Crisis Support	Ongoing and individualized survivor-led process to address potential risks, safety concerns and threats in survivors' lives. It can address safety threats at the interpersonal level (about a current or former partner); community level (neighborhood safety) or systemic level (within systems such as CPS and criminal and civil legal systems).
Case Management	Individual goal setting process guiding survivors through creation of survivor-led, individualized service plans, facilitating access to resources, providing motivation to help survivors meet their self-defined goals and education.

Family Violence Non-Residential Service Model

From project activities, the evaluation team created a logic model that uplifts the ideals of how these principles and domains could be brought to life in service delivery, based in the best practice models being implemented across the state that were examined for this project. The overarching goal of non-residential family violence services is to improve the lives and well-being of survivors of family violence and their children through increased safety, connection, and resource access. The framework incorporates the model service approach and core domains through eight interlocking goals with matched activities and outcomes. These activities, goals, and outcomes were developed from staff and survivor interviews, secondary data analysis, a review of literature, and repeated reviews with the FV practitioner community in Texas. The logic model was further tested through the Texas Community Support Survey, where survivor input provided critical verification of outcomes. The logic model is meant to serve as a blueprint for providing services and measuring their impact within this service approach and is adaptable to individual programs. A visualization of the model is available in figure 7 and the full logic model can be found in Appendix B. In this next section, the goals for the logic model, with corresponding activities, are presented, with project data to enhance understanding of programming.

Figure 7: FV Service Model Circle

Goal: Increase Physical and Emotional Safety from Individual and Structural Harm.

The first goal of non-residential FV services is to reduce violence and increase survivor and family safety from individual and structural violence. Through program activities, survivors work in collaboration with staff to address a broad range of individual and community safety needs, which contributes to reducing and ending violence. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

On Safety Planning:
"*Safety planning with them—they do a dangerous assessment. They do a strangulation questionnaire too if they said that something like that happened in their—because we have to cover all of that."*
Staff 6

- **Intake to assess needs.** Staff work collaboratively with survivors to understand their pressing individual needs through open and closed-ended questions.

- **Crisis intervention.** Survivors and staff address pressing issues impacting physical and emotional safety with the goal of stabilization.
- **Lethality discussion(s).** Staff use tools such as the Danger Assessment[37] to assess and address risks for homicide and severe injury.
- **Ongoing safety planning. (including digital safety and safety regardless of whether the survivor plans to leave a relationship or not).** Staff work collaboratively with survivors to make dynamic, inclusive and survivor-driven plans for improving physical and emotional safety based on strategies that are practical and acceptable to survivors regardless of relationship status.
- **Housing and economic needs (including shelter).** Staff provide, resource, referrals, and direct assistance to survivors to address housing and economic needs related to safety.
- **Emergency medical service linkage.** Staff provide, by referral or directly, assistance accessing emergency medical services related to family violence for adults and children, including addressing injuries, and facilitating access to forensic examinations.
- **Protective order applications.** Staff provide information, education, and access to processes to apply for protective or restraining orders at survivor request.
- **Child or family safety planning.** If applicable, survivors, staff, and youth work together to create dynamic and flexible plans for families and individual child safety.
- **Custody and visitation planning.** If applicable, survivors and staff collaborate on plans to increase safety at child custody and visitations, which may include advocacy in court systems to improve safety.

[37] The Danger Assessment is an instrument that helps to determine risk factors that survivors face and that are associated with intimate partner homicide: https://www.dangerassessment.org/

Goal: Adapt Services for Diverse Cultural Groups and Center Racial Justice in FV work

A goal of non-residential FV services seeks to ensure that services are equitable, appropriate, and effective for survivors from diverse cultural groups, making FV services more accessible for survivors who have historically experienced oppression and marginalization, both within and outside of FV service settings. This goal aligns with an equity focused and trauma-informed service approach. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

Learning from Culturally Specific Groups

"So, you have to have that cultural responsiveness into the system, into the services so that they are all trauma informed and culturally responsive to the survivors of color. And I know it's not so easy because I was going to a training with the police officers and they were saying that they went into the LGBTQ. They had some policy; they went into the LGBTQ community and they didn't even -they did it totally wrong. So, they had to learn from the LGBTQ community how to respond. That is, that should be right. So yeah, we might ask, we go to you, we talk about our culture and you can take over a few things that you can incorporate in your services. So that's what we want."

Staff 2

- **Collaboration with culturally specific groups**. Agencies actively support and facilitate referrals and outreach with culturally specific and grassroots organizations and develop partnerships with them to meet the needs of diverse survivor groups.
- **Provide culturally specific programming**. FV agencies create, provide, or refer clients to programming that is grounded and rooted in cultural communities to meet the needs of diverse groups in their communities to increase access and promote equity.
- **Practice language justice**. Support survivors in receiving services and engaging with systems in the language in which they prefer and feel most comfortable and powerful.
- **Facilitate access to materials and support in client language of choice**. Agencies

provide high-quality translated materials to clients in their language of choice and offer free and timely interpretation services.

- **Agency policy and practice centers equity and cultural humility**. Agency staff and leadership engage in intentional strategies and policy making to reduce inequities based on marginalization, practice cultural humility and promote the strengths of diverse populations, facilitating equitable access to services.

Goal: Enhance Peer, Social, and Structural Support

A goal of non-residential FV services is to enhance peer, social, and structural support so that survivors experience connection, on-going access, and support from program staff and in their communities. Increasing support helps to address isolation from abuse and creates positive social networks that in turn increase survivor safety. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

- **Support groups.** FV agencies help to facilitate supportive peer and therapeutic groups for survivors to discuss their experiences with other people with similar life experiences.
- **Referrals to community agencies and events**. Staff help to increase support to survivors by referring to additional needed and wanted services and sharing information about events to meet people and make social connections.

- **Peer support services.** Agencies may facilitate peer-to-peer connections among current and former clients through formal or informal mechanisms, such as group, individual, and family events.
- **Empathic and non-judgmental understanding.** When working with survivors, staff express understanding and refrain from judgmental statements to enhance connection and rapport.
- **Support (re)connecting informal supports as wanted.** Staff may work with survivors to help identify safer sources of support, such as friends, family, and community members, and to (re)connect with potentially supportive former relationships.
- **Volunteer and outreach opportunities for current and former clients.** FV agencies may provide opportunities for survivors to engage with the agency in volunteer work, such as donations support, childcare, or public speaking.
- **Referrals to faith, recovery, and other support communities.** Staff may provide referrals to support-oriented communities that meet survivor needs and are culturally accessible, such as churches, cultural groups, and NA/AA meetings.

Helping to Build Support

"Before I think the main thing, it wasn't even the donations. It was just the support. Her being open to—how you speak to some people and they're like, 'Uh-huh, uh-huh,' or they'll brush you off. You get where they're not really listening. It's like, 'Then why even ask?' With her, it was different. It was to where there's time that I tell her certain things, and this is going back to when I first moved here in [month], *I told her things. Up until now she'll be like, 'I remember you told me that you liked this.' I'm like, 'I don't even remember telling you that.' You know what I mean?"*

Survivor 12

Goal: Increase Access to Needed and Wanted Resources

A goal of non-residential FV services is to increase access to needed and wanted resources to support survivors in getting basic needs, increasing knowledge of community supports, meeting

educational and employment goals, and establishing economic safety and security. Meeting expressed needs aligns with a survivor-centered framework and contributes to safety and health stability. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

- **Individual service plan/goal setting.** Survivors work with staff to identify goals based in needs and strengths and plans to address those goals for their time engaging in FV services.
- **Direct financial support (flexible funds).** FV agencies may offer, directly or by referral, cash and gift cards to address survivors expressed needs to improve safety and stability, such as support for basic needs, utilities, transportation, and medical care.
- **Financial skills and training as needed, including support addressing credit & debt.** Staff work with survivors to support economic literacy, develop budget, banking, credit knowledge, and address credit and debt related needs, often from financial abuse.
- **Housing navigation and referrals.** Staff work with survivors to identify housing needs and provide information and guidance navigating program requirements and resources and provide referrals to programs.

Individual Service Plans

"Well, we start the conversation with that survivor. As she or he is sharing with us, then we're gonna be goin' into all the services. We might touch base on the—okay, for instance in services, we might touch base on, 'Oh, we have a legal advocate, and this is what we can provide.' That survivor might not be interested in that, or the need of that survivor might not necessarily be the legal advocacy. We're just gonna mention it. We're gonna focus on what that person is sharing with us that she needs."
Staff 24

- **Housing vouchers/ long term housing options.** FV agencies may provide directly, or in coordination with local housing programs, short- or long-term vouchers or financial support for housing of choice.
- **Rental assistance**. FV agencies may provide, directly or by referral, assistance with rent, especially in order to improve safety or avoid the need for emergency shelter.
- **Help with government benefits.** As needed or wanted by survivors, staff work with clients and other systems to apply for and maintain government benefits, like SNAP and TANF, and provide support for obtaining needed identification to access these resources.
- **Employment support.** Survivors and staff collaborate on locating and accessing resources to help clients find and maintain safe and equitable employment.
- **Educational access support.** Survivors work with staff to identify any educational and training goals to promote economic stability, and address goals through resources to aid application, and information about financial aid.
- **Childcare support.** Staff help survivor clients to locate safe and affordable childcare, access onsite programs, and apply for assistance such as state voucher programs.
- **Food assistance.** FV agencies may provide direct food aid in coordination with local foodbanks, assistance with accessing WIC and SNAP, and referrals to food pantries and other supports.
- **Transportation assistance.** Staff work with survivors to identify transportation options to promote access to work, education, and resources such as bus vouchers, providing gift cards to cover gas, car repairs, or a ride-hailing service.
- **Referrals.** Staff routinely provide referrals for additional economic needs based in survivor's expressed concerns and preferences.

- **Economic advocacy.** Staff work with survivors to develop tailored economic action plans that center the actual lived needs and experiences of the survivor by using survivor-defined strategies for accessing a range of financial resources, including using legal remedies to address financial needs.

Facilitating resource access is one of the most powerful approaches used collaboratively by staff and survivors to improve stability and health. The vignette of Rachelle illustrates the importance of ongoing and fluid economic supports.

Survivor Vignette 2: Addressing Economic Needs

Six months ago, Rachelle (they/them) fled with their three children, Chloe, Jamal, and Jordan (ages 2, 7, 13), to the Peace Place shelter after their partner, JT, became physically violent again and strangled Rachelle. Rachelle's neighbor called the police, but JT took off, threatening to come back to kill Rachelle and the kids, before the police arrived. The police said Rachelle should go to the shelter and offered to transport them there. Because of JT's threats, they decided to go. While in shelter, they kept getting threatening social media messages from JT, but didn't tell anyone. They didn't want to report them to the police or get a protective order because they distrusted the police and the legal system -- they never helped Rachelle or their family before.

Rachelle's apartment was in public housing. In their mail forwarded to the shelter, they received a notice to vacate letter from the housing authority based on the police going to their apartment multiple times and damages where JT had kicked the wall. They said that Rachelle had "abandoned" the apartment. In addition to that, shelter was really hard on Rachelle's kids. Rachelle's oldest daughter, Jordan, "*run away on me. I'm talking within the first two weeks of staying there"* to Rachelle's sister, Monique's apartment across town. Rachelle didn't know what to do; but just knew they had to get out of shelter for their kids' sake and didn't feel safe returning to their apartment. Monique agreed that Rachelle and the kids could stay with her for a little bit – not long --while Rachelle tried to figure out what to do with their apartment.

Before Rachelle left shelter, their shelter advocate, Arlene, set up a meeting with a non-residential service advocate, Sharla. Sharla immediately put Rachelle at ease. From the get-go, Rachelle felt like "e*verything was very hands on."* Public housing is hard to get, and Sharla knew that. She immediately talked with Rachelle about their housing rights and possible solutions through VAWA to protect their public housing. "*She said she was willing to go to bat for me for housing*," Rachelle sighed, "*'cause housing's been havin' it out for me. I'm gonna be honest with you. They've been havin' it out for me. They told me if I left, that I wouldn't be able to keep my housing."* With Sharla's help, Rachelle was eventually able to move to a unit in another public housing complex and keep their housing.

Rachelle found some part-time work; but money was tight, and they and Sharla would "*come up with little plans—Come up with my finances. See what I gotta pay where. See what I gotta do to save money—to save money so if I do need it, I'm gonna have that extra to bounce back with*." The Peace Center was able to help with utilities occasionally, like the time that Sharla called and said that Rachelle "*was approved for funding to help with my light bill and my water, so that's been a blessing that really has helped me*."

Sharla would offer help with basic needs like groceries, diapers for the baby, shoes for the kids at the beginning of the school year, clothing vouchers at the Peace Place's thrift store, new bras, underwear, and hygiene products, like deodorant, pads, and tampons, for their teen daughter, Jordan. These were such a relief for Rachelle. *"Every time she* [Sharla] *received donations that she knew it was something that I was gonna need, she would text me right away. 'Hey, there's this, and this, and this. Do you need this?'*" She even helped get a new bed for their 7-year-old son, Jamal, who had been sleeping on a blow-up mattress, "*That she pulled through right away. I don't know where she got the bed from. It's the most comfortable bed we have in the house!"* When Rachelle brings their younger kids to meetings with Sharla, "*she'll give them a little toy, a little bear. They hold onto that*." The Peace Place has been there to help make birthdays and holidays special for their kids. "*They pretty much made their Christmas. I could tell it was a big impact on them* [the kids]".

After working with Sharla for a while, Rachelle began to open up about JT's continued stalking and threats via social media. Sharla understands that Rachelle did not want to go to police and helps them devise a plan for staying safer online and for documenting the stalking in case it escalates or they need that documentation. Transportation continues to be a huge issue for Rachelle and while the Peace Place gives them monthly bus passes, it still means "*we have to catch three buses or four buses to go back home*." Now that Rachelle is working, they are trying to find childcare for 2-year-old, Chloe, so they can take on more hours; but so many childcare places have closed during COVID. Everywhere has a wait and then there is the cost. "*At Workforce they have some programs* [for childcare]*, but there's a process."* With their childcare issues and the SNAP notice they just got "*denying her case*," they plan to talk through options with Sharla the next time they meet. The last six months have been so hard, but Rachelle, is proud of how they have worked to make things safer for themself and their kids. Rachelle says that the kids and knowing that Sharla is always out there looking for options and thinking about what might work for them, helps them deal with the anxious feelings they have in their body a lot of the time. At least they have those connections.

Goal: Promote Healing from Violence and Other Forms of Harm Across Developmental Stages/Ages.

A goal of non-residential family violence services is to address the health impacts of violence and promote physical and mental health for survivors and children across the lifespan. As needs might change across the lifespan, this adaptable goal uses a trauma-informed framework to address changing health needs related to violence. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Survivors have access to ongoing support after primary FV services have concluded. Skills for this goal used collaboratively by staff and survivors include:

- **Counseling (adult, child, family).** This may include peer and therapeutic group and individual evidenced-based modalities for working with FV survivors.
- **Identification of strengths.** Staff work with survivors to identify and build from existing strengths and to develop new skill areas.
- **Validation.** Staff validate survivor perspective and experience through verbal and non-verbal skills that reduce risk of judgement and increase empathic understanding.
- **Promotion of survivor agency.** Survivor clients and staff partner for client voice and choice in health decisions, including provider referrals and priorities.
- **Education about the impacts of trauma.** Staff provide, as needed, psychoeducation and resources about the impact of trauma, such as symptoms, reactions, and health impacts, to reduce blame and increase understanding.
- **Referrals to physical and mental health care.** Staff cultivate high-quality and trauma-informed accessible health referrals and facilitate access to those referrals in the client's community of choice.

- **Brain health support (i.e., information, screening/assessment for TBI).** Assessment and screening for TBI and other brain injuries are conducted in partnership with medical care providers.
- **Collaboration and referrals with local mental health & substance use treatment providers.** When possible, FV agencies partner with providers to increase access to supportive health services with stigma or barriers.
- **Collaboration with developmentally specific groups (i.e., older adults, youth).** FV agencies adapt and provide developmentally appropriate services with qualified staff.
- **Disability related accommodations and supports.** FV services are accessible and inclusive to differing abilities, and safety, health, and referrals are vetted for disability inclusion.
- **Staff wellness support.** Support for staff in economic, health, and community wellness needs, including those that seek to build more inclusive and supportive work environments and reduce occupational stress.

Connection to Substance Use Supports

"It helps because my advocate has helped me find substance abuse places to where I can go to meetings—AA, NA—all these places. She's tryin' to look out for me because, in a domestic violence situation, if you're feeling you have no more hope then you're gonna say, "Aw, F-it," and just start drinkin', start boozin', start druggin'. I don't wanna be that person. My advocate is going above and beyond to find me places like that. She sends me text messages, okay, this appointment's gonna be here, or this class, you know. Yeah, she does. She's amazing."

Survivor 9

Goal: Navigate Legal and Regulatory Systems.

A goal of non-residential family violence services is to support survivors as they make choices about and engage with systems including the civil and criminal legal systems, immigration systems, and child and adult protective services. Providers support survivors to

facilitate understanding of system processes and potential impacts, share information about survivors' choices and options, and facilitate engagement with systems based on survivors' wishes and preferences. Support navigating legal systems not only contributes increased safety, but also supports survivor-defined goal making. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

- **Utilize CPS/Adult Protective Services (APS) liaison.** Each HHSC-funded FV agency must designate at least one staff person who serves as a liaison to DFPS (both CPS and APS) to help facilitate coordination, address concerns, and assist in resolving conflict that may arise between FV agencies and CPS/APS.
- **Court and legal accompaniment and advocacy.** FV staff may attend and liaison on court related matters with survivors at their request to provide education, support, and increase safety.

Court Accompaniment

"I would say court accompaniment can be really helpful. Just having that support there because court is so scary for victims. A lot of times advocacy between the client and CPS can help. It can help get things moving or it can help clarify things."
Staff 4

- **Provide legal representation (if available) to address system engagement.** FV agencies may provide a staff attorney, pay fees for a community-based attorney, or provide referrals to free legal support for survivors engaged in the criminal justice system.
- **Information and education on criminal and civil legal rights and remedies.** At survivor request, FV staff provide information about legal rights and remedies for victims of crime, including those related to protective orders, custody, divorce, evictions, and immigration.

- **Assistance navigating other systems such as Office of the Attorney General (OAG) for child support or HHSC for public benefits.** FV staff educate survivors and help them navigate the potential additional safety risks that can arise when survivors attempt to access some public benefits (TANF, SNAP) or civil orders for access, visitation, and child support orders for their children through the OAG.
- **Referrals to other legal supports.** Survivors may incur legal debts or face large legal fees for civil and/or criminal court cases. FV agencies, when funding is available, can provide assistance directly or by referral attorneys or court filing fees.
- **Support with immigration legal processes.** If applicable, FV staff provide information about U and T visas, legal supports and resources, and education on the U.S. immigration system.
- **Childcare for survivors during court hearings.** As available and needed, FV staff arrange for, help locate or provide short-term childcare while survivors attend civil and/or criminal court proceedings.

Goal: Educate Individuals, Families, and Communities about Violence, Shared Risk and Protective Factors

A goal of non-residential FV services is to educate individual, families, and communities about family violence, increasing individuals' awareness about healthy relationships, community resources, and potentially harmful behaviors to reduce perpetration and (re)victimization in the community and enhance community resiliency and protection from violence. These activities aim to create long-term community change to reduce perpetration & victimization at the community level and increase community level knowledge of health and unhealthy relationship dynamics. This goal is achieved through inputs that may include staff time, financial resources,

and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

- **Classes for survivors to address their needs (such as classes on survivors' rights or debt reduction).** FV agencies provide topical classes for survivors based on information needs, including classes that may help comply with CPS case requirements.
- **Cross training with other community agencies, businesses, and organizations.** Agencies offer training about the dynamics of FV to help entities better identify and respond to family violence.
- **Information about healthy and unhealthy relationships.** Staff provide information to clients and community members about the "red" and "green" flags for relationships, boundaries, and consent.
- **Community education about FV, underlying causes, and related risks.** Staff engage in learning opportunities for community members for education in multiple formats and provide guidance on their services to increase access and awareness.
- **Prevention education for youth and emerging adults.** Staff may engage in educational, youth development, social service, and other community-based settings with evidence-based approaches to support the primary, secondary, and tertiary prevention of youth dating violence and related forms of harm.

Youth Violence Prevention has Intergenerational Ripples

"We do have a primary prevention who we—our staff goes out into the schools here in our 10-county service area to educate the children on domestic violence. They talk about bullying, consent, boundaries, things like that. We talk specifically about services to help educate the children even that way they know if these things are going on at home, there is help. We've had a couple kids who call and they're like, "My mom really needs help. How do I talk to her about that?" We talk to 'em, and we give them some different ways to approach it. That way they can do it without making their mom upset or ashamed."
Staff 3

- **Battering intervention and prevention programs (BIPP).** FV agencies may provide, directly or by referral, evidence-based approaches to reduce harm by focusing on the partner using violence.

Goal: Advocate for Survivor-centered and Trauma-informed Communities

A final goal of non-residential family violence services is to represent survivors and making space for their voices and involvement in community spaces, addressing survivors needs in the and encouraging trauma-informed and survivor centered approaches that address discrimination and marginalization across settings. This work can lead to enhanced service access for survivors, reduced barriers and gaps in community services, and reduced victim-blaming in the community. This goal is achieved through inputs that may include staff time, financial resources, and office space and supplies. Skills for this goal used collaboratively by staff and survivors include:

- **Participate in community meetings (such as a coordinated community response or high-risk team).** FV staff engage in multidisciplinary work to support community-based responses to violence and provide a survivor-centered perspective.

Community Connections

"A lot of times we see we've started to see where the clients are now being arrested. Why is that happening? What is the gap between the police departments and the victim services where we can unite and understand why a client may react a certain way when an officer is seen after being abused? And so, we're starting to see that connection come together through the DVHRT program."
Staff 8

- **Represent survivor needs with other community members and organizations.** Staff provide perspective on survivor needs and strengths to promote supportive strategies in a manner that promote confidentiality, privacy, and survivor strength.

