FVPSA ARPA Supplemental Funding to VDSS for Domestic Violence Program COVID-19 Mitigation Strategies 2022-2025

Virginia Domestic Violence Programs Needs Assessment Summary and Recommendations

Virginia Sexual and Domestic Violence Action Alliance: *Kristi VanAudenhove, Ruth Micklem and Shabana Shaheen*

SECTION 1: ARPA NEEDS ASSESSMENT PURPOSE

In a Notice of Supplemental Funding dated October 25, 2021, the Administration for Children and Families within the Department of Health and Human Services announced a significant investment of American Rescue Plan Act funds for the Family Violence Prevention and Services Act (FVPSA): $550 million would be made available to assist states, territories, and Tribes with providing access to **COVID-19 testing, vaccines, and mobile health units for domestic violence shelters, domestic violence programs**, Tribes, rural communities, culturally specific programs, and underserved communities.

The purpose of these supplemental funds in the FVPSA program is to **prevent, prepare for, and respond to COVID-19 with an intentional focus on increasing access to COVID-19 testing, vaccines, and mobile health units to mitigate the spread of this virus, and increase supports for domestic violence survivors.** Within these parameters, **grant recipients have flexibility to determine which services best support the needs of survivors, children, and families experiencing family violence, domestic violence, and dating violence.**

This investment recognizes that domestic violence is a significant public health issue for survivors and their dependents. Expanding the access to health care and supportive services increases survivor safety, as well as strengthens the health and wellbeing of 1.3 million survivors served by FVPSA-funded programs every year.

In Virginia, a total of $8,316,672 has been awarded to the state FVPSA fund administrator, the Office of Family Violence in the Virginia Department of Social Services (VDSS). The funds are to be awarded to domestic violence service providers. The supplemental funding will expire September 30, 2025.

In addition to awarding funds to each state and territory FVPSA program that supports community domestic violence services, the FVPSA office has also distributed funds to state and territory coalitions, Tribes and Tribal Coalitions, and national resource centers providing related

resources, training, and evaluation. **The Virginia Sexual and Domestic Violence Action Alliance (Action Alliance), as Virginia's federally recognized state domestic violence coalition, received $357,143** for a two-year project focused on healing and resiliency for domestic violence service providers that will include regional and identity-focused healing circles. These circles will capture lessons learned from the ongoing experience of advocacy during the pandemic in order to develop recommendations to strengthen the advocacy workforce and bolster resilience as COVID-19 continues.

In preparation for developing and administering a competitive process for awarding the Supplemental Funds, VDSS has contracted with the Action Alliance to conduct a needs assessment with local domestic violence programs (DVPS) and health departments and to partner with VDSS in the development of a plan that will make the best possible use of these limited one-time resources.

SECTION 2: ARPA NEEDS ASSESSMENT PROCESS

DOMESTIC VIOLENCE PROGRAM INTERVIEWS

Three Action Alliance staff conducted on-site visits with twenty-two agencies, interviewing seventy individuals between April and August of 2022. Staff scheduled visits with DVP Directors and encouraged them to invite staff representatives to participate as well. Six agency Directors chose to be the sole representative from their agency; the remaining agencies included were represented by the Director and one or more staff member(s). **The interviews ranged from 90-minutes to 3 hours.** All the visits began with an opening conversation about how staff are doing.

During each visit staff asked a set of questions about each of the three core areas that are priorities for funding: 1) Vaccines and Testing; 2) Health Care and Partnerships; and 3) Workforce Retention. In each core area we asked agencies to describe their current efforts, the related activities of which they are most proud. We also asked them to describe unmet needs in each core area, and the needs that are the highest priority across the populations they serve. In each area we also asked a set of specific follow-up questions.

Follow up questions for each category:

- **Vaccines/Testing**: (If the agency is not engaged in promoting vaccines and testing), why is the agency not promoting vaccines and testing?

- **Health Care/Partnerships**: Please describe access to health care for staff and how that is being paid for in each of the following areas: dental care; vision care; reproductive health care; preventative screenings. What is in place in the way of services and partnerships? If there are on-site services in shelter or outreach centers, please describe the partnership and how it works. What are survivors telling you they need? Has that changed in the past two years?

- **Health Promotion**: Are you able to promote wellness for staff and for survivors through policy/activities/structural design? Has the agency used resources to make the design of their spaces more trauma-informed? Does the agency assist with access to stress management strategies or preventative screenings? When/how do staff engage with survivors about their health concerns and needs, like smoking cessation or healthy eating strategies?

- **Workforce Retention**: What is working? What is not working? Could you describe your pay and benefits, work schedules, workspace, equipment, and tools—do they meet basic needs? Are they assessed/updated regularly? Any big changes in the past two years—and impact of those changes?

Staff did not record interviews in order to encourage everyone to speak candidly about the impact of the pandemic on themselves and their agencies and about their current needs. In lieu of audio/visual recording, staff took extensive notes which were then transferred to a data table without identifying information.

To ensure diverse geographic representation in the interviews, staff conducted five interviews in the southwestern part of the state, seven in the northern area (including two culturally-specific agencies), five in the southeastern part of the state, and the remaining five across the center of the state. Among the 22 agencies we interviewed, 3 Directors were Black, Indigenous, People of Color (BIPOC); in 10 of the agencies, BIPOC staff participated in the interviews.

DVP DIRECTORS' ZOOM DISCUSSIONS

The Action Alliance facilitates two technical assistance sessions with DVP Directors via Zoom each month. These sessions offer an opportunity to share information and discuss a wide variety of topics. In June, we devoted **30 minutes to a group discussion about how COVID-19 vaccine and testing protocols are evolving in DVPs**. We used this as an opportunity to gather information

about the greatest areas of need related to this supplemental ARPA funding for COVID mitigation. Fourteen DVPs were part of the discussion.

In July, we devoted **30 minutes to a conversation about workforce retention, and specifically the types of "wellness benefits" (e.g. flexible schedules, remote working, or other options to enhance work/life balance) that agencies were testing out and/or wished to implement if they had sufficient resources.** Twenty-seven DVPs were part of this discussion.

HEALTH DISTRICT INTERVIEWS

Action Alliance staff **reached out to Nursing Managers in each of the 35 Health Districts affiliated with the Virginia Department of Health** and then arranged **phone interviews with 11 Health Districts**. Four of the five health regions were represented in the interviews—there was not an interview conducted in the Northwest region. Nursing Managers described their districts as predominantly rural (3), a mix of rural and suburban (2), suburban (3), predominantly urban (1) and a mix of rural and urban (2). Interviews were generally 30 minutes or less.

The interviews with Nursing Managers included the following questions:

- Do you have a current partnership with the Domestic Violence Program in your community? (If yes, please describe. If no, are you familiar with the agency and their services?)
- What is your capacity for partnering with the local Domestic Violence Program in COVID mitigation activities? (Follow up about that capacity specific to vaccines and testing)
- What resources do you have available for survivors? Have you developed any resources for specific underserved/at risk populations?
- Please describe your health district. (Including specific info about rural, suburban, urban characteristics)

THE LIMITATIONS OF THIS NEEDS ASSESSMENT

Two of the three staff who conducted site visits have been working in the field in Virginia for at least thirty years. **We could see and feel the cumulative stress/trauma in many of the agencies we visited.** Agency offices were often unusually cluttered, in some cases because of a high volume of donations and lack of time and space to organize and store the items and in some cases, it just felt like the physical impact of exhaustion. Conversations lasted much longer than we anticipated; it was clear that people needed to talk.

Many agencies spoke about feeling excessively overburdened at the start of the pandemic when they were one of the only agencies besides law enforcement still operating 24/7; this problem persists in some areas. As will be described throughout the report**, DVPs are experiencing record increases in requests for shelter and other forms of assistance. Advocates report seeing higher levels of violence, more serious injuries, "a lot more death than usual," more use of firearms, more untreated addiction, and an escalation in assaults against staff.** One group of staff described it this way: "Walking in the door in the morning, it just feels heavy."

