

WOMEN AGAINST ABUSE

Case Management Manual

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PART I

Introduction to Women Against Abuse

Women Against Abuse (WAA), founded in 1976, is the leading domestic violence service provider and advocate in Philadelphia, serving more than 13,900 individuals each year through emergency residential services, supportive transitional and permanent housing, legal aid, trauma-informed behavioral therapy, and community education and training. WAA strives to provide a continuum of care - from telephone crisis counseling to long-term supportive housing - in a manner that promotes individual and family safety, autonomy, and dignity.

Purpose of This Manual

This manual, created in partnership with The Oak Foundation, is to provide a process guide and training manual for case management staff of Women Against Abuse as well as to provide an efficient way for WAA to communicate to partners regarding WAA's menu of services and the manner in which services are provided. It is expected that this manual will not only serve to train internal case management staff, but will also inform best practices and program development in order to benefit other community service providers.

Divided into three parts, the manual serves to provide three levels of information that can be used separately or in tandem, depending on the audience. Part 1 is an introduction and overview of the services provided by WAA, the various programs WAA delivers, a background on the models and evidence based practices used, and the goals for case management. Part 2 is the case management processes and serves as the step-by-step manual for training case management staff. Part 3 is the critical elements of case management services and provides more in-depth guidance on the processes discussed in Part 2. It is recommended that all parts be used in the training of new staff with parts two and three being used for on-going training and evaluation. Finally, though the manual was designed to be used as both a printed and computer-based / on-line resource, the computer-based / on-line version will provide the most access to all the features (e.g. hyperlinks and footnote references).

Agency Mission

The mission of WAA is to provide quality, compassionate, and nonjudgmental services in a manner that fosters self-respect and independence in persons experiencing intimate partner violence and to lead the struggle to end domestic violence through advocacy and community education.

Program Highlights

- WAA leads operations for the Philadelphia Domestic Violence Hotline¹, a 24 hour resource where individuals with questions or concerns about domestic violence can speak to trained counselors for anonymous and confidential support.
- Since 1977, WAA has operated Philadelphia's only safe haven² for victims of domestic violence. WAA's two 100-bed Safe Havens provide safety, security, basic needs, and supportive services to approximately 1,200 women and children each year.
- WAA operates Sojourner House, the region's first transitional housing program for abused women and children. This facility was recently updated and expanded from 12 to 15 apartments used for transitional housing services.
- WAA operates the Safe at Home Program, providing long-term supportive services in housing that includes support in healing from trauma, relocating, maintaining independent housing, budgeting finances, and other essential life skills.
- WAA established one of the nation's first legal centers for victims of domestic violence. WAA's Legal Center provides free attorney representation, court advocacy, and telephone counseling to help more than 3,800 individuals each year access legal protections from abuse.
- WAA recently stationed a domestic violence advocate in Philadelphia's central intake system for emergency housing. This advocate provides onsite trauma-informed domestic violence crisis counseling and resources, including intake to WAA's Safe Havens, which allows for immediate access to domestic violence support and safety plan services.
- WAA combined efforts with a diverse range of non-profit and governmental health and human service partners in Philadelphia to complete a strategic plan for a Coordinated Community Response to domestic violence in early 2015. When fully implemented, victims of domestic violence will be better able to receive the help they need whether their first point of service request is in a hospital, in a shelter, through police contact, or through services for their children.
- WAA's education and training programs address the need for prevention and awareness surrounding teen dating violence among boys and girls with age-appropriate education from fifth grade onward, and also promote understanding of the dynamics and effects of domestic violence among professionals whose work brings them in contact with individuals

¹ For more information on the Philadelphia Domestic Violence Hotline (866-723-3014) visit their [website](#).

² The term "safe haven" is used to refer to the emergency shelter services and not to refer to the HUD term of "safe haven." WAA believes that this term best embodies the intention toward providing a safe place for survivors of domestic violence.

experiencing domestic violence. The education team is also responsible for building the capacity of various community partners to effectively respond to and intervene in domestic violence situations.

WAA's Unique Services

For people who have experienced domestic violence, WAA's services and protections go far beyond those provided by general homeless or emergency shelters. WAA provides a trauma-informed model of care that is critical to meet the needs of children and adults recovering from intimate partner violence. Mandatory 45-hour training on the dynamics of domestic violence, including skill development in creating and ensuring safety, is required for all staff. The location of the safe havens are confidential, which reduces the potential for confrontations by abusers. In this way, safety is increased for all—the woman herself, other safe haven residents, and staff.

Only domestic violence service providers, such as WAA, are subject to certain Violence Against Women Act (VAWA) and Pennsylvania confidentiality regulations. These rules require WAA to refuse requests for information about victims, including court orders and federal, state, and local requirements for participation in electronic data systems. Additionally, the addresses of the safe havens and Sojourner House are kept confidential for the safety of the residents. These protections cannot be provided by general homeless shelters, thus endowing WAA with a unique level of protection for our residents.

Services: From Crisis to Community

WAA's continuum of programs, from emergency to aftercare services, protects and guide women and their families from the chaos of crisis back to the stability of community.

Domestic Violence Hotline

The Philadelphia Domestic Violence Hotline (1-866-723-3014) offers 24 hour a day, 7 day a week, free access to counselors trained in domestic violence. As the lead of operations, WAA works with area community partners Congreso de Latinos Unidos, Lutheran Settlement House, and Women in Transition to staff the hotline. Services include the following:

- Confidential supportive counseling
- Crisis counseling
- Bilingual counselors
- Safety planning
- Referrals to community resources
- Admission to WAA Safe Havens

The hotline is open nights, weekends, and holidays to provide critical, confidential, and anonymous support to individuals concerned about domestic violence. In FY15 the Philadelphia

Domestic Violence Hotline received 15,090 calls for assistance. The hotline is also the main source of referrals and admissions to the WAA safe havens.

Safe Haven Emergency Shelter Services

The Safe Havens provide comprehensive support services to help women and children move beyond the trauma of abuse. The 24-hour, secure, emergency program provides free services including the following:

- Up to 90 days of shelter
- Three meals a day
- Children's health assessments
- Onsite child care
- After-school and summer-school programs
- Case management
- Behavioral health care
- Computer lab
- Community referrals
- Emergency relocation funds (as available)

Case management services provide counseling on housing, finances, and employment to help women plan for long-term safe housing upon exit from Safe Haven. Case managers also work with women to develop a comprehensive safety plan that fits their unique situations. Children and their mothers meet with children's case managers to address issues pertaining to safety, education, health (physical, mental, and emotional), social support, and behavioral and developmental well-being. Children's case managers ensure minimal disruption to schooling, particularly if a child needs to relocate to a new school for safety reasons.

Safe Haven

Stepping Away from Abuse

The rate of protection-from-abuse orders issued in Philadelphia is about twice as high as elsewhere in Pennsylvania,* with Philadelphia County ranked second to last with respect to issuing final PFA orders. For this reason, many women and children need emergency shelter, yet WAA operates the only emergency safe havens for victims of domestic violence in Philadelphia. Because the safe havens are almost always at full capacity, many domestic violence victims must seek refuge in the general homeless shelter system. In fact, Philadelphia's Office of Supportive Housing (OSH) found that domestic violence victims fill 37% of the family shelter beds in general homeless shelters.* These factors led to funding for an additional 100 bed emergency shelter facility operated by WAA, which opened in 2014, through the support of Philadelphia City Council and a \$2.5 million grant from the Office of Supportive Housing. In FY15, calls to the hotline increased by 54% over FY14 and requests for shelter to WAA increased by 28%.

* Evelyn Jacobs Ortner Center on Family Violence. (2012), *Violence Against Women in Philadelphia: A Report to the City*. Philadelphia: University of Pennsylvania.

Sojourner House Transitional Housing

Sojourner House, WAA's transitional housing program, has delivered longer-term housing and supportive services to individuals and families affected by domestic violence for over a quarter of a century. These services provide a crucial link in the continuum of care for those experiencing domestic violence, as transitional housing provides a critical stepping stone toward safety and self-sufficiency for families who have become homeless as a result of domestic violence.

Safe Havens must assist residents to exit quickly to make room for the next person in need of emergency assistance. But often, the maximum stay is not enough time for many people to reach a point of sustainable living on their own. By providing the longer-term support, Sojourner House not only frees up room in the safe haven for the next person in need of services, but also greatly increases the chances that a family will not have to return to an abusive home.

Sojourner House provides family apartments for women and their children for up to 18 months. Supportive services include the following:

- Case management
- Onsite child care
- Economic management education
- Group activities and skill building
- Afterschool and summer school programs
- Parenting and life skills education

Clients can enter the longer-term housing facility after approval from the Office of Supportive Housing.

Residents meet with an assigned case manager who helps identify and meet self-determined housing, financial, education, and career goals. The case manager helps individuals plan for safety, connect with community resources, and build life skills for financial and housing stability. Residents participate in weekly meetings that include life skills workshops on topics such as financial literacy and employment. Clients may also meet with an onsite behavioral therapist to address the impact of post-traumatic stress on daily functioning and overall well-being. Staff-run educational services for pre-school and school-aged children are available throughout the day and in after-school programs. Children at Sojourner House also participate in the Young Survivor's Summer Camp.

Sojourner House Critical Stepping Stone to Stability

Philadelphia suffers from a citywide shortage of affordable housing units for families needing transitional and permanent housing. Sojourner House has helped address this need by offering a safe and stable environment for hundreds of families since its inception in 1987. A recent renovation and expansion of the original building resulted in a 25% increase in capacity for Sojourner House: three additional apartments mean that 15 families at a time can now be served at the facility.

Safe at Home

Stepping Stone into Community

Aftercare services were developed in 2005 by WAA to provide support to families transitioning into independent housing, with a similar care management model to that of Sojourner House. With a possible service term of up to two years, Safe at Home case managers provide support and guidance to participants with obtaining and maintaining permanent housing, financial independence, employment, education, parenting, physical and behavioral health, and other domains. The services aim to help clients develop the self-sufficiency needed to merge safely and successfully back into the community.