- **Encourage programs, polices, and practices that support trauma-informed approaches.** FV agencies and staff advocate on micro (individual & interpersonal), mezzo (agencies & communities), and macro (policy, systems, & structures) levels for policies that provide a more inclusive, supportive, and understanding community response to trauma and violence.
- **Address risk and protective factors for FV in communities, including discrimination and marginalization.** FV agencies collaborate actively with a plethora of community members and partner agencies to identify macro-level risk and protective factors that contribute to FV rates and survivor impacts and work to minimize risks and increase protective factors.

Community-based engagement and advocacy is central to creating a more trauma-informed community for survivors. In the vignette below, Tonya's story shows the power of advocating for survivors across the community.

Staff Vignette 2: Community Supports

Tonya (she/her) has worked as a non-residential advocate for Family Support Program for over 15 years. She works out of their outreach office in a small Texas town and is the only staff member in her area. She covers four counties which span over 75 miles, and she puts a lot of miles on her old car travelling from county to county. It can be brutal in the summer when her car's air conditioning sometimes goes out. Each small town in those 4 counties has a unique culture that she has, over the years, learned about and developed trusted relationships in -- "*it's a very rural area with isolated, small communities*." Building trust can be hard and it's easy to be seen as an outsider even when you are from just the next town over.

Tonya is a survivor herself and advocating on behalf of other survivors is her life's work. She leaves business cards with her work cell number everywhere she can and gets calls and texts from survivors, church pastors, school staff and other community members all the time. In one county, she has a small office in the county seat on a nearly empty main street, where she has a clothing closet and weekly food boxes that can be picked up or delivered. That can get busy, because it is the only local food distribution program in the whole county. Some folks who come aren't dealing with current domestic violence, but it doesn't matter to Tonya. They have trauma histories in their past and they need food now, so she'll figure out a way to help them. In another county, she uses a local church as a place to meet survivors to do intakes and to provide services. Sometimes, if they mutually agree it is a safe choice, she will go to people's houses to meet with them. She regularly reaches out to clients on her work cell phone through texts and calls. They all know they can reach out to her when they need support or resources – she is always a text or a phone call away. They have a weekly support group in one town in her area that is well attended – some people have been coming to it for over 5-10 years. She knows that in small towns "*there's no anonymity ever."* Because of this, *"we do always talk to people, with it bein' a small town, about confidentiality.*" She approaches things differently than her colleagues at their main office who work in a larger city- sometimes they don't understand what she is doing, but she knows that safety planning in a small town takes creativity, especially for survivors who are still living with their partners who used violence against them. Tonya has had clients put her number in their phones as one of their doctors' names, use code words, or set a specific time to talk or meet in public. She has one client she meets at a local playground when she takes her children there each week since that is one of the only times she is allowed to leave the house.

Tonya has seen it all and knows how to support survivors in overcoming big obstacles with very few resources. She is constantly looking up new resources online and sharing them with survivors because *"since we're in a rural area, we don't have a lot of specialized services for multicultural or the LBTQ community. I hate that. I'm just gonna be honest. It's a big barrier."* She also struggles to find her clients resources for substance misuse, "*we're isolated and there's not a whole lot of things to do to entertain people—we don't have any malls. We've got one little movie theater. There's not a lot to do. People do fall into drugs and alcohol*." She feels like the survivors in her area are strong and many come and volunteer to give back. Several have helped her at community meetings and have become active in public speaking on behalf of other survivors in their community, which her clients tell her is healing for them. She knows that being visible and present in each of these communities is making a difference. Her services are some of the only services in these small towns – and she is dedicated in meeting their needs as best as she can.

Adaptations to Skills and Program Design

FV agencies may adapt their service approach based on the populations they serve, community conditions, and public health concerns to meet the needs of clients best inclusively and safely. One staff member shared the importance of adaptation:

> We're always looking at the different approaches and trying to put into practice the best possible approaches for each individual person and each individual child that we serve because we know that everybody's different. We want to make sure that those services are directly for that specific person. (Staff 3).

The most common adaptations are cultural ones, changes for virtual formats, alterations for developmental phases, and augmentations based on health needs.

Cultural Adaptations

FV staff may alter or enhance their skills and approaches to better meet the needs of diverse cultural groups, such as immigrant survivors, Hispanic/Latinx populations, LGBTQIA+ communities, survivors in rural areas and Black/African American survivors. These adaptations include increased bilingual staff, centering cultural values and celebrations, culturally specific peer support groups, a focus on regional strengths and connections, and attention to language that emphasizes a spectrum of diversity. The use of pronoun identification and visual cues, such as rainbow flags, pictures that represent racially diverse survivors, and Spanish-language signage may also be part of a cultural adaptations. One staff shared that in their agency, "*We asked people their pronouns, what they kind of identify as we don't just assume, you know."* (Staff 9). Some agencies have shifted to more inclusive, gender-neutral agency names, "o*nce we've done that, though, we've seen an increase in the number of men we serve. We've seen an increase in the number of LGBTQIA+ community. We've seen an increase in the number of undocumented."* (Staff 42). Staff may add additional questions during sessions to query important cultural identities and preferences. Several staff members shared that they often use a broad-based approach that centers cultural curiosity, inclusive language, and client-driven adaptations to support diverse populations. Staff that are not representative of certain cultures also discussed efforts to address issues of race, power, and privilege,

> So, we want to acknowledge that because our services are free, most of our clientele are either Hispanic, most clients are or Black. And that's not because it happens more in their community, it's just that we are available in their community and just accessible. And so, I have to acknowledge that as a White therapist, something I bring into every group. (Staff 27).

Agencies also use structural approaches, such as hiring staff that better represent that cultural constellation of the agency clients in order to increase comfort, access, and representation. As one staff shared,

> for example, right after George Floyd's murder, I was like, "We are not doing a good enough job in reaching out to our Black community partners. We're just not, and we have to do better." Also, I don't want to be reactionary, and be like, "Hey, we're here," I wanna be really intentional, so I was like, "How do we do that?" Also, I have to know going in that I might not be the most trusted person because I am a White straight female, and so I have to know walking into the door that that might not be well-received, so that's why we have a very diverse staff. (Staff 30).

Virtual Formats

The COVID-19 pandemic accelerated rapidly the use of chat, video, and other digital means to support survivors of family violence. As such, programs altered their service approach by enhancing skills around the use of technology and by centering privacy, confidentiality, and equitable access. These adaptations include training on social presence in chat communication[38], education in safe platforms, and working with clients to set boundaries and expectations around the use of text. Adaptations for the use of technology allow survivors to access services in the modality of their choice, promoting a survivor-centered perspective, and addressing barriers related to transportation, childcare, and scheduling. On counselor shared about how their agency has adapted to a 'hybrid service modeling, sharing:

> All of our groups are online right now. So, we are hybrid. So, on the Spanish side, so our bilingual counselors, for the most part, see people in person. On my end, with the English speakers, nearly all my clients are telehealth. (Staff 27).

The TCSS addresses the availability of services in a range of formats to meet survivors' expectations, life circumstances, and preferences. TCSS participants reported using a wide

[38] Social presence is the degree to which a person is perceived as 'real and present' by a communication partner when engaged in technology mediated communication

variety of service formats. A quarter of participants only accessed services virtually (email, video, text, chat), while 17% only accessed services over the phone and 22% only accessed services in person. The rest used more than one mode of services access during their time receiving services from the FV agency. Programs may adapt their skills or approaches for application on diverse platforms to meet survivor needs.

Developmental Phases

FV program staff are aware of the differing needs and experiences of survivors and their children across the life course. One staff person reflected on addressing developmental needs of survivors, stating:

> We get survivors at all ages. We get 16-year-olds coming in. We get 60-year-olds coming in. It is different sometimes because, oftentimes, the older survivors—what I have seen is that it's not just a case of, "Oh, I've been with him three or four years." It's sometimes of a case of, "I've been with him 30 years." If leaving is the goal, leaving looks very different at that point. Everything is very tied together in terms of finances and future and housing. (Staff 12).

Service approaches may vary based in changing needs and the primary mode of service access. Skills such as safety planning or educational classes may be altered to account for life experiences. Resources and referrals may be tailored to coordinate with developmentally focused providers (e.g., pediatricians and gerontologists). For example, staff shared about emphasizing coordination with local universities to address the developmental needs of youth adults, with one staff person noting "*We're trying really hard to build up a better relationships with the University because...that's a big deal, obviously...We really need to reach that population."* (Staff 12). Adaptions that have been identified in advocacy literature for emerging adults include increase psychoeducation about relationships and mental health, enhanced systems navigation support, and an emphasis on autonomy and survivor led decision making to support the developmental tasks of emerging adulthood (Arnett, 2000; Wood et al, 2021). Similarly, older

survivors of family violence may have unique needs that require specific adaptations to the non-residential service model, including engaging with survivors' families as caregivers and support systems, recognizing the need for taking enough time to address the complex needs of older survivors, and addressing intersecting factors such as financial, technological, and elder abuse (Backes et al, 2021).

Disability and Health Status

FV program staff work to make services accessible and appropriate for survivors with a wide range of needs related to health, mental health, and disability status. This frequently starts with deep listening to understand the specific experiences and needs of the survivor and their family, and then creative problem solving and on-going awareness of issues to ensure that needs related to health and disability are consistently addressed in a way that brings dignity to the survivor as well as ensures access to efficacious FV services. One staff person highlighted how they engaged in advocacy to support the needs of a survivor dealing with substance misuse:

> We started addressing those [substance misuse issues] and while she got housing, she was also able to go into a rehab facility. And then when she comes back, she's able to have housing. So, at that point, we made sure to address two of her big issues at the same time. That way, she didn't have to miss housing because she was going to the rehab center amidst the rehab center because she had to stay here for housing. So, we did. We do adapt to what our clients need, and we do know that they need to address those issues to continue to live a life that's successful and live a life that's efficient. (Staff 8).

Another staff member reflected that "*We have a lot of people that we work with who have mental health conditions and mental health issues or drug and alcohol addiction issues. We use different approaches depending on what their needs are."* (Staff 9). A third advocate noted the way that technology can support services access for survivors with disabilities, sharing that if a participants preferred "*language is American Sign Language, we have a phone number where we could contact somebody that would help us. We have the Chromebooks*." (Staff 18), illustrating

one adaptation to service modality available to meet the needs of survivors with disabilities. Staff work to adapt skills and approaches based on expressed health needs, and to connect survivors with disabilities with accessible, tailored resources.

Threats to Service Model Fidelity

Fidelity (or the degree to which services are "faithfully "implemented in line with the outlined approaches) is an important construct to program evaluation. Fidelity to the non-residential FV service model outlined in the logic model can be viewed as an indicator of quality services, a staff assessment, as a key potential factor in services efficacy, and a goal for agencies and staff to strive for (Carroll et al, 2007). Agencies across the state are doing important and effective work that is well represented by the non-residential services logic model presented in this report. However, several issues also emerged underscoring factors that repeatedly threatened agencies & staffs' ability to implement services that are fully in line with the non-residential FV services logic model. They include lack of resources for survivors and agency deficits in support for staff, programmatic barriers to service access and use, and inconsistent community support.

Lack of Resources

Participants discussed the way that resource deficits within agencies and in the community impacted how they offered services and what types of support are available to survivors, compromising best practice. A lack of resources impacts the types of supports survivors are able to access- for example, limiting the ability of agencies to address economic, housing, or food needs at all, or in a way that aligns with survivors needs and preferences. One staff member noted that many survivors they work with at their agency are from areas without consistent cell or internet coverage, sharing: "*They don't have internet there. How I'm gonna help them if they don't have internet?"* (Staff 16). Without that sort of basic community

infrastructure, offering services in a survivors' preferred modality is impossible. Another staff highlighted the impact of a lack of community resource on their ability to support survivors in addressing their basic needs, stating: "*We've seen a decrease in the availability of community resources."* (Staff 30). At the agency level, a lack of material resources (clothes, food, cash assistance) or funding barriers on how that assistance can be spent means that survivors are not able to get their needs met to improve safety and stability.

Deficits in Staff Support

Staff challenges related to occupational stress, workload and support pose another important threat to providing non-residential FV services with fidelity to the logic model. To provide FV services to as many survivors as possible, staff sometimes reported high caseloads, or wide areas of responsibility that caused them to feel overextended. These stressors impacted their ability to provide the kind of intensive and focused services that are outlined in the logic model, particularly towards the beginning of non-residential FV service engagement. High quality, accessible supervision has been shown to reduce the impact of constant exposure to traumatic material on staff (Wachter et al, 2022), but evidence from these interviews suggests that accessing such supervision became more difficult during the pandemic as staff worked remotely more often and increased needs meant increased demand on staff time and resources. Staff also shared about the ways that specific gaps in services and supports impacted their ability to provide services. One staff member shared their experience being one of the only bilingual staff people at their agency, and the toll that additional work takes on them, sharing:

> I'm having to constantly translate information all day long from English to Spanish…There is that language exhaustion in my part. Also, feel like I'm-that advocacy is 10 times more because you are not only advocating for your clients with the DV part. You're advocating for your clients with the services that they're getting provided. You're like, "Okay, all these services that are up there, are they available for my clients?"...I feel

> like a lot of bilingual case managers get that type of burnout, having that cultural burnout to make sure that we are being seen, that our clients are being seen. (Staff 21).

Further, chronic low pay contributes to staff stress and reduces service quality. Staff in non-residential FV services have faced monumental challenges addressing the impacts of COVID-19, on top of doing their already challenging and emotionally difficult jobs. The story of Erika in the vignette below highlights some of the current challenges facing the non-residential FV workforce, and the way those challenges impact the survivors they serve.

Staff Vignette 3: The Impact of COVID-19 on Staff

Erika (she/her) has worked at Family Haven for over five years. She started as a non-residential advocate and quickly moved up - first to the lead advocate position, and now the Director of non-residential services, supervising a team of 4 advocates, 2 counselors, counseling interns, one legal advocate and one youth advocate. She believes that "*advocating for survivors was the biggest intervention*" they provided at Family Haven, and she is really proud of her team and the impact they make in their community. She often talks with staff about, "i*f you don't listen"* to survivors and *"if you're not compassionate, they're not going to continue to come back. So that engagement piece is the most important."* She knew this to her core; but she knows that this continual engagement is hard on staff – the past 2 and half years during COVID had taken its toll on her, her staff, and 'her' survivors.

So many of her team have left during COVID. She struggles to keep the positions filled. She finds that "*in our limited pool, we can't be too picky on who we hire because there's few applicants when we have openings. There's not necessarily people with those backgrounds in the community. When there are, we can't pay enough for them.*" She is grateful for her agency's partnership with the local university's School of Social Work for counseling interns; but having counselors short-term leads to even more turnover. Erika shares with Family Haven's CEO, Marilyn how she loves knowing that "*someone who's going into that field is going to work with intimate partner survivors and sexual assault survivors,"* and understand the dynamics of intimate partner violence; but Erika does worry about how that impacts their counseling clients – having to switch counselors each semester and working with folks who are just starting out in their careers.

"*We have to be able to innovate, we have to*," Marilyn, stresses to Erika. Erika knows "*we need flexibility in funding to be able to provide the individual needs of victims that are going to be able to help them get out of crisis, create stability, but also create long-term solutions.*" They all want to expand service options; but Erika just cannot see how they could pull it off with the current resources.

Just maintaining the services that they have is a big challenge. There is the paperwork for funders and the fact that "*everything is done still on paper right now. We're tryin' to veer into the electronic,"* but they don't have enough computers or new software yet to make that transition. Erika finds herself constantly trying to explain to her staff the importance of documenting their work for funders, yet also not documenting too much in the files to protect survivors' confidentiality. It is a fine line and a challenge to explain.

Family Haven's advocates have been voicing lately, "*that because of COVID we've had an increase in violence, and we've seen an increase in the amount of survivors coming in -- everybody is stretched so thin*." The counselors "*tend to have a lot of wait time. Like now, we have a wait list*." Everyone is feeling the impact of not having enough resources to be able to support all the survivors reaching out. One advocate recently shared during supervision that, when working with survivors, she has to figure that "*you get out of it what you bring to it.* [survivors] *have to work. Obviously, they have to be willing to make changes. They have to be willing to put the effort in."* Two years ago, Erika would have challenged that staff person to reconsider that approach and to be creative and to meet with client where they are; but she just doesn't have the energy and at times, finds herself agreeing with that sentiment. Thinking about the temporary influx of funding they have right now due to COVID, "*We actually have a surplus."* Erika reflects, *"We don't necessarily need to say no on account of not having enough money. It's more of a—every time that we give out funds, we have to think, 'What are we teaching the client? Are we helping them to become independent, or are we helping them to become dependent on us?' If we deny people, it's just—it's all individual.* " She thinks back when she was an advocate and had more energy to challenge the more systemic barriers facing their clients and push to provide more "*mobile advocacy and services, and the least amount of restrictions as possible;" to "meet survivors where they are,"* and *"to be flexible*." But now she finds herself more and more focusing on what each individual survivor can do because the systemic barriers just seem to be too far beyond what they can change.

Programmatic Barriers to Service Access and Use

Real or perceived barriers to accessing certain program services inherently disrupt a program's ability to fully implement the voluntary and low-barrier service model outlined in the non-residential FV service logic model. These barriers might include actual program requirements to be co-enrolled in one service to receive another (for example, requiring advocacy to be referred to counseling), or actual program rules related to who qualifies for certain non-residential FV services (for example, income requirements for housing supports, or income caps on legal support), or limits on the number of survivors who can be served in a particular service at any given time for resource focused reasons like limits to the number of housing units, vouchers, or therapy time slots available. It can also include the tension with the voluntary service model when a survivor perceives that they have to access FV services as part of a pending criminal legal case or a CPS case. Along with these barriers, it is also important to consider barriers that are perceived by survivors, to the extent to which survivors feel like services are actually accessible to them. Survivors may understand that FV agencies are stretched thin, for example, the survivor who said, "a*t this point the program is- you are on a waiting list,"* (Survivor 1) and not want to burden their advocate or the agency if they feel like others "*might need a service more.*" Similarly, survivors might perceive session limits or limits on the length of services that may not be officially part of a program's rule but exist in how the program operates or presents to the survivor.

Inconsistent Community Support

The non-residential services logic model is best implemented when a FV agency is embedded in a robust network of services, communities, and systems that are functioning effectively. Where that is not the case, effective referral processes and navigation support are

impossible. As outlined in logic model goals, advocates are engaged in community building, community education, and community navigational tasks along with survivors every day. Where the community is under-resourced or hostile to survivor needs, those tasks shift from focusing on connection to focusing on protection, necessarily limiting the extent to which survivors will experience the building of a truly robust 'web of support.' Example of inconsistent community support including a lack of attention to FV from local criminal and civil legal actors; insufficient response to FV calls from EMS or law enforcement; a lack of locally available child or health care; and a lack of property owners who will accept housing vouchers.

Section 3: The Impact of Non-Residential FV Services in Texas

Using a mixed-methods approach, the evaluation team partnered with TCFV, HHSC and 28 FV agencies across the state to examine the impact of non-residential FV services in addressing survivors' needs. TCSS survey participants were asked to share what the most important service was that the FV agency provided. Out of 83 participants, 67 shared the services they found most impactful. Of impactful services, counseling topped the list (32), followed by listening and advocacy from staff (15), and legal (10), housing (8), and other economic services (8). One TCSS participant summarized:

> I also hope they <FV agency> NEVER close because they are literally saving lives. I wish I had known about <agency> and grateful for everything they do not just for me, but for everyone else. The <agency> has been the best thing for me in my darkest season.

These impacts are represented in the non-residential service logic model. Below, the key service impacts and areas of growth within these potential outcomes are summarized, as organized by logic model goals.

Goal: Increase Physical and Emotional Safety from Individual and Structural Harm

Goal Impacts

Family violence services are impactful in improving survivor safety by addressing immediate needs through information and collaborative planning, and longer-needs through flexible planning for safety and resource access. Economic and legal remedies, including financial assistance, and housing, help to stabilize families and promote autonomy from financial dependence on partners using violence. Survivor-defined engagement with criminal justice remedies like protective orders provided needed systemic supports that offered physical and emotional safety. FV agencies also facilitated a sense of safety with their attention to privacy and confidentiality. One survivor shared:

> Privacy, confidential. If you ask them about me, then they don't give that information until they get permission from me. They will send a form, release of information. Until I sign on that form. Suppose if my dad called about me to know about me and to check on me, they don't give that information until they get written permission from me. I like that confidentiality and privacy. They are maintaining clients' privacy and confidentiality. They don't even share with the other staff member in their agency. I like that privacy. (Survivor 13).

The TCSS provided insight into how FV agencies across the state are achieving improved safety. Survey respondents were asked about their perceptions of their own ability to keep themselves safe, the tools that are available them to help with safety, and their expectations of agency support when working to keep safe. Examples of questions include, "*I feel comfortable asking for help to keep safe"* and "*I know what to do in response to threats to my safety."* Participants consistently rated safety-related statements as mostly or always true, endorsing high levels of confidence in their own ability to take safety related steps, and high levels of trust in FV agencies to support them in safety needs. For example, 71% of respondents reported that it was mostly or always true that they "*know what [their] next steps are on the path to keeping safe*," and 66% of

respondents reported it was mostly or always true that "*community programs and services provide support I need to keep safe*." One survivor gave an example of knowing the steps for her to be safer:

> What signs to watch for, what signs to look for. Red signs, basically what to look for from the abuser and to just be safe. Don't go in dark spots by yourself. Watch your surroundings. They gave me a list and she also wanted to make sure that where I live now, that I feel safe where I am now. She didn't want me to just be somewhere. She wanted to make sure that I felt safe where I am now. (Survivor 26).

When considered as a whole scale, empowerment related to safety varied statistically significantly by participant race, with Hispanic/Latinx participants having the highest overall empowerment related to safety (mean = 41.27), and Asian participants having the lowest overall empowerment related to safety (mean = 30.6) (p =.04). In other words, Hispanic/Latinx participants endorsed higher levels of internal empowerment related to safety and greater confidence in community supports compared to survivors identifying as Asian. It should also be noted that participants' overall sense of empowerment related to safety was strongly and negatively correlated with the number of types of violence they experienced after service engagement (r= -.41; p>.05). In other words, the less violence participants were experiencing, the greater their sense of empowerment related to safety.