This is all against a backdrop in which DVP staff, like everyone, have been navigating personal journeys of fear, anxiety, and confusion about the pandemic and journeys of loss and grief and figuring out how to attend their own health needs. **Domestic violence advocates are a feisty and resilient bunch and leaders across the state are pulling together some inspiring strategies and resources to sustain their teams—and still, we must acknowledge that the pandemic has been a *nearly* overwhelming challenge for the movement.** This needs assessment captures a part of the picture of how DVPs and advocates have been impacted by COVID-19--and we look forward to linking this data with a broader story of the movement's experience with the pandemic. **With a more holistic picture, we can work together to support healing, restore hope, and fully return ourselves and all of the individuals who make up this movement into a collective and thriving force for good in our communities**.

SECTION 3: THREE FRAMING TOOLS

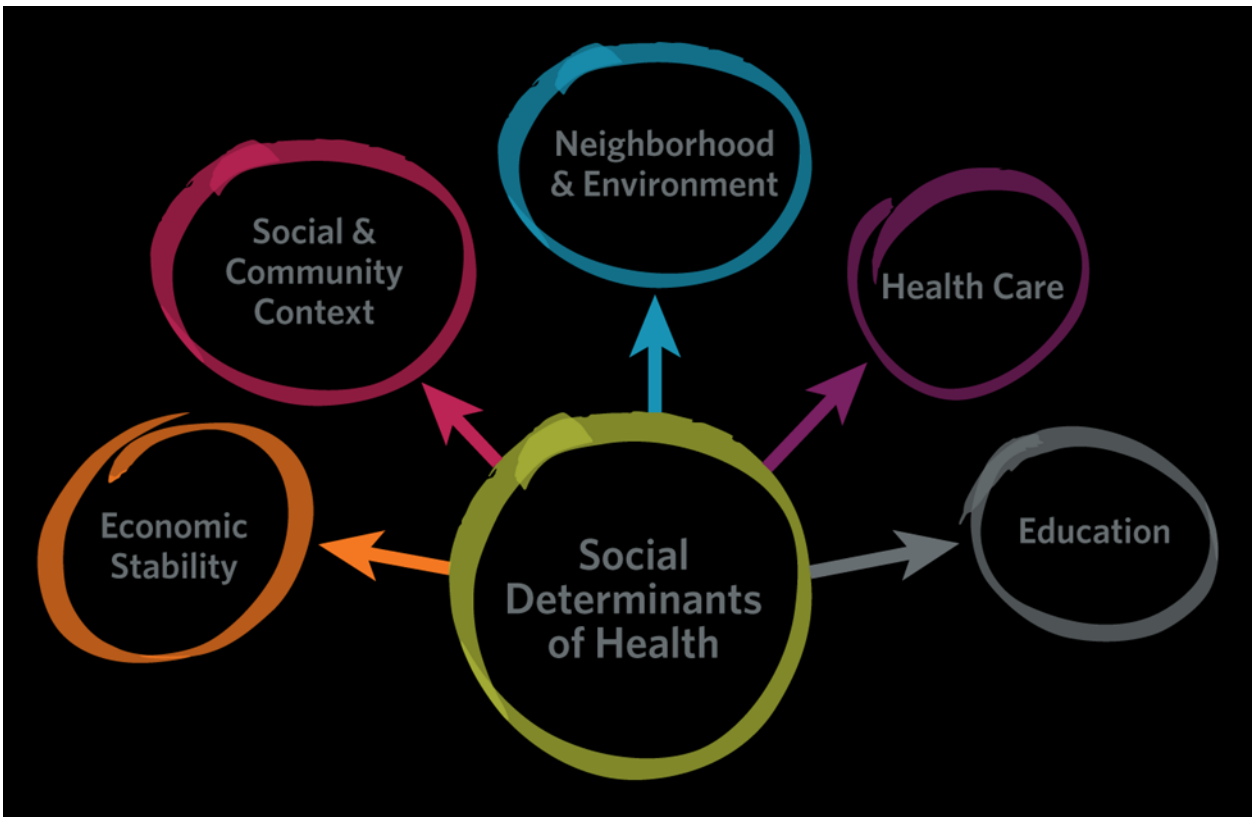
The Action Alliance used **three tools as a structural framework to make meaning of our interviews and discussions.**

The **SAMSHA principles of a trauma-informed approach** provided a foundation**.** This tool was also used as a framing tool for the recent Underserved Populations Learning Collaborative Partnership that brought together VDSS, the Action Alliance, the Department of Criminal Justice Services and two cohorts of 15-20 community sexual and domestic violence agencies. DVPs have received extensive training and practice opportunities for applying the six principles in their daily work. These principles are also best practices guides for effective health care services. In each

area of funding priority, we begin by describing how the uniquely trauma-informed practices of DVPs can be an effective platform for COVID-19 mitigation strategies.

1 Source: SAMHSA's National Center for Trauma-Informed Care

The **Social Determinants of Health**, as described by the Centers for Disease Control and Prevention, provide a second lens for viewing the work of DVPs and its connection to COVID-19 mitigation and health promotion. There is a strong link between health inequities and the reasons that domestic violence survivors are an at-risk population for COVID-19 transmission and serious illness. DVPs not only play a role in addressing immediate survivors' needs, but they are also catalysts for systemic changes in their communities that can lead to better health outcomes for all.



2 Source: UPMC Enteprises, University of Pittsburgh

Finally, as we turned to the task of prioritizing funding recommendations based on extensive input from the DVPs, we utilized the work of the **Domestic Violence Evidence Project at the National Resource Center on Domestic Violence, and specifically research and resources from Cris Sullivan** who created a *Theory of Change Underlying How Domestic Violence Program Activities Impact Adult and Child Survivors' Well-Being.* The theory of change describes common elements of DVP services, related program outcomes, and their link to factors that predict social and emotional well-being. **Our goal was to prioritize funding recommendations that could be clearly linked to program outcomes that lead to well-being**.

SECTION 4: VACCINES AND TESTING

FVPSA RFA Language Describing Intent and Examples of Possible Funded Activities:

COVID-19 VACCINE ACCESS and COVID-19 TESTING: The intent of this ARP COVID-19 testing, vaccines, and mobile health units supplemental funding is to provide resources for states, territories, and Tribes to provide access to COVID-19 vaccines for domestic violence survivors and their dependents including individuals from vulnerable and medically underserved communities. States, territories, and Tribes and subrecipients may use funds to address any barriers to vaccines that may be experienced by domestic violence survivors and their dependents.

Examples of possible funded activities:

- planning and implementation of projects and partnerships that increase vaccine access or administration on-site, as co-sponsored pop-up clinics, or at existing community sites
- including providing interpreters, providing translated materials for LEP survivors and their dependents
- developing and sharing culturally specific outreach and education materials
- making vaccine appointments for individuals and arranging transportation, childcare, interpreters and translated materials as needed
- supplying DVPs with rapid COVID-19 testing supplies for survivors and for employees
- encouraging more extensive testing efforts

- making testing understandable and accessible for rural communities, racial and ethnic specific communities, and people with limited English proficiency.

HOW IS VACCINE AND TESTING PROMOTION LINKED TO TRAUMA-INFORMED CARE AND THE SOCIAL DETERMINANTS OF HEALTH?

Systemic health inequities increase vulnerability to COVID-19 for many survivors. It is critical for any efforts to address COVID-19 to increase access to culturally relevant, trauma-informed care that considers the unique needs and experiences of marginalized communities. **Domestic Violence Programs (DVPs) are adept at "meeting survivors where they are"—in their communities, in their unique healing journeys, and in ways that reduce stigma, shame and blame** (*Futures Without Violence*). Survivors trust DVPs to offer safety, transparency, and the ability to exercise choice in their decisions—all core tenets of trauma-informed responses. Domestic violence advocates receive extensive training in the consideration of cultural, historical and gender issues—another essential element of effective trauma-informed care. **As a result, DVPs are in a strong position to remove barriers to vaccines and testing by listening to the unique needs of survivors, educating survivors about the risk and safety considerations linked to public health strategies to minimize COVID-19 impact, and helping survivors find solutions to the challenges that impede their ability to access vaccines and tests.**

In doing so, DVPs contribute to strengthen two vital components of the social determinants of health: increasing access to health and health care and strengthening social and community connections.