Safe at Home Aftercare Services

Safe at Home aftercare case management provides continuity for clients to help families sustain long-term well-being during crucial months after they leave WAA housing. Safe at Home provides up to 24 months of community-based supportive services to residents who are transitioning into independent housing and working towards long-term stability and safety from abuse. Case managers help clients to budget finances, seek employment, plan for long-term safety, continue to heal from trauma and plan for permanent housing. Work is focused on developing each client's essential life skills and resources to care for self and family.

Safe at Home increase the chances that a family will not have to return to an abusive home. At the same time, the aftercare program frees up room in the safe haven for the next person in need of emergency residential services. Continued focus on providing trauma-informed services promotes healing from adversity and troubled life experiences. Support is consistently offered throughout to empower women with the resources they need to sustain safe, affordable housing.



Models Informing Services and Care Delivery at WAA

Several models and strategies of organizational culture, care delivery, and treatment services inform WAA's care infrastructure. The models used are:

- Sanctuary Model® of Trauma-informed Services
- Building on Strengths and Advocating for Family Empowerment (BSAFE), using Critical Time Intervention (CTI)
- Empowerment Model
- Domestic Violence (DV) Informed Safe Housing (DASH)
- Theory of Change and Program Goals (WAA)

Each model informs a different aspect of case management services for WAA. All models and strategies interweave, creating a promising and best practice infrastructure in case management and delivery of trauma-informed services for WAA. Summaries and highlights of each model follow.

Sanctuary Model® of Trauma-informed Services at WAA

In July of 2015, Women Against Abuse became certified in the [Sanctuary Model®](#). The [Sanctuary Model®](#) is the gold standard for evidence-supported, trauma-informed models that comprehensively enhance whole organizations and their cultures.³ The Sanctuary Model® ensures that WAA provides trauma-informed services in a manner that promotes healing from victimization by offering choices, respecting individuals, promoting safety and trust, and increasing transparency.

WAA's Leadership

Implementing the Sanctuary Model® in Philadelphia

As a result of WAA's leadership and commitment to trauma-informed care, the Philadelphia Office of Supportive Housing selected WAA as one of three shelter provider organizations to provide leadership for Sanctuary transformation of the city's shelter system. WAA kicked off the 4-year implementation process to become a Sanctuary-certified site in the Spring of 2011. Such progress will ensure that homeless shelters in Philadelphia are trauma-informed and sensitive to the needs of survivors of domestic violence.

Most clients presenting to shelter provider organizations such as WAA have been exposed to significant adversity, chronic stress, and frequently, overwhelming trauma. The trauma is often chronic. The goal of the **Sanctuary Model®** is to facilitate the development of an organizational culture that can contain, manage, and help transform the traumatic life experiences that have shaped clients in their care. The Sanctuary Model® is a non-hierarchical "trauma-informed and

³ The Sanctuary Model® is owned by the Julia Dyckman Andrus Memorial, Inc. For more information on the Sanctuary Model®, see the website of The Sanctuary Institute at <http://www.thesanctuaryinstitute.org/>.

evidence supported” organizational culture that creates a common language and structure for people and organizations in human services to communicate and collaborate with each other.

Based on trauma-informed theory and treatment, clients learn that they are not sick, crazy, or bad, but rather injured, and as a result, they have challenges. The Sanctuary Model® creates a community based on shared responsibility that supports clients in their efforts to change behaviors while also respecting clients’ experiences. “We change the question from ‘What’s wrong with you?’ to ‘What happened to you?’” The model is congruent with restorative practices in that it is about working *with* people instead of doing things *to* or *for* them.⁴

For WAA to adhere and demonstrate fidelity to the practices and philosophy of the Sanctuary Model® in case management services, the agency follows the **Standards for Certification, 2nd edition, 2.23.12** as a self-assessment tool for the organization and staff.⁵ The standards are organized along the four pillars of Sanctuary:

- Trauma Theory
- S.E.L.F Framework
- Seven Commitments
- Sanctuary Toolbox

⁴ Laura Mirsky. 2009. “The Sanctuary Model®: A Restorative Approach for Human Services Organizations.” www.iirp.edu/iirpWebsites/web/uploads/article_pdfs/21539_sanctuary.pdf.

⁵ Information on the standards can be found at: www.thesanctuaryinstitute.org/images/sanctuary%20certification%20standards%202012.pdf.



Four Pillars of the Sanctuary Model®

- Trauma Theory
- S.E.L.F. (Safety, Emotional Management, Loss, and Future) Framework
- Seven Commitments
 - Nonviolence
 - Emotional Intelligence
 - Social Learning
 - Open Communication
 - Democracy
 - Social Responsibility
 - Growth and Change
- Sanctuary Toolbox

Pillar One—Trauma Theory



Trauma Theory is the foundation for creating a trauma-informed environment. Trauma, adversity, and chronic stress are universal to the human experience and affect individuals and organizations in predictable ways. The understanding of the ways in which trauma impacts functioning and health and the use of the Sanctuary Model® to mitigate these effects are the building blocks of this pillar. WAA will use its

understanding of trauma theory and the “lens” of Sanctuary to see connections between behaviors and events, to problem-solve, and ultimately to create a high-functioning, compassionate, healthy community for high quality domestic violence services.

There are seven standards under trauma theory against which an organization can be evaluated, with a Table of Evidence on page 5 of the standards to demonstrate ways of adhering to the model, such as having “treatment plans include language that reflects a lens of injury rather than sickness.” An understanding of the Sanctuary Model® should be reflected by the staff, the clients, and the clients’ families.

Pillar Two—S.E.L.F. (Safety, Emotional Management, Loss, and Future) Framework



The **S.E.L.F. Framework** organizes the way in which we think about individuals, organizations, and treatment.

S.E.L.F. provides a shared language, affords a framework for case management/treatment, and functions as an important problem-solving tool. WAA’s application of the principles of S.E.L.F. are outlined in the table below.

WAA’s Implementation of the S.E.L.F. Framework	
Safety	Physical, psychological, social, and moral safety for everyone in the community (staff, clients, and clients’ families) is a primary value of WAA.
Emotional Management	Members of the WAA community recognize and manage feelings in non-harmful ways.
Loss	Acknowledging and grieving about loss and trauma, and using the past to constructively inform decisions about present and future issues are key. We recognize that all change involves loss.
Future	The focus is creating or restoring a sense of hope in the clients we serve and spreading this hope outward to the WAA community.

The Table of Evidence for Pillar Two is found on page 8 of the standards, suggesting that “admission/intake documents and service treatment plans” focus on a sense of hope and that “staff can describe examples of using the S.E.L.F. framework for problem solving” with clients, other staff members, and the overall organization.

Pillar Three—Seven Commitments



The Seven Commitments reflect the value system of the Sanctuary Model® that guides the individual and organizational beliefs, practices, and policies for WAA. The table below explains how WAA values the standards of the Seven Commitments in our community.

WAA's Application of the Seven Commitments	
Nonviolence	We work hard to make sure that we are physically safe, that we feel safe with the people around us, that we feel able to express our feelings in ways that are safe for us and others, and that we “do the right thing” when we have decisions to make.
Emotional Intelligence	We work to express our feelings in healthy ways that don't hurt ourselves and don't hurt others. We also try to learn more about what kind of different and complicated feelings we have.
Democracy	Being empowered to share input and ideas to be considered within the agency's decision-making process and to enhance achievement of the agency's mission. Democracy does not mean that the majority opinion rules but that insights are valued and that space is created for the expression of opinions as appropriate.
Open Communication	We don't keep our thoughts to ourselves. We say what we mean...but we aren't mean when we say it. We are committed to take the time to focus on communication as a necessary part of creating a healthy organization, so we think about how best to communicate with each other before we do; are clear, specific and explicit in our communication; use active listening, and; are clear about our goals, needs and expectations of each other.
Social Responsibility	Together we get more done. We are committed to helping each other because it benefits us all in the long run.
Commitment to Social Learning	We are committed to sharing our ideas with others and listening to others share their ideas. We know that we can learn from each other
Growth and Change	If we want things to get better, we need to believe that we can grow and change. We know it's hard to try something new or different, but the future looks brighter when we agree to grow and change.

On page 12 of the standards, the Table of Evidence highlights ways of measuring adherence to the Seven Commitments, such as client councils; policies and procedures reflecting no or minimal use of restraint/seclusion; evidence of staff or client recognition; performance improvement plans; client grievance forms and procedures, and other measures.

Pillar Four—Sanctuary Toolbox



The tools in the **Sanctuary Toolbox** are the concrete activities or rituals that individuals or organizations use to inoculate themselves against the effects of trauma and chronic stress. These tools are vital elements for the implementation and sustained success of the Sanctuary Model®. WAA’s toolbox, outlined in the table below, builds support for the Sanctuary Model®.

WAA’s Toolbox for Supporting the Sanctuary Model®	
Community Meetings	Practiced regularly and with fidelity by WAA.
Safety Plans	Used by staff, clients and families.
Red Flag Reviews	Respond to critical incidents and practiced with fidelity.
Team Meetings	Every staff member at WAA participates in Sanctuary Team Meetings, held regularly to build a strong community, reinforcing the tenets of Sanctuary.
Sanctuary Psychoeducation	Sessions about trauma and the Sanctuary Model® are conducted regularly with clients and/or their families throughout residential services at WAA.
Self-care Plans	All community members (staff and clients) have these plans and practice self-care. Family members are offered the opportunity to do a self-care plan if they wish.
Sanctuary Treatment or Service Planning Conferences	Client treatment and/or service planning conferences incorporate the principles of the Sanctuary Model® and include a trauma-informed perspective, which meet the standards of the Model.
Sanctuary Supervision or Coaching	Every staff member participates in these formal, consistent sessions, which are held on a regular basis.
Sanctuary Training	Provided to all staff members, this training uses content from the Sanctuary staff training manuals and includes an ongoing training plan for module training, orientation training, and booster training.

In the Table of Evidence standards for Pillar Four, found on page 18 of the standards, measurable evidence of adherence to the Sanctuary Tools would include: staff and clients participate in reported community meetings; team meeting minutes reflect open dialogue, conflict resolution and/or differing opinions; Red Flag review protocols are known; treatment/service plans incorporate trauma-informed principles with the Sanctuary Model® tenets, etc.