When asked about their overall safety before starting FV agency services, 24% of respondents rated their own safety as safe or very safe. After working with the FV agency, 80% of respondents rated their safety as "safe" or "very safe," this means that 56% of survivors moved from feeling unsafe before service use to feeling safe after service use. Specifically, before starting services, 47% of respondents rated their safety as "very unsafe." After non-residential FV services, 5% of respondents rated their safety as "very unsafe." Among participants who described themselves as "unsafe" or "very unsafe" before accessing FV

services, 89.6% described themselves as "safe" or "very safe" after accessing FV services. Changes in safety were largely attributed to increased resources and support. One survivor shared in an interview, "*I wasn't afraid anymore because I got so much support, so many tools to use.*" (Survivor 19). After starting services at their FV agency, only 35% of survey participants reported experiencing any measured forms of family violence[39], with only 12.5% reporting exposure to physical violence since starting services, and only 8.45% reporting exposure to sexual abuse since beginning services. Slightly higher percentages of participants reported exposure to psychological violence (22%) and stalking behavior (27%) since starting services. There were no significant differences observed in post-service engagement victimization by participant race or ethnicity.

TCSS participants strongly endorsed the helpfulness of safety focused FV services, as seen in Table 20. Of those who received hotline services, 83% rated services as helpful or very helpful, while 82% of those who received safety planning support rated it as helpful or very helpful.

Table 20. Safety Related Service Helpfulness and Need

	Very Helpful/ Helpful	Neutral: neither helpful or unhelpful	Very unhelpful/ Unhelpful	I needed this kind of help, but did not get it	I did not need this kind of help
Hotline/Chat/Text Crisis Line Support	58%	9%	2%	1%	29%
Safety Planning	67%	12%	3%	1%	18%
Safety Planning While Living with Partner	41%	11%	0%	1%	47%

Overall, Texas family violence non-residential programs are very effective at increasing survivor safety and reducing violence. Qualitative interviews with staff, as well as HHSC program definitions, suggest that safety planning activities are often coded as a subset of the

[39] Participants were asked a series of validated behaviorally specific questions (see measures chart) about their experiences before and after using services with behaviors spanning physical, emotional, economic, and sexual IPV/Family Violence as well as stalking. Participants were considered to have experienced a form of violence if they endorsed experiencing at least one of those behaviors.

'intervention services' category. While this category also includes other advocacy activities, it is noteworthy that it encompasses safety planning, which is in many ways the central non-residential service task outlined in the logic model and is also far and away the most frequently indicated service code in the HHSC data across all three years.

Goal Growth Areas

There are three key growth areas for Texas FV agencies to enhance their ability to address survivor safety needs. The first is that a persistent lack of resources for economic tools means that many survivors who have housing, financial, or material needs, are not able to get those resources, thus compromising their safety. The second is the lack of accessible and evidence-based batterers intervention and prevention programs (BIPP), restorative justice, transformative justice, and upstream solutions like youth violence prevention programs. Many survivors express significant interest in programs that can prevent their children from modeling controlling behavior and reduce the use of violence by their current/former partners. Those needs are not robustly met across the state. The third growth area for safety improvement is the relative lack of criminal justice and community practice interventions to address stalking, one of the most persistent ongoing violence challenges for survivors. More attention is needed to enhance safety planning skills to address stalking experiences.

Goal: Adapt Services for Diverse Cultural Groups and Center Racial Justice in FV Work

Goal Impacts

Survivors who responded to the TCSS were asked about how they experienced respect and understanding in their FV agency, including items examining trauma informed practices and survivor perception on agency practices related to cultural understanding. Survivors report feeling that FV agencies are responsive to their unique needs and that their cultural backgrounds

are respected and supported within the agency. Findings are found in Table 21. Importantly, no significant differences were found in responses to the scores across participate race or ethnicity, with 89% of participants feeling that their cultural background was respected at the agency and 80% feeling that staff understand how discrimination and injustice impact experiences of family violence. It is interesting to note that respondents' level of endorsement of these items was moderately and positively correlated with both empowerment related to safety (r = .27, p<.05) and advocate behaviors (r = .45, p<.05). In other words, survivors who felt that the agency they worked with used trauma-informed and culturally relevant practices both have greater empowerment related to safety and reported their advocate used approaches that were aligned with the service module outlined in the logic model.

Table 21. Trauma Informed and Culturally Relevant Practices

	Strongly Agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
I felt connected to staff at this agency	58%	31%	9%	3%	0%
Staff at this agency treated me fairly	64%	27%	6%	1%	1%
	Very True	**Somewhat True**	**A little True**	**Not at all true**	**I don't know**
My cultural background was respected at this agency	83%	6%	1%	4%	6%
Staff at this domestic violence agency understand how discrimination and injustice impact experiences	73%	7%	5%	4%	11%
	Strongly Agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
Translators or interpreters at this agency are easily available to assist me and/or my family (only for those who indicated they need translators, n = 40)	16%	15%	13%	1%	4%
Reading materials at this agency are available in the language that my family and I speak at home	35%	40%	19%	1%	5%
There are staff at this agency who speak the language that I speak at home	50%	33%	4%	5%	9%
I am able to get services at this agency regardless of my immigration status	35%	33%	26%	3%	4%
My culture is represented in the staff and leadership at this agency	32%	37%	23%	1%	8%

No statistically significant differences were observed by participant race/ethnicity in responses to the questions "If I needed help like this again, I would use the services at this agency" and "How likely are you to recommend the services at this domestic violence agency to friends, family, or other people in your community?" This indicates that agencies are working towards creating inclusive and culturally relevant environments. When non-residential FV programs are providing culturally specific services, they are a resource for the whole community. As one staff person shared:

> So, we do a lot of outreach events. We go to the mainstream agencies like, you know, law enforcement, to the hospitals, to, you know, anywhere that the clients may go, the stakeholders, and make presentations on cultural competency. So, they understand that they need, the there is a there is an agency who they can send their survivors of color, right, and be culturally competent. (Staff 2).

Goal Growth Areas

Important areas for growth for this goal were identified in project data collection. Gaps persist in terms of service access, particular for Black/African American survivors who are under-represented compared to their overall presence in services in legal assistance and counseling. Further, non-residential services and service providers need to commit to intentional, and on-going work to learn practices and ways of service to build more equitable and inclusive systems and programs for survivors. This need is highlighted by the sharing of one survivor, who illustrated the way that centering cultural strengths and intentional recognition of their unique background could have transformed their service experience. They shared, *"*[Program staff] *never ask me 'what is your culture?' or 'what is your tradition?.' They were always talking to me about my problems and how to get rid of from those problems." (*Survivor 13).

Goal: Enhance Peer, Social, and Structural Support

Goal Impacts

Low-barrier service access, rapport, and active listening facilitate connection for survivors, which is intimately intertwined with safety improvements. Accessible services from a caring advocate provide a base of connection from which survivors can build. One survivor shared the impact of a caring advocate:

> Then they make it clear that I can reach out whenever I need it. Having the breakdown or feeling that rare I'm feeling lost or something. They did make it clear that I can call them, or text them, or really email them. They were really there for me, and I really appreciate that. It was so helpful, honestly. (Survivor 15).

Findings from the TCSS illustrate how FV agencies are facilitating connection and support between survivors and staff and between survivors and the community. Survivors were asked a series of questions about their experiences with the staff and program in non-residential FV services. Ninety percent (90%) of survivors surveyed felt that staff actively worked to connect them with community resources, and 94% of survivors reported that staff provided them with regular support during their time working with the FV agency. Across the 17-item service experience scales, survivors rated services highly, endorsing that they felt valued (93%) and listened to (93%) by staff, and that staff were supportive and encouraging (96%) and nonjudgmental (95%). An interview participant expanded on the impact of staff being non-judgmental.

> "I'm not here to judge you," "I'm not here to tell you what to do," "I'm here to help you on what you want to get better on or your goals that you want to achieve," "Let's talk about those, but to let you know I'm not here to judge you." Once they start hearing that, they do share. I let them know, "I'm not writing this down on notes this is between me and you." "What I'm gonna write on my notes is basically the resources that I'm giving you, the goals that you're going to set that you want to achieve but not your personal feelings." (Staff 42).

No differences were observed in overall service experience score by participant race or ethnicity. Survivors also shared that they felt like they have control over their FV service experience, with 82% indicating that they felt that they decided alone or in collaboration with a

staff member what they worked on while engaging in FV services. This indicates high levels of fidelity to a survivor-centered model. Surveyed survivors indicated a strong sense of trust in the agency. When asked if they would use services at the agency if they needed help like this again, 81% of respondents agreed or strongly agreed, and when asked if they would recommend services at this FV agency to friends, family, or others in their community, 90% of respondents agreed or strongly agreed.

TCSS participants strongly endorsed the helpfulness of case management and advocacy services in Texas FV agencies. Of those TCSS participants who received advocacy services, 89% rated advocacy/case management services as helpful or very helpful, 8% indicated it was neutral, 1% indicated it was not helpful, of the overall sample, 16% indicated they did not need advocacy or case management. A survivor described their advocate as "*I mean just somebody in my corner to coach me, help me, encourage me*."

Survivors also report good access to informal social support. Nearly 75% of participants reported that they felt the statement "there are people who care about my feelings and what happened to me" was either somewhat or mostly true, while 76% of participants reported that there are "people who would give them good suggestions and advice." The seven item Informal Support Scale assessed participants' sense of having informal supports who are reliable and caring, with the overall participant mean suggesting that respondents found the positive statements about their access to informal social support somewhat true. Participants who reported higher levels of social support also reported higher levels of empowerment related to safety (r = .45, p <.05), and rated their service experiences more highly (r = .41, p<.05). Several survivors shared in interviews that developing friendships with other survivors while in services was vital to their lives. One survivor explained, "a*ctually, tomorrow I wanna go to* [city] *to go*

see some of the girls over there [at the FV agency]. I made really good friends with two of them. I haven't seen them. I wanna go. Just breathe a little bit." (Survivor 12).

Goal Growth Areas

Inability to access or maintain access to FV services limits connection opportunities not only with staff, but with peers and the community. Insensitive treatment from staff, long wait times and session limits can hinder the ability for survivors to connect with staff and engage with support benefits of programming. Geographic isolation and community violence can also impede survivors from being able to engage in social and structural support, highlighting the need to address environmental conditions and transportation to facilitate access goals. Finally, limitations on "after" or follow-up care may hinder trust in the FV agency, with could limit survivor comfort with reaching out as needs change over time. HHSC service use data also reflects that "support group" services are a critical component of non-residential services in Texas. Between 5% and 8% of total services are coded as "support group" services in each of the three years of data reviewed, but it should be noted that this trend is in a negative direction from FYs 2019-2021.

Goal: Increase Access to Needed and Wanted Resources

Goal Impacts

Addressing resource access promotes safety and provides support and stability for survivors engaging in non-residential services. Resources are tailored to address holistically survivor-defined needs and priorities.

> Whatever issues I had with my life and with everything, one by one, they addressed, like right now. Like right now, I am dealing with my PTSD, and also, I need job and everything. She's <advocate> looking into it. She's looking into it, and she's making sure that I get those jobs and I get housing and everything. She's connecting me to every other person which I should be connected with because they don't have options available. They are connecting me to people who have those options available which I needed. (Survivor 10).

Through goal identification, survivors are able to get information to address economic and health needs, including housing. Like the 2019 TCFV State Plan, housing is a top need for survivors in this study. Over 82% had been homeless at least once before using FV program services. Nearly half (47%) had also been homeless at least once since working with the FV program, representing a substantial decrease in homelessness after service engagement, yet still a significant number. One survivor shared how their advocate helped address homelessness:

> I'm very appreciative of that because if it wasn't for her, I would be still havin' problems. I would be still homeless. They would be still bullying me because they told me if I left [town], one of the times it got cold, and it was rainin', if I left, that I wouldn't get my housin'. (Survivor 24).

Table 22. Survivor Housing Impact Indicators

Housing Impact	N	%
How many times in your lifetime have you experienced homelessness?		
Never	15	18%
Once	23	28%
2-3 times	31	37%
4-6 times	4	5%
More than 6 times	10	12%
How many times since working with this domestic violence agency have you experienced homelessness?		
Never	43	53%
Once	27	33%
2-3 times	10	12%
4-6 times	1	1%
More than 6 times	2	2%

Direct financial assistance was another needed resource that was obtained by some survivors to help them achieve their goals. One survivor shared the agency gave her "*money for the driver license to the driving instructor.*" Others received assistance for medical payments, clothing, diapers, and food. On the TCSS, 27% of participants had received cash assistance or gift cards from the FV agency, ranging from under $100 to over $1000 in value. Fourteen

percent (14%) of participants received utility assistance from the FV agency, and 17% were receiving on-going rental assistance from the agency or another community partner. This direct cash assistance was instrumental in stability and safety impacts.

Table 23. Survivor Economic Impacts

Economic Impacts		%
In the last 12 months, have you received any cash assistance, or gift cards from the domestic violence agency you are working with?		
Yes	22	27%
No	59	73%
How much in total did you receive?		
$100 or less	7	32%
101-200	4	18%
201-500	7	32%
501-1000	2	9%
More than 1000	2	9%
How did you use most of these funds?		
Housing	5	23%
Bills	2	9%
Food	6	27%
My children	2	9%
Savings	1	5%
Household Items	3	14%
Pay off debt	0	0%
Other	3	14%
In the last 12 months, have you received any utility help from the domestic violence agency you are working with?		
No	71	86%
Yes	12	14%
Are you currently receiving any regular, ongoing rental assistance?		
No	69	83%
Yes	14	17%
How much does your regular, ongoing rental assistance cover?		
Less than 30% of my monthly rent	1	7%
50-74% of my monthly rent	3	21%
75-99% of my monthly rent	2	14%
100% of my monthly rent	8	57%

Where do you get your regular, ongoing rental assistance?		
Housing Voucher or Rental Help from the domestic violence agency	6	43%
Housing voucher or rental help from another community agency	4	29%
A friend or family member	2	14%
Section 8 Voucher	1	7%
Other	1	7%

TCSS participants were also asked to reflect on their perception of the helpfulness of services related to housing and economic needs that they received from the FV agency, and those that they did not receive. Table 21 highlights these findings. Participants found housing and economic supports generally to be helpful or very helpful. However, these services also have the highest percentages of respondents stating that they needed that kind of help but did not get that help compared to other types of supports assessed in the TCSS.

Table 24. Housing and Economic Services Helpfulness

	Very Helpful/ Helpful	**Neither helpful or unhelpful**	**Very un-helpful/ Unhelpful**	**I needed this kind of help, but did not get it**	**I did not need this kind of help**
Help with housing	40%	6%	4%	18%	32%
Food assistance	42%	11%	4%	18%	25%
Utility or other bill assistance	40%	8%	6%	17%	28%
Transportation assistance	29%	8%	5%	7%	51%
Help with government benefits	43%	15%	5%	12%	43%
Help with my education	32%	11%	02%	11%	43%
Help getting documents	19%	12%	3%	4%	62%
Help with budgeting	30%	14%	6%	5%	46%
Job seeking /employment assistance	36%	15%	3%	6%	40%
Referrals for housing or job help	40%	12%	5%	10%	33%

Resources and referrals provided by the FV program helped survivors meet their goals. "*I got resources, lots of resources. The agency sets you up to succeed*." (Survivor 19). Resources like housing, financial assistance, and connections to other community organizations help survivors address their needs, promote trust with the FV agency, and improve safety. This is further supported by HHSC service use data, which reflects that in all three fiscal years

"information and referral to community services" was the second most frequently indicated service category. Between 18% and 20% of all non-residential FV services were coded as "information and referral to community services" in the three years assessed.

Goal Growth Areas

Access to resources was among the most important skills provided by the FV agency to address survivor needs, especially in housing, but resource access is often lacking or unavailable, as indicated by the 47% of TCSS participants that have experienced homelessness since survey engagement. Housing support was reported by staff and survivors alike as often unavailable in their area or unusable because of the current rental market (e.g., no property owners will accept vouchers at the current rental rate). The lack of ability to get promoted resources, coupled with extensive waiting lists, created frustration and safety problems for some survivors, reducing FV program impact. Additional support is needed to help make resources more available and usable for survivors. Further, staff report that even when cash assistance is available, agencies may choose to not provide this resource if they do not value what the survivor's expressed need is, representing reduced impact on individual goal planning. Finally, the lack of focus on housing in Chapter 51, given its high level of impact for survivors, merits attention to focus resources and priorities.

Goal: Promote Healing from Violence and Harm across Developmental Stages/Ages

Goal Impacts

Resources and support from FV service engagement helped survivors to address physical and mental health needs. Table 25 displays TCSS participants self-reported health related impacts. While 39% of participants rated their overall health as "good", "very good", or "excellent" before using FV agency services, 77% reported their health as "good", "very good",

or “excellent” after using FV agency services, representing a substantial increase in good health after FV service engagement, representing 38% of survivors moving from fair or poor to good, very good, or excellent health.

Table 25. Participant Self-Reported Health Impacts

Health Impacts		**%**
In general, **before using services** at this agency, would you say your physical health was	Excellent	5%
	Very Good	9%
	Good	25%
	Fair	41%
	Poor	20%
In general**, since using services** at this agency, would you say your physical health was	Excellent	8%
	Very Good	23%
	Good	46%
	Fair	23%
	Poor	1%

As discussed in the survivor needs section, TCSS survey participants reported high rates of depression and PTSD symptoms. Among TCSS participants, reported levels of empowerment related to safety were moderately and negatively correlated with both somatic (r = -.30, p<.05) and depression symptomology (r = -.36, p<.05), meaning that participants with higher levels of empowerment related to safety tend to have lower reported somatic and depression symptomology. A facet of empowerment related to safety was a sense of self-efficacy that grew in part from service engagement, as one survivor described:

> Personally, they <FV agency> have helped me to get stronger, to obtain calm; they have helped me to be myself. In other words. To be able to know that I’m not dependent on anybody, to understand that I’m self-sufficient to do what I want. (Survivor 6)

TCSS participants were also asked to reflect on their perception of the helpfulness of services related to health and mental health that they received from the FV agency (see table 26). The majority of participants were able to get the mental or physical health support they needed, and they generally found those services very helpful or helpful. Referrals for physical health services

were the most likely category in this group to be needed but not received. Similarly, both the medical care and medical accompaniment service categories in the HHSC service use data were among the least endorsed categories, generally making up less than 1% of services provided in a given fiscal year.

Table 26. Impacts of Health and Social Supports

	Very Helpful/ Helpful	Neutral: neither helpful or unhelpful	Very unhelpful/ Unhelpful	I needed this kind of help, but did not get it	I did not need this kind of help
Counseling Services for Me	80%	5%	4%	3%	8%
Educational Classes (DV education)	60%	6%	4%	1%	27%
English as a second language classes	18%	8%	1%	4%	68%
Support Group	60%	13%	5%	3%	19%
Help with psychiatric prescriptions	16%	16%	4%	4%	59%
Referral for mental health or psychiatric services	26%	18%	4%	5%	47%
Referrals for physical health services	30%	16%	3%	11%	41%

The health service that was most important to survivors was counseling. In both survey and interviews, participants detailed the profound impact of free, accessible, trauma-informed, and survivor-centered counseling in helping to improve their lives. One TCSS survey respondent shared:

> Counseling. Their counseling was my life saver. I was in a really dark place. It was exactly what I needed at that time. They had me share my experiences which at that time it sucked, but it was necessary in order for me to begin healing

Another survivor shared how counseling helped to improve their safety:

> La consejeria que estoy tomando ttatar de ayudarme a reconocer que estaba pasando por violencia domestica ya recuperar mi autoestima. [The counseling I am taking is trying to help me recognize that I was experiencing domestic violence and to regain my self-esteem]

Most FV agencies provide traditional “talk” therapies and specifically modalities for trauma survivors like Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Processing Therapy (CPT), and Trauma-Informed Cognitive Behavioral Therapy (TF-CBT). Staff considered EMDR especially impactful for FV survivors.

> So, I love EMDR, mostly because it's just a gentle way to get at really deep pain, but I also don't need all the details for it to be successful. So, you don't have to tell me a lot of details and it's very gentle. So EMDR has had a huge impact on the clients because I am training in it currently and I've had clients before I was training in it, clients that I'm using with now and I can see a noticeable difference. (Staff 27).

In the vignette below, the health impacts of FV services are further expanded through the story of Julia, a survivor working on health goals.

Survivor Vignette 3: The Impact of FV Services on Survivor Health

Julia (she/her) reflected on the past 2 years working with her advocate, Sonia, "*I'm just like a different person. I swear...her talks are just like—it showed me that I could be like a different person. I could do this. I'm shocked at myself. If I would've seen myself a year ago, this is not me, just going out there*." Two years ago, she was hospitalized with injuries from her husband's abuse although no one knew that that was the real reason she injured. "*I was literally shut out from the world for three years because my husband didn't let me engage with strangers or even with friends*." This time in the hospital though, one of doctors seemed to understand that something else was going on and saw that Julia's husband rarely left her side or let her talk. So, she arranged for Julia to have "some tests" done, told her husband he was not allowed to be there when they did the tests and took her to an office where she told her about Sanctuary, a local domestic violence agency, and invited Sonia in to talk with her about her options.

Fast forward a year, and she was now in her own apartment using a housing voucher through Sanctuary and is still working closely with Sonia. "*She's amazing. I'm telling you, she's giving me my navigation—telling me she's gonna keep in contact with me all week. I'm happy about that. She takes the time. She goes out of her way."*

She loved that she could call Sonia "*on phone for moral support*" and that she made her "*feel equal. That we're equal. She never shows signs of power.*" Sonia checks up on her if she hasn't "*heard from me for a while. They wanna make sure I'm okay*." Sometimes, Julia forgets appointments, which doctors say an after-effect from the traumatic brain injury she suffered due to abuse. Sonia helps with this, and "*sends me text messages… okay, this appointment's gonna be here, or this class, you know. She's amazing*."