WHAT IS HAPPENING IN VIRGINIA'S DOMESTIC VIOLENCE PROGRAMS?

About **one-third of DVPs described being well resourced for both staff and survivors when it comes to accessing COVID-19 vaccines and testing.** This is often achieved through a partnership with the local health department or with a strong community health center. In some cases, domestic violence advocates were considered a priority population for vaccine access; in those agencies there was an elevated level of awareness and advocacy on behalf of survivors obtaining vaccines as well.

On the other hand, it was also common to hear staff in DVPs describe vaccines as "very political," or as one of several politically divisive issues in their community—leading those agencies to be less likely to place an emphasis on advocacy to vaccines or testing. One agency described a board of directors' prohibition on requiring or even encouraging vaccines for staff and that extended to

prohibiting mask mandates as well. One agency shared that only about half the staff chose to get vaccinated, leading to more than half the staff becoming ill with COVID-19 in the past year.

Domestic violence programs have tried a variety of strategies to promote vaccination, masking, testing and other safeguards over the past two years. Several agencies have local health department materials (e.g., vaccine clinic schedules) and CDC safety information posted or available as people enter their offices/outreach centers. One agency had information easily visible in both English and Spanish. A few agencies have health partners who visit the shelter to offer education, and in at least two cases, to offer vaccines on site. One agency has partnered with health care providers to offer three vaccine clinics (first shots, second shots and one round of boosters) specifically for the Latino and immigrant communities in their service area who may be linked to families they have assisted. Fifty community members received first and second shots, and at the time of our visit, eighteen had returned for a booster. **All the agencies we spoke with described a need for resources in plain language that help to explain COVID-19 and answer the question, "Why get a vaccine?", with culturally specific materials for rural, urban, Black and Latinx communities.**

DVPs have had to adapt shelter practices to the new COVID-19 reality. Many agencies changed their intake process, placing families at hotels for up to 10 days and requiring negative PCR tests at the end of that period and prior to entering shelter. Some agencies have moved away from congregate residential shelters to scattered site arrangements where families do not have to share spaces. Those who have opened their residential shelters are requiring masks in most areas and arranging space so that social distancing is easier, with just a few exceptions. Agencies are periodically emptying shelters (including scattered site facilities) to engage in "terminal cleaning", similar to disinfecting protocols in medical facilities.

It is also important to note that over the past year requests for shelter have "skyrocketed," and at the same time, access to affordable housing has plummeted in most communities. One agency shared that the average shelter stay has gone from 42 days to 150 days in their program, and another shared that in a recent month they received 126 requests for shelter but were only able to assist seven families. This overwhelming demand leaves survivors in jeopardy, exhausts domestic violence advocates, and increases health risks for everyone. **Vaccines and testing are one important piece of a complicated puzzle that DVPs are navigating as they plan for services in the continuing pandemic environment.**

WHAT IS HAPPENING IN LOCAL HEALTH DEPARTMENTS?

Since the beginning of the pandemic, **local health departments in Virginia have administered 16,580,437 doses of COVID-19 vaccines.** As a result, 72% of the population is fully vaccinated, with rates ranging from below 50% in several rural localities to more than 80% in a mix of urban, suburban, and rural cities and counties on the Eastern side of the state. Asian Pacific Islanders and Latino individuals are substantially more likely to have had at least one dose of the vaccine than other racial/ethnic groups, and the rates for both whites (68%) and Blacks (66%) are the lowest.

In our interviews with **local health departments, about 50% were aware of their local DVP and had partnered with them in some way as part of their COVID-19 mitigation work**. All the providers indicated that they would be willing to enter a partnership—with capacity linked to the size of the department. At a minimum, **health departments are happy to share information and to consider invitations to community events as sites for vaccine clinics**. In a few cases, nurse managers indicated that they would like to consider more regular partnership work around the delivery of ongoing health care.

When asked about specialized resources for survivors, none of the providers were aware of materials specifically for domestic violence survivors or designed to address the specific concerns of marginalized or underserved communities**. Materials are available from the Virginia Department of Health, including posters and signs in multiple languages with people depicted as from many races/ethnicities**.

PRIORITIES FOR ARPA FUNDING LINKED TO THE DOMESTIC VIOLENCE EVIDENCE PROJECT THEORY OF CHANGE

The Domestic Violence Evidence Project's Theory of Change describes eight common elements of DVPs and anticipated program outcomes for intrapersonal change and interpersonal and social change. Applying these elements to promoting vaccines and reducing barriers to testing, DVPs could enhance the health and well-being of survivors in the following ways:

- DVPs providing **culturally specific education about why it is important to get vaccinated (and have your children vaccinated), addressing common myths or misconceptions about the COVID-19 Vaccine**, and providing information about options, where to access vaccines and where to access tests, could

    - **decrease the suspicion, distress and skepticism of survivors** who have not yet been vaccinated about vaccines as well as precautions like masking and testing, leading to increased use of those mitigation strategies.
- Advocates **incorporating gender and culturally specific COVID-19 safety strategies into their overall safety planning** could
    - lead to a **greater sense of self-efficacy for survivors**.
- **Encouraging survivors to tell the unique stories of their experience with the pandemic**, and listening with both empathy and respect could
    - **Promote healing and resiliency and a sense of hope for the future**.
- Providing **access to vaccines, testing and related health care for survivors** and for their children could
    - expand overall **access to community resources** and **build a sense of connection** to the larger community.

Priorities for funding identified by DVPs include:

1. A **broad array of education and information materials for diverse populations in plain language about COVID-19, vaccines, masking, and testing**. DVPs would like the materials to speak to survivors specifically, and especially survivors who are parents. They ask that the materials directly address people's fears. They would like varied materials for rural communities, urban communities, Black communities and Latinx communities. They would prefer to be able to purchase these materials from trusted sources (to be identified as part of the Toolkit work) or developed on a regional or statewide basis. They would like the materials to be available in a variety of languages.
2. Partnerships with health care providers including health departments and community health agencies to **implement or expand shelter-based clinics and/or community clinics where vaccines are easily accessible to survivors and their children**. They would like to be able to provide translators where there are significant numbers of people with limited English proficiency or when the target population is a culturally specific population for whom English is not the first language.
3. **Transportation for survivors, including agency vehicles, cab fare, and gas cards, to help survivors and their children get vaccines, tests, and other forms of health care.** For

agencies that have agency vehicles, it is also helpful if they can provide hourly pay to a driver as a more cost-efficient option than having full-time advocacy staff devote substantial amounts of time to providing rides and waiting on people during their appointments. In some cases, survivors also need interpreters to meet them at their appointments to ensure that they have voice and choice in the services provided.

4. Agencies need a small amount of funding to be available for the **purchase of COVID-19 tests** so that they are available 24/7 during shelter intakes, at the time of exit, and in the case of outbreaks within congregate living facilities.
5. **Improving standards of cleanliness throughout both shelters and outreach offices is also a priority for DVP COVID-19 mitigation.** Agencies would like to be able to contract for regular deep cleaning in those spaces to ensure that all surfaces are disinfected. Clean air is an important prevention strategy, and funding could help DVPs optimize fresh air ventilation and enhance air filtration and cleaning in partnership with their HVAC providers. Shelter managers also identified industrial strength cleaning appliances including vacuums and washer/dryer units as key to keeping those areas clean.