BSAFE⁶, Using CTI

The National Center on Family Homelessness developed the model *Building on Strengths and Advocating for Family Empowerment*, known as BSAFE,⁷ an adaptation of the *Critical Time Intervention* (CTI) model.⁸ CTI is a time-limited, phased treatment approach originally developed to bridge the service gap for people with serious mental illness as they moved from shelters/institutions back into the community. CTI is designated as an evidence-based practice by SAMHSA's Registry of Evidence Based Programs and Practices. BSAFE has been advanced as a promising practice that helps families achieve access to community-based services and supports.

Despite limited research to date; these basic principles of care have emerged from years of experience serving homeless and shelter-based families and children. All programs serving families and children in this environment should implement policies and practices that address the needs of every family member—including the children. At a minimum, programs should promote the principles of care outlined in the table on the following page.



⁶ Since BSAFE was created for families not necessarily experiencing domestic violence, certain aspects of the model may be slightly altered to provide safety for the family exiting the unsafe circumstances.

⁷ Bassuk, E.B., Guarino, K., Clervil, R. & Cowan, B.A. Building on Strengths and Advocating for Family Empowerment: A Promising Practice for Families and Children who are Homeless or Formerly Homeless. Unpublished manuscript.

⁸ Herman, D., Conover, S., Felix, A., Nakagawa, A., Mills, D. 2007. *Critical Time Intervention: an empirically supported model for preventing homelessness in high risk groups. Journal of Primary Prevention*, 28, 295-312.

BSAFE Principles of Care	
Rapidly Rehouse Families	Every effort should be made to rehouse families as quickly as possible, minimizing their time in shelter.
Respond to Immediate Needs	Programs must first work to ensure that families' immediate needs for safety, housing, financial assistance, and pressing health, mental health, and substance abuse needs are addressed before engaging them in longer term care.
Link Housing with Services and Supports	For all families, housing is essential but not sufficient. Supports such as child care and transportation are critical. In addition, many families require specialized and sometimes intensive services at various times in their lives.
Assess Families and Create Individualized Housing/Service Plans	The needs of homeless families and children are heterogeneous, each with individual strengths and challenges. Programs must assess the needs of each family member and create individualized housing and service plans.
Support Family Unity	Families experiencing homelessness should not be separated unless the health and well-being of children are at immediate risk.
Deliver High Quality Services	Services provided to families experiencing homelessness must be effective and of high quality. The services should be family oriented and employ evidence-based and promising practices that are strengths based.
Provide Trauma-informed Care	The physical and emotional safety of all family members is ensured while providing trauma-informed care. Given the high rates of interpersonal and random violence experienced by these families and children, all services must be provided through the lens of trauma.
Address Unique Needs of Children	<p>The needs of homeless children are often overlooked, especially in settings with limited resources. At a minimum,</p> <ul style="list-style-type: none"> • Child-specific services and child friendly settings must be provided. Services must be developmentally appropriate. • Programs must help children access and succeed in schools. • Medical, trauma-specific, and mental health services must be available for children.
Ensure a Basic Standard of Care by Training the Workforce	All staff working with homeless and shelter families should receive basic training that supports the development of specific competencies, provides appropriate supervision, assures continuing education, and enhances career opportunities for staff.
Monitor Progress and Outcomes	Programs need to understand the needs of the families they serve and measure effectiveness of services to assure high quality care.

While BSAFE is modeled after CTI and rapid rehousing into a safe and affordable setting is an acknowledged priority, BSAFE recognizes that many families need other services and supports. Developed within an ecological framework, BSAFE emphasizes the integral connection among the following services and systems:

- Community-based services
- Social networks and broader systems of care
- Housing, health, and well-being of families

This trauma-informed, family-centered intervention is designed to address the needs of families and children as they transition into the community and/or stabilize in supportive housing.

BSAFE is a 12-month case management intervention divided into three phases, each of 4 month duration. This intervention works by accomplishing the following tasks:

- Identifying the needs of all family members, including children
- Establishing plans for each family unit and each family member
- Facilitating access to community supports and services
- Creating referral networks of culturally competent and developmentally appropriate services
- Enhancing social and community connectedness

BSAFE can be implemented by paraprofessionals who are trained and have some clinical backup.



This innovative model is promising. However, it will be necessary to evaluate rigorously not only the outcomes for children and families receiving the intervention (including the degree to which they evidence increased social connections and linkages with their broader communities), but also the process components (e.g., the specific services and supports received and the nature and intensity of those services). Doing so will yield data that can guide the refinement of the approach, including the allocation of resources to maximally benefit families.

Empowerment Model

Empowerment services in domestic violence service delivery often advocate, “How we deliver the services to our clients is as important as the services we deliver.” Domestic violence services are best grounded in the empowerment model, as well as being trauma-informed in nature. The relationship between empowerment and trauma-informed service is harmonious and complementary. Empowerment and trauma-informed care often use different language to articulate many of the same basic principles.

The Empowerment Model has been a foundational concept of working with survivors of domestic violence since the earliest days of the battered women’s movement. The core principle of the empowerment model is based on the individual being the expert on his or her own life, with the individual possessing the intrinsic inner awareness, strength, and essential capacity to gain the skills and knowledge needed to exercise productive power in her own life.

The empowerment model is consistent with a strengths-based approach to services. A strengths-based approach assumes each individual in domestic violence care and services has the capacity to secure safety and to recover from the experience and effects of domestic violence. In a strengths-based approach, as in the empowerment model, the responsibility of case managers is to support clients and their family members to discover and use these strengths in ways that work for each individual.

Trauma-informed service delivery focuses on what has happened to the individual rather than on what might be wrong with her or him. The importance of tailoring responses to the specific needs of each individual is essential. When working with an individual in providing case management services, staff need to listen attentively to each person and truly understand what combination of factors has sparked the ability to break through the challenges met on the road to healing.

Domestic Violence (DV) Informed Safe Housing

Domestic Violence (DV) Informed Safe Housing, which was developed by District Alliance for Safe Housing (DASH), located in Washington, DC, is a model that WAA desires to incorporate into any Philadelphia area housing program providing services to women.⁹ WAA wants to ensure that all victims of domestic violence are receiving services that address the needs of trauma survivors, such as ongoing safety planning, information on the dynamics of domestic violence, and counseling. WAA desires a **housing provider community** across Philadelphia where survivors have a multitude of safe housing options, so that regardless of where a survivor turns for help, she will be met by service providers who can provide information and support that directly address the impact of domestic violence, abuse, and trauma.

Through the provision of increased community linkage, training, and technical assistance fostered by WAA case management staff, WAA promotes **DV-informed responses** in the following ways:

⁹ For more information on DASH, visit the website at www.dashdc.org.

- Building safe housing capacity by working with community-based organizations and advocating for safe housing options and choice
- Building the capacity of housing and homeless programs for women to be safe housing programs for survivors. A significant number of women in the homeless system have experienced domestic violence. WAA assists housing and homeless programs serving women in incorporating policies and procedures informed by the specific safety needs of survivors by offering information, training, and technical assistance on the following topics:
 - Safety planning with victims
 - Strategies for creating economic empowerment for victims
 - Provision of linkages and referrals with resources, including support groups and legal services
 - Response to safe housing needs
 - Provision of trauma-informed advocacy and counseling



WAA Theory of Change

Strategic focus of the Theory of Change for WAA is twofold:

- To enhance the safety and independence of people affected by domestic violence through provision of emergency and transitional housing, legal interventions, behavioral health, case management, education, crisis response, and aftercare
- To raise awareness and prevent domestic violence at the local, state, and national levels through education, system advocacy, outreach, public policy reform, and **collaboration**

WAA enjoys strong relationships with community-based partners, which significantly enhances collaborations, thereby increasing community resources for case management staff to offer clients in achieving their goals. The City of Philadelphia, in shelter services, is adopting the

Sanctuary Model® with a trauma-informed care lens to develop and provide services citywide. When resources and beds are limited, as they are in Philadelphia, it will be beneficial to WAA to have access to and support from other trauma-informed programs and shelters. Collaboration among stakeholders increases chances of success, improves efficiency, and avoids duplication.

The first element of strategic focus—safety, independence, and empowerment—case management services would focus on “the provision of a continuum of housing options and client centered supportive services.”

The second element of strategic focus—community awareness and prevention of domestic violence—case management services emphasis would be “collaboration,” increasing options available to clients through advocacy and shared program resources.

WAA believes that community resources in job skills and marketability; receipt of entitlements; comprehensive, holistic health care; legal assistance; and safe housing are essential to the provision of effective case management services.



Case Management Services: Bringing These Models Together

To deliver effective, outcome-driven case management services of quality that encompass the best and promising practices of all these models, the infrastructure for case management services at WAA will contain these elements:

- The **Sanctuary Model®**, through development and implementation of trauma-informed services, will inform case management protocols, policies and procedures, documentation, information gathering, and communication, and “define a way of being with a client and/or family member” in providing case management services.
- **Standards of the Sanctuary Model® and assessment of scoring for the standards** will measure adherence and fidelity to the practices and philosophy of the Sanctuary Model®. Specific standards that reflect case management services will be identified, with evidence of adherence to those standards being incorporated into case management practice at WAA.
- The **BSAFE case management model®** will focus on strong development, implementation and transition capacities for families in the areas of housing, safety, financial assistance, health care, child care, transportation, and other social services and support. Individualized service planning, with a focus on safe rapid rehousing and robust transition supports for families, is a key focus.
- The **BSAFE case management model, with the 12-month intervention plan**, is being used in the Safe at Home model. Evaluation tools may be incorporated into this model to review data and feedback for continual quality improvement and assessment of the BSAFE model.