One of the most important things Sonia did was talk with Julia about her anxiety, depression, and PTSD, "*I felt lost and I knew I needed more help.*" Sonia stressed, "*I'm not here to judge you. I'm not here to tell you what to do. I'm here to help you on what you want to get better on or your goals that you want to achieve."* That felt amazing- to have someone whose goals for her were really just about her- and what SHE wanted. Sonia also talked about their counseling services – Julia had been hesitant to use counseling before; but decided she was now ready. However, there was a waiting list. In the meantime, Sonia stressed that if Julia was "*having the breakdown or feeling that rare 'I'm feeling lost or something'",* she could call the hotline or call, text, or email Sonia. Sonia was*, "really there for me, and I really appreciate that. It was so helpful, honestly*."

Once she was connected to her counselor, Veronica, Julia really thrived. In addition to her counseling sessions, she started to attend a virtual support group, did a few sessions using Eye Movement Desensitization and Reprocessing (EMDR) with Veronica, and had started to share information she was learning with a few new friends she was making in her apartment complex. Veronica "*helped guide me. that's why I recommended my friend because she needed guidance and information. There are things from my childhood that affect me all my life – i needed to discover a lot about myself. I didn't have that guidance. The agency gave me a broader vision of my life and helps me figure that out."* Julia got to figure it out on her own terms, with her supporters alongside her.

Julia is now going to start taking a class offered at Sanctuary as part of their community outreach and peer support program. She is going to be part of Sanctuary's Survivors Leading Group, sharing her expertise about domestic violence and how to help survivors with her community. She is very excited to do community outreach, share her story and help other survivors. "*I am independent again. I can make my own decisions again without being scared. I have my own place to stay for now. I wasn't even able to decide to go run an errand by myself before. Now I'm on my own. It saved my life. I'm me again. I can breathe again*."

Goal Growth Areas

Health, and especially mental health, services are among the most impactful for FV survivors seeking non-residential services, however ongoing access issues, a lack of adaptation, and an inconsistent coordination and partnership with health care systems can reduce the

potential impact of services on health goals. Health services fail to be as impactful when session limits and staff turnover create disruptions in services, as detailed by some survivors and staff. Interview participants also noted that counseling services are often not available for children or in languages other than English, meaning that adaptations for diverse survivor groups are not available. While counseling services were a frequently endorsed category in HHSC data, Black/African American survivors are under-represented in this service category compared to their overall presence in non-residential services, making up only 7% of counseling service recipients in 2019, even as they represented 13.2% of survivors in services overall. Physical health care, especially for uninsured survivors, those in rural areas, or people lacking stable transportation, is unavailable. This is particularly a concern for specialty care related to FV, such as brain injury, where there is a lack of providers with expertise statewide, as reported by staff interview participants. Survivors and staff also shared that healthcare systems frequently fail to discuss family violence with patients, let alone provide resources and referrals. Finally, the lack of focus on counseling in Chapter 51, given its high level of impact for survivors, merits attention to focus resources and priorities.

Goal: Navigate Legal and Regulatory Networks

Goal Impacts

The impact of legal and regulatory supports not only provides grounding information about rights and responsibilities but helps to access the justice system in a more supportive and trauma-informed way *if the survivor chooses to do so.* Indeed, one positive impact of FV services reported by staff and survivors is the ability to get safety needs met elsewhere outside of the legal system. However, for survivors engaged voluntarily or by mandate with CPS or the

criminal justice system, FV agencies were impactful in providing supportive navigation. One survivor shared how her advocate assisted her with CPS case:

> With all of that, I liked that when I reached out to [advocate], and I said, “Hey, [advocate]. CPS is calling me 'cause they wanna close that case. Now that I’m over here in [town], they’re trying to see if they wanna reopen it or just close it. I don’t know. They’re not believing me that I was at shelter.” Then from there I had to come and sign papers, so that she could be able to talk to them. She spoke to them on my behalf, and everything got closed. (Survivor 12).

Overall, FV agencies and child protective services (CPS) coordination has shifted from historical mistrust, lack of communication, and perception of conflicting goals to higher levels of collaboration, specialized support services and better understanding of their two missions.

Forty-one percent of participants in the TCSS currently or previously have had a protective order against their most recent partner using violence, with an additional 10% waiting for a hearing and an another 10% having applied but having been denied. As illustrated in Table 27, TCSS participants worked with FV agencies related to a wide range of legal or systems issues, with participants receiving support related to divorce, protective orders, financial assistance for court or legal costs. In particular, 51% indicated they had received FV program help related to getting information about legal rights and options. One interview participant shared the impact of court accompaniment, saying:

> They went to court with me. They sat there. They basically held my hand over there the whole time, and I felt like I wasn't alone. Yeah, how like when you're in a situation like that you feel like, "Oh my god, I'm gonna be here all by myself." But they were there for me, and they sat. They didn't just like, "Okay." They didn't leave. They stayed there the whole time to be there for me. I really appreciated that because it felt ugly for me to be there with me not doing nothing wrong. (Survivor 9).

One TCSS survey participant shared about the impact of having an attorney from the FV agency:

> My attorney there <FV agency> is the best of the best, not only is she fighting with me to get a protective order, she is fighting for my children and I. You would have thought I paid this attorney like half a million and I’m not exaggerating. She’s helping taking all my worries and fears away.

During the COVID-19 pandemic, many court services were available via teleconference, which enabled more survivors to safely participate and reduced transportation needs. Court access via technology enhanced opportunities for legal skills used by programs to be impactful.

Table 27. Legal Services Access & Helpfulness

	Very Helpful/ Helpful	Neither helpful or un-helpful	Very un-helpful/ unhelpful	I needed this kind of help, but did not get it	I did not need this kind of help
Help with divorce	32%	5%	5%	9%	49%
Help with child custody, visitation, and child support	26%	5%	7%	9%	53%
Help with getting a protective order (restraining order)	47%	5%	4%	8%	37%
Help with immigration	23%	7%	6%	3%	63%
Defense attorney for a criminal case	24%	4%	4%	8%	60%
Help with eviction or other lease issues	19%	7%	10%	8%	57%
Information about my legal rights & options	51%	8%	1%	9%	29%
Financial assistance to pay for court costs or attorney fees	21%	4%	5%	17%	47%
An advocate to go to court or legal meetings with me	30%	10%	5%	9%	45%
Referral to other legal help	42%	9%	4%	4%	41%

While participants generally felt the services, they received to address legal and systems needs were helpful or very helpful, it should be noted that the need that was most needed but unaddressed was financial assistance for court costs or legal needs.

Goal Growth Areas

Legal services are not available at the scale or capacity needed, especially for immigrant survivors, minimizing the potential impact of navigation. Through interviews and survey data, survivors are clearly seeking a more robust legal support system than many agencies have the staffing and financial capacity to provide. This includes fast access to legal representation for family violence related challenges, as well as for issues such as immigration and tenants' rights situations. Within HHSC service use data, 11% of services in each of the three fiscal years under

study were coded as “legal assistance,” which could include identifying legal needs, rights, and options, and providing support and accompaniment in pursuit of those options, suggesting that many survivors are not able to access this critical service. Financial assistance for court fees is another pressing issue limiting impact. The strength of the FV agency connection with CPS and the criminal legal system can also minimize impact in two critical ways: a lack of partnership reportedly prevents the granting of protective orders from courts, equitable and safe treatment from law enforcement, and a response from CPS that is understanding of the unique context of family violence. However, an enmeshed relationship between CPS, the criminal justice system and FV services may minimize survivor autonomy when choosing whether to use these systems. Impact for this goal could be improved by increasing swift access to legal services, while centering survivor autonomy in engagement.

Goal: Educate Individuals, Families, and Communities about Violence and Shared Risk and Protective Factors

Goal Impacts

Through FV agency activities, individual clients, their children, friends and family, and community members learn more about domestic violence. Positive findings from the empowerment related to safety scale outlined in above also support the success of community agencies in building knowledge of family violence and healthy relationship strategies among participants, as does the generally positive sense of participants related to the referral support they received from FV agencies. One staff shared their approach to this task, stating:

> We talk about red flags, we talk about building up that concept of trusting your gut and following through on this. So the hope is that it does reduce a client's chances of being in a domestic violence relationship again. (Staff 27).

Similarly, a survivor shared how learning this information helps them feel more secure that they can identify warning signs of violence in the future. This survivor shared about a group education class she attended:

> It was other people that had been in a domestic violence situation. Everybody's situation was different, but we were all tryin' to get ourselves back up and just get past it and watch for the red signs so if anyone wants to get into another relationship, they would see the signs and they would be able to identify their abuser. (Survivor 26).

For many survivors, working with FV non-residential staff to share and learn about violence and potential risk factors has the added impact of helping them feel validated and heard. One survivor shared that their advocate "…*heard me, she guided me, she told me there's such a thing as psychological violence. I had finally found someone who told me that existed and didn't call me dramatic." (*Survivor 8). Importantly, data from staff interviews also highlights the impacts of these education activities, as one staff member shared,

> We are seeing more people staying away from abusive relationships which is fantastic. Then if they get into new relationships, they are really observant about the potential red flags and they put boundaries in place. That is a huge thing. As we're seeing people building stronger more firm boundaries about accepting abusive behavior, they don't want it. They're not gonna accept it. That's great. (Staff 3).

Along with individual education, non-residential services increase their impact through community education. One staff member in a program that serves rural areas highlighted the impact that effective community education can have on survivors when they start the process of seeking services, saying:

> We've really tried to embrace the aspect of prevention and education in everything that we do. From every position that we have, we recognize that the more that we can be in front of people and talking about what the dynamics of power and control look like and really help identify some of these, help with that education piece, then that helps us identify, and that also increases referrals. We look at that as kind of a big piece of what we do. We have all of our advocates go and really—especially in our rural areas, really we encourage them to look at where are people going. If someone was experiencing this, where might they show up? (Staff 42).

Goal Growth Areas

As FV agencies continue to adapt to new service contexts and environments, continuing to focus on the tasks of individual and community education is critical. In some cases, previously central strategies or venues for community education were closed or shifted during the COVID-19 pandemic, so finding new routes thorough which to pursue this work is critical. As one staff member shared:

> I think that's probably one of the bigger shifts we've seen...in the last few years, and especially as we come off of the pandemic...We can go where survivors may present themselves and really shift what that looked like, and we can still do that in a very safe, confidential way, so we do see those pieces, but those connections in with our counterparts on the military bases, at the universities, and then within the prison systems have been critical. (Staff 42).

Providing community education in rural areas of Texas may pose a particular challenge as an analysis of counties in which non-residential FV services have their headquarters found that those counties are on average 76.74% urban, meaning staff may be more based in urban centers and less immediately available in rural communities. Staff in satellite offices and predominantly rural FV agencies thus are likely to need to do greater amounts of community education work to extend these impacts into rural areas, which should be considered in resource allocation and planning decisions.

Goal: Advocate for Survivor-centered and Trauma-informed Communities

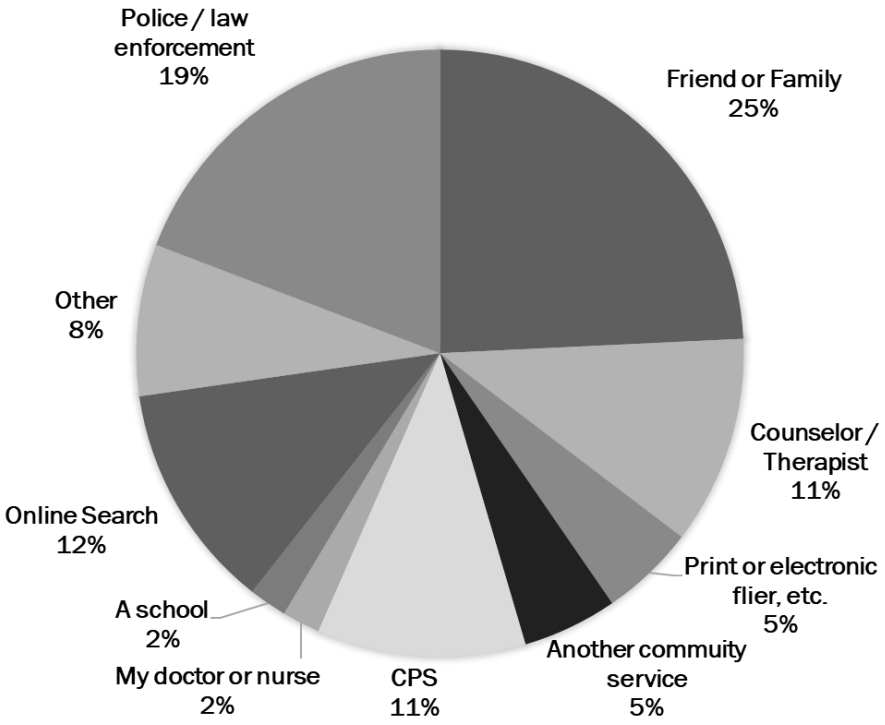
Goal Impacts

The value of this goal can be seen in the wide range of sources which participants in the TCSS first found out about FV agency services. See figure 8. for a depiction of initial referral sources. Importantly half of these sources are parts of the formal response system (e.g., CPS, another counselor or therapist, police, or law enforcement). The community support system is also illustrated by the high number of TCSS participants who reported receiving FV program

help with referrals to other formal services as part of their service experience. Participants reported receiving legal referrals (58%), supportive service referrals (49%), housing and economic referrals (57%), and parenting referrals (53% of parents). As indicated elsewhere, information and referrals also make up a large segment of services recorded in the HHSC FVP service use data, suggesting this is a critical component of FV services in Texas as they currently exist.

> We have medical-legal partnerships now, so partnering with the healthcare sector. Literally everybody and anybody who wants to partner with us—we have an MOU with [agency name], so when people are accessing a local food bank, we've already trained every single [agency name] employee on who we are, what we do, and we're doing cross-referrals. They're referring clients to us, and we're referring clients to them, and we do that with an individualized referral form. It's the thought process of, "Let's break down barriers." (Staff 30).

Figure 8. Initial FV Program Referral Sources for TCSS Participants



Interviews with staff and survivors further indicate that informal support sources, such as friends and family, are how survivors most often hear about FV services. This “word of mouth” referral

mechanism includes people who have already used the program, as one staff member described. "*…by word of mouth. Maybe they know somebody that is already connected to our program and that person is sharing."* (Staff 19). Other common referrals sources include law enforcement, who may refer to FV agencies after they have responded to a FV call. One staff member shared *"Law enforcement is really good too. They like to connect people right away*." (Staff 39). Particularly in rural areas, CPS provides many referrals to FV services. Medical care providers may also provide referrals but were described by survivors and staff as less consistent. One survivor detailed being in a local hospital for injuries sustained by a partner, where medical providers failed to provide resources or screening. Mental health providers, church members, and social service providers were other access linkages. Finally, several survivors and staff detailed "self-referring" by using the web or seeing print materials about FV services. This may involve trying to access services via social media pages or general emails. Staff actively seek ways to engage with survivors using the internet.

> We have two other people in our agency that monitor the website, and then they will distribute those messages to me and say, "Hey, can you contact this person?" or they'll distribute it to [staff name], who works with me as well in our outreach. They'll see which one of us they need to go to, and then we make contact with them from there. (Staff 32).

Impacts from this goal are also evident in agency outreach work, which increases understanding of family violence issues. One staff from a culturally rooted agency shared,

> We do a lot of outreach events. We go to the mainstream agencies like, you know, law enforcement, to the hospitals, to, you know, anywhere that the clients may go, the stakeholders, and make presentations on cultural competency. So, they understand that they need, the there is a there is an agency who they can send their survivors of color, right, and be culturally competent. (Staff 2).

Another described how they approach community outreach,

> We try to do it in a lot of common areas, public libraries, police stations, the courthouse, where somebody who might need our services might normally go to. Sometimes we'll do

> special events or do an event to a specialized group. We've done that in the past, like church groups who just wanna learn about our services. (Staff 23).

Finally, a few agencies described the important role that survivors who have received services play in their community work, "A *lot of our clients are also volunteers and help us during the health fairs or community events. In those instances, yes, we go together*." (Staff 24).

Goal Growth Areas

As non-residential FV programs seek to facilitate change within their local contexts in order to enhance the systems of supports in which survivors find themselves, they run into community level barriers. One survivor spoke about their experience trying to access services outside of the FV agency in a more rural area of the state this way:

> I would say more agencies to help [area name] because, like I said, there's really nothing for them. If they don't have good connections over there already, there's nothin'...There's a lack of agencies, and there's a lack of people in that community to help. (Survivor 24).

Further, persistent myths about family violence can influence community responses, as can beliefs about who deserves support or what level of support is needed. Agencies and staff need ongoing resourcing and encouragement to engage these questions productively and work in their local contexts to educate system actors about trauma, domestic violence, and survivor support.

Limitations

It is important to highlight several methodological and practical limitations that should be considered in evaluating the study findings and recommendations. First, the TCSS was collected at one point-in-time, meaning all data are cross-sectional and cannot speak to causation. These data do not represent a pre-service use baseline and should be considered in that light. There was a limit put on how long TCSS participants had been in services (a year or less) in order to reduce the extent of recall bias in questions asking about experiences prior to services. This means the

perspective of longer-term clients is not captured in the survey data but instead is represented in the interviews. Further, the statewide service use data obtained through an open records request to HHSC are limited by what data HHSC collects and by what FV agencies enter, and that these data only reflect HHSC funded FV agencies and service categories. Additionally, demographic trends within HHSC data are necessarily influenced by where HHSC funded family violence agencies are located and where there are gaps in access to HHSC funded family violence services across the state. Several other types of FV support work are occurring in the state outside of these frameworks that is not captured in that portion of the data.

The TCSS final sample size was 83, which was less than the initially targeted number of participants, preventing the data set from being powered for some initially planned analyses. While several strategies were used to find and recruit non-residential FV service users, including individual efforts by program staff across the state as well as the study team and agency collaborators, participation was consistent, but slower than anticipated. Based on communication with agency staff and findings from survey eligibility questions, this is partly due to the inclusion criteria (only participants who had been in non-residential FV services for under 1 year), a lack of contact information for one-time service use clients or could speak to reduced agency engagement with non-residential clients after they have completed services. Further, only 28% of TCSS participants had used FV services 1-2 times, meaning we are not able to fully capture the impact of one-time service use, which comprises a meaningful group of survivors who may use FV services once (e.g., hotline). Importantly, while the sample size was smaller than initially hoped, it was highly diverse in terms of participant race/ethnicity, allowing for enough power to look at differences across four racial/ethnic groups (Black/African American, Hispanic/Latinx, White/Non-Hispanic, Asian).

Across all types of data, there is a risk of social desirability bias, as both staff and survivors may feel internal or external pressure to reflect positively on their work or service recipient experiences for fear of ramifications to the agency or their access to services. Steps including having an external evaluation team and strict confidentiality protocols were taken and emphasized across data collection activities to reduce this risk.

Finally, very few of the participants in staff interviews identified as Black/African American, meaning that Black/African American staff perspectives are not as represented in the qualitative data. It is unclear if this gap is based on few staff who are Black/African American working in non-residential services across the state or on few Black/African American staff reaching out to participate in interviews. This is a gap that should be explored within FV agencies across Texas.

Evaluation Recommendations

Project activities were focused on describing non-residential FV services across Texas, examining the impact of these services, informing statewide planning and response, developing tools to support agencies in effectively and equitably evaluating their non-residential FV services, and developing guidance to enhance the implementation of non-residential FV services. Based on a collaborative, mixed-methods data collection approach, the evaluation team has developed a set of recommendations for supporting and enhancing non-residential FV services. First, TCSS participants were asked to share any recommendations they had to improve FV services. Of 83 participants, 37 shared recommendations for improvement. The most common recommendation was increased access and length of services (13), more economic and housing support (9), increased focus on meeting child needs (6), and more legal aid (6). Nine participants shared other recommendations, such as offering yoga services, having more diverse staff, and

offering more in-person services again. An additional 23 survey takers noted that they had no recommendations to add for FV services, and that services met their needs. One survey participant noted *"I feel each victim of a crime of domestic violence should be given a gift car with a set dollar amount to use as they see fit for food, transportation, shelter, clothing, and medical needs. IMMMEDIATLEY."* Recommendations from survivors in the TCSS were triangulated with other data sources and are listed below.

Chapter 51 should be amended to be more inclusive of activities to meet survivor needs across the state and represent a best practice service model.

- See Building a Non-Residential Service Model on pages 61-69 for a discussion of recommendations around revisions to Chapter 51.

FV agencies should continue to focus on implementing a survivor-centered, voluntary, and low barrier service model for non-residential services.

- Across data types, survivors repeatedly identified the positive impact of services free from coercion or session limits and rooted in survivor choice and empowerment, highlighting the central nature of the service model to effective practice. Voluntary and low barrier, or more accessible, service models are also linked to increased survivor autonomy and empowerment in the literature (Nnawulezi et al, 2018; Sullivan & Goodman, 2020; Wood et al, 2020b). Flexible service delivery models, including virtual services and mobile advocacy can support this approach. However, the extent to which Texan survivors and advocates experience services as 'voluntary and low-barrier' in practice is not always clear (Voth Schrag et al., 2021). Results from this study suggest that the service model may not be implemented consistently across the state, as survivors sometimes perceive services as having specific expectations, time limits or eligibility

criteria. For example, only 28 agencies reported service survivors who identify in gender categories other than male and female, alarming considering the high risks for interpersonal violence among gender non-conforming populations (Brown & Herman, 2015). This strongly signals the need for FV agencies to focus on equitable outreach. Inclusive, efficacious, and accessible non-residential services are uniquely critical for those communities where survivors face additional access barriers to residential services.

To support survivors, FV agencies must center racial justice and support culturally specific services.