SECTION 5: MOBILE HEALTH CARE AND HEALTH CARE PARTNERSHIPS

FVPSA RFA Language Describing Intent and Examples of Possible Funded Activities:

MOBILE HEALTH UNITS ACCESS: Mobile health units are an innovative model of health care delivery that could help alleviate health disparities among vulnerable populations and individuals with chronic diseases. The target populations of mobile health units include vulnerable communities such as homeless people, displaced populations, immigrant communities, migrant workers, people who are under-insured, and children. Historically, these populations and communities are often disconnected from traditional health care settings and require support in accessing health care. Mobile health units travel to partnering locations and provide services on

a recurring basis. For example, mobile health units across the country have successfully partnered with other agencies serving the homeless in the community, such as homeless shelters, faith-based organizations, and food banks. Access to services, engagement in care, and successful utilization of services may lead to measurable improvements in health care outcomes among homeless populations of individuals and families. The FVPSA Program is providing supplemental testing funding to assist states, territories, Tribes, domestic violence shelters, domestic violence programs, culturally specific programs, and rural communities with establishing partnerships with health departments, hospitals, and IHS facilities to access mobile health units with the purpose of mitigating the spread of COVID-19 among domestic violence survivors and their dependents.

PARTNERSHIPS: The impact of experiencing domestic violence has lifelong, health related consequences for survivors, including chronic pain, traumatic brain injury, digestive problems, reproductive and maternal health concerns, and the potential loss of a medical home. Housing instability and homelessness exacerbate this problem. Health care providers, working in partnership with states, territories, domestic violence service providers, Tribes, and culturally specific organizations, represent important opportunities for mitigating the spread of COVID-19 through integrated health and community-based supports for families that face particular barriers at the intersection of domestic violence, homelessness, and health care. A consortium of community partners and health care providers enables domestic violence programs, culturally specific organizations, Tribes and rural communities to support the safety and health needs of domestic violence survivors and increases health supports to mitigate the spread of COVID-19.

Examples of possible funded activities:

- Establish/maintain contracts with existing mobile health units operated by hospitals, clinics, and public health organizations.
- Expand access to mobile health clinics for survivors and their families in rural areas of the state and for other underserved communities where they may be isolated from health care.
- Support partnerships which include public health agencies and other community entities addressing the social determinants of health.
- Expand partnerships to meet a variety of health needs related to domestic violence and homelessness.

HOW ARE MOBILE CLINICS AND HEALTH PARTNERSHIPS LINKED TO TRAUMA-INFORMED CARE AND THE SOCIAL DETERMINANTS OF HEALTH?

Physical health and wellness are linked to resilience, especially in the face of violence. When subjected to domestic violence, adult survivors and their children are most often exposed to

continuous trauma. Whatever the form of that trauma, it is experienced in both the mind and the body, and it can cause serious physical injuries and have adverse impacts on adult and child brains. "Neuroplasticity" refers to a complex process whereby our brains adapt and change in response to stimuli that can either enhance that ability or weaken that ability. Physical health and wellness enhance our neuroplasticity. Exposure to continuous trauma weakens our neuroplasticity.

Physical health and wellness enhance our ability to recover from injuries to bodies and minds—increasing the ability to heal quickly and completely from both physical injuries and traumatic interruptions to the ability to process what is happening and make positive adaptive changes. Financial insecurity, which is common amongst survivors who reach out to DVPs, decreases our capacity for physical healing, and impedes the ability to process trauma and heal. **The work of DVPs is to deliver trauma-informed care in an environment and in such a manner that neuroplasticity is positively impacted—increasing the capacity of survivors and their children to process and heal from the trauma to which they have been subjected.**

DVPs are trusted partners to survivors, providing safe environments and approaching their work as peers and with transparency. They are strong advocates for voice and choice in systems, including health care systems. They have the training and capacity to consider cultural, historical and gender issues in their individual counseling and advocacy, and one of their roles is to educate community partners about those issues as well as about the impact of trauma on survivors and their children.

Advocates can play a vital role in promoting three important social determinants of health in their mobile health care and partnership work. Simply removing barriers and **increasing access to health care** (and therefore, to health) is one key factor. DVPs also **promote safer, more trauma-informed neighborhoods and built environments** through the environmental design of their outreach offices and shelters, and through their prevention work across communities. Finally, increasing access to preventative care and **linking survivors to wellness resources, including housing resources, increases the capacity of survivors to build safer lives for themselves and their children—contributing to economic stability for individuals and for communities.**

WHAT IS HAPPENING IN VIRGINIA'S DOMESTIC VIOLENCE PROGRAMS?

General Health Care and Health Partnerships: DVPs across Virginia have widely varying experiences with establishing mobile health care partnerships and developing health care partnerships in their communities.

At one end of the continuum, **there are agencies with strong partnerships in place that include DVPs in developing mobile health services in the community**. As a result, their shelters/outreach offices are one of the mobile health care sites, providing consistent access to basic health and wellness services, including vaccines and testing throughout the pandemic. On the other end of the continuum, **there are DVPs working without these partnerships in communities where there are no free/charitable clinics, no community health centers, and minimal staff in the public health department, making access to mobile health services impossible and significantly limiting care of any kind for survivors and their children**. Along the center of the continuum are agencies that are currently exploring the creation of mobile clinics with community partners, DVPs in communities where there are no mobile health services yet strong and accessible community health centers providing services to survivors, and agencies that have had health care providers (e.g. nurses) or liaisons (e.g. health care navigators) on staff and described tremendous benefits—but none have been able to sustain that model in recent years.

DVPs spoke repeatedly about the challenge of finding providers across health care settings who are trained in the provision of trauma-responsive care. Advocates would like to see access to training increased and supports for a wider network of trauma-informed care providers.

Across Virginia, **DVPs consistently mentioned the positive impact of Medicaid expansion for survivors with whom they work**, especially those in shelter. Medicaid expansion enabled survivors to access a wide variety of medical care that had previously been out of reach. It is unclear how the return to standard enrollment in the upcoming year will impact survivors as a whole.

Behavioral Health and Substance Abuse Care and Partnerships: Access to behavioral health practitioners (e.g., therapists, psychiatrists) and substance abuse services and treatment is extremely limited across the state. **This is one form of care that been dramatically and adversely affected by the pandemic as needs increased and access to providers decreased.** DVPs described long waiting lists for behavioral health services, including medication management, and a dearth of community options for substance abuse treatment, especially for survivors who are also single parents. DVPs observed that partner agencies have had trouble hiring qualified and experienced therapists, limiting access to care. In some rural communities, telehealth projects that were piloted during COVID and included access to licensed counselors, increased access dramatically. Those pilot programs are now shutting down and are not being replaced with comparable services. Advocates also shared anecdotal evidence that more survivors are

coming to shelter with serious addiction issues—posing a wide variety of health and safety risks given the extremely limited access to treatment.

Many DVPs have licensed therapists on staff or on contract to provide counseling and therapy for survivors. Agencies reported having difficulty filling positions, especially where there are huge pay gaps between what the public and non-profit sector can offer a licensed clinician and what they can earn in the private sector. In addition to being short-staffed for these services, staff reported that survivors' needs (and the needs of their children, who may also be accessing therapeutic services) have grown during the pandemic and agencies are offering services for a longer period. Waiting lists are now growing within DVPs—in one case an agency described having a waiting list of forty people, many of whom will not have access to therapeutic services for months.

Advocates described a unique adverse impact for survivors when they do not have access to appropriately trained neurologists, psychiatrists and other providers who are key to diagnosing and treating brain injuries. **During the pandemic there appears to have been a significant increase in the number of survivors reaching out to DVPs after violence that has led to cognitive impairments—from strangulation and from multiple concussive blows to the head. Access to screening and diagnosis is critical for survivors' health and safety. Appropriate screening and diagnosis are essential for prosecution of perpetrators and to obtaining economic supports in the form of compensation for injuries, ongoing spousal support, or access to disability benefits.**

There are a few bright spots around the state. One agency is using another source of Rescue Plan funds to contract for regular weekly hours with the Community Services Board, which has made services immediately available to survivors and been sufficient to support ongoing services. Another agency, recognizing a community gap, has developed their own array of therapeutic services for children of survivors. Another DVP is working with a consortium of community providers on a preventative health care project and behavioral health services are being considered because of their participation.