- In considering the Sanctuary Model® and BSAFE elements in case management services, **children's case management services** will be a focal point, with specific trauma-informed services geared towards children. Identification of specific needs for each child will be incorporated into case management planning, with emphasis on educational and social supports in the community.
- The **Empowerment** model will inform a focus on strengths based and resiliency factors to incorporate into case management service planning. Case management planning will highlight that the individual is the expert on her own life, with the individual possessing the intrinsic inner awareness, strength, and essential capacity to gain the skills and knowledge needed to accomplish case management goals.
- **Domestic Violence (DV) Informed Safe Housing** will guide case managers to increase development of multiple safe housing options across Philadelphia, while building a strong collaboration network with other social service, legal, and health care organizations. Case managers will provide information, linkages, and education in collaboration with other community providers to create a robust community response where an individual in need of domestic violence services can receive a trauma-informed response focused on safety planning and immediate access to a range of trauma-informed services.
- In achieving the strategic direction and goals of the Theory of Change plan for WAA, case management interventions and services will focus on the provision of high-quality services in a client-centered continuum of housing options and supportive services. Increasing options available to clients through collaboration and shared program resources will be an essential component of effective, efficient case management services at WAA.

Part II

Case Management Processes

The mission of Women Against Abuse (WAA) is to provide quality, compassionate, and nonjudgmental services in a manner that fosters self-respect and independence in persons experiencing intimate partner violence and to lead the struggle to end domestic violence through advocacy and community education. To that end, WAA strives to provide the best possible services to the women and children who seek shelter in our programs. One of the many ways in which these services are provided is through high-quality, strengths-based case management. Case managers play an integral role in the healing and future success of clients.

Tip Boxes are spread throughout this section. It is recommended that case managers read their section(s) plus the tip boxes in each section, as these boxes are designed to be helpful to all case managers.

This part of the manual outlines the Case Management Processes for the Safe Havens, Sojourner House Transitional Housing, and Safe at Home Residential Programs. The first section is an overview of case management. This section will give readers an idea of what roles, duties, and goals case managers have with each program participant to meet the specific needs of domestic violence survivors. Since much of the processes across WAA services are similarly managed, the second section has directional information for all case managers in all areas of WAA programming. The third section outlines the programs individually, with steps regarding intake, ongoing case management, and transition planning.

Section 1: What is “Case Management”?¹⁰

The term “case management” has evolved over time and encompasses a wide array of services, strategies, and interventions. Therefore, it is imperative to understand what is meant by the term “case management” within the WAA system. In short, it is the duty of case managers to utilize

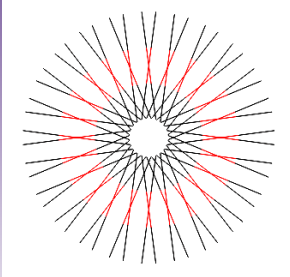
¹⁰ Strengthening At Risk and Homeless Young Mothers and Children. (2011). *Step by Step: Approach to Case Management*. Agoura Hills, CA: Author.

National Alliance for Direct Support Professionals. (2008). *The 15 NADSP Competency Areas*. Minneapolis, MN: Author.

Taylor, M., Bradley, V., & Warren, R. Jr. (1996). The Community Support Skill Standards: Tools for Managing Change and Achieving Outcomes. *Skill Standards for Direct Service Workers in the Human Services*. Human Services Research Institute. Cambridge, MA.

Arizona Coalition Against Domestic Violence. (2000). *Best Practices Manual for Domestic Violence*. AZ: Author

the models of care presented in Part I of this manual to assess the needs and strengths of those we serve, assist them in planning for safety and future stability, assist them in addressing crisis situations, provide referral services, and provide support and education about finances, employment, education, health and wellness, and housing stability in a confidential, trauma-informed, and empowering way. Furthermore, it is the responsibility of case managers to understand the unique needs and struggles of adults and children who have survived domestic violence and to provide services in a manner that creates safety, develops tools for coping, and supports growth and healing.



The wheel concept of case management puts case managers and clients together as a team at the center of the wheel with each aspect of the client's life, healing, or goals along the outside of the wheel. The work toward management of life domains and fulfilling goals is represented by spokes turned by the case manager and client together, thus helping the client move forward.

The case managers at WAA utilize the Brokerage, Generalist, and Strengths-based styles of case management to assess clients, coordinate care, model healthy behavior, focus on strengths and empowerment, identify goals and make a plan to meet them, advocate, and evaluate progress.¹¹ Case management can be visualized as seeing the client and / or client unit (such as a family unit) as a system and addressing each part of that system as appropriate. This is not to say that the clients should lose their individuality or be treated as anything other than a unique human, but planning case management care that is robust and complete can be aided through this conceptualization. Every adult, child, and family has complex situations and goals that require an organized, holistic, and partnership approach to reach goals.

Assessment

Each case manager will conduct an initial assessment of the clients' needs, strengths, and situation through an initial intake process and through garnering information from the application and referral source. Assessment serves three primary purposes:

- To ensure program eligibility and appropriateness and to place the client in the correct level of care,
- To identify areas of need for the case manager to provide support and strengths/available skills on which the client and case manager draw to achieve goals related to those needs, and
- To encourage enlightenment of the client to their own strengths, needs, and solutions.

¹¹ Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, E. (2007). Effectiveness of Different Models of Case Management for Substance-Abusing Populations. *Journal of Psychoactive Drugs*, 39(1), 81–95.

Assessment is a continual, developmental, and dynamic process though the weight of assessment tends to be at intake. Throughout the time frame of work with a client, case managers are assessing and re-assessing a client's situation, needs and strengths and encouraging the client to do the same. Rather than telling the client what the case manager thinks the client should do, ask what they feel, think, want, and can take action on. Questions should be used artfully to assess the client's capacity for collaboration and change. This will help to identify the correct level and style of intervention needed for the particular client, the skills available to the client to use to handle the current situation, and their ability to cope.

Questions are powerful, and often just asking the correct questions can move clients to the best action and motivation for themselves.

Coordination of Care/ Referrals¹²

Providing referrals and then coordinating that care is a primary function of case management that ensures quality, specialized care and services for each client and family that can continue beyond their stay at WAA. Since case managers cannot possibly be experts in every subject, having a tool box of referral sources and resources will help to truly personalize the unique set of services and resources that each client will require. At WAA, a list of referral sources is located in Client Track, and supplemental resources can be found on the shared document drive. Colleagues, the internet, clients, and supervisors are also valuable sources of referral resources. Two things to remember with referrals are:

- Referrals must be effective and appropriate: Providing a client with several referrals that will not work for their benefits, need(s), comfort level, etc. may just serve to overwhelm and frustrate the client;
- Referrals must be followed up: whether you are following up with the outside service provider or with the client to see how they are accessing and utilizing the referral, it is best practice to follow up on referrals to ensure that a connection is made to meet the need.

If the community-based services are appropriate and the case manager is following up to ensure access and utilization, the client is more likely to be able to continue using the resource independently in the future.

¹² Case Management Society of America. (2010). *Standards of Practice for Case Management*. Little Rock, AR: Author.

Modeling Healthy Behavior

For many clients, especially those who have been traumatized, the case management staff are among the first safe and trustworthy people the client is able to enter into relationship with, even though it is a service-based relationship. One way for the case manager to support clients in their growth is to model healthy behavior in general and as it relates to mutually respectful relationships: setting and maintaining healthy boundaries, confidence, empathy, safe behavior, and rational problem solving. Each interaction a case manager has with a client can be educational for the client through modeling rather than explicit teaching. At times, setting case manager in a role of teacher is disempowering to clients, where modeling the concepts and behavior is more effective. Remember that the clients at WAA have very specific needs and traumatic histories that make them especially susceptible to further trauma if the service relationship does not balance the power of the relationship and model mutual respect and care.

Healthy and ethical boundaries in the case management relationship is empowering, provides for emotional safety, and models healthy boundary setting to the people being served. Supporting them in setting and maintaining boundaries through engaging them in the practice of this behavior is powerful.

Strengths and Empowerment

Maintaining awareness of oppressive language and stereotypes that are reflected in society and avoiding such language and stereotypes is imperative to empowering people of various backgrounds, beliefs, and experiences.

Just as Trauma Informed Care assumes that we all have experienced trauma, true cultural competency assumes that we are always encountering people of diverse and marginalized groups since not all differences are easily seen or identified.

Take care to utilize inclusive language that is not disparaging or micro-aggressive.

Case management services should focus on strengths the client can utilize to reach goals and meet areas of need. Focusing on strengths can be empowering in and of itself, as it reinforces a positive view of self while helping to strengthen the client/case manager team as mutually respectful. As shown in Part I of this manual, the models of care and service provision utilized at WAA are based on empowerment and strengths. The empowerment model provides an environment of support, choices, and responsibility. Case managers should assist in naming and defining options for clients, as well as assessing possible outcomes of choices without making the choice for the client. Trusting that case managers have the strength themselves to let go of judgement and give clients space to make choices for themselves is the other side of a strengths based approach, as it is important to recognize the strengths of the whole client-case manager team. An important note is that, though the case manager will not be making decisions for the client, clients who are immobilized by

crisis may need a more direct approach in order to be mobilized toward change. Being direct about suggestions and the consequences of choices is not the same as telling the client what to do or making decisions for the client. Supervisory support is imperative if a case manager is finding difficulty in navigating client empowerment.

Supporting client strengths and empowering them to make choices and live their life as they see fit can only happen in an environment of true respect and appreciation for who they are and what they have accomplished. This environment is created partially through partnership and collaboration and partially through cultural competence, awareness of privilege, and respect for diversity. Diversity exists in belief systems, racial or ethnic backgrounds, sexual orientation, age, gender/gender identification, socialization, disability, medical condition, physical and mental impairment, socio-economic status, and many other factors. Attention and respect should be paid to the unique beliefs, experiences, and social expectations that may affect how a client views their situation and choices. This is referred to as Cultural Competency, which is further defined as a set of policies and behaviors that allow a professional or agency to effectively work cross-culturally. Specialized needs (language, deaf, Braille, cultural, disabilities, etc.) are addressed by WAA case management services coordinating with specialized service providers. Case managers should seek on-going training and supervision support around diversity and cultural competency in order to be able to support and empower clients from all backgrounds.

Trauma Informed Advocacy

Actions that support principles and goals, such as assisting a person to change their life or meet their self-defined goals, are defined as advocacy. An important piece in trauma – informed advocacy is to allow the client to participate in advocating as much as they are able in that moment or situation and to not allow case manager advocacy efforts to usurp the client's independence, choice, and ability. Advocacy should encourage self-reliance rather than being aggressive, rescuing, or infantilizing. With each advocacy opportunity, ask the question, “Will this help the client gain understanding in order to more effectively cope with their situation and make necessary changes while garnering independence?”