- Data from HHSC FVP demonstrate consistently, that a majority of survivors being served in non-residential FV agencies identify as people of color. Data also demonstrate that many survivors who experience marginalization may not have equitable access to FV services, as evidenced in access differences for Asian and Native survivors, and service use differences for Black/African American survivors. Based on findings from this project, expanding access to legal and counseling services to Black/African American survivors, and ensuring that those services meet the needs and preferences of Black/African American survivors, is a crucial step towards enhancing racial justice in Texas non-residential FV services. Further, for marginalized survivors, FV is often intertwined with forms of structural oppression that can limit access to needed resources after violence (Ghanbarpour et al., 2018) While many clients view non-residential FV services and service providers as being sensitive to their cultural needs and the role that other forms of oppression play in survivors' experiences of FV, improvements are needed to increase supports to culturally specific practice that promote equity. FV agencies can demonstrate this commitment through efforts to: ensure language access; name and

identify the impact of racism and other forms of oppression on survivors, their experiences of violence, and their service experiences; ensure program staff, leadership, and spaces reflect the diversity of survivors served; and actively provide outreach to immigrant communities. An understanding of the impacts of family violence on marginalized groups, and a concerted individual and community advocacy approach to support diverse survivors is critical to increasing equitable services. Additionally, there is a need for further exploration of the impact of microaggressions, racial injustice, white privilege, culturally rooted services, and staff diversity in FV services and agencies (Donnelly, et al., 2005; Nnawulezi & Sullivan, 2014; Wood et al, 2022a).

Safety planning that is individualized, on-going and available whether a survivor is seeking to leave the relationship or not should be viewed as key to non-residential services.

- Study findings indicate that for survivors using non-residential services, safety planning is an on-going process of value for all survivors, including those who have left a partner, those who are contemplating leaving their partner, and those intending to remain in their relationship. Survivors should not have to terminate a relationship to receive high-quality services and safety planning should not only focus on plans to leave the relationship. Safety planning activities may include work to access systems (e.g., courts and schools) to support survivors, and to support survivors in staying safe from systems that might be hostile (e.g., law enforcement or CPS). For non-residential services, safety planning should center not only physical and emotional safety from violence, but also economic safety and stability as a key aspect of being 'safer.' Safety planning at its most impactful is culturally informed, taking into consideration such issues as survivors' immigration status, abuse by in-laws or extended family, and personal preferences and knowledge

(Sabri, et al, 2018). Survivors and staff in this study jointly reflected on how transformative it is to be able to address the unique economic needs of survivors. Safety planning addresses the treatment of Black/African American survivors, LGBTQIA+ survivors and other survivors of color within systems such as child protective services (Lippy et al, 2020; Roberts,2022; Thomas et al, 2022) or the police and legal systems (Coker et al, 2015). A flexible, inclusive, and survivor-driven approach to safety planning should be central to practices across the state.

Survivors need FV agencies and funders to emphasize economic, housing, and food security remedies.

- Economic and housing security are key to long-term survivor safety. Participants repeatedly reported about the extensive economic needs of survivors across Texas, and the struggle agencies are facing to address those needs. Indeed, 47% of TCSS had been homeless since using FV services, indicating the potential for growth in this area. Among HHSC FVP Exceptional Item Funding (EIF) services funded by HHSC, housing and economic remedies were the most frequently used, highlighting the importance of these services at the state level. Additionally, before the COVID-19 pandemic, FV agencies saw an average of 42 calls a month for shelter unmet, which is a strong sign of a lack of housing capacity in local communities. Survivors and staff both reflected on how transformative it is to be able to address the unique economic needs of survivors. Providing housing options beyond shelter makes safety accessible for a wider range of survivors and families. Food security, efforts to address food needs and the challenges that programs face in meeting this basic need, was a major theme in survivor and staff interviews, along with transportation needs. Flexible funding resources are needed for

agency staff to be able to address the unique and changing financial needs of survivors on an individual basis. Access to cash assistance, housing, and material support increases safety, reduces stress, and improves health and community connections.

Services access should be approached as an on-going process for non-residential service recipients.

- Hotlines and program intake processes provide an effective point of entry for services, but there is a need to continually work to support survivors' on-going access to and engagement with services. Short-term service engagement can result in many positive outcomes for survivors, as illustrated by the findings of the TCSS, however continued engagement and connection with program staff may be a critical ingredient of longer-term positive impacts. Non-residential services are voluntary, and it is also incumbent on program staff to check in with survivors and not let non-residential service recipients fall off the radar unintentionally.

FV agencies should extend their mental and physical health infrastructure.

- A key component of non-residential FV services is addressing the health needs of survivors and their children through counseling and referrals. Survivors rate counseling and support for themselves and their children as very impactful, but sometimes inaccessible. Wait lists, session limits, high staff turnover, and lack of language access negatively impact access to mental health support for survivors and their children. Further, referrals for physical health services we among the most likely services to be needed but not received by survivors participating in the TCSS. Yet the observed high rates of depression, PTSD, and somatic (physical) symptomology demonstrate a clear need for a range of mental health supports, including support groups, peer support, and

therapies. Agencies are using a variety of innovative solutions to address shortages in qualified mental health providers, including supporting virtual modalities in rural areas and to promote language access, and providing support for peer led and supportive services.

A focus is needed on how to engage both youth and older survivors in non-residential services.

- Secondary service access data demonstrate that most individuals receiving non-residential FV services in Texas fall between the ages of 18 and 65. Youth aged 0-17 made up 23.8% of service recipients in FY2021, a reduction from 28% in FY2019, even as qualitative data reflect a deep need for services for children and adolescents among adult survivors. This downward trend is concerning especially in the aftermath of COVID-19 pandemic and its negative impact on youth. While children may be provided comprehensive residential services, support to youth living outside of shelter and housing programs is lacking. TCFV's recent collaboration with the Center for Violence Prevention at UTMB provides summary recommendation on children's services that should be adopted for non-residential services (Wood et al., 2021). Further, only 1.4% of service recipients in HHSC data were over 65 years of age in 2021, despite representing over 12% of the state population. Older survivors have unique needs related to their life stage, which FV agencies could more explicitly and publicly address in order to bring older survivors into services. For further information about the needs of older survivors, recommendations from TCFV's recent collaboration on the needs of older survivors should be considered (Backes et al., 2021).

Agencies need support and resources for evaluation.

- Staff are motivated to provide high-quality non-residential services but may lack the resources and guidance for evaluation. Support is needed for on-going quality improvement and evaluation efforts, especially in smaller agencies which may not have dedicated staff time for data and evaluation tasks. Agencies need staff time funded for evaluation efforts, and the ability to include collaborators (from key communities, and those with research expertise) in the development of evaluation plans. Based on the diversity of those accessing services across the state, language access at all points of evaluation should be considered, with material support for evaluation tool translation. Initial impact evaluation activities should begin after a first service interaction (e.g., after intake or 1st advocacy session), and be conducted periodically thereafter. Measures used in this report have been tested and validated with Texan non-residential survivors in English and Spanish and are available to Texas FV agencies from the authors by request. Finally, state, and federal partners should activate resources with academic research partners for large-scale planning and longitudinal research efforts, ongoing prevalence, risk and protective factor monitoring, implementation research of best practices, and analysis of existing data.

The field should emphasize addressing structural and agency causes of turnover and occupational stress for non-residential FV staff.

- A clear theme throughout data collection was the ways that turnover hurts survivors as well as staff, creating ruptures in service experiences and resulting in the loss of experienced advocates with critical community knowledge. Staff across the state have been stretched thin by the challenges of a global pandemic, natural disasters and mental

health crises that have contributed to violence increases and expanded service demands, as well as the limited resources available to them to meet survivors' needs. This impacts staffs' ability to provide quality services and maintain personal wellbeing. Staff in FV agencies are underpaid compared to others in helping professions with similar expertise and years of experience, and face structural barriers including institutional racism, institutional resource constraints, high caseloads, limited access to quality supervision, and lack of advancement opportunities (Wachter, Voth Schrag, & Wood, 2020). Pay equity, improved working conditions, and a focus on equitable and safe environments are needed to reduce staff turnover and increase satisfaction, resulting in improved worker health and client outcomes. Addressing these barriers at the agency and field level will positively impact both staff and survivors. Finally, further research investments are needed to examine the impact of turnover, agency environment, and turnover on service quality and outcomes.

Conclusion

Over the course of 18 months, with participation from well over 100 survivors and half as many FV agency staff, the evaluation team and our community collaborators sought to build the picture of Texas non-residential FV services. This work was further enhanced by the three previous statewide assessments (Backes et al., 2021; Wood et al, 2019; Wood et al, 2021). Through multiple types of data, it is evident that when survivors want is non-residential family violence services, which are voluntary, low-barrier, induvial/survivor centered, trauma-informed, confidential, and focused on equity and cultural responsivity. Project findings support the efficacy of this service model in supporting survivors' safety, economic, and well-being outcomes. Further, the project findings emphasize the need for individualized services to address

survivors' unique personal and family needs, including direct housing and economic support, mental health support, legal assistance, child focused needs, and social support and close connection with an advocate. Survivors appreciate and benefit from services offered in a range of in-person and virtual modalities as well as services offered onsite in FV centers and in the community via mobile advocacy models. In Texas, state and local level collaborators should focus on providing support to agencies in implementing non-residential services with fidelity to this model, including providing support for flexible funding to address immediate survivor needs, centering equity and cultural responsivity in services.

Appendix A: References

Adams, A. E., Sullivan, C. M., Bybee, D., & Greeson, M. R. (2008). Development of the Scale of Economic Abuse. *Violence Against Women*, *14*(5), 563–588. https://doi.org/10.1177/1077801208315529

Amstadter, A.B., McCauley J.L., Ruggiero K.J., Resnick H.S., Kilpatrick D.G. (2008). Service utilization and help seeking in a national sample of female rape victims. *Psychiatric Services*, *59*(12), 1450-1457. doi: 10.1176/appi.ps.59.12.1450. PMID: 19033173; PMCID: PMC2735844

Arnett, J.J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*, 469–480. http://dx.doi.org/10.1037/0003-066X.55.5.469

Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M., & Wood, D.S. (2017). Short-Term Interventions for Survivors of Intimate Partner Violence: A Systematic Review and Meta-Analysis. *Trauma, Violence, & Abuse*, *18*(2), 155–171. https://doi.org/10.1177/1524838015602736

Assistant Secretary for Planning and Evaluation (ASPE) (2022). *HHS Poverty Guidelines for 2022.* https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Backes, B., McGiffert, M., Stephenson, M., Hairston, D., Fernandez, K., Dempster, M., Baumler, E., Gaudette, S., & Wood, L. (2021). *Survivors of Sexual Assault and Domestic Violence: Understanding Gaps in Systems Reponses and Community Services.* University of Texas Medical Branch and University of Central Florida

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence: A

Statewide Evaluation. *Journal of Interpersonal Violence*, *19*(7), 815–829. https://doi.org/10.1177/0886260504265687

Bent-Goodley, T.B. (2007). Health Disparities and Violence Against Women: Why and How Cultural and Societal Influences Matter. *Trauma, Violence, & Abuse*, *8*(2), 90–104. https://doi.org/10.1177/1524838007301160

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *American Journal of Emergency Medicine*. *38*(12), 2753-2755. https://doi.org/10.1016/j.ajem.2020.04.077.

Breiding, M.J., Smith, S.G., Basile, K.C. Walters, M.L., Chen, J., Merrick, M.T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization--national intimate partner and sexual violence survey, *United States. Morbidity and Mortality Weekly Report MWR Surveillance Summaries, 63*(8), 1-18. PMID: 25188037; PMCID: PMC4692457.

Braun, V. & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counseling and Psychotherapy Research*, *21*(1), 37-47 https://doi.org/10.1002/capr.12360

Braun, V. & Clarke, V. (2021). *Thematic Analysis: A Practical Guide 1st Edition.* Sage Publications.

Brereton, A.I., Serrata, J.V., & Hurtado Alvarado, M.G. (2019). *Understanding the Needs of Underserved Communities in Texas, Austin, Tx.* Texas Council on Family Violence. https://texas-state-plan.tcfv.org/wp-content/uploads/2019/09/Understanding-the-Needs-of-Underserved-Communities-8.20.pdf

Brown, T.N.T., & Herman, J.L. (2015). *Intimate partner violence and sexual abuse among LGBT people: A review of existing research.* Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/publications/ipv-sex-abuse-lgbt-people/

Burman, E., Smailes, S.L., & Chantler, K. (2004). 'Culture' as a Barrier to Service Provision and Delivery: Domestic Violence Services for Minoritized Women. *Critical Social Policy*, *24*(3), 332–357. https://doi.org/10.1177/0261018304044363

Burse, J., Voth-Schrag, R., Fields, N.L., & Woody, D. (2022). Domestic Violence Survivorship Among a Sample of Older African American Women: An Interpretative Phenomenological Analysis. *Journal of Interpersonal Violence, 37*(23-24), NP22000-NP22025. https://doi.org/10.1177/08862605211066541

Bybee, D.I. & Sullivan, C. (2002). The Process Through Which an Advocacy Intervention Resulted in Positive Change for Battered Women Over Time. *American Journal of Community Psychology, 30*(1), 103-122. https://doi.org/10.1023/A:1014376202459

Carroll, C., Patterson, M., Wood, S. Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science*, *2(*40). https://doi.org/10.1186/1748-5908-2-40

Cattaneo, L., & Goodman, L. A. (2010). Through the lens of therapeutic jurisprudence: The relationship between empowerment in the court system and well-being for intimate partner violence victims. *Journal of Interpersonal Violence*, *25*(3), 481–502.

Clark, D.L., Wood, L. & Sullivan, C.M. (2019). Examining the Needs and Experiences of Domestic Violence Survivors in Transitional Housing. *Journal of Family Violence*, *34*, 275–286. https://doi.org/10.1007/s10896-018-0010-4

Coker, D.K, Park, S. S., Goldscheid, J., Neal, T. & Halstead, V. (2015). Responses from the Field: Sexual Assault, Domestic Violence, and Policing. *University of Miami Legal Studies Research Paper* No. 16-2, Available at SSRN: https://ssrn.com/abstract=2709499 or http://dx.doi.org/10.2139/ssrn.2709499

Constantino, R., Kim, Y. & Crane, P.A. (2005) Effects of a Social Support Intervention on Health Outcomes in Residents of a Domestic Violence Shelter: A Pilot Study. *Issues in Mental Health Nursing*, *26*(6), 575-590, DOI: 10.1080/01612840590959416

Davies, J. (2011). *Helping Battered Women in Contact with Current or Former Partners A Guide for Domestic Violence Advocates.* Futures Without Violence. https://vawnet.org/sites/default/files/materials/files/2016-08/AdvocacyBeyondLeavingGuide.pdf

Davies, J., & Lyon, E.J. (2014). *Domestic violence advocacy: Complex lives/difficult choices* (2nd ed.). SAGE.

Donnelly, D.A., Cook, K.J., van Ausdale, D., & Foley, L. (2005). White Privilege, Color Blindness, and Services to Battered Women. *Violence Against Women*, *11*(1), 6–37. https://doi.org/10.1177/1077801204271431

Family Violence Prevention and Services Act (FVPSA), 42 U.S.C. §110. Family Violence Prevention And Services. (2010). https://uscode.house.gov/view.xhtml?edition=prelim&path=%2Fprelim%40title42%2Fchapter110

Forbes, D., Bisson, J., Monson, C., & Berliner, L. (2020). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* (3rd Ed). Guilford Press.

Free From (2022). *Support Every Survivor: How Race, Ethnicity, Gender, Sexuality and Disability Shape Survivors' Experiences and Needs*. https://www.freefrom.org/support-every-survivor/

Gilbert, L., Goddard-Eckrich, D., Hunt, T., Ma, X., Chang, M., Rowe, J., McCrimmon, T., Johnson, K., Goodwin, S., Almonte, M., & Shaw, S.A. (2016). Efficacy of a computerized intervention on HIV and intimate partner violence among substance-using women in community corrections: A randomized controlled trial. *American Journal of Public Health,106*(7), 1278–1286.

Gillum, T. L. (2019). The intersection of intimate partner violence and poverty in Black communities. *Aggression and Violent Behavior*, *46*(May/June), 37–44. https://doi.org/10.1016/j.avb.2019.01.008

Goodman, L.A., Cattaneo, L.B., Thomas, K., Woulfe, J., Chong, S.K., Smyth, K.F. (2015). Advancing domestic violence program evaluation: Development and validation of the Measure of Victim Empowerment Related to Safety (MOVERS). *Psychology of Violence, 5*(4), 355-366.

Goodman, L.A., & Smyth, K.F. (2011). A call for a social network-oriented approach to services for survivors of intimate partner violence. *Psychology of Violence*, *1*(2), 79–92. https://doi.org/10.1037/a0022977

Goodman, L.A., Thomas, K.A., Nnawulezi, N., Lippy, C., Serrata, J.V., Ghanbarpour, S., Sullivan, C., & Bair-Merritt, M.H. (2018). Bringing Community Based Participatory

Research to Domestic Violence Scholarship: An Online Toolkit. *Journal on Family Violence, 33,* 103–107. https://doi.org/10.1007/s10896-017-9944-1

Hamby, S., Grych, J., & Banyard, V.L. (2015). Life Paths measurement packet: Finalized scales. Sewanee, TN: Life Paths Research Program. http://www.lifepathsresearch.org/strengths-measures/

Hameed, M., O'Doherty, L., Gilchrist, G., Tirado-Muñoz, J., Taft, A., Chondros, P., Feder G., Tan M., & Hegarty K. (2020). Psychological therapies for women who experience intimate partner violence. *Cochrane Database of Systematic Reviews, 7.* DOI: 10.1002/14651858.CD013017.pub2.

Hartley, C.C. & Renner, L.M. (2016). *The Longer-Term Influence of Civil Legal Services on Battered Women. A Final Technical Report*. National Institute of Justice, U.S. Department of Justice. https://www.ojp.gov/pdffiles1/nij/grants/249879.pdf

Hartley, C.C., & Renner, L.M. (2018). Economic Self-Sufficiency among Women Who Experienced Intimate Partner Violence and Received Civil Legal Services. *Journal of Family Violence, 33,* 435–445. https://doi.org/10.1007/s10896-018-9977-0

Hepburn, P., Louis, R. & Desmond, M. (2020). *Eviction Tracking System: Version 1.0.* Princeton: Princeton University. https://evictionlab.org/

Holliday, C.N., Bevilacqua, K., Grace, K.T., Denhard, L., Kaur, A., Miller, J., & Decker, M.R. (2021). Examining the Neighborhood Attributes of Recently Housed Partner Violence Survivors in Rapid Rehousing. *International Journal of Environmental Research and Public Health, 18*(8), 4177. https://doi.org/10.3390/ijerph18084177

Illowsky, B., & Dean, S. (2022). *Introductory Statistics*. Open Stax. https://openlibrary-repo.ecampusontario.ca/xmlui/handle/123456789/292

Jategaonkar, N., & Ponic, P. (2011). Unsafe & unacceptable housing: Health & policy implications for women leaving violent relationships. *Women's Health and Urban Life*, *10*(1), 32–58. https://hdl.handle.net/1807/27218

Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive- behavioral treatment of PTSD in residents of battered women shelters: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*,*79*(4), 542–551. https://doi.org/10.1037/a0023822

Kennedy, A.C., Bybee, D., McCauley, H.L., & Prock, K.A. (2018). Young Women's Intimate Partner Violence Victimization Patterns Across Multiple Relationships. *Psychology of Women Quarterly, 42*(4), 430–444. https://doi.org/10.1177/0361684318795880

Kim, E. & Hogge, I. (2015). Intimate Partner Violence among Asian Indian Women in the United States: Recognition of Abuse and Help-Seeking Attitudes. *International Journal of Mental Health, 44*(3), 200-214, DOI: 10.1080/00207411.2015.1035073

Klein, L.B., Chesworth, B.R., Howland-Myers, J.R., Rizo, C.F., Macy, R.J. (2021). Housing interventions for intimate partner violence survivors: A systematic review. *Trauma, Violence, and Abuse, 22*(2), 249-264. https://doi.org/10.1177/1524838019836284

Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613.

Kroenke K., Spitzer R.L., Williams J.B. (2002). The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine, 64*(2), 258-66. doi: 10.1097/00006842-200203000-00008. PMID: 11914441.