Specialized Health Care: DVPs generally do not screen for specialized health care needs, but still they described significant unmet needs for dental care, vision care and reproductive health care across the state. Rural areas of the state described unique barriers to accessing reproductive health care—including long drives to hospitals for delivery, and even longer drives for any type of care related to a high-risk pregnancy. In areas of the state that are grappling with high rates of addiction, they are also working with children of survivors who are born with a chemical addiction, adding a complex need for trauma-informed health services.

Similarly, **geographically isolated areas have limited access to things like dental and vision care because of the extremely low number of providers in the community**. In some communities, a once-a-year free dental clinic is the only option for low-income residents. Advocates in these communities said that it was common to work with survivors (and children) who had never been to a dentist.

Several agencies described specific partnerships with community providers around either reproductive health care or dental care. Advocates described the value of access to both services and education for survivors. DVPs have used a variety of funding to pay for these services in cases where they are a priority for survivor safety and wellbeing.

Underserved Populations: DVPs shared examples of **thoughtful and strategic partnerships to meet the needs of populations that are traditionally underserved**. These diverse partnerships include **working with Spanish-speaking therapists** to ensure access to services for survivors in their first language, co-locating staff with community health centers during special clinics for underserved populations and **partnering with the community AIDS response network** to remove barriers for HIV^+ survivors. DVPs have also expanded their own programming to tackle the root causes of health inequities—for example, one agency has **hired staff who are working on racial justice issues across the community with a particular focus on maternal health**. Their goal: "Build an empowered racial justice machine that meets community care needs for ALL."

DVPs also described **many barriers that uniquely impact those who are part of underserved communities. These include long waiting lists for language-specific care, safety risks for immigrant survivors who are undocumented, and stigma/lack of empathy for those who are grappling with both addiction and domestic violence.** Advocates were particularly concerned about access to holistic health care for high-risk survivors who often have many barriers to obtaining services—and wondered if more co-located or mobile services could be a solution to addressing trauma impacts on mind and body in a more holistic way.

Building Healthy Environments and Health Promotion: Across Virginia there are a few DVPs that have made substantial investments in creating trauma-informed shelter, outreach, and office environments. However, **for the most part, DVPs have only taken limited steps (e.g., changing paint colors, adding more fresh foods to menus) to make the environments for advocates and survivors a foundational part of their trauma response.** Agencies described feeling overwhelmed by the prospect of trying to "fix" structural challenges and/or unsure of where to begin. All agreed that they would like to learn more about trauma-informed environmental design, and they would like to create spaces that promote wellness.

One DVP described an **exciting community wellness partnership that brought together many agencies to evaluate the status of each social determinant of health**. Results of a community needs assessment identified two priority needs: transportation, and housing. All of the partners, including the DVP, are now working to address the transportation gap with the goal of establishing systems, partnerships and services that will become an ongoing part of the community infrastructure.

PRIORITIES FOR ARPA FUNDING LINKED TO THE DOMESTIC VIOLENCE EVIDENCE PROJECT THEORY OF CHANGE

The common elements of DVP activities described in the Domestic Violence Evidence Project's Theory of Change provide a roadmap leading to positive change in health and wellness outcomes for survivors. These activities can include expanding access to mobile health care services and strengthening health care partnerships and health promotion activities.

- When DVPs provide **culturally specific education about the immediate impact and ongoing health risks of trauma** and information about trauma-informed health care options, they can
    - educate survivors about care options that can treat identified health concerns for themselves and their children, increasing knowledge and building skills that can lead to changes in physical and emotional health.
- When advocates screen for a wide range of health care concerns as a routine part of safety planning, they can
    - work with survivors to reduce barriers to obtaining necessary care, increasing access to care, and expanding safety throughout the community.
- As advocates encourage survivors to tell the unique stories of their experience with trauma and the physical and emotional effects of trauma, and listen with both empathy and respect, they can
    - promote healing and resiliency and a sense of hope for the future.
- As DVPs build health and wellness partnerships throughout the community, they can
    - expand overall access to safety, justice, and community resources and build a sense of positive connection to the larger community.
- When DVPs create trauma-informed environments for the delivery of shelter and other services, they can

- reduce survivor stress, promote emotional regulation, and communicate respect, leading to positive intrapersonal and interpersonal outcomes for survivors and their children.

Priorities for Funding identified by DVPs include:

1. **A diverse array of health care partnerships that includes mobile health clinics on-site, more immediate access to affordable care within the community, ongoing access to a range of general and specialized services that includes behavioral health services, substance abuse treatment, dental care and reproductive health care, and preventative care.** DVPs identified a number of ways to use grant funding to help build out this array of services. The toolkit that will be developed as part of this project will be invaluable in helping agencies with many of these activities by providing in-depth information about successful models in Virginia and nationally. Priorities identified by DVPs include:
    a. **Replicate or expand successful mobile health partnerships** that bring health care services to shelters and outreach offices.
    b. Hire **dedicated staff (e.g. case manager, healthcare navigator) to build health care partnerships, help people apply for Medicaid and other benefits, participate in local trauma-informed care networks and advocate for survivors** within existing community agencies and systems.
    c. Hire health care professionals (e.g., nurse, health educator) to provide community partner training, to conduct basic screening and to teach basic wellness/preventative care strategies (e.g., how to check blood pressure) to survivors.
    d. Enter into **partnership agreements with health care providers to share positions, co-locate services, provide wellness checks for all shelter residents and their children, or contract for dedicated hours for survivors**.
2. **Dedicated education for health care partners on the dynamics of domestic violence and trauma-informed care. (note: this could be community-based, regional or statewide)** Virginia is fortunate to have a valuable resource at Eastern Mennonite University, the

STAR (Strategies for Trauma Awareness and Resilience) certification program. Trainers will work with an agency (e.g., DVP) or a community network (e.g., DVP + health partners) to *increase understanding of trauma, interrupt cycles of violence and build resilience*. The individual cost of the 5-day intensive is $995; EMU will also negotiate a cost to bring the training to a community network.

3. **Specialized outreach and care for underserved populations, including education on chronic conditions that impact health and access to care, language interpreters during health care visits, and innovations with health care partners that address complex issues** including the intersections of trauma and addiction, domestic violence and brain injuries, and poverty and persistent trauma exposure.
4. **Trauma-informed environments that promote health and wellness during times of crisis and expand impact as healing begins**. This might include working with donors to increase donations of healthy foods and decrease donations of high sugar/high fat food items, or it could look like delivering healthy hot meals to survivors and their children at scattered site locations. **Many DVPs need to make substantial changes to their facilities and there are excellent resources on trauma-informed design for shelters and outreach offices. Agencies requested clear guidance on what types of costs would be eligible to be covered by grant funding.** Common elements of trauma-informed environment assessments include making improvements where necessary to ensure: safe and well-lit parking areas, sidewalks and entrances; ensuring that there is a welcoming environment that is language-accessible when entering buildings; providing water, restrooms, Wi-Fi and child friendly furniture and play elements in waiting areas and common areas; considering lighting, acoustics, colors and visual elements, temperature and other sensory elements throughout the space; ensuring private and confidential space for activities such as intakes, counseling/advocacy/case management sessions, and support groups that provide clear views to exits, calming sensory elements, and stress reduction tools; ensuring that common spaces are designed to allow for people to retreat to space where they feel protected, observe in spaces where they feel safe, and participate fully

based upon their readiness and ability; and ensuring there are green spaces and appropriate outdoor seating and stress reduction elements.

5. **Development and training opportunities for DVP staff to expand capacity to engage effectively in health care partnerships and health promotion activities. (note: this could be community-based, regional or statewide)** Agencies would like to provide more extensive training for staff on voluntary services for individuals with serious behavioral health and substance abuse challenges. This is a need that has increased during the pandemic. DVPs also identified needs for training on harm reduction strategies, on screening/referral/health care advocacy for all staff, and for cross training mobile advocates so that they have team members who can work where they are most needed on a particular day—whether that is in court, at the shelter, or as a health care advocate.
6. **Designated funds for cash assistance to meet health care needs** including meeting co-pays and deductibles, obtaining medications, and obtaining supplies such as diabetic care items, which may also include paying for safe disposal of needles. DVPs are covering these types of costs with local donations and limited budgets and would benefit from increased funding, even if it is for a very limited period of time.