Domestic violence advocacy, using a trauma informed approach, supports a client's emotional safety as well as their physical safety. Access to advocacy services without stigma for clients of domestic violence services is critical. Trauma informed advocates seek to respond to clients with supportive intent, language that is not value or judgement based, and determination not to re-traumatize while providing case management services. Advocacy services are provided based on the client's goals and preferences, with sensitivity and respect being the central to the interaction.

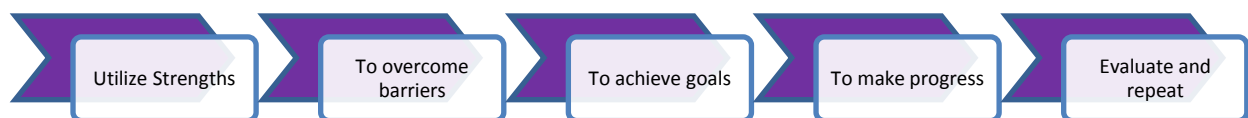
Goal Identification/Planning and Evaluation of Progress

Flowing from the assessment process, goal setting, planning, and implementation comprise the core of case management. The goal setting and planning process should be client driven, with the case manager's main role being to assist the client in seeing the relationship between strengths, barriers, needs, and goals and to assist the client in remaining engaged and motivated in the implementation process. Once needs are identified by the client, goals can be developed to meet those needs. Once strengths and skills are identified, they can be used to develop realistic objectives to overcome barriers and meet the goals.

Ensuring that goals are realistic can be a difficult process. At times, clients may identify goals that seem unrealistic to the case manager. Depending on the client, the relationship between client and case manager, and where the client is at the moment with the barrier or situation, the case manager may be able to help the client break the goal up into smaller goals and action steps or re-assess the goal. For example, if the client did not finish high school but his/her employment goal is to be a psychiatrist, the case manager can assist the client in starting with a goal of obtaining a GED or diploma, then entering college, etc. Having honest, yet supportive and compassionate conversations about goal setting will make goal setting easier for both client and case manager.

Another challenge can be helping clients to gain motivation to set goals or maintain motivation and engagement during the implementation process. The keys to success will be non-judgemental support, clear communication about expectations and potential outcomes, and identifying what is most important as a motivator *for the client*. Common mistakes are trying to motivate clients through fear (if you don't achieve x, then something bad may happen), false accountability (not following through with consequences or threatening consequences that are not realistic), or motivating factors that don't resonate with the client. Motivational Interviewing can be a useful intervention to identify a client's motivation for change. For more information, visit <http://www.motivationalinterviewing.org/>

Evaluating progress on goals is important to determine if goals should be changed or action steps should be added or removed. Additionally, a goal plan review or progress evaluation can be a useful tool for case managers to review the successes and improvements made by the client/case management team and can be re-invigorating for case managers who are feeling "stuck" with a client. Evaluation is an on-going piece of goal setting, not necessarily the end step.



Outcomes

Women Against Abuse has identified three primary outcomes for case management services:

- Safe, affordable, and stable housing.
- Increase income and entitlements through connection to entitlement programs, education and employment.
- Engage clients around healing from trauma so they can break the cycle of violence.

Section 2: Standards and Governance

The work done at Women Against Abuse is outlined and governed by several rules, regulations, and guidelines from multiple levels and sources, including federal, state, and city level. Auditing is done by state and city oversight agencies to assure compliance with case management standards. The sources of governance with particular case management specific guidelines and regulations are outlined in this section. For more detailed information and specific regulations, it is recommended that the referenced documents be reviewed.

Federal Laws and Protections and Confidentiality

Confidentiality is not only an empowering right of the client, it is a matter of safety. There are three main federal codifications of the rights of victims of crime, including or specifying domestic violence victims explicitly: Violence Against Women Act (VAWA), Victims of Crime Act (VOCA), and the Family Violence Prevention and Services Act (FVPSA). Each of these contains strong confidentiality provisions to protect the personally identifying information of victims, including entering information into public records and databases. VAWA and FVPSA also permit limited sharing when mandated by state law or a valid court order.

The specific laws are:¹³

- VOCA: 42 U.S.C §§ 10601-10607¹⁴
- VAWA: 42 U.S.C. §§ 13925 (a) (20) & (b) (2) and 42 U.S.C. §§ 11383 (McKinney-Vento Homeless Assistance Act as amended by VAWA 2005, Section 605)
- FVPSA: 42 U.S.C. §§ 10406 (c)(5)

Confidentiality in the Community can be awkward and difficult. Case managers should not acknowledge clients when they see them in the community unless the client initiates contact first. In the case that the client approaches you, refrain from explaining to others how you know the person. Remember that this is a matter of safety as well as a right of the client.

¹³ <https://www.techsafety.org/faq-federal-laws>

¹⁴ VOCA is a provision for funding that has guidelines for confidentiality that govern any funded programs.

Case managers should be careful to follow WAA guidelines regarding confidentiality, and check with supervisors for guidance regarding confidentiality. Because protecting clients' rights and advocating for their protection is an important part of case management services as well as the law, best practice is to only reveal the information about a client that is necessary and permissible for the particular situation under state and federal law. Names and other identifying information should never be released outside of the agency without a Release of Information with the exception of an emergent situation necessitating such release as summarized in WAA's confidentiality policy. It is imperative that all case managers familiarize themselves with federal law, state law, and WAA's policies relating to confidentiality, mandated reporting, and conflict of interest. It should be noted that WAA's confidentiality policy covers not only registered and enrolled clients, but also anyone seeking services. Furthermore, educating clients about their rights of confidentiality increases their empowerment and ability to advocate for themselves.

State Level Core Standards – Pennsylvania Domestic Violence Program Standards (PCADV)

Functions of Case Management

Core Standards for case management services incorporate the state level standards of the Pennsylvania Coalition Against Domestic Violence, found at www.pcadv.org. On page 1 of the core standards, section C1, required services are outlined. Functions of case management defined by PCADV include:

- Safety planning
- Domestic violence counseling/advocacy
- Children's services and advocacy
- Legal systems advocacy
- Other social services advocacy
- Information and referral
- Support/education groups



Core standards utilize the empowerment model for case management services, which supports one of the key elements defined for WAA case management services. A focus on strengths based and resiliency factors is incorporated into case management service planning.

Partnerships with Community Agencies

Developing and maintaining partnerships with community based agencies that serve clients and their families is strongly supported within case management services under state core standards. Partnerships of importance include:

- Child Protective Services (DHS and Childline)
- County Assistance Office (CAO) for welfare, housing, etc.
- Court Personnel
- Police
- Area Agency on Aging
- Area Schools
- Domestic Relations – Police Department

Case management service linkages are required through listings of services/resources under the state core standards. The PCADV Section C16: Information, Referral, and Resources list an extensive list of service linkages with direction to have an internal resource list. At WAA, this resource list is located in Client Track and found by clicking the magnifying glass next to “Refer to Provider” when entering a referral service. Supplemental resources are also available on the shared document drive. Some of the resources and referral sources outlined by PCADV are:

- Emergency service phone numbers
- Housing alternatives
- Medical and health care services; dentistry services
- Legal services
- Alcohol and drug related services
- Translation services/interpreter services
- Child Protective Services
- Welfare-related services
- Housing options/resources
- Services for those with cognitive or physical disabilities
- LGBTQ* support services
- Counseling services for adults, children and families
- Emergency and other transportation services
- Continuing education and job training
- Child care services, parenting education and resources
- Abuser services
- Consumer, credit and financial services
- Adolescent services and programs
- Elderly support services
- Sexual assault services
- School based services
- Victim Witness Programs

Access the resource and referral list at WAA by clicking on the magnifying glass next to “Refer to Provider” when entering a referral service. The referral categories in Client Track are:

- Arts and Culture
- Basic Needs
- Behavioral Health
- Children’s Services
- Daycare
- Education and Training
- Financial Services
- Health Care
- Housing
- Immigration Services
- Internal Referral
- Job Training
- Law Enforcement
- Legal Services

State Recordkeeping Requirements

State core standards emphasize safety planning for all clients and their dependent children as a primary goal. WAA will assure the discussion of safety issues and options for each person seeking assistance. All counseling/advocacy services are to be respectful, focusing on the client's right to an individualized case management plan and self-determination, and should be documented in the same manner. Specialized needs (language, deaf, Braille, cultural, disabilities, etc.) are addressed by WAA case management services coordinating with specialized service providers and documented in a culturally sensitive way.

Case Notes should be clear and concise. Case managers should consider the ramifications if a note were to be subpoenaed. For example, can the note harm the client in any way? Does the note reflect judgement or does it simply state the facts? In the example below, example A is the best note: factual, clear, concise, strengths-based.

A. Client and CM completed housing applications. Client will return next week.

B. CM completed housing application for client due to client's stress inhibiting her ability to complete paperwork. CM encouraged client not to miss any more appointments.

State core standards set basic recordkeeping requirements including:

- statement of need for service
- eligibility form
- service/goal plan
- documentation of services provided
- service evaluation

Case management notes must have clear and specific information pertinent to the client's situation and the services provided, which support the case plan and service data reported to PCADV. WAA staff members who are working with the client need to be identified in the case record.

Case management notes, for both adults and children, cannot contain "any direct quotes" from the client and/or children. No emotional or feeling content will be recorded in the case management notes, as well as no psychiatric or emotional assessments will be housed within the case management record. Though this is the state standard, in WAA's philosophy, we do include feeling and emotional content when appropriate.



City of Philadelphia Case Management Standards (Office of Homeless Services)

Core Standards for case management services incorporate city level standards of the Office of Homeless Services, found at this link on their [website](#).

Guiding Values: NASW Code of Ethics¹⁵

The National Association of Social Workers (NASW) Code of Ethics serves as a guiding set of values and principles on which the foundation of case management services is built in the Office of Supportive Housing guidelines. The values of:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

are emphasized within these case management standards.