Lacey, K.K., McPherson, M.D., Samuel, P.S., Powell Sears, K., & Head, D. (2013). The Impact of Different Types of Intimate Partner Violence on the Mental and Physical Health of

Women in Different Ethnic Groups. *Journal of Interpersonal Violence*, *28*(2), 359–385. https://doi.org/10.1177/0886260512454743

Leslie, E. & Wilson, R. (2020). Sheltering in place and domestic violence: evidence from calls for service during COVID-19. *Journal of Public Economics*, *189*, 104241. https://doi.org/10.1016/j.jpubeco.2020.104241

Lippy, C., Jumarali, S.N., Nnawulezi, N.A., Williams, E.P. & Burk, C. (2020). The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking, and the Need for Change. *Journal of Family Violence*, *35*, 255–267. https://doi.org/10.1007/s10896-019-00103-w

Lucea, M.B., Stockman, J.K., Mana-Ay, M., Bertrand, D., Callwood, G.B., Coverston, C.R., Campbell, D.W., & Campbell, J.C. (2013). Factors Influencing Resource Use by African American and African Caribbean Women Disclosing Intimate Partner Violence. *Journal of Interpersonal Violence*, *28*(8), 1617–1641. https://doi.org/10.1177/0886260512468326

Lyon, E., Bradshaw, J., & Menard, A. (2011). *Meeting survivor's needs through non-residential domestic violence services and supports: Results of a multi-state study*. U.S. National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. https://vawnet.org/material/meeting-survivors-needs-through-non-residential-domestic-violence-services-supports

Mbilinyi, L. (2015). *The Washington State domestic violence housing first program. Cohort 2 agencies. Final evaluation report. September 2011–September 2014*. Washington State Coalition Against Domestic Violence. Retrieved from https://wscadv.org/wp-content/uploads/2015/05/DVHF_FinalEvaluation.pdf

McFarlane, J., Symes, L., Maddoux, J., Gilroy, H., & Koci, A. (2014). Is Length of Shelter Stay and Receipt of a Protection Order Associated with Less Violence and Better Functioning for Abused Women? Outcome Data 4 Months After Receiving Services. *Journal of Interpersonal Violence*, *29*(15), 2748–2774. https://doi.org/10.1177/0886260514526060

Mehrotra, G. R., Kimball, E., & Wahab, S. (2016). The Braid That Binds Us: The Impact of Neoliberalism, Criminalization, and Professionalization on Domestic Violence Work. *Affilia*, *31*(2), 153–163. https://doi.org/10.1177/0886109916643871

Missouri Coalition Against Domestic & Sexual Violence. (2012). *How the earth didn't fly into the sun: Missouri's project to reduce rules in domestic violence shelters*. Jefferson City, Missouri. https://vawnet.org/sites/default/files/materials/files/2016-07/NRCDV_ShelterRules_0.pdf

National Network to End Domestic Violence [NNEDV] (2022). *Domestic Violence Counts: 16th Annual Report: Texas Summary*. Washington, DC. https://nnedv.org/wp-content/uploads/2022/03/16th-Annual-Domestic-Violence-Counts-Texas-Summary-FINAL.pdf

Nnawulezi, N., Godsay, S., Sullivan, C.M., Marcus, S., & Hacskaylo, M. (2018). The influence of low-barrier and voluntary service policies on survivor empowerment in a domestic violence housing organization. *American Journal of Orthopsychiatry*, *88*(6), 670–680. https://doi.org/10.1037/ort0000291

Nnawulezi, N.A., & Sullivan, C. (2014). Oppression within safe spaces: Exploring racial microaggressions within domestic violence shelters. *Journal of Black Psychology*, *40*(6), 563–591. https://doi.org/10.1177/0095798413500072

Ogbe, E., Harmon S., Van den Bergh R., & Degomme, O. (2020). A systematic review of intimate partner violence interventions focused on improving social support and/ mental health outcomes of survivors. *PLoS ONE, 15*(6): e0235177. https://doi.org/10.1371/journal. pone.0235177

Page, R.L., Montalvo-Liendo, N., Nava, A., & Chilton, J. (2021). 'Now My Eyes are Open': Latina women's experiences in long-term support groups for intimate partner violence survivors. *International Journal of Mental Health Nursing*, *30*(3), 715-723. https://doi.org/10.1111/inm.12840

Peitzmeier, S. M., Fedina, L., Ashwell, L., Herrenkohl, T. I., & Tolman, R. (2022). Increases in Intimate Partner Violence During COVID-19: Prevalence and Correlates. *Journal of Interpersonal Violence*,*37*(21-22). https://doi.org/10.1177/08862605211052586

Peitzmeier, S.M., Malik, M., Kattari, S.K., Marrow E., Stephenson, R., Agénor, M., and Reisner, S.L. (2020). Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. *American Journal of Public Health*, *110*, e1_e14, https://doi.org/10.2105/AJPH.2020.305774

Perez, S., Johnson, D.M., & Wright, C.V. (2012). The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters. *Violence Against Women*, *18*(1), 102–117. https://doi.org/10.1177/1077801212437348

Petrosky, E., Blair, J.M., Betz, C.J., Fowler, K.A., Jack, S.P.D., & Lyons, B.H. (2017). Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence - United States, 2003-2014. *Morbidity and Mortality Weekly Report*, *66*(28), 741-746. doi: 10.15585/mmwr.mm6628a1

Piquero, A.R., Riddell, J.R., Bishopp, S.A., Narvey, C., Reid, J.A., & Piquero, N.L. (2020). Staying home, staying safe? A short-term analysis of COVID-19 on Dallas domestic violence. *American Journal of Criminal Justice, 45*, 601–635. https://doi.org/10.1007/s12103-020-09531-7.

Postmus, J.L., Hoge, G.L., Breckenridge, J., Sharp-Jeffs, N., & Chung, D. (2020). Economic Abuse as an Invisible Form of Domestic Violence: A Multicountry Review. *Trauma, Violence, & Abuse*, *21*(2), 261–283. https://doi.org/10.1177/1524838018764160

Prins, A., Bovin, M.J., Kimerling, R., Kaloupek, D.G, Marx, B.P., Pless Kaiser, A., & Schnurr, P.P. (2015). *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* [Measurement instrument]. https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

Ragavan, M.I., Thomas, K.A., Fulambarker, A., Zaricor, J., Goodman, L.A., & Bair-Merritt, M.H. (2020). Exploring the Needs and Lived Experiences of Racial and Ethnic Minority Domestic Violence Survivors Through Community-Based Participatory Research: A Systematic Review. *Trauma, Violence, & Abuse*, *21*(5), 946–963. https://doi.org/10.1177/1524838018813204

Renner, L. M., & Hartley, C. C. (2021). Psychological Well-Being Among Women Who Experienced Intimate Partner Violence and Received Civil Legal Services. *Journal of Interpersonal Violence*, *36*(7–8), 3688–3709. https://doi.org/10.1177/0886260518777552

Rivas, C., Ramsay, J., Sadowski, L., Davidson, L.L., Dunne, D., Eldridge S., Hegarty K., Taft A., & Feder G. (2016). Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women who Experience Intimate Partner Abuse: A Systematic Review. *Campbell Systematic Reviews 12*(1), 1-202. doi: 10.4073/csr.2016.2

Roberts, D. (2022). *Torn Apart: How the Child Welfare System Destroys Black Families and How Abolition Can Build A Safer World*. Basic Books, New York.

Robinson, S.R., Maxwell, D.R., Rogers, K.R. (2020). Living in Intimate Partner Violence Shelters: A Qualitative Interpretive Meta-Synthesis of Women's Experiences, *The British Journal of Social Work*, *50*(1), 81–100, https://doi.org/10.1093/bjsw/bcz079

Sabri, B., Simonet, M., & Campbell, J.C. (2018). Risk and protective factors of intimate partner violence among South Asian immigrant women and perceived need for services. *Cultural Diversity and Ethnic Minority Psychology*, *24*(3), 442–452. https://doi.org/10.1037/cdp0000189

Sabri, B., Tharmarajah, S., Njie-Carr, V.P.S., Messing, J.T., Loerzel, E., Arscott, J., & Campbell, J.C. (2021). Safety Planning with Marginalized Survivors of Intimate Partner Violence: Challenges of Conducting Safety Planning Intervention Research with Marginalized Women. *Trauma, Violence, & Abuse, 25*(5) 1728-1751. https://doi.org/10.1177/15248380211013136

Scheer, J. R., & Poteat, V. P. (2022). Trauma-Informed Care and Health Among LGBTQ Intimate Partner Violence Survivors. *Journal of Interpersonal Violence*, *36*(13–14), 6670–6692. https://doi.org/10.1177/0886260518820688

Serrata, J. V., Rodriguez, R., Castro, J., & Hernandez-Martinez, M. (2019). Well-being of Latina survivors of domestic violence and sexual assault receiving trauma-informed and culturally-specific services. *Journal of Family Violence*, *35*, 169–180. https://doi.org/10.1007/s10896-019-00049-z

Sharps, P.W., Bullock, L.F., Campbell, J.C., Alhusen, J.L., Ghazarian, S.R., Bhandari, S.S., & Schminkey, D.L. (2016). Domestic violence enhanced perinatal home visits: The DOVE randomized clinical trial. *Journal of Women's Health*, *25*(11), 1129–1138.

Silva-Martínez, E., Stylianou, A.M., Hoge, G.L., Plummer, S., McMahon, S., & Postmus, J.L. (2016). Implementing a Financial Management Curriculum with Survivors of IPV: Exploring Advocates' Experiences. *Affilia*, *31*(1), 112–128. https://doi.org/10.1177/0886109915608218

Sullivan, C.M. (2012). *Support Groups for Women with Abusive Partners: A Review of the Empirical Evidence*, Harrisburg, PA: National Resource Center on Domestic Violence. http://www.dvevidenceproject.org.

Sullivan, C.M. (2018). Understanding How Domestic Violence Support Services Promote Survivor Well-being: A Conceptual Model. *Journal of Family Violence*, *33*, 123–131. https://doi.org/10.1007/s10896-017-9931-6

Sullivan, C.M. & Allen, N. (n.d.) *The community advocacy fidelity questions.* https://cap.vaw.msu.edu/maintaining-program-integrity/

Sullivan, C. M., & Olsen, L. (2016). Common ground, complementary approaches: Adapting the housing first model for domestic violence survivors. *Housing and Society*,*43*(3), 182–194.Retrieved from https://doi.org/10.1080/08882746.2017.1323305

Sullivan, C.M., & Goodman, L. (2015). *A guide for using the Trauma Informed Practices (TIP) Scales*. https://www.dvevidenceproject.org/evaluation-tools/

Sullivan, C. M., & Goodman, L. A. (2019). Advocacy With Survivors of Intimate Partner Violence: What It Is, What It Isn't, and Why It's Critically Important. *Violence Against Women*, *25*(16), 2007–2023. https://doi.org/10.1177/1077801219875826

Sullivan, C. M., Strom, J., & Sheridan-Fulton, E. (2019). *Evaluation of a domestic violence rapid re-housing program in Houston, Texas: Final report*. Harris County Domestic Violence Coordinating Council. https://www.hcdvcc.org/wp-content/uploads/2020/01/DV-Rapid-Rehousing-Evaluation-Final-Report.pdf

Sullivan, C.M., Chiaramonte, D., Farero, A., & Allen, N. (2019). *Foundational Advocacy Behaviors Scale*. East Lansing, MI: Michigan State University

Spencer, C., Mallory, A. B., Cafferky, B. M., Kimmes, J. G., Beck, A. R., & Stith, S. M. (2019). Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychology of Violence*, *9*(1), 1–17. https://doi.org/10.1037/vio0000156

Stubbs, A., & Szoeke, C. (2022). The Effect of Intimate Partner Violence on the Physical Health and Health-Related Behaviors of Women: A Systematic Review of the Literature. *Trauma, Violence, & Abuse*, *23*(4), 1157-1172. https://doi.org/10.1177/1524838020985541

Tashakkori, A., Johnson, R., & Teddlie, C. (2021). *Foundations of Mixed Methods Research*, 2nd Ed. Sage

Texas Council on Family Violence [TCFV] (2022). *Honoring Texas Victims: Family Violence Homicides in 2021*. https://tcfv.org/wp-content/uploads/tcfv_htv_rprt_2021.pdf

Texas Administrative Code, Title 1, Part 15, §379. Family Violence Program (2013). https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=1&pt=15&ch=379

Texas Family Code, Title 4, Subtitle C, §93. Confidential And Privileged Communications (2017). https://statutes.capitol.texas.gov/Docs/FA/htm/FA.93.htm

Texas Human Resource Code, Title 2, Subtitle E, §51. Family Violence Centers (2015). https://statutes.capitol.texas.gov/Docs/HR/htm/HR.51.htm

Thomas, M.M.C., Waldfogel, J., & Williams, O.F. (2022). Inequities in Child Protective Services Contact Between Black and White Children. *Child Maltreatment, 0*(0), 1-13. https://doi.org/10.1177/10775595211070248

Tlapek, S.M., Knott, L.H., & Voth Schrag, R. (2022). A Process to Identify and Address Barriers to Providing Financial Capability Programming to Survivors of Intimate Partner Violence. *Families in Society*, *103*(1), 65–77. https://doi.org/10.1177/10443894211031484

United States Census Bureau (2021). *Texas Quick Facts*. https://www.census.gov/quickfacts/TX

United States Census Bureau (2021). *Census Data*. https://data.census.gov/cedsci/

USDA Economic Research Service (2022). *State Fact Sheets*. Washington, DC. https://data.ers.usda.gov/reports.aspx?StateFIPS=48&StateName=Texas&ID=17854

Voth Schrag, R., Ravi, K., Robinson, S., Schroeder, E., & Padilla-Medina, D. (2021). Experiences with help seeking among non-service engaged survivors of IPV: Survivors' recommendations for service providers. *Violence Against Women, 27*(12-13), 2313-2334. https://doi.org/10.1177/1077801220963861

Voth Schrag, R.J., Leat, S., Backes, B. Childress, S. & Wood, L. (2022). "So many extra safety layers:" Virtual service provision and implementing social distancing in interpersonal violence service agencies during COVID-19. *Journal of Family Violence*. https://doi.org/10.1007/s10896-021-00350-w

Waller, B.Y., Harris, J., & Quinn, C.R. (2021). Caught in the Crossroad: An Intersectional Examination of African American Women Intimate Partner Violence Survivors' Help

Seeking. *Trauma, Violence, & Abuse, 23*(4), 1235-1248. https://doi.org/10.1177/1524838021991303

Waller, B.Y., Joyce, P. A., Quinn, C.R., Hassan Shaari, A.A., & Boyd, D.T. (2022). "I Am the One That Needs Help": The Theory of Help-Seeking Behavior for Survivors of Intimate Partner Violence. *Journal of Interpersonal Violence, 0*(0). https://doi.org/10.1177/08862605221084340

Willis, G., & Boeije, H. (2013). Reflections on the Cognitive Interviewing Reporting Framework: Efficacy, expectations, and promise for the future. Methodology: European Journal of Research Methods for the Behavioral and Social Sciences, *9(*3), 123–128. https://doi.org/10.1027/1614-2241/a000074

Wingood, G.M., DiClemente, R.J., & Seth, P. (2013). Improving health outcomes for IPV-exposed women living with HIV. *Journal of Acquired Immune Deficiency Syndrome*, *64*(1), 1-2. doi: 10.1097/QAI.0b013e3182a29f1b. PMID: 23846571; PMCID: PMC3775352.

Wood, L., Backes, B., McGiffert, M., Wang, A., Thompson, J., & Wasim, A. (2019) *Texas State Plan 2018: Availability of Services at Texas Family Violence Programs and Assessment of Unmet Needs of Survivors of Family Violence. Technical Report* for Texas Council on Family Violence. University of Texas at Austin, Austin, Texas. https://texas-state-plan.tcfv.org/wp-content/uploads/2019/09/FINAL-State-Plan-Report-September-2019.pdf

Wood, L., Clark, D., Cook Heffron, L., & Voth Schrag, R. (2020a). Voluntary, survivor-centered advocacy in domestic violence agencies. *Advances in Social Work, 20*(1), 1-21. https://doi.org/10.18060/23845

Wood, L., Cook Heffron, L., Voyles, M., & Kulkarni, S. (2020b). Playing by the rules: Agency policy and procedure in service experience of IPV survivors. *Journal of Interpersonal Violence, 35*(21-22), 4640-4665. https://doi.org/10.1177/0886260517716945

Wood., L., McGiffert, M., Wasim, A., Hairston, D., Backes, B., Baumler, E., & Faulkner, M. (2021). *Children Exposed to Domestic Violence: Understanding the Community Service Response and Needs in Texas- Project Technical Report.* Center for Violence Prevention; The University of Texas Medical Branch. https://www.utmb.edu/cvp/divisions/evaluation/children-exposed-to-domestic-violence-(cedv)-report

Wood, L., Backes, B., Baumler, E.& McGiffert, M. (2022a). Examining the Impact of Duration, Connection, and Dosage of Domestic Violence Services on Survivor Well-Being. *Journal of Family Violence*, 37, 221–233. https://doi.org/10.1007/s10896-021-00298-x

Wood, L., Baumler, E., Schrag, R.V. et al. (2022b). "Don't Know Where to Go for Help": Safety and Economic Needs among Violence Survivors during the COVID-19 Pandemic. *Journal of Family Violence*, 37, 959–967. https://doi.org/10.1007/s10896-020-00240-7

Wood, L., McGiffert, M., Fusco, R.A. & Kulkarni, S. (2022c). "The Propellers of My Life" The Impact of Domestic Violence Transitional Housing on Parents and Children. *Child Adolescent Social Work Journal*. https://doi.org/10.1007/s10560-021-00809-1

Wood, L., Voth Schrag, R., McGiffert, M, Brown, J. & Backes, B. (2022d). "I Felt Better When I Moved into My Own Place": Needs and Experiences of Intimate Partner Violence Survivors in Rapid Rehousing. *Violence Against Women,* 1-26. DOI: 10.1177/10778012221117600

Wood, L., Voth Schrag, R., Baumler, E., Hairston, D., Guillot-Wright, S., Torres, E., & Temple, J. (2022e). On the front lines of the COVID-19 pandemic: Occupational experiences of the intimate partner violence and sexual assault workforce. *Journal of Interpersonal Violence, 37*(11-12), 9345-9366, https://doi.org/101177/0886260520983304

World Health Organization (WHO). (2020). *COVID-19 and violence against women: What the health sector/system can do*. https://www.who.int/reproductivehealth/publications/vaw-covid-19/en/

Appendix B: Non-Residential Family Violence Services Logic Model

<table>
<tr><td colspan="4">Overarching Goal of Non-Residential Family Violence Services:
To improve the lives and well-being of survivors of family violence, their family, and communities through increased safety, connection, and resource access.</td></tr>
<tr><td colspan="4">Overarching Service Approach:
Voluntary--Low-Barrier--Survivor-Centered--Trauma Informed— Confidential
Focused on Dismantling Systemic Oppression—Culturally Responsive</td></tr>
<tr><td colspan="4">Core Services:
- Individual and system advocacy
- Hotline services
- Legal assistance
- Economic support
-Housing support
-Peer and social connection
- Health and mental health support
- Prevention
- Child advocacy
- Safety planning and crisis support
- Case management</td></tr>
<tr><th>Goal</th><th>Staff activities-Goal</th><th>Short-term outcomes-Goal</th><th>Long-term outcomes-Goal</th></tr>
<tr><td>Increase physical and emotional safety from individual and structural harm
Reducing violence across the social ecology</td><td>-Intake to assess needs
-Crisis intervention
-Lethality discussion(s)
-Ongoing safety planning regardless of relationship status
-Address housing and economic needs, including shelter
-Emergency medical service linkage
-Protective order applications
-If applicable:
-Child or family safety planning
-Custody and visitation planning</td><td>-Awareness of threats to safety are increased
-Survivor preferred strategies to improve safety are identified
-Potential legal support and rights are identified
-Housing and economic options are identified
-Immediate medical needs are addressed
-Immediate physical and emotional safety needs are addressed
-Understanding of protective orders/legal remedies are increased</td><td>-Violence is reduced
-Feelings of safety are increased at home and in the community
-Safety plan approaches are considered successful by survivors
-Safety resources are accessed as needed
-Protective orders are accessed as needed</td></tr>
</table>

Goal	Staff activities-Goal	Short-term outcomes-Goal	Long-term outcomes-Goal
Adapt services for diverse cultural groups and center racial justice in FV work *Making services equitable and accessible for historically oppressed and marginalized communities*	-Collaboration with culturally specific groups -Provide culturally specific programming -Practice language justice -Facilitate access to materials and support in client language of choice -FV programs' policy, training and practice centers equity and cultural humility	-Diverse staff, including survivors, hired at all levels - Diverse appointments, including survivor representation, to FV programs' Boards of Directors and training for Boards about centering racial justice work - Partnership with culturally specific groups are implemented and upheld -Survivors can participate fully in services in the language of their choice -Staff are respectful and supportive of survivor cultural needs -The built environment centers racial justice and equity	-FV services are accessed as needed and wanted by diverse survivor groups -FV programs provide material support to culturally specific groups -FV programs are perceived by the community as accessible and safe for racially and ethnically diverse survivors - FV programs have staff and Board of Directors that reflect the diversity of survivors served
Goal	**Staff activities-Goal**	**Short-term outcomes-Goal**	**Long-term outcomes-Goal**
Enhance peer, social, and structural support *Creating a web of support*	-Support groups -Referrals to community agencies and events -Peer support services -Empathic and non-judgmental understanding -Support (re)connecting with informal supports as wanted -Volunteer and outreach opportunities for current and former clients -Referrals to faith, recovery, and other support communities -Host community building gatherings for survivors	-FV services are accessible upon survivor request -Survivors have a sense of connection with staff -Formal and informal supports are identified -Survivors feel accepted as they are -Survivors have the opportunity to connect with other people with lived experiences -Survivors feel supported by FV program/advocates	-Social support increases - Survivors' support system understands FV dynamics -Survivors have institutional trust with FV program -Survivors understand that they can reach out again to the FV program as new needs emerge /situation changes -Survivors perceive their unique lived experience as valued at the FV program -Supports in communities are used if needed and wanted -Access to supports in the community are enhanced

Goal	Staff activities-Goal	Short-term outcomes-Goal	Long-term outcomes-Goal
Increase access to needed and wanted resources *Building economic security*	-Individual service plan/goal setting -Direct financial support (flexible funds) -Financial skills and training as needed, including support addressing credit & debt -Housing navigation and referrals, including where survivors want to live -Housing vouchers/ long term housing options -Rental assistance -Help with government benefits -Employment support -Educational access support -Childcare support -Food assistance -Transportation -Referrals -Economic advocacy	-Short and long-term goals are identified by the survivor - Survivors have their basic needs (shelter, food, utilities) met -Increased knowledge of community economic supports -Educational and employment goals are identified -Increased knowledge about rights and strategies to address impacts of economic abuse -Immediate economic crises are resolved -Transportation support is identified -*If applicable*- childcare resources are identified	-Survivors have safe and permanent housing - Survivors have safe and stable income sources -Transportation is accessible to meet needs, including social engagements -Progress on individual plan is made on the survivor's own terms -*If applicable*- safe and stable childcare is obtained
Goal	**Staff activities-Goal**	**Short-term outcomes-Goal**	**Long-term outcomes-Goal**
Promote healing from violence and other forms of harm across developmental stages/ages *Improving physical and mental health*	-Counseling (adult, child, family) -Identification of strengths -Validation -Promotion of survivor agency -Education about the impacts of trauma experienced at the individual, relational, community, and structural levels -Referrals to physical and mental health care	-Physical health needs and goals are identified -Mental health needs and goals are identified -Community health supports are identified and barriers to accessibility are addressed -FV programs' environment is safe and accessible for all survivors -Services are available in accessible formats	-Physical health is stabilized -Mental health is stabilized -Coping skills are used as needed -Accommodations are accessible -Survivors have increased hope -Survivors have increased self-efficacy -Survivors have reduced self-blame

	-Brain health support (i.e., information, screening/assessment for TBI) -Collaboration with developmentally specific groups (i.e., older adults, youth) to meet health needs -Disability related accommodations and supports -Collaboration and referrals with local MH & SU treatment providers - Staff wellness support	-Accommodations to address disability-related needs are identified -When possible, survivors are provided the option to work with a therapist from the same cultural or racial background - Staff have access to wellness supports	
Goal	**Staff activities-Goal**	**Short-term outcomes-Goal**	**Long-term outcomes-Goal**
Navigate legal and regulatory networks. *Promoting access and agency*	-Utilize CPS/APS liaison system -Court accompaniment and legal advocacy -Provide legal representation (attorneys), if available -Information and education on criminal and civil legal rights and remedies -Assistance navigating other systems such as child support, public benefits, immigration -Referrals to other legal supports -*If applicable:* Support with immigration legal processes -*If applicable*: Childcare for survivors during court hearing	-Survivors understand their rights -Survivors understand potential positive, negative, and neutral impacts of working with systems -Survivors have information about civil and criminal legal remedies -Survivors can access system resources *of their choice* -Survivors feel comfortable sharing concerns about systems with FV program staff -Staff understand who CPS/APS liaisons are and when to use them -Staff are trained to understand the various legal systems and how to assist survivors navigate them	-Engagement with formal systems leads to survivor-defined successful outcomes -Survivors understand relevant confidentiality and long-term considerations of system engagement -Survivors feel supported by the FV program during system engagement

Goal	Staff activities-Goal	Short-term outcomes-Goal	Long-term outcomes-Goal
Educate individuals, families, and communities about violence and shared risk and protective factors *Facilitating primary, secondary, and tertiary prevention*	-Classes for survivors to address their needs (such as classes on survivors' rights or debt reduction) -Cross training with other community agencies, businesses, and organizations -Information about healthy and unhealthy relationships -Community education about FV, underlying causes, and related risks -Prevention education for youth and emerging adults -Battering intervention and prevention programs (BIPP)	-Boundaries and needs related to relationships are identified -Potentially harmful behaviors are identifiable -Healthy relationship indicators are identified -Resources for support are identifiable -Increased community and media discussion about FV	-Reduced perpetration -Reduced victimization -Reduced revictimization -Reduced recidivism -Increased information about FV, including resource awareness, in the community -Early risks for FV are more identifiable -Protective factors to address FV are enhanced - Community resiliency factors are bolstered
Goal	**Staff activities-Goal**	**Short-term outcomes-Goal**	**Long-term outcomes-Goal**
Advocate for survivor-centered and trauma-informed communities *Networking to bring FV to the forefront across systems and in the community*	-Participate in community meetings (such as a coordinated community response or high-risk team) -Represent survivor needs with other community members and organizations -Encourage programs, polices, and practices that support trauma-informed approaches -Address risk and protective factors for FV in communities, including discrimination and marginalization	-Services are perceived by the community as meeting the needs of survivors -Staff at other community organizations have increased understanding of survivor needs and the impact/dynamics of FV -FV service gaps are identified -Increased knowledge among community members about FV services -FV program facilitates the involvement of survivors in services and the community	-Decreased "victim blaming" in non-FV community services -Survivor use of non-FV services increases -Service gaps and barriers are addressed through community planning -FV program representatives are engaged in community planning to address FV survivor needs - Increased community support for survivors

Appendix C: Vignettes

Vignette 1: The Central Role of Hotline Services.[40]

Lori (she, her) has been working as a hotline advocate at the front desk of Safe Center's outreach office for about one year. While she is 25 and new to domestic violence work, she has worked other places with people who have experienced trauma and domestic violence -- as a receptionist at private therapist office and a case aide in a juvenile detention center. She has always enjoyed helping people.