SECTION 6: WORKFORCE EXPANSION, CAPACITY BUILDING AND SUPPORT

FVPSA RFA Language Describing Intent and Examples of Possible Funded Activities:

WORKFORCE EXPANSIONS, CAPACITY BUILDING, AND SUPPORTS: The purpose of these allowable workforce capacity building expenses are to ensure the continuity of domestic violence services in local communities by allowing supplement funding to be used to sustain an advocacy workforce to prevent, prepare for, and respond to the needs of domestic violence survivors impacted by the COVID-19 public health emergency. A sustainable workforce is needed to

operate COVID-19 testing programs, COVID-19 mitigation programs, or mobile health units access programs; and to coordinate partnerships with health departments for each local program to keep families healthy and safe during the COVID-19 public health emergency.

The supplemental testing funds can be used for COVID-19 workforce related expansions and supports, or to reimburse subrecipients for such costs and for costs that include but are not limited to:

- Planning for implementation of a COVID-19 testing program, COVID-19 mitigation program, or mobile health units access program;
- Training providers and staff on COVID-19 testing procedures, COVID-19 mitigation activities, or mobile health unit coordination activities;
- Hiring culturally-competent and linguistically-appropriate providers and staff to carry out COVID-19 testing procedures, COVID-19 mitigation activities, or mobile health unit coordination activities;
- Reporting data to HHS on COVID-19 testing activities, COVID-19 mitigation activities, or mobile health unit coordination activities; and
- Expenses to secure and maintain adequate personnel may be considered allowable costs under applicable HHS regulations if the activity generating the expense and/or the expenses are necessary to secure and maintain adequate personnel. All FVPSA grant recipients should thoroughly review these regulations before developing your proposed budget. Such expenses may include:
    - o Hiring bonuses and retention payments,
    - o Childcare,
    - o Transportation subsidies, and
    - o other fringe or personal benefits authorized by HHS regulations (45 CFR part 75).

HOW IS WORKFORCE EXPANSION, CAPACITY BUILDING AND SUPPORT LINKED TO TRAUMA-INFORMED CARE AND THE SOCIAL DETERMINANTS OF HEALTH?

As stated in a recent Futures Without Violence webinar, **promoting staff wellness in the workplace during COVID-19 is critical, given high rates of stress, little or no access to childcare, and increased financial insecurity**. Staff wellness is especially important for health providers and advocates, as they are both frontline workers.

There has been little recognition throughout the pandemic of the vital role that DVPs play as crisis responders, akin to first responders in systems like law enforcement, firefighting and emergency departments. DVP advocates remained on the job 24/7 throughout the pandemic, risking their health at a time when we knew truly little about COVID-19 and before vaccines were available. **Maintaining workplaces for domestic violence advocates that are safe, trustworthy, collaborative, empowering and culturally responsive, and where workers have a voice—all the elements of effective trauma response—is vital to community well-being.**

There is a link to the social determinants of health throughout the work of DVPs. When DVPs can provide **good pay and benefits**, particularly health care benefits, they contribute to the **economic stability** of a community. When shelters and outreach centers and offices are **designed with trauma responsive principles** in mind, they contribute to a **healthy community environment**. When staff are **knowledgeable about health promotion and health care, and participate as valued providers within a strong network,** they **improve health outcomes** for everyone. DVPs that view their advocates as lifelong learners and provide **continuous opportunities to learn and grow** help to sustain **strong educational values**. **All these contributions strengthen well-being across communities**.

WHAT IS HAPPENING IN VIRGINIA'S DOMESTIC VIOLENCE PROGRAMS?

A majority of DVPs have experienced a myriad of workforce challenges throughout the pandemic. In several agencies that we visited more than three-quarters of the staff have been on the job for less than a year, and it was typical to hear of multiple vacancies in the current staffing of DVPs. Some of the specific challenges that agencies shared with us included:

- **Low wages and limited benefits** that were not competitive in the market as employers scrambled to attract workers.
- Delays in grant reimbursements/payments, reductions in funding levels and a loss of community support as local economies struggled, leading to **uncertainty about paying bills and meeting payrolls**—leading some employees to leave for more secure work.
- **Elevated levels of stress and trauma in the workplace**—due to the uncertainty about COVID-19 transmission and precautions, and due to escalating violence as the pandemic has continued.
- Difficulty hiring, training, and retaining staff who are willing to work **overnights and weekends**.
- Difficulty providing sufficient **training, support and supervision** while working partially remotely.
- Working long hours **without adequate compensation** to maintain 24/7 responses.

- **Lack of affordable housing** in the community, requiring staff to incur longer and longer commutes to work in many of the communities across the state (those commutes were made difficult by skyrocketing gas prices).
- Erratic school schedules and a shortage of childcare options that **required a higher degree of flexibility than jobs allowed**.
- The impact of delays in seeking health care services for long-time employees—which has resulted in needing **time off for treatment of more serious conditions**.

The toll of this constant turnover could be felt throughout our conversations in these agencies—manifesting simultaneously in a sense of urgency to resolve this crisis, and a sense of resignation and exhaustion.

There are **lessons to be learned from the multiple DVPs who have had a more supportive workforce experience the past three years**. This group of agencies shared several common characteristics:

- **Flexibility:** In some cases, staff are setting their own schedules, in others the agency utilized flexible scheduling to get through pandemic hot spots, for example, working a rotating schedule with half the staff on-site one week and the other half remote, and then switching roles the next week.
- **Balance:** In some cases, DVPs were balancing the needs of the individual with the needs of the collective, making provisions for staff with health needs or dependent care responsibilities, and adjusting overall expectations so that those provisions did not burden other staff. These DVPs also placed a high value on reasonable and equitable work schedules throughout the pandemic.
- **Transparency:** Leadership in this group of DVPs consistently communicated with their teams, asked how folks were doing, requested input on improving working conditions, kept everyone apprised of safety precautions, and earned the trust of the group with their responsiveness and adaptability.
- **Valued and Fought for Improvements in Compensation**: These agencies were not exempt from the financial challenges that have been felt across the state, but they did view this crisis period differently. They redistributed resources in the agency to improve compensation, sometimes in the form of better pay scales and benefits packages, and sometimes in the form of hazard pay, new levels of on-call compensation, adding to leave packages, strengthening EAPs, and paying for staff to have access to confidential extra support through group and/or individual sessions with therapists.

One agency brought a unique perspective on their workforce to the table, **viewing turnover as a strength and opportunity within the agency**. Situated in a community with three major universities, leadership recognized years ago that geographically they were operating within a very transient community. Rather than seeing this is a liability, the DVP developed a philosophy that they are teaching a wide range of people the essential tenets of advocacy, trauma-informed responses, and prevention of sexual and domestic violence. They value the process, the time that they have with each staff member, invest in excellent training, and when the employees are ready to leave, they value the opportunity to send them out into a variety of venues in the community and in the world with essential knowledge and skills to build better relationships and communities.

Across Virginia we also witnessed **innovative practices that have been adopted by DVPs during the pandemic to support employees more robustly**. DVPs are knowledgeable about the stages of trauma recovery and recognized that much of their focus had been on the first three stages—acknowledging the trauma of COVID-19, addressing safety, and expanding resources to help staff process their personal and secondary trauma experiences. To "close the loop," some agencies have expanded their efforts to include intentional support of the recovery and integration stage that completes the cycle of trauma recovery.

One agency is including 4 hours of **stress recovery time in each advocate's weekly schedule**. Another has sought out and obtained **private funding to provide gift cards for staff monthly** for small wellness items like hot/cold tumblers, and larger items like massages or tickets to an outdoor concert. Several agencies have shut down for several days in a row, operating with minimal staffing to **give most of the group an opportunity to take extra time off and replenish themselves**. Agencies are using a variety of tools to help staff make personal "safety plans," "self-care plans," and **"trauma management plans," so that everyone has a plan that meets their unique needs**. We also spoke with an agency that has found a way to **acknowledge the social justice dimensions of the pandemic** and vicarious trauma. The agency has added a facilitated staff support group focused on addressing the intersections of violence.