Required Elements of Case Management Services under Office of Homeless Services

Case management services are an integral part of the mission of Office of Homeless Services (OHS) and are viewed as a critical component of every shelter and long term housing program. Responsiveness to client's needs and presenting situation are components of a process designed to maximize the client's and family's self-sufficiency and self-determination.

The components of the case management process include:

- An assessment of the client's and or family's needs
- Development of a realistic service plan which focuses on client gaining independence
- Provision of assistance in identifying and obtaining health care, housing and other services
- Advocacy to overcome barriers in receiving required services

Consumer Progress Reviews (CPR) are a required element of practice under the case management standards for OHS. This term is meant to refer to holistic client reviews, such as the Internal Clinical Client Review at the Safe Havens. These meetings are designed to support the client and to review their progress, while identifying challenges that may be present, as well as recognizing completion of goals. The objective is to assist and empower the client in moving

¹⁵ For more information, please visit the NASW website at <https://www.socialworkers.org/About/Ethics/Code-of-Ethics>

forward towards self-sufficiency. Participants should include the client, case management staff, behavioral health staff, children's services staff, and other safe haven staff, as appropriate. Department of Human Services staff, if appropriate and the OHS social worker can participate, if available. If the client is facing barriers to moving forward, these obstacles can be identified and discussed, developing a plan to address them. Specific steps and timeframes for completion can be identified for the client in a contract plan. Each program at WAA has different review schedules and processes for these collaborative reviews.

Bringing it all Together: The Federal, State, and City Standards and The Case Management Models

The State of Pennsylvania and City of Philadelphia requirements outlined are the main requirements of the standards for case management services. The key identified standards align well with the WAA designated models of case management:

- BSAFE, using CTI model: Resources identified to respond to immediate needs of clients and their families. Link housing with services and supports.
- Empowerment: Resources identified and tailored to meet individual need.
- Domestic Violence (DV) Informed Safe Housing: Building safe housing capacity occurs by working and partnering with other community based organizations. Provide linkage and referrals with resources.
- WAA Theory of Change: Enhance the safety and independence of people affected by domestic violence through emergency and transitional housing; legal interventions; behavioral health; case management; education; crisis response and aftercare. This can best be accomplished through strong community partnerships.

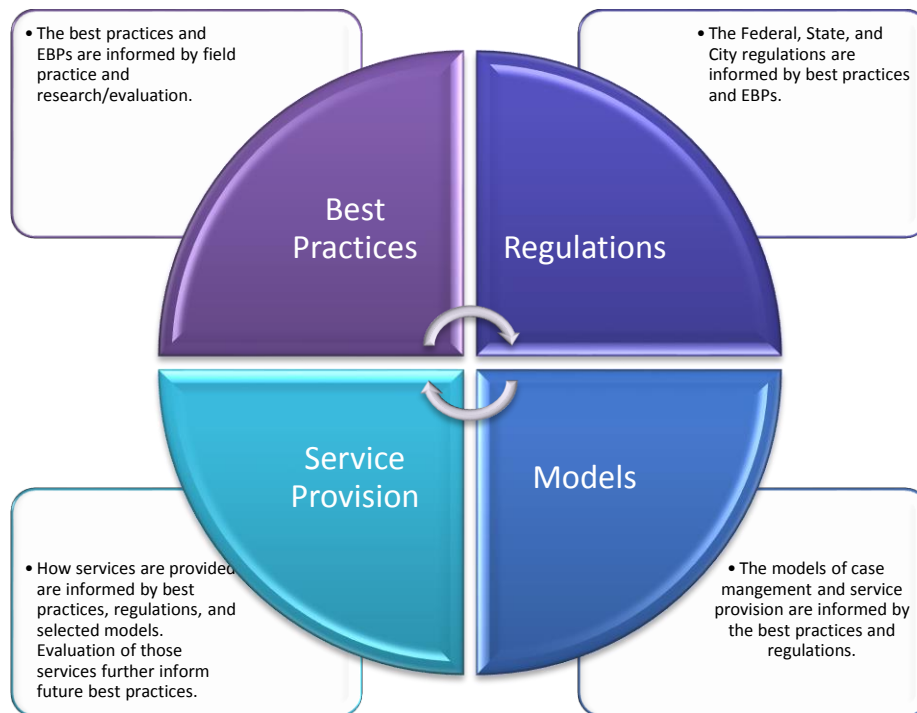
To better understand how the best practices, regulations, and models work together to inform services provision, consider the following case (which will also be revisited in later sections):

Betsy is a 29 year old woman with two children, aged 5 and 7. Her long term boyfriend has been abusing her for the last three years. Before meeting him, Betsy and her children were homeless for a year, staying in a hotel in which she cleaned rooms in return for shelter after leaving the abusive father of her children. Betsy reports that her parents used to fight often when she lived at home, and those fights were very physical. When her parents split up, her stepfather abused both she and her mother until she left home at 17. Betsy has a high school diploma, and she is interested in going to school for nursing but thinks she may not be smart enough. She has experience working in hotels as a house keeper and waiting tables in a café, but her work experience is sporadic because she often loses jobs or quits due to issues with child care or missing work due to abuse. Her son, 7, is showing episodes of anger and is often withdrawn. He is struggling in school, and his teacher is concerned that he does not have many friends. There is an open case with the Department of Human Services from the last time he went to school with bruises that were self-inflicted, according to his mother. Her daughter, 5, is socially appropriate at school and seems to be doing well in kindergarten, but does not have all of her immunizations, as she has not been to the doctor in over 3 years. Betsy is estranged from her family, since she has not talked to them since she left home at 17. She does not identify any true friends, and reports feeling depressed. Betsy came to the shelter from the emergency room after a neighbor called the police during an especially loud fight with her boyfriend. The police were unable to arrest the boyfriend as he was gone when they arrived, and Betsy is afraid to tell them what happened to her. However, she was able to confide in a nurse at the hospital where the police took her to be treated.

How best practices, regulations, and models inform services for Betsy

Starting with Betsy and her children entering the shelter, it is well documented in research that initial needs assessments with goal plans to meet the identified needs are vital in providing needed services for clients in crisis (Best Practices). An assessment and linkages to needed services and recorded goal plans are also required by the State (PCADV) guidelines for case management, since the regulations are formed by the known best practices (Regulations). To meet the best practices and the regulations, the models used also encourage or require the use of assessment and goal planning with the client (Models). For example, service planning is one of the tools in the Sanctuary Toolbox, is one of the Principles of Care in the BSAFE model, and is a key element of Empowerment, through providing the client with an opportunity to take part in her own healing and have clear steps to follow to implement change for herself. The service plan is then implemented through the regular provision of services (i.e. case management meetings and activities/referrals), as required by WAA policies and procedures.

Due to Betsy's long history of trauma related to violence, best practices also dictate a trauma informed approach to providing services (Best Practices). In actual service provision, this will include offering her confidential services (required by Federal, State, and City standards and dictated in the Sanctuary Model®, Empowerment, BSAFE, and DASH), allowing her to lead her own treatment/service planning (also included in all the models), and providing a supportive environment with a plan for safety (also required by State standards and the models). This is only a snippet of how best practices inform the standards which inform the models selected for use, thus informing and guiding service provision.



Section 3: Program Specific Processes

Each program at Women Against Abuse (Safe Haven Adult Services, Safe Haven Child Services, Sojourner House, and Safe at Home) has slightly different procedures for intake, ongoing case management, and discharge. This section reviews the steps to be taken in each program for Intake, On-going Case Management, and Transition out of programming. ***Any forms that are needed are underlined in italics and are hyperlinked to the WAA shared document drive.*** If the manual is being used in printed format, each form can be located on the shared document drive under the Residential Services folder. In-depth descriptions of these processes can be found in Part III of this manual.

Safe Haven - Adult Services

Women Against Abuse's two 24-hour safe havens, known as Ameya's Place and Carol's Place, provide free services to women and children who are victims of domestic violence. The locations of both safe havens are kept confidential to maintain client safety, with 24 hour security provided. Each safe haven has the capacity to hold up to 100 residents (including children). All clients typically share a common bathroom/shower area with another family or other singles, with larger families being allocated two units with their own bathroom and shower area. Community areas are found on each floor, and case management offices are located on the premises.

Services include:

- Up to 90 days of shelter
- Case management (adult and child)
- Individual and group counseling
- Three meals a day
- Donated goods as needed
- Children's health assessments
- Emergency relocation funds (as available)
- Adult education and job readiness referrals
- Community room and computer lab
- Employment and financial stability support
- After school and summer school programs
- On-site child care

A trauma informed approach will allow for emotional, social, moral, and physical safety for women in crisis.

A program or system that is trauma-informed:

1. *Realizes* the impact of trauma
2. *Recognizes* the signs and symptoms of trauma
3. *Responds* by integrating knowledge of trauma into practices
4. *Seeks to actively resist re-traumatization.*

Policies and Procedures as well as corresponding forms are contained within the WAA Safe Haven Operations Manual found on the shared document drive (the table of contents for that manual is linked [here](#).) Throughout this manual, necessary forms and resources are hyperlinked to the form or resource on the shared document drive.



Intake

WAA Safe Haven case managers receive clients through referral and assignment by the hotline. An intake packet is completed which is then passed on to the case manager, and the case management assignment is communicated through a “Welcome” email to all safe haven staff.

WAA Safe Haven has a welcome handbook for clients, which outlines expectations of community living and responsibilities of the client/family entering the safe haven. The Intake staff initially reviews the handbook with the client and has the client sign a form indicating receipt of the handbook. However, the case manager will go through the handbook again with the client at the first meeting to answer any questions and assure understanding of material.

The case manager is to have contact with the client within 48 hours of admission, with exception given to clients admitted Friday-Saturday. Both the case manager and the client are held accountable for this standard, and some flexibility is allowed around weekends and holidays. The case manager should reach out to the client in her room as soon as possible after case assignment, and leave a note if she is not present.

Client engagement through use of trauma informed strategies is essential in building a solid, trusting working relationship.

First Meeting: The first meeting can take place in the client’s room or in the case manager’s office and the children may be present depending on the preference of the mother and the age and understanding of the children. There are some pieces of the intake that may not be appropriate for some children to overhear.