Lori loves the high paced juggle of her work. She loves the challenge of going from general phones calls, like people wanting to donate clothing and furniture, to crisis phone calls from survivors needing immediate safety planning, and then again to someone who just wants to talk which "*is really tricky, because it's like when someone is calling and they just wanna talk, you just wanna listen to them.*" At work, she handles a constant stream of other needs, including greeting those coming in for counseling and advocacy appointments and helping walk-in clients. Luckily, if a caller is "*suicidal or they're in a really, really unsafe situation"* she can send them directly to the counselor on call. She is also in charge of checking the crisis emails that people send through their agency's website and messages that people post on the Center's Facebook page. She sends those messages to one of the non-residential advocates for follow up. She speaks a little Spanish but can transfer Spanish-speaking callers to a bilingual advocate if she needs back up. She has used the Language Line a couple of times for other languages, but some callers had hung up before she could get the Language Line on the phone. At night, on the weekends and when she is on her lunch break, the hotline is routed to their shelter.

Lori feels a lot of responsibility in her job, and that can be hard sometimes. "*I control the traffic of all of that because I take in all of the phone calls, and I direct people to where they need to go. I also am the first face that clients see when they come in.*" She knows that she is the gatekeeper – that first connection for someone reaching out for help. Young people who call often ask if she can text them a resource or information; but unfortunately, they do not have that capability at her agency yet. Lori hopes they can do that in the future, but also knows that she is already juggling a lot of tasks and responsibilities already. About half of their calls from survivors are people looking for shelter, and half are needing other supports, like counseling, safety planning, or other housing options. Housing is the hardest because in her community there are very few housing resources. Shelter and counseling often have waiting lists – so she is constantly providing referrals to other organizations that may or may not be able to help survivors in her community. Lori keeps an ever-changing binder full of community resources, constantly updating them based on feedback that callers and other advocates give her. Sometimes things change faster than she can keep up with. Occasionally, callers can be really frustrated when referrals that Lori provides don't work out. As the first person at the agency that folks talk with, people sometimes unload a lot of frustration and hurt on her. That can be painful for Lori, but it helps to be able to check in with her supervisor when they meet every week. Lori reflects on her challenging; but rewarding job, "*I feel like my purpose is to make them feel welcome, make them feel brave enough to take*

[40] These case vignettes were prepared solely for training and educational discussions. They are not intended to suggest either effective or ineffective service provision, nor the experiences of any one specific survivor, advocate, or agency. Rather, these vignettes are compilations based on qualitative interviews with survivors and staff providing non-residential services in a wide range of agencies conducted for *Creating A Safer Texas: Understanding Family Violence Non-Residential Service Use and Impact: Final Report*. All names and certain facts have been disguised to protect confidentiality. Quotations in each vignette are directly from survivors and staff, but no vignette relies on quotations solely from one individual or agency. The authors wish to thank the survivors and staff who participated in the research for their contributions

that step, give them options, let them know. I mean, even if not here, there are other places you can go."

Discussion Questions:

1. What non-residential staff role does Lori have at Safe Center? And what have been some of her experiences in her job?
2. What are some of the challenges that Lori faces in her job? What is an example of her handling a challenge well?
3. What else could Lori and/or her agency do to address some of these challenges?
4. What does Lori mean when she says she "*knows she is a gatekeeper*"? In what ways are you a "gate keeper" in your job?
5. How can we improve the experience of survivors as they get connected to local agencies?

Vignette 2: The Need for Culturally Inclusive Services

Xochitl (she/her) knew she needed to talk to someone about the stomach aches, headaches, and nightmares she was experiencing after years of abuse. Two years ago, she left her ex-husband, Raul; but after recently being evicted when she lost her job, she decided to move back in with their 16-year-old son, Matías, to Raul's apartment and get back together with Raul. Soon though the verbal abuse from Raul and his controlling behavior, like not letting her get a job, escalated again and she was not sure if she could stay. Matías pleaded with her to try to make it work, "*If you leave, it's just gonna mess up everything. Everyone's gonna be upset. We're not gonna manage. Don't worry about it. We can get you counselling, and you'll be fine*."

She had tried to reach out to a couple of resources, but she was just put on hold for long periods of time at the places she called. She wondered if it was because she spoke in Spanish when she called. Finally, a friend told her that Hope Services, was a place where she could talk to someone, and she decided to walk in there to get help. When she walked in, the person at the front only knew a few words in Spanish; however, Xochitl could speak a little English, so she asked about counseling. She was told they didn't have a Spanish speaking counselor available but did have a counseling opening with an English-speaking therapist. She was scared at first, but she tried to make it work. It was hard. She felt like there were cultural barriers on top of the language ones – like the therapist minimizing the abuse she experienced as a product of her culture's machismo. Xochitl was frustrated with this and vented to her friend, *"When they don't get that* [our culture] *or don't speak our language, it makes it more difficult for both of us. We need to be understood in more ways than one."* She also felt that her therapist sometimes blamed her Catholic religion and Mexican culture for the abuse and didn't see the strength that her religion and culture provided her – "*I don't feel that the religion is the problem*!"

At first Xochitl's therapist kept talking with her about how she needed to plan to leave her relationship; when Xochitl explained she was not wanting to leave, the therapist seemed to shut down and not really offer much help. "*I remember her telling me,* '*We can't do anything about those issues. You can't get a job. You can't do this. You can't do that. Just try focusing on other things.' What I needed her to do was help me with those things that I can't do. That is what I need help.*" She felt alone both at home and when getting counseling. Once, when Xochitl was waiting for an appointment with her therapist, she started talking to another survivor at Hope Services. Maria also spoke Spanish, and they had a lot in common. Maria told Xochitl about an immigration lawyer who was really good with U-Visa cases, and immediately understood all the ways Xochitl was working to keep her family safe. That conversation meant so much to Xochitl, she often wishes she could have that kind of connection with other women in her same situation more often and wishes that Hope Services offered some sort of way to do that. She also wished there were a counselor who understood her culture and spoke her language.

Discussion Questions:

1. Why did Xochitl reach out to Hope Services? What were some of her needs when she reached out?
2. What was Xochitl's relationship like with her therapist?
3. How could Xochitl's therapist address the situation in a different way?
4. What steps can family violence staff when working with someone of a different race, culture, or gender identity?
5. What could your agency do to improve the experiences of survivors with language access needs?

Vignette 3: Addressing Economic Needs

Six months ago, Rachelle (they/them) fled with their three children, Chloe, Jamal, and Jordan (ages 2, 7, 13), to the Peace Place shelter after their partner, JT, became physically violent again and strangled Rachelle. Rachelle's neighbor called the police, but JT took off, threatening to come back to kill Rachelle and the kids, before the police arrived. The police said Rachelle should go to the shelter and offered to transport them there. Because of JT's threats, they decided to go. While in shelter, they kept getting threatening social media messages from JT, but didn't tell anyone. They didn't want to report them to the police or get a protective order because they distrusted the police and the legal system -- they never helped Rachelle or their family before.

Rachelle's apartment was in public housing. In their mail forwarded to the shelter, they received a notice to vacate letter from the housing authority based on the police going to their apartment multiple times and damages where JT had kicked the wall. They said that Rachelle had "abandoned" the apartment. In addition to that, shelter was really hard on Rachelle's kids. Rachelle's oldest daughter, Jordan, "*run away on me. I'm talking within the first two weeks of staying there"* to Rachelle's sister, Monique's apartment across town. Rachelle didn't know what to do; but just knew they had to get out of shelter for their kids' sake and didn't feel safe returning to their apartment. Monique agreed that Rachelle and the kids could stay with her for a little bit – not long --while Rachelle tried to figure out what to do with their apartment.

Before Rachelle left shelter, their shelter advocate, Arlene, set up a meeting with a non-residential service advocate, Sharla. Sharla immediately put Rachelle at ease. From the get-go, Rachelle felt like "e*verything was very hands on."* Public housing is hard to get, and Sharla knew that. She immediately talked with Rachelle about their housing rights and possible solutions through VAWA to protect their public housing. "*She said she was willing to go to bat for me for housing*," Rachelle sighed, "'*'cause housing's been havin' it out for me. I'm gonna be honest with you. They've been havin' it out for me. They told me if I left, that I wouldn't be able to keep my housing."* With Sharla's help, Rachelle was eventually able to move to a unit in another public housing complex and keep their housing.

Rachelle found some part-time work; but money was tight, and they and Sharla would "*come up with little plans—Come up with my finances. See what I gotta pay where. See what I gotta do to save money—to save money so if I do need it, I'm gonna have that extra to bounce back with*." The Peace Center was able to help with utilities occasionally, like the time that Sharla called and said that Rachelle "*was approved for funding to help with my light bill and my water, so that's been a blessing that really has helped me*."

Sharla would offer help with basic needs like groceries, diapers for the baby, shoes for the kids at the beginning of the school year, clothing vouchers at the Peace Place's thrift store, new bras, underwear, and hygiene products, like deodorant, pads, and tampons, for their teen daughter, Jordan. These were such a relief for Rachelle. *"Every time she* [Sharla] *received donations that she knew it was something that I was gonna need, she would text me right away. 'Hey, there's this, and this, and this. Do you need this?*'" She even helped get a new bed for their 7-year-old son, Jamal, who had been sleeping on a blow-up mattress, "*That she pulled through right away. I don't know where she got the bed from. It's the most comfortable bed we have in the house!"* When Rachelle brings their younger kids to meetings with Sharla, "*she'll give them a little toy, a little bear. They hold onto that*." The Peace Place has been there to help make birthdays and holidays special for their kids. "*They pretty much made their Christmas. I could tell it was a big impact on them* [the kids]".

After working with Sharla for a while, Rachelle began to open up about JT's continued stalking and threats via social media. Sharla understands that Rachelle did not want to go to police and helps them devise a plan for staying safer online and for documenting the stalking in case it escalates or they need that documentation. Transportation continues to be a huge issue for Rachelle and while the Peace Place gives them monthly bus passes, it still means "*we have to catch three buses or four buses to go back home*." Now that Rachelle is working, they are trying to find childcare for 2-year-old, Chloe, so they can take on more hours; but so many childcare places have closed during COVID. Everywhere has a wait and then there is the cost. "*At Workforce they have some programs* [for childcare]*, but there's a process."* With their childcare issues and the SNAP notice they just got "*denying her case*," they plan to talk through options with Sharla the next time they meet. The last six months have been so hard, but Rachelle, is proud of how they have worked to make things safer for themself and their kids. Rachelle says that the kids and knowing that Sharla is always out there looking for options and thinking about what might work for them, helps them deal with the anxious feelings they have in their body a lot of the time. At least they have those connections.

Discussion Questions:

1. How did Rachelle find out about non-residential services at the Peace Place? What were some of the barriers that Rachelle faced?
2. How did Sharla help Rachelle address some of the barriers they faced? How did she handle Rachelle not wanting to involve law enforcement any further in their situation?
3. What do you think could have happened to Rachelle and their children if Arene did not introduce Rachelle to Sharla prior to leaving shelter?
4. Rachelle feels connected to Sharla because Sharla helped Rachelle get resources that make their life better. How do you build connection with your non-residential clients?
5. In your experience, what are some of the major government and service systems that survivors interact with? How do you support them with navigating those systems?

Vignette 4: Community Supports

Tonya (she/her) has worked as a non-residential advocate for Family Support Program for over 15 years. She works out of their outreach office in a small Texas town and is the only staff member in her area. She covers four counties which span over 75 miles, and she puts a lot of miles on her old car travelling from county to county. It can be brutal in the summer when her car's air conditioning sometimes goes out. Each small town in those 4 counties has a unique culture that she has, over the years, learned about and developed trusted relationships in -- "*it's a very rural area with isolated, small communities*." Building trust can be hard and it's easy to be seen as an outsider even when you are from just the next town over.

Tonya is a survivor herself and advocating on behalf of other survivors is her life's work. She leaves business cards with her work cell number everywhere she can and gets calls and texts from survivors, church pastors, school staff and other community members all the time. In one county, she has a small office in the county seat on a nearly empty main street, where she has a clothing closet and weekly food boxes that can be picked up or delivered. That can get busy, because it is the only local food distribution program in the whole county. Some folks who come aren't dealing with current domestic violence, but it doesn't matter to Tonya. They have trauma histories in their past and they need food now, so she'll figure out a way to help them. In another county, she uses a local church as a place to meet survivors to do intakes and to provide services. Sometimes, if they mutually agree it is a safe choice, she will go to people's houses to meet with them. She regularly reaches out to clients on her work cell phone through texts and calls. They all know they can reach out to her when they need support or resources – she is always a text or a phone call away. They have a weekly support group in one town in her area that is well attended – some people have been coming to it for over 5-10 years. She knows that in small towns "*there's no anonymity ever."* Because of this, *"we do always talk to people, with it bein' a small town, about confidentiality.*" She approaches things differently than her colleagues at their main office who work in a larger city- sometimes they don't understand what she is doing, but she knows that safety planning in a small town takes creativity, especially for survivors who are still living with their partners who used violence against them. Tonya has had clients put her number in their phones as one of their doctors' names, use code words, or set a specific time to talk or meet in public. She has one client she meets at a local playground when she takes her children there each week since that is one of the only times she is allowed to leave the house.

Tonya has seen it all and knows how to support survivors in overcoming big obstacles with very few resources. She is constantly looking up new resources online and sharing them with survivors because *"since we're in a rural area, we don't have a lot of specialized services for multicultural or the LBTQ community. I hate that. I'm just gonna be honest. It's a big barrier."* She also struggles to find her clients resources for substance misuse, "*we're isolated and there's not a whole lot of things to do to entertain people—we don't have any malls. We've got one little movie theater. There's not a lot to do. People do fall into drugs and alcohol*." She feels like the survivors in her area are strong and many come and volunteer to give back. Several have helped her at community meetings and have become active in public speaking on behalf of other survivors in their community, which her clients tell her is healing for them. She knows that being visible and present in each of these communities is making a difference. Her services are some of the only services in these small towns – and she is dedicated in meeting their needs as best as she can.

Discussion Questions:

1. What is Tonya's job and what services does she provide to her clients?
2. How does Tonya make herself accessible to her clients?
3. What are some of the unique barriers that Tonya faces providing services in a rural area?
4. How can rural programs provide support to LGBTQIA+ and other communities when there are no resources available locally?
5. How does Tonya and her agency provide peer support opportunities and how do they involve people who have received services in the past?
6. How do you or your agency provide peer support or ways for survivors to get involved with the agency (if at all)? What types of things could your agency do?

Vignette 5: The Impact of COVID-19 on Staff

Erika (she/her) has worked at Family Haven for over five years. She started as a non-residential advocate and quickly moved up - first to the lead advocate position, and now the Director of non-residential services, supervising a team of 4 advocates, 2 counselors, counseling interns, one legal advocate and one youth advocate. She believes that "*advocating for survivors was the biggest intervention*" they provided at Family Haven, and she is really proud of her team and the impact they make in their community. She often talks with staff about, "i*f you don't listen"* to survivors and *"if you're not compassionate, they're not going to continue to come back. So that engagement piece is the most important."* She knew this to her core; but she knows that this continual engagement is hard on staff – the past 2 and half years during COVID had taken its toll on her, her staff, and 'her' survivors.

So many of her team have left during COVID. She struggles to keep the positions filled. She finds that "*in our limited pool, we can't be too picky on who we hire because there's few applicants when we have openings. There's not necessarily people with those backgrounds in the community. When there are, we can't pay enough for them*." She is grateful for her agency's partnership with the local university's School of Social Work for counseling interns; but having counselors short-term leads to even more turnover. Erika shares with Family Haven's CEO, Marilyn how she loves knowing that "*someone who's going into that field is going to work with intimate partner survivors and sexual assault survivors,"* and understand the dynamics of intimate partner violence; but Erika does worry about how that impacts their counseling clients – having to switch counselors each semester and working with folks who are just starting out in their careers.

"*We have to be able to innovate, we have to*," Marilyn, stresses to Erika. Erika knows "*we need flexibility in funding to be able to provide the individual needs of victims that are going to be able to help them get out of crisis, create stability, but also create long-term solutions.*" They all want to expand service options; but Erika just cannot see how they could pull it off with the current resources.

Just maintaining the services that they have is a big challenge. There is the paperwork for funders and the fact that "*everything is done still on paper right now. We're tryin' to veer into the electronic,"* but they don't have enough computers or new software yet to make that transition. Erika finds herself constantly trying to explain to her staff the importance of documenting their work for funders, yet also not documenting too much in the files to protect survivors' confidentiality. It is a fine line and a challenge to explain.

Family Haven's advocates have been voicing lately, "*that because of COVID we've had an increase in violence, and we've seen an increase in the amount of survivors coming in -- everybody is stretched so thin*." The counselors "*tend to have a lot of wait time. Like now, we have a wait list*." Everyone is feeling the impact of not having enough resources to be able to support all the survivors reaching out. One advocate recently shared during supervision that, when working with survivors, she has to figure that "*you get out of it what you bring to it.* [survivors] *have to work. Obviously, they have to be willing to make changes. They have to be willing to put the effort in."* Two years ago, Erika would have challenged that staff person to reconsider that approach and to be creative and to meet with client where they are; but she just doesn't have the energy and at times, finds herself agreeing with that sentiment. Thinking about the temporary influx of funding they have right now due to COVID, "*We actually have a surplus."* Erika reflects, *"We don't necessarily need to say no on account of not having enough money. It's more of a—every time that we give out funds, we have to think, 'What are we*

teaching the client? Are we helping them to become independent, or are we helping them to become dependent on us?' If we deny people, it's just—it's all individual. " She thinks back when she was an advocate and had more energy to challenge the more systemic barriers facing their clients and push to provide more "*mobile advocacy and services, and the least amount of restrictions as possible;" to "meet survivors where they are,"* and *"to be flexible*." But now she finds herself more and more focusing on what each individual survivor can do because the systemic barriers just seem to be too far beyond what they can change.

Discussion Questions:

1. What is Erika's current job and responsibilities at Family Haven and how has it changed over time?
2. How has COVID impacted Family Haven, their staff, and their clients?
3. What are some of the challenges that Erika is facing and how does it impact her and her staff?
4. What signs of staff stress and burnout are happening at Family Haven? What supports could the agency provide to staff?
5. How does staff turnover and the limited resources within agencies impact survivors?

Vignette 6: The Impact of FV Services on Survivor Health

Julia (she/her) reflected on the past 2 years working with her advocate, Sonia, "*I'm just like a different person. I swear...her talks are just like—it showed me that I could be like a different person. I could do this. I'm shocked at myself. If I would've seen myself a year ago, this is not me, just going out there*." Two years ago, she was hospitalized with injuries from her husband's abuse although no one knew that that was the real reason she injured. "*I was literally shut out from the world for three years because my husband didn't let me engage with strangers or even with friends*." This time in the hospital though, one of doctors seemed to understand that something else was going on and saw that Julia's husband rarely left her side or let her talk. So, she arranged for Julia to have "some tests" done, told her husband he was not allowed to be there when they did the tests and took her to an office where she told her about Sanctuary, a local domestic violence agency, and invited Sonia in to talk with her about her options.