Even the DVPs that have found their way to trauma-informed and promising new employment practices or innovative ways to address vicarious trauma share in the experience that is common to all the agencies: **the past 34 months have been a time of fear, anxiety, loss, and grief in our families, in our communities and in our world.** We may not be able to see for many years just how the pandemic, the state violence against Black people and communities, growing political divide, and global issues like climate change are related, but they have certainly been intertwined

in our lives as people **committed to building safe, respectful, and healthy communities where all people can thrive**.

PRIORITIES FOR ARPA FUNDING LINKED TO THE DOMESTIC VIOLENCE EVIDENCE PROJECT THEORY OF CHANGE

The Domestic Violence Evidence Project's Theory of Change includes "important contextual factors impacting work and success." **The contextual factors named include working in collaboration with other community members and policy makers to achieve an outcome in which the community supports victim safety, offender accountability and provides resources**. All of this leads to the well-being of the staff, board, volunteers and survivors in the community.

COVID-19 has led the breakdown of many collaborative working relationships. For example, some hospitals not allowing advocates to accompany survivors who needed health care or forensic exams. Some hospitals remain closed to advocates, and it will require dedicated efforts to restore those collaborations. Changes across the criminal justice system, including extended closures of some offices and decisions to reduce arrests and to limit incarceration elevated safety risks for survivors. The failure of most communities to maintain coordinated community response teams or to adopt protocols for identifying and responding to high-risk domestic violence cases meant that serious violence escalated dramatically—and advocates had very few partners promoting offender accountability.

COVID-19 also paved the way for new collaborations and partnerships. Many DVPs formed their first formal partnerships with local health care providers to access vaccines and testing for staff and survivors.

This shifting environment around community collaboration appears to have had a negative impact on outcomes. Although we do not have hard data to support the observations at this point, DVPs across Virginia share concerns about victims at higher risk of injury or death, significant new gaps in offender accountability, and declining resources overall. **Strengthening the DVP workforce is key to preparing agencies to restore relationships and return to systems advocacy that will improve safety and accountability.**

Priorities for Funding identified by DVPs include:

1. **Increase the number of DVP staff**. DVPs must have sufficient staff to maintain activities in each of the 8 essential program components of DVPs referenced in the DV Evidence Project Theory of Change, even when a position is vacant, a person is out sick, or staff are

using earned leave. DVPs also need **infrastructure** that supports those important activities—for example, staff dedicated to answering phones and welcoming people into outreach and office spaces, shelter maintenance service providers, and grants and benefits managers. Agencies would also like to create structures for regional or statewide **"relief teams" of trained advocates** who could provide coverage during periods of transition, in emergencies, and to support agency-wide training/development time.

2. **Improve salary and benefits at all levels**. DVP pay scales should be competitive for the field and for comparable positions in communities, and benefits packages should ensure good health care, mental health benefits, adequate leave including disability leave, and retirement benefits. Agencies need funds to conduct compensation surveys to establish target goals, and to begin to adjust and improve pay and benefit packages. DVPs also expressed an interest in **pooling resources for benefits and HR services** to reduce local administrative burdens, reduce costs, and have a wider array of options available to their teams. **This exploration could be done on a regional or statewide basis.** Several agencies spoke of the **generational differences in benefits needed and/or valued** by their staff members and would like to explore more flexible benefits packages to meet a wider range of needs.

3. **Identify sustainable solutions to the challenges associated with 24/7 service provision**. DVPs are interested in learning more from other first responders about different types of infrastructure for round the clock services. Some are looking for **creative ways to manage on-call schedules and compensation, others are considering which overnight and weekend activities can be done remotely, and which require in-person delivery**. Several agencies would like to be able to use funding to hire consultants to help them find a better solution to these staffing issues and to link sustainable staffing to better outcomes for survivors. DVPs also want to replace "broken pipelines" that are the result of volunteering going down and higher education changing during the pandemic. There is a **need for strong pipelines for recruiting and onboarding new advocates** when there is turnover in their agencies—and solutions may be community-based, or regional.

4. **Team building, staff development and staff training.** DVPs would like to be able to **engage in restorative and strategic team building, away from their offices in healing environments** for their staff. They also want **to restore regular in-person training for their staff**—new staff who have never had a group opportunity to practice advocacy skills, and experienced staff who have been immersed in crisis environments and would benefit from deeper engagement with addressing advocacy challenges. Agencies that have adopted more trauma-informed practices would like to be able to send mid-level staff to trauma-informed supervision training. New Directors would like the opportunity to go through in-person leadership training designed to meet the needs of DVP leaders.
5. **Promote a culture and environment of wellness.** DVPs would like funding to be used to **update office space**—including fresh coats of paint, healthy lighting, and upgrades to furnishings and equipment. Some agencies are seeking storage solutions for donations that help survivors establish new homes and the supplies necessary for shelter operations. Agencies are also interested in **creating sanctuary space for staff**, either indoors or outdoors, where team members can take time to pause within their workdays and reset after addressing particularly difficult challenges. DVPs also want to **continue to innovate as they cultivate staff wellness**. Workplace wellness apps could be a tool for encouraging a variety of health and fitness activities. Bringing yoga, tai ji or meditation classes into the workplace might be an innovation that would be beneficial in some agency spaces. Providing easy access to water and healthy snacks was on another agency wish list. **Simple and affordable options that added together, make a world of difference.**

SECTION 7: GRANTS ADMINISTRATION FEEDBACK FROM THE FIELD

As VDSS prepares a request for applications, DVP leaders are making the following general requests and assurances:

- This report describes a wide spectrum of experiences**. DVPs have requested that all of the recommendations included in this report be eligible for funding based on community and regional needs.**
- Recognizing that flexibility has been key to COVID-19 mitigation, **please allow as much flexibility as possible**. For example, agencies would like to be able to undertake activities in more than one of the allowable categories. DVPs may have ideas for health partnerships or workforce retention strategies that evolve over the 2-year grant period, and they would like the flexibility to adapt their activities easily.
- Where there are limitations on expenses that can be funded, **please provide specific information as part of the RFA on allowable costs** so that agencies are not delayed after awards are made negotiating around issues of allowable costs. If possible, provide a chart of what is and is not allowable.
- Clearly communicate the VDSS commitment and the limitations of that commitment and then **let agencies make the decision about whether to request funding for an activity that they might want to sustain beyond the 2-year grant period.** Non-profits are familiar with juggling time-limited grants. It can be especially useful to agencies to receive funding that helps to demonstrate the value of a new position, partnership or activity—and gives DVPs the data they need to seek alternative sources of support.
- Please **open this funding opportunity not only to DVPs, but also to culturally-specific and population-specific domestic violence services providers** whose work could also benefit from implementation of these recommendations.

COMPLETE LIST OF RECOMMENDED FUNDING PRIORITIES

1. A **broad array of education and Information materials for diverse populations in plain language about COVID-19, vaccines, masking, and testing**. DVPs would like the materials to specifically speak to survivors, and especially survivors who are parents—and they want the materials to directly address people's fears. They would like varied materials for rural communities, urban communities, Black communities and Latinx communities. They would prefer to be able to purchase these materials from trusted sources (to be identified as part of the Toolkit work) or developed on a regional or statewide basis. They would like the materials to be available in a variety of languages.
2. Partnerships with health care providers including health departments and community health agencies to **implement or expand shelter-based clinics and/or community clinics where vaccines are easily accessible to survivors and their children**. They would like to be able to provide translators where there are significant numbers of people with limited English proficiency or when the target population is a culturally specific population for whom English is not the first language.
3. **Transportation for survivors, including agency vehicles, cab fare, and gas cards, to help survivors and their children get vaccines, tests, and other forms of health care.** For agencies that have agency vehicles, it is also helpful if they can provide hourly pay to a driver as a more cost-efficient option than having full-time advocacy staff devote substantial amounts of time to providing rides and waiting on people during their appointments. In some cases, survivors also need interpreters to meet them at their appointments to ensure that they have voice and choice in the services provided.