In the initial interview, the focus is to:

- Familiarize and orient the client to the guidelines and expectations of the safe haven
- Assure any issues related to client’s eligibility for safe haven services are addressed
- Initiate an assessment of the client’s needs to begin development of a service plan
- Obtain appropriate client releases to address needed referrals and to develop linkages to services
- Review client service agreement signed at intake and ensure a signed copy is in client’s file

The entire intake may take up to two meetings, but may be completed in one 45-60 minute meeting. This often depends on the client and where she is emotionally and mentally. It is important for the case manager to pay attention to the client to ensure that the intake goes at her

pace and comfort level as much as possible. Before starting any forms, the case manager should have a conversation with the client to introduce herself, review the Welcome packet she received from the intake staff, review programming, and review the expectations of both the client and the program. The case manager will then start going through the [Adult Needs Assessment](#) found on the shared document drive. The Adult Needs Assessment includes the History of DV, History of housing, TBI Screening, Safety Planning, Goal Planning, and Policies to be signed. In-depth discussion about Goal Planning and Safety Planning processes can be found in the third part of this manual. Other forms utilized for intake are the [Emergency Contact Forms](#) and [Release of Information](#). If at any time in the intake process the case manager has reason to believe that the client is having difficulty with language or literacy, the case manager should take measures to read the forms to the client or seek support via language line as necessary. Additionally, careful attention should be paid to the trauma that clients have experienced prior to entering the safe haven, with case managers seeking to provide comfort and safety while assessing the impact the abuse had on the clients.

Transition Statements are a helpful tool in case management, especially in intake. When you have many items to go through, switching between topics can be awkward. For example, moving from demographic and income questions into a TBI screen can feel disjointed for the interviewer and the client. Try using statements such as, “Thank you for answering all these questions about your income and housing. We are going to shift gears a little bit for this next form to talk about your abuse history again. Are you ready to start this piece?”

What other transition statements are helpful in case management?

1. History of DV – This is the first part of the Adult Needs Assessment that garners information about the client’s history of trauma and relationship. It is important to ask the client open-ended questions to garner as much information as possible from the client about her experience. Other case managers have found the following questions useful:

- Tell me about your relationship.
- Tell me about the last incident that brought you to the safe haven.
- How did you find out about WAA? (This one can be helpful not only for referral information, but also to get an idea if the nature of the abuse led others to reach out to her to refer her to WAA).
- Tell me about other key relationships over the course of your life.
- Have you experienced past abuse?

2. Demographic, Financial, Legal, and Housing Information – The case manager should feel free to ask follow up questions if necessary to gather accurate information. Clients in crisis may have some difficulty remembering exact information or elaborating on important information. For example, asking about eviction history even though it is not on the form is important for housing planning. Additionally, asking clients what they

receive SSI or SSDI for can potentially add information for employment possibilities and other goal planning. Types of housing that may be available to clients include: transitional housing (including Sojourner House, as well as other City programs), permanent supportive housing, rapid rehousing, veteran housing, fair market rental, or subsidized rental housing.

3. Traumatic Brain Injury Screening – This form assesses clients for TBIs to aid in proper health services referrals.

4. Policies – The policies are also included in the Adult Needs Assessment. Client must sign off on five separate policies:

- Resident Savings Agreement – notifying client of the opportunity to participate in a Savings Program;
- Transportation Assistance – notifying the clients about available transportation assistance and the limitations of such assistance;
- Translation Services – informing client of the availability of and her right to utilize translation services;
- Personal Belongings Storage – reviews guidelines for personal belongings and mail once the client leaves the safe haven;
- Business Calls – informs client of the business call policy, including which calls count as business calls.

5. Goal Planning- Goal Planning should be done early in the intake process to identify areas of need, specifically identifying which areas the case manager can be of assistance. The Goal Plan is a form with preset goal areas and an open section for goals the client may have that do not fit into the preset areas. For safe haven services, these goals usually surround crisis management, safety, and housing.

6. [Safety Planning Form](#) – The Self-care Safety Plan and DV Safety Plan focus on helping the client keep herself and others safe in the safe haven and community. Safety plans encourage skills in emotional management and set expectations for the entire community. Plans should be simple and straightforward with immediate tools clients can use in stressful or dangerous situations. Completing these plans is a dynamic process that asks the client to identify obstacles to her safety and safety of others, what steps she will take to ensure safety, and who she can go to for support in maintaining safety. Safety plans can be used as an initial plan for safety or as a response to inappropriate behavior that will pose a danger to the client's ability to remain at the safe haven.

There is also a separate Sanctuary Model® safety plan (not a form) that addresses emotional regulation and works with the same principles of keeping clients emotionally safe and stable. Clients are encouraged to have their Sanctuary Model® safety plan cards available to assist with emotion management as needed (in an accessible place rather than put away in a stack of paperwork or a drawer). *In depth*

information on the types of safety plans and the distinction between them can be found in Part III of this manual.

7. Case manager gives the client the paperwork to complete for their housing packet and reviews it with client. Case manager will also offer any assistance needed to complete the packet due to language barriers.

8. Case Manager starts the paper file, enrolls the client into the program in Client Track, and reviews the intake in Client Track. The paper file must be kept up to date with documented proof of income and current identification. The format for the [paper file](#) and the [instructions for Client Track](#) can be found on the shared document drive. Paper files are kept in a locked file cabinet or desk in the case manager's office.

There are three types of **Safety Plans** at WAA:

1. Sanctuary Safety Plan
2. DV Safety Plan
3. Self-care Plan

Each type of safety plan is meant to help clients maintain one or more of the following:

Physical Safety: being physically safe from harm.

Psychological Safety: ability to keep one's self safe in the world - includes self-discipline, self-esteem, self-control, self-awareness, and self-respect.

Social Safety: ability to be safe with other people in relationships and in social settings.

Moral / Ethical Safety: ability to maintain a set of standards, beliefs, and operating principles that are consistent, that guide behavior, and that are grounded in a respect for life.

Safety plans are empowering by allowing the client to take control of her outcomes based on her behaviors and actions.

On-going Case Management

The length of stay at the Safe Havens is 60 days with a possible extension of up to 90 days. During their stay, all clients are expected to meet with their case manager weekly. Meetings can take place in the case manager's office or in the client's room at the safe haven.

Case management services in the Safe Havens incorporate the following elements, some of which were addressed at intake:

- Adult Needs Assessment
- Identification of pressing needs, with more immediate planning to address needs
- Establishment of a housing plan, linking with identified necessary services and supports
- Review of lethality assessment completed during intake to begin process of safety planning
- Completion of an individualized safety plan, utilizing the Sanctuary Model/trauma informed approach, updating as needed
- Development of a service/goal plan, designed to be updated every 15 days
- Assessment of referral and service linkage needs, offering resources and assistance to client as needed
- Advocacy, encouragement and support on behalf of clients and their families
- Education and supportive counseling with emphasis on trauma informed care, safety and emotion management
- Focus on creating and supporting a healing environment to restore a sense of hope for clients and safe haven community

Tips for Advocacy with Empowerment:

*Encourage clients to advocate for themselves in order to promote independence and empowerment while also being the advocate when necessary.

*Empower clients by talking through all their options. The bulk of empowerment case management is providing options and supporting client choice.

The main objectives of case management in the Safe Havens are to assist the clients in making and implementing a plan for safety and finding a stable living arrangement upon exit. Case managers will work through the client's goal plan and safety plan to help them create stability and safety.

Goal Plan, Safety Plan, Clinical Client Reviews:

A Goal Plan must be developed within two weeks of the client's entry into the safe haven. This is generally done on the second case management meeting with the client. Every plan needs to be individualized and based on the client's personal goals and preferences. Plans are to be completed with the client present and engaged, with the case manager utilizing strategies to increase engagement, such as motivational interviewing techniques, empowerment strategies, etc. Oftentimes, clients struggle to stay engaged with goals due to their trauma and crisis status.

Honest discussions about how the client can get the most out of the program for the remainder of their time may be helpful. More in depth information regarding goal planning can be found in Part III of this manual.

Goal plans are assessed every fifteen days for progress and need for ongoing assistance and support. Suggested strategies for the case management goal development process are:

- In developing goals with the client, incorporate more realistic goals that can be achieved within the timeframe of the safe haven stay.
- Start with short term goals, sometimes as little as an hour, a day, a week, etc. Clients in crisis can have difficulty organizing and planning effectively to meet broader expectations.
- Accomplishing short term, smaller goals will help clients build competency and confidence in their ability to accomplish goals. It helps in feeling productive.
- As clients are able to build on successes, goal planning can involve larger goals, such as obtaining housing or gaining employment. Take care not to overwhelm client by moving too quickly through goals.
- Build on successes and work on identifying barriers and address challenges, remembering to use a trauma informed lens. Keep addressing and ensuring psychological and social safety.
- Prioritize goals with client, focusing on immediate and current needs. Provide support through periods of challenge and discouragement.
- Keep encouraging and coaching to identify and address barriers, normalizing experience and emotions along the way.
- Remember everyone has a different experience with structure, which may trigger trauma symptoms in client. Continually assess along the way, adapting strategies to meet the unique needs of the client.
- Update and review goal plan every 15 days. Goal planning is an ongoing process and will need to be revised regularly.
- Engage client in developing network of community resources. Educate client regarding the importance of engaging with community supports to achieve goals.

Keeping clients motivated for change and action can be difficult, especially in times of crisis. Clients can feel immobilized or weakened by their trauma.

Motivational Interviewing is a practice model that has several tools and techniques to help mobilize clients toward change.



Client will have a transition meeting at 30 days of residency. The 30 day meeting is with the case manager and case management supervisor as well as any clinical staff or child case managers to discuss progress and begin exit planning. During this meeting, it is determined if the client is given a 15 day extension or given their exit date. 60 day length of stay can be extended to 90 days, per recommendation of case manager and case management supervisor. If the client is given an extension, then review meetings are scheduled for every 15 days until exit (45 days, 60 days, and 75 days).

Safety Plans should be reviewed at the weekly case manager meetings as appropriate. At a minimum, case managers should be reinforcing the use of safety plans by referring clients to their plans in decision making, emotional regulation skill building, and goal planning.