Fast forward a year, and she was now in her own apartment using a housing voucher through Sanctuary and is still working closely with Sonia. "*She's amazing. I'm telling you, she's giving me my navigation—telling me she's gonna keep in contact with me all week. I'm happy about that. She takes the time. She goes out of her way."*

She loved that she could call Sonia "*on phone for moral support*" and that she made her "*feel equal. That we're equal. She never shows signs of power.*" Sonia checks up on her if she hasn't "*heard from me for a while. They wanna make sure I'm okay*." Sometimes, Julia forgets appointments, which doctors say an after-effect from the traumatic brain injury she suffered due to abuse. Sonia helps with this, and "*sends me text messages… okay, this appointment's gonna be here, or this class, you know. She's amazing*."

One of the most important things Sonia did was talk with Julia about her anxiety, depression, and PTSD, "*I felt lost and I knew I needed more help.*" Sonia stressed, "*I'm not here to judge you. I'm not here to tell you what to do. I'm here to help you on what you want to get better on or your goals that you want to achieve."* That felt amazing- to have someone whose goals for her were really just about her- and what SHE wanted. Sonia also talked about their counseling services – Julia had been hesitant to use counseling before; but decided she was now ready. However, there was a waiting list. In the meantime, Sonia stressed that if Julia was "*having the breakdown or feeling that rare 'I'm feeling lost or something'",* she could call the hotline or call, text or email Sonia. Sonia was*, "really there for me, and I really appreciate that. It was so helpful, honestly*."

Once she was connected to her counselor, Veronica, Julia really thrived. In addition to her counseling sessions, she started to attend a virtual support group, did a few sessions using Eye Movement Desensitization and Reprocessing (EMDR) with Veronica, and had started to share information she was learning with a few new friends she was making in her apartment complex. Veronica "*helped guide me. that's why I recommended my friend because she needed guidance and information. There are things from my childhood that affect me all my life – i needed to discover a lot about myself. I didn't have that guidance. The agency gave me a broader vision of my life and helps me figure that out."* Julia got to figure it out on her own terms, with her supporters alongside her.

Julia is now going to start taking a class offered at Sanctuary as part of their community outreach and peer support program. She is going to be part of Sanctuary's Survivors Leading Group, sharing her expertise about domestic violence and how to help survivors with her community. She is very excited to do community outreach, share her story and help other survivors. "*I am independent again. I can make my own decisions again without being scared. I have my own place to stay for now. I wasn't even able to decide to go run an errand by myself before. Now I'm on my own. It saved my life. I'm me again. I can breathe again*."

Discussion Questions:

1. What were Julia's needs when she was receiving services at Sanctuary?
2. What are some of the positive impacts that Julia has experienced because of her work with her advocate, Sonya, at Sanctuary?
3. What leads to Julia feeling comfortable to share her mental health concerns with Sonya?
4. Sanctuary provided some unique forms of outreach (hospital, survivor leader group). How does your agency do outreach about your non-residential services? What would you like to add or change?
5. What does survivor-defined-success mean at your agency?

Appendix D: Health and Human Service Commission Service Definitions for Key Non-Residential FV Services[41]

- **Family Violence Option-**Providing a client with a Family Violence Option (Good Cause) form or a Family Violence Exemption and can be done in-person, through face-to-face technology, or over-the-phone.
- **Emergency Orientation-** Providing a client Emergency Orientation during a one-time critical assistance service, such as at the hospital, court, or for a hotel stay and can be done in-person, through face-to-face technology, or over-the-phone.
- **Educational Arrangement for Children-** Providing services that result in a resident or nonresident child being in compliance with the compulsory attendance requirements found in the Education Code. Examples include providing clothing or supplies for school, conferring with schoolteachers or administrators. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Child Services-** Providing services to a child resident that includes activities such as structured arts and crafts activities and/or non-counseling, information activities provided by a trained staff person or a volunteer. This service also may include childcare for non-residential clients when the child's parent is receiving a family violence service or when childcare services are provided for current family violence clients by the center's licensed or permitted DFPS childcare facility.
- **Child Recreation or Social Group-** Providing a child client with group social activities such as daycare programming, after-school programming, arts and crafts, special outings, or other

[41] Adapted from the 2021 HHSC Family Violence Program Data Element Guide provided to the study team by TCFV.

non-counseling information group activities. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.

- **Transportation-** Providing a client with transportation and/or transportation assistance such as arranging transportation to and from emergency medical facilities for shelter residents and nonresidents and/or from a safe place to the shelter for persons being considered for acceptance as residents of the shelter and who are located within the shelter's service area. This also includes non-emergency transportation for the adult/child resident, nonresident or program participant to a single destination or to a series of destinations in a single trip. Transportation can include staff providing or arranging clients' transportation to court, place of employment and other appointments. Transportation service also includes the provisioning of bus passes or taxi fares. Rideshare companies like Uber and Lyft may also be utilized for a transportation service. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Medical Care-** Providing a client with assistance in responding to any urgent medical situations for the adult/child residents, nonresidents or program participants accessing shelter center services. This also can include basic first aid, arranging for non-emergency professional medical services for adult/child residents, nonresidents, or program participants, or obtaining prescription or nonprescription medication for the victim's self-administration. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.

- **Medical Accompaniment-** Accompanying a domestic violence victim to, or meeting a victim at a hospital, clinic, or medical office. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Intervention Services-** Providing a client (including children) intervention services such as; safety planning, understanding and support, advocacy, case management, and dating violence services to victims of family violence. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Information and Referral-Community Services-** Providing a client with information and referrals about existing community resources, including but not limited to the following: medical care providers, legal assistance providers, protective and regulatory services, resource assistance, public assistance, counseling and treatment services, children's services, and any other appropriate family violence services. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Information and Referral-Employment-** Providing a client with information and referrals about employment training and employment opportunities, either directly or through formal arrangements with other agencies. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Legal Assistance-** Providing a client with legal assistance including identifying individual legal needs, legal rights, and options, and providing support and accompaniment (including

court accompaniments) in their pursuit of those options. Legal Assistance can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.

- **Support Groups-** Providing a client with support groups related to family violence led by trained staff, survivors, or volunteers covering educational material or issues brought up by the group. Support groups may be gender, population and/or age specific. Support groups may be open-ended or closed, time specific or on-going. Weekly support groups must be provided, but attendance cannot be mandated. The shelter center's adult support groups may include recreational and/or social activities. These services can be done in-person, through face-to-face technology, or over-the-phone with an established client who has had an intake or has received continued services within the previous 12 months.
- **Orientation-**Providing introductions to the organization by a trained staff. This service should be provided in person or through face-to-face technology; however, it can be provided over the phone in certain circumstances as a last-resort option.
- **Counseling/Therapy-**Providing a client (including children) with the use of therapeutic methods of treatment and/or one-on-one support delivered by a trained staff or a volunteer. This includes professional counseling, peer therapy, group therapy and any other form of therapeutic treatment. Counseling can be counted if in person, through face-to-face technology, or over the telephone with an established client who has had an intake or has received continued services within the previous 12 months.

Appendix E: Measurement Chart: Texas Community Support Survey

For more information, please contact the research team.

Title & Citation	Domain and Definition	Sample Item(s)	Notes, Adaptations, & Psychometric Findings	Logic Model Goals Aligned	Notable TCSS Findings
Eligibility Screen	Items to determine eligibility to complete the survey	1. How old are you? 2. Are you **currently** living (**or lived in the past month**) at a domestic violence agency's shelter or in their <u>on-site</u> transitional or permanent housing (housing located with the agency shelter and/or offices)? a. Yes b. No 3. Are you receiving services, **other than** emergency shelter or **onsite** transitional housing (non-residential services), at a domestic violence agency related to experiences of harm or conflict in an **intimate relationship**? These services may include working with a case worker or advocate, counseling, parenting classes, support groups, legal advocacy, support for housing in the community, legal representation or other services not listed. a. Yes b. No 4. How long have you received services at this domestic violence agency? We mean other than emergency shelter or on-site transitional housing. These services may include working with a case worker or advocate, counseling, parenting classes, support groups, legal advocacy, legal representation, or other services not listed?	Based on study eligibility criteria, 4 items total	All	83 participants screened into participate in the survey
Demographic Questionnaire	Individual survivor characteristics	1. What is your race/ethnicity (as you define it)? Please select all that apply. a. White or Caucasian-Non-Hispanic b. Hispanic or Latino/a c. Black or African American d. American Indian or Alaskan Native e. Asian or f. Pacific Islander g. Multiracial, please specify: 2. What is your preferred language to speak at home? a. English (1) b. Spanish (2) c. Vietnamese (3) d. Chinese e. Urdu	Includes several "select all that apply" response sets, which complicates analysis but better captures survivors' identities. 17 items total	All	See report table 4 for participant demographics

		f. Arabic g. French h. Tagalog i. Russian j. Other: (4) _____			
Finances	Questions focused on survivor's current employment, monthly income, and receipt of cash or utility assistance.	3. What is your current monthly income from all sources, including work, government benefits, social security, support from friends and family or any other income source? a. Less than $500 b. $501 – 1,000 c. $1001-2000 d. $2001-3000 e. $3001-4000 f. $4001-5000 g. $5001 or more 4. In the **last 12 months** have you received any cash assistance, or gift cards from the domestic violence agency you are working with? a. Yes (1) b. No (2)	Includes survey logic to gain additional detail for those receiving certain forms of assistance. 10 items total	Increase access to needed and wanted resources Increase physical and emotional safety Enhance peer, social, and structural support	Participant Income: • < $500: 29% • $501-$1000: 26% • $1001-$2000: 27% • < $2000: 18% Participant Housing: • Owned/Rented by the participant: 60% • Paid via voucher program: 9% • Staying with friend/family: 23% • Other: 8%
Needs, Domestic Violence Help Seeking, and Services (Adapted in part from Sullivan & Allen, n.d.)	Questions focused on survivors need for and use of services at the domestic violence agency, with sets of items focused on legal, safety & health support, housing & economic support, and child focused services.	Example of Service Categories: Help with divorce Support Group Food Assistance Childcare Response options: 1. I needed and received this service, it was: • Very helpful • Helpful • Neutral: neither helpful nor unhelpful • Unhelpful • Very Unhelpful 2. I needed but did not receive this service 3. I did not need this kind of service	Matrices developed by the study team were employed to gather information on survivors need for and usefulness of services simultaneously. 49 items total	All Adherence to the advocacy model	Of those who received hotline services: • 83% rated services as helpful or very helpful, while • 82% of those who received safety planning support rated it as helpful or very helpful.
Fidelity to the advocacy model (Adapted from Sullivan et al. 2019.)	Items focused on the advocacy relationship and experiences with staff and the agency.	Since I started using services at this agency, the main staff member I worked with knew how to connect me to community resources a. Not at all b. A little c. Somewhat d. Very much or a lot Between you and staff members at this domestic violence agency who decided what you worked on? a. I did, completely	Adapted by the study team to fit the context of nonresidential services. 23 items total Alpha = .95	Enhance peer, social, and structural support Adherence to tenants of the advocacy model (model fidelity)	Overall: Mean 57.18 SD 9.92 Range 16-64 No statistical differences by participant race/ethnicity

		b. I did, mostly c. We did, equally d. The staff person did, mostly e. The staff person did, completely I felt connected to staff at this agency. a. Strongly agree (1) b. Agree (2) c. Neither agree nor disagree d. Disagree (3) e. Strongly disagree Staff at this agency treated me fairly. a. Strongly agree (1) b. Agree (2) c. Neither agree nor disagree d. Disagree (3) e. Strongly disagree	Not at all (1) – Very much or a lot (4)		
Adapted Trauma informed practice scale (TIP) (Sullivan & Goodman, 2015; Serrata, Rodriguez, Castro, & Hernandez-Martinez, 2019)	Items focused on staff actions, connection, and understanding of power and oppression.	Staff at this domestic violence agency understand how discrimination and injustice impacts experiences. a. Not at all true b. A little true c. Somewhat true d. Very true e. I don't know	Additional items adapted from Serrata et al were employed to capture language and cultural access. 7 items total Alpha .77 Very True to Not at all true	Adapt services for diverse cultural groups and center racial justice Promote healing from violence and other forms of harm Adherence to tenants of the advocacy model (model fidelity)	Overall: Mean 24.79 SD: 4.17 Range 14-30 No difference in mean TIPS score by race/ethnicity
Violence Experiences – IPV: Adapted from the National Center for Injury Prevention and Control. National Intimate Partner and Sexual Violence Survey (NISVS): https://www.cdc.gov/violenceprevention/datasources/nisvs/index.html) Economic abuse scale (Adams, Sullivan, Bybee & Greeson, 2008)	IPV perpetrated by an intimate partner before and during service use at the domestic violence agency.	Did a romantic or dating partner or spouse ever do any of the following… Insulted, humiliated, or made fun of you in front of others? Yes, in my life BEFORE I started using services ad this agency Yes, in my life AFTER I started using services at this agency No, this never happened to me.	Selection of items from NISVS, shortened to reduce survey length and expanded to include economic abuse Response set adapted by the study team to reflect the aims of the project. 24 items total Two economic abuse items were adapted from the Adams et al, 2008 7 item scale	Increase physical and emotional safety from individual and structural harm.	After starting services at their FV agency: • 35% reported experiencing any form of family violence • 12.5% reported exposure to physical violence • 8.45% reported exposure to sexual abuse • 22% reported exposure to psychological violence • 27% reported exposure to stalking behavior

Violence Experiences: Coercive Control (Kennedy, Bybee, McCauley, & Prock, 2018)	Coercive and controlling behaviors of a partner before and during service use at the domestic violence agency.	Have you ever had a romantic or dating partner or spouse do any of the following to you… …Try to keep you from doing what you wanted to do? Before using services at this agency Since using services at this agency	Response options adapted by the study team to reflect study aims. Responses were check all that apply 7 items total	Increase physical and emotional safety from individual and structural harm.	94% of participants reported having a partner who said they had to do what they wanted because of their relationship prior to working with the FV agency, 1% reported it happening only after working with FV agency, and 4% reported it happening before and after working with the agency
Measure of Victim Empowerment Related to Safety (MOVERS) (Goodman et al, 2015)	Captures survivor feelings of empowerment related to their safety from violence, their own ability to manage their safety, and their sense of community support for their safety.	Please tell us how true the following statements are for you when you think about your life: I can cope with whatever challenges come at me as I work to keep safe. Never true Sometimes true Half the time true Mostly true Always true	Scale adapted and shortened by the study team 10 items total Alpha = .94 10 Items Never True (1) – Always True (5)	Increase physical and emotional safety from individual and structural harm Adherence to the advocacy model	Overall: • Mean: 37.48 • SD: 9.55 • Range: 10-50 Means: • White: 37.7 • Latinx/Hispanic: 41.3 • Black/AA: 36.3 • Asian: 30.6 • Multiracial: 35.7
Patient Health Questionnaire 15 (Kroenke, Spitzer, & Williams, 2002).	Captures somatic (physically felt) symptoms of depression such as stomach pain or chest pain	Over the last week, how often have you been bothered by • Stomach pain • Back pain • Pain in your arms, legs, or joints? Answer choices: Not at all Bothered a little Bothered a lot	15 items total Alpha .89 Not at all (1) to Bothered a lot (3)	Promote Healing from Violence	Overall: N % Mild: 19 27% Moderate: 14 20% Severe: 29 41% Mean Score: White 30.6 Latinx 25.3 Black/AA 26.7 Asian 32.7 Multiracial 25.6 *ANOVA significant for differences in PHQ15 score
Patient Health Questionnaire 9 (Kroenke, Spitzer, & Williams, 2001).	Captures symptoms of depression	Over the last two weeks, how often have you been bothered by any of the following problems: • Little interest or pleasure in doing things • Feeling down, depressed, or hopeless • Feeling tired or having little energy Answer choices:	8 items total (adapted by the team to remove suicide screener) Alpha .94 Not at all (1) to nearly every day (4)	Promote Healing from Violence	Overall: N % mild 19 28% moderate 13 19% severe 15 22%

		Not at all Several days More than half the days Nearly every day			No significant differences by race or ethnicity
Primary Care Screen for PTSD (PC-PTSD-5) (Prins et al, 2015).	Captures symptoms of PTSD	Have you had any experience in your lifetime that was so frightening, horrible, or upsetting that, in the PAST MONTH, you, Had nightmares about it or thought about it when you did not want to? Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? • Yes • No	5 items total Alpha .78 Yes/No	Promote Healing from Violence	Positive Screen for PTSD is answering yes to four or five items 54% of participants screened positive No significant differences by race/ethnicity
Informal Support Systems (Hamby, Grych, & Banyard, 2015).	Support from friends and family outside the DV service agency	When answering the following questions, think about people in your life right now (family, friends) other than staff at this agency… My friends really try to help me I can count on my friends when things go wrong • Mostly true • Somewhat true • A little true • Not true	Adapted by the study team to meet project aims. 7 items total Alpha = .96 Mostly True (4) – Not True (1)	Enhance peer, social, and structural support	Overall: • Mean: 20.67 • SD: 6.6 • Range 7-28 A marginal difference was observed by participant race/ethnicity, with Latinx participants scoring slightly higher and Black and Asian participants scoring slightly lower, with White and Multiracial participants in the middle (p = .08).

Appendix F: Staff Interview Guide

Please note that this is list of potential interview questions.

Introduction:

I will be asking you questions about your demographics; non-residential services in your agency, goals of those services; your overall thoughts and perceptions; and recommendations of how non-residential services could shift. By non-residential, I mean services provided to people not living in shelter or transitional housing.

Demographics

I am going to start by asking you a few quick demographic questions.

1. What is your age? How old are you? In years _____
2. How do you identify your race/ethnicity?
3. What is your current gender identity?

Overview of Staff Experience, Job, and Agency

Next, I am going to ask you a few questions about your job and your agency.

4. Which best describes your agency?
    a. Dual Domestic Violence and Sexual Assault focused agency with a shelter
    b. Dual Domestic Violence and Sexual Assault focused nonresidential center
    c. Domestic Violence focused agency with a shelter
    d. Domestic Violence focused nonresidential center
    e. Multipurpose Crime Victim Agency
    f. Other
5. How many years in total have you worked on issues related to domestic violence and sexual assault? _____
6. What is your current job title/role? _____

7. How many years have you been in your current position? _____

8. Can you tell me a little about what you do at your agency [*more detail about your role*]?

Availability/Access of Non-residential Services

Next, I am going to ask you more about the non-residential services your agency provides.

9. What nonresidential services does your agency provide for survivors?

10. How do survivors reach/access you and or your non-residential services and programs?

Nonresidential Service Provision

These next questions will be about <u>how</u> you provide nonresidential services at your agency.

11. HOTLINE: Does your agency provide hotline services? [For staff at HHSC-funded agencies]: One of your agency's funders, HHSC, defines **intervention services** as *including safety planning, understanding and support, information, education, referrals, resource assistance and developing individual service plans*: What does providing non-residential **intervention services** look like to you at your agency? [*Sub-prompts (depending on **someone's role** or the flow of an interview)]:*

    a. *INFO & REFERRAL: What does I & R look like for survivors accessing nonresidential services (other than hotline) in your agency services? How do you assess the efficacy of I & R services?*

    b. *SAFETY PLANNING: What is your approach to safety planning with survivors accessing nonresidential services?*

        i. *How often do you safety plan with survivors receiving nonresidential services? [one time or incrementally over time?]*

        ii. *How do you safety plan with survivors who are not planning to leave the relationship?*

iii. *How do you safety plan when someone does not feel safe involving police or the courts?*

c. *SERVICE PLANS/GOALS: How do you create service plans/goals with survivors? How do you know if a survivor's goals have been met?*

12. Many of the services you and your agency provide are one-on-one; but sometimes staff do more macro or system advocacy-related work that brings about changes in systems impacting more than one client at a time. In what areas (if any) do you or your agency provide these more macro system advocacy pieces (i.e., in civil legal systems, CPS system, homeless service coordination)?
13. Does your agency offer any peer-led services (led by other survivors)?
14. Where do you typically meet non-residential clients (home visits, your office, online via zoom, phone)?
15. When thinking of mobile advocacy (*like going into the community with a survivor or meeting in their home or at another location other than your office in person*), what does that look like or what could that look like?
16. How does your agency provide virtual services (*online via Zoom or other video platforms*)?
17. How do you work with survivors with different and often intersecting identities who access nonresidential services [*Possible examples*]:
    a. *LGBTQIA+: LGBTQ community resources, sexual health, welcoming environment for all gender identities; information about transitioning*
    b. *Race/ethnicity: culturally specific services or programs; staff diversity*
    c. *Gender: services for male survivors; serving teenage boys*

d. *Age/life stage – accommodations for older survivors; services for teenagers*
e. *Language/ immigration status: advocacy in immigration system, language access beyond Spanish; multiple Spanish speaking staff*
f. *Different abilities, mental health challenges or substance use: harm reduction, collaborations with local psychiatric resources/substance abuse treatment centers*

18. What else do you think needs to be provided to meet the diversity of survivor needs?
19. How do non-residential clients differ from residential clients in their needs and goals demographics (if at all)?

Impact of Services

Next, I am going to ask you about the impact of your agency's nonresidential services.

20. Of all the nonresidential services you offer- which do you think are the most impactful?
21. How do you think the nonresidential services at your agency impact the survivors you work with?
22. How do your agency's nonresidential services help survivors reduce experiences of harm or violence?
23. How do your agency's nonresidential services change survivors' knowledge of community resources and supports?

Recommendations for Change

The last set of questions I want to ask you about are about what you see as the unmet needs of survivors seeking nonresidential services and what changes are needed in agencies and with services that funders require.

24. What services do survivors tell you they want? Is your agency offering what they need?

25. (*Provide participant with handout with HHSC services*) Please look over this handout of required services that are detailed in both Chapter 51 of the Texas Human Resource Code and Chapter 379 of the Texas Administrative Code.
    a. If you were going to revise HHSC's Chapter 51 required services, what would you change?
    b. What services are missing from Chapter 51? What nonresidential services are you already providing that you wish would be included under Chapter 51?
26. What nonresidential services do you wish your agency was able to provide? How could agencies support survivors more effectively? What would they need to change to do that?
27. Is there anything else you think we should know?