4. Agencies need a small amount of funding to be available for the **purchase of COVID-19 tests** so that they are available 24/7 during shelter intakes, at the time of exit, and in the case of outbreaks within congregate living facilities.
5. **Improving standards of cleanliness throughout both shelters and outreach offices is also a priority for DVP COVID-19 mitigation.** Agencies would like to be able to contract for regular deep cleaning in those spaces to ensure that all surfaces are disinfected. Clean air is an important prevention strategy, and funding could help DVPs optimize fresh air ventilation and enhance air filtration and cleaning in partnership with their HVAC providers. Shelter managers also identified industrial strength cleaning appliances including vacuums and washer/dryer units as key to keeping those areas clean.
6. **A diverse array of health care partnerships that includes mobile health clinics on-site, more immediate access to affordable care within the community, ongoing access to a range of general and specialized services that includes behavioral health services, substance abuse treatment, dental care and reproductive health care, and preventative care.** DVPs identified a number of ways that they would like to use grant funding to help build out this array of services. The toolkit that will be developed as part of this project will be invaluable in helping agencies with many of these activities by providing in depth information about successful models in Virginia and nationally. Priorities identified by DVPs include:
    a. **Replicate successful mobile health partnerships** that bring health care services to shelters and outreach offices.
    b. Hire **dedicated staff (e.g. case manager, healthcare navigator) to build health care partnerships, help people apply for Medicaid and other benefits, participate in local trauma-informed care networks and advocate for survivors** within existing community agencies and systems.
    c. Hire health care professionals (e.g., nurse, health educator) to provide community partner training, to conduct basic screening and to teach basic wellness/preventative care strategies (e.g., how to check blood pressure) to survivors.

d. Enter into **partnership agreements with health care providers to share positions, co-locate services, provide wellness checks for all shelter residents and their children, or contract for dedicated hours for survivors**.

7. **Dedicated education for health care partners on the dynamics of domestic violence and trauma-informed care. (note: this could be community-based, regional or statewide)** Virginia is fortunate to have a valuable resource at Eastern Mennonite University, the **STAR (Strategies for Trauma Awareness and Resilience) certification program**. Trainers will work with an agency (e.g., DVP) or a community network (e.g., DVP + health partners) to *increase understanding of trauma, interrupt cycles of violence and build resilience*. The individual cost of the 5-day intensive is $995; EMU will also negotiate a cost to bring the training to a community network.
8. **Specialized outreach and care for underserved populations, including education on chronic conditions that impact health and access to care, language interpreters during health care visits, and innovations with health care partners that address complex issues** including the intersections of trauma and addiction, domestic violence and brain injuries, and poverty and persistent trauma exposure.
9. **Trauma-informed environments that promote health and wellness during times of crisis and expand impact as healing begins**. This might include working with donors to increase donations of healthy foods and decrease donations of high sugar/high fat food items, or it could look like delivering healthy hot meals to survivors and their children at scattered site locations. **Many DVPs need to make substantial changes to their facilities and there are many excellent resources on trauma-informed design for shelters and outreach offices. Agencies requested clear guidance on what types of costs would be eligible to be covered by grant funding.** Common elements of trauma-informed environment assessments include making improvements where necessary to ensure: safe and well-lit parking areas, sidewalks and entrances; ensuring that there is a welcoming environment that is language-accessible when entering buildings; providing water, restrooms, Wi-Fi and child-friendly furniture and play elements in waiting areas and common areas; considering lighting, acoustics, colors and visual elements, temperature and other

sensory elements throughout the space; ensuring private and confidential space for activities such as intakes, counseling/advocacy/case management sessions, and support groups that provide clear views to exits, calming sensory elements, and stress reduction tools; ensuring that common spaces are designed to allow for people to retreat to space where they feel protected, observe in spaces where they feel safe, and participate fully based upon their readiness and ability; and ensuring there are green spaces and appropriate outdoor seating and stress reduction elements.

10. **Development and training opportunities for DVP staff to expand capacity to engage effectively in health care partnerships and health promotion activities. (Note: this could be community-based, regional or statewide)** Agencies would like to be able to provide more extensive training for staff on voluntary services for individuals with serious behavioral health and substance abuse challenges. This is a need that has increased during the pandemic. DVPs also identified needs for training on harm reduction strategies generally, on screening/referral/health care advocacy for all staff, and for cross training mobile advocates so that they have team members who can work where they are most needed on a particular day—whether that is in court, at the shelter, or as a health care advocate.
11. **Designated funds for cash assistance to meet health care needs** including meeting co-pays and deductibles, obtaining medications, and obtaining supplies such as diabetic care items, which may also include paying for safe disposal of needles. DVPs are covering these types of costs with local donations and limited budgets and would benefit from increased funding, even if it is for a limited period of time.
12. **Increase the number of DVP staff**. DVPs must have sufficient staff to maintain activities in each of the 8 essential program components of DVPs referenced in the DV Evidence Project Theory of Change, even when a position is vacant, a person is out sick, or staff are using earned leave. DVPs also need **infrastructure** that supports those important activities—for example, staff dedicated to answering phones and welcoming people into outreach and office spaces, shelter maintenance service providers, and grants and benefits managers. Agencies would also like to create structures for regional or statewide

"relief teams" of trained advocates who could provide coverage during periods of transition, in emergencies, and to support agency-wide training/development time.

13. **Improve salary and benefits at all levels**. DVP pay scales should be competitive for the field and for comparable positions in communities, and benefits packages should ensure good health care, mental health benefits, adequate leave including disability leave, and retirement benefits. Agencies need funds to conduct compensation surveys to establish target goals, and to begin to adjust and improve pay and benefit packages. DVPs also expressed an interest in **pooling resources for benefits and HR services** to reduce local administrative burdens, reduce costs, and have a wider array of options available to their teams. **This exploration could be done on a regional or statewide basis**. Several agencies spoke of the **generational differences in benefits needed and/or valued** by their staff members and would like to explore more flexible benefits packages to meet a wider range of needs.

14. **Identify sustainable solutions to the challenges associated with 24/7 service provision**. DVPs are interested in learning more from other first responders about different types of infrastructure for round the clock services. Some are looking for **creative ways to manage on-call schedules and compensation, others are considering which overnight and weekend activities can be done remotely, and which require in-person delivery**. Several agencies would like to be able to use funding to hire consultants to help them find a better solution to these staffing issues and to link sustainable staffing to better outcomes for survivors. DVPs also want to replace "broken pipelines" that are the result of volunteering going down and higher education changing during the pandemic. There is a **need for strong pipelines for recruiting and onboarding new advocates** when there is turnover in their agencies. Solutions may be community-based or regional.
15. **Team building, staff development and staff training.** DVPs would like to be able to **engage in restorative and strategic team building, away from their offices in healing environments** for their staff. They also want **to restore regular in-person training for their staff**—new staff who have never had a group opportunity to practice advocacy skills, and experienced staff who have been immersed in crisis environments and would benefit

from deeper engagement with addressing advocacy challenges. Agencies that have adopted more trauma-informed practices would like to be able to send mid-level staff to trauma-informed supervision training. New Directors would like the opportunity to go through in-person leadership training designed to meet the needs of DVP leaders.

16. **Promote a culture and environment of wellness.** DVPs would like funding to be used to **update office space**—including fresh coats of paint, healthy lighting, and upgrades to furnishings and equipment. Some agencies are seeking storage solutions for donations that help survivors establish new homes and the supplies necessary for shelter operations. Agencies are also interested in **creating sanctuary space for staff**, either indoors or outdoors, where team members can take time to pause within their workdays and reset after addressing particularly difficult challenges. DVPs also want to **continue to innovate as they cultivate staff wellness**. Workplace wellness apps could be a tool for encouraging a variety of health and fitness activities. Bringing yoga, tai ji or meditation classes into the workplace might be an innovation that would work in some agency spaces. Providing easy access to water and healthy snacks was on another agency wish list. **Simple and affordable options that added together, make a world of difference.**