[Clinical Client Reviews](#) are weekly interdisciplinary, trauma informed reviews with the purpose for staff to collaborate and share information regarding clients and to plan for future interventions to best serve each client. The policy and associated forms can be found on the shared document drive. Case managers present each new client to the team with [the Clinical Client Review Form](#). This form will help the case manager prepare the client presentation in the format of client strengths, trauma history as presented in the [iceberg conceptualization](#), safety concerns with DV safety plan (if one is needed), emotions and emotional triggers identified, losses identified, and future plans and needs as reflected by the [SELF tool](#). For on-going clients, case managers will provide updates on housing for those who have been at the safe havens for more than 30 days and prepare for warm hand-offs to Safe at Home and Sojourner House case managers as necessary.

Documentation and Notes: Case notes for every meeting, collateral meetings and all referrals are kept in Client Track. Notes are a summary about what was discussed or accomplished in the meeting and may include plans for the future meeting. Notes are recorded for every client contact, not just face to face meetings, or significant event (i.e. no-shows, cancellations, outreach, etc.). Notes should be concise, non-judgmental, and containing only the necessary facts regarding what was reviewed in the session.

Additionally, case managers should ensure that necessary items are updated in the file. Updates to the Goal Plans, Safety Plans, and housing applications must be entered into the file along with referrals, PFAs, ROIs, and legal information (custody, child support).

Housing: Housing is an important factor in clients being able to be independent, stable, and safe upon exit from the safe haven. Housing will look different for different clients. Some clients will be able to exit to their home once their perpetrator is put in jail or removed from the home, some may exit to be with family or friends either locally or out of state, and some may need to find new housing. Clients will fill out the housing application while in the safe haven, but should also be creative in exploring all their options. It is helpful for the Safe Haven case managers to start talking to clients early on about saving to prepare for relocation, moving costs, application expenses, and other moving related expenses.

There are some options for housing assistance available through WAA and WAA partners. These include moving costs through PCADV as well as subsidized housing available through WAA partners. Permanent housing placements within the community are available to qualified, income eligible Safe at Home clients. Scattered site units and Safe Crossing placements are available as subsidized housing through WAA partners.

Skill building: The case manager will be assisting clients with a variety of skills during their period of program participation. At the safe havens, this skill building is largely focused on immediate needs and crisis management. The needs of clients in the safe havens can be overwhelming to case managers and will require a large amount of referral work to be met. When providing clients with community referrals, helping them practice their safety plan skills along with learning to reach out to community resources will be the focus of skill building activities. Other skill building that occurs in the safe havens involves effective self-advocacy, increasing motivation for change, emotional regulation, and healing/recovery skills. See Part III of this manual for more information on some of these skill building functions.

*“Provide support and be the safe person that they are able to go to. “
- Carly Range, Adult Case Manager at Ameya’s Place, 2015*

Transition or Discharge

Case managers are responsible for the exit interview and follow up plans for clients transitioning out of the Safe Haven programs whether clients go to Sojourner House for residential stays of up to 18 months, go into Safe at Home aftercare program, or leave Safe Haven services, with no further services identified. Details of the [Exit Process](#) can be found in the operations manual.

Exit plans should be finalized with residents during the 30-day review. It is recommended that conversations about exiting begin within 30 days of entering the safe haven. Case managers should also communicate upcoming exits with safe haven staff. Clients will transition out of Safe Haven services in one of three ways:

- Graduating or Completing the program – This is a voluntary, ideal reason for ending services and transitioning to independence with an exit to a safe place identified. The process of transitioning out of services will begin when the goal plan has been achieved or safe housing is found. The case manager should have a conversation with the client about exiting that focuses on what she has achieved and building positive self-regard and confidence for her future and ability to meet future goals. It is customary to give the client at least one transition meeting in which the client and case manager spend time reviewing the safety plan, budget, future goals, etc.
- Timing out of the program – This may be a voluntary transition due to program completion or may be involuntary if the client still identifies a great need for support. In the case of the client timing out of services, the case manager should start talking to the client about transition in advance of the end date of services, and focus on what the client would like to achieve with the case manager in the time they have remaining as well as how the client would like to prepare for program completion, i.e. contact other service providers, make a plan for crisis situations, etc.
- Termination of services due to non-compliance – This is generally an [involuntary exit](#) due to behaviors that pose safety risks to themselves or others

Transitioning out of safe haven or services can be frightening and anxiety-provoking for clients, even if the exit is under the best of circumstances. Try the following ideas to help the exit process be as positive as possible:

- ❖ Focus on the strengths of the client
- ❖ Help them change the narrative of their inner talk by showing and telling them that you believe in their ability to be successful.
- ❖ Provide resources and referrals for on-going support
- ❖ During the exit process, review accomplishments and skills learned
- ❖ Review safety plans and goal plans as tools for future success

in the community as well as disappearing from the safe haven. A client *may* be considered non-compliant if they are refusing to communicate with the case manager, repeatedly missing meetings, or not engaging in goal or safety planning. Any and all efforts should be made to engage the client in an empowering way in the instance of disengagement. Clients who reach the point of exit for non-compliance most likely have a safety plan in place, but may not in the instances of egregious behavior.

****The client is also considered to be non-compliant for aggressive or threatening behavior. If the client is acting dangerously, safety precautions should be taken**

- All discharges must be approved by a Director. The supervisor/manager and case manager will meet with the client to have a discussion about the decision to terminate services and to review the appeals policy with them.

With each exit, the case manager will complete the [exit interview form](#). The exit interview process includes a discussion of community resources, updating the safety plan, updating the goal plan with at least two goals to work on post care, and an opportunity for the client to give feedback about services. The case manager will also ask for contact information for the client and provide her with a cab voucher to get to her next destination.

Once the client has been transitioned out of the program, the case manager should write a final case note about the discharge in Client Track, print the case notes and referrals for entry into the paper file, close the paper file, exit the client in Client Track, and move the paper file to the closed file storage. Instructions for closing a file and exiting the client from Client Track can be found in the Operations Manual. It is also best practice to follow up with the client with phone calls from case management and possible limited services (i.e. referrals) as necessary. It is the policy at WAA to request information from clients at discharge to allow for post-discharge follow-up in order to ensure that clients are living safely in the community once they leave residential programming. Utilizing the Post-Discharge Client Survey Form, case managers should follow up with clients via phone or mail at six months and twelve months. These contacts should also be recorded in Client Track and any interest in volunteer, board, advocacy, or other future involvement should be forwarded to the appropriate WAA contact per the policy found on the shared drive.



Safe Havens – Child Services

Children exposed to domestic violence may experience short and long term effects, including a higher risk of violent behavior, psychological symptoms of abuse, and long-term behavioral, emotional, and developmental symptoms of abuse. Symptoms of violence exposure in children include withdrawal, anxiety, and depression that manifest as aggression, delinquency, and hyperactivity. The strongest risk factor for violent behavior in children is witnessing violence between parents or caretakers, and children exposed to violence are more likely to struggle in behavioral, academic, and social functioning.

Children's services are wrapped into family services in Sojourner House and Safe At Home programs. At the safe havens, children services are carved out to child-specific case managers and are more intensive. However, the key components of children's services will be similar in nature and philosophy between all three programs. Since the children's services at the safe havens are more intensive, that is the focus in this section.

Many women will not seek services for domestic violence if they are not assured that their children will also receive care and services.

Effects of DV on Children

Children who witness domestic violence might feel:

- ❖ **Powerless:** Because they couldn't stop the violence
- ❖ **Confused:** Because it doesn't make sense.
- ❖ **Angry:** Because it shouldn't be happening.
- ❖ **Guilty:** Because they think they've done something wrong.
- ❖ **Afraid:** Because they may lose someone they love or they may get hurt.
- ❖ **Alone:** Because they think it's happening only to them.

Devon County Council (June, 2007). Talking to Children about Domestic Violence and Abuse.



Women Against Abuse's two safe havens, known as Ameya's Place and Carol's Place, provide free services to women and children who are victims of domestic violence. The locations of both safe havens are kept confidential to maintain client safety, with 24 hour security provided. Each safe haven has capacity to hold up to 100 residents (including children). Community spaces are found on each floor, and case management offices are located on the premises.

There are two children's case managers per safe haven with caseloads of 26-32 children at a time. Children and their mothers meet with child case managers to address issues pertaining to safety, education, health, social support, and behavioral and developmental well-being. Children's case managers ensure minimal disruption to schooling, particularly if a child needs to relocate to a new school for safety reasons.

Intake

Case managers receive clients through assignment by the hotline staff who conduct intake screening and communicate safe haven admissions and case management assignments via a "Welcome" email to the safe haven staff. The hotline staff will also pass the intake packet on to the assigned case manager. Occasionally, the intake is conducted by the DV Specialist at OSH, and they will email the intake information to the safe haven.

Case managers should have a meeting with the children and mother within 72 hours of arrival at the safe haven, with a preference for contact within 48 hours. Case managers should reach out to the mother in her room, leaving a note if she is not there.

Behavioral reactions for children who witness DV may include the following:

- Regress: bedwetting, whining, temper tantrums
- Earlier childhood fears return
- Aggressive to other kids, brothers and sisters, pets
- Treat Mom like Dad (or other parent) treats her
- Experience problems concentrating
- Easily distracted
- Fight at school
- Get bad grades
- Lie, steal
- Withdraw and unusual shyness
- Forgetful
- Have trouble sleeping
- Very anxious
- Physical illness: stomach aches, nausea, headaches
- Easily startled
- Unable to play
- Highly sensitive to noise

The first meeting should take place within 72 hours of the family's arrival at the safe haven, and usually takes place in the case management office. The children should be present, if they are on-site, and depending on the preference of the mother.

Before starting intake paperwork, the case manager should have a conversation with the client about the children's program and services overall, including requirements, process, and expectations. Case manager will then begin the intake process, which should only take one meeting. In rare cases, the intake may need to be broken into two meetings to

meet the needs of the clients. If this occurs, schedule the second meeting as soon as possible. Case manager will work with the client to complete the following:

- The [*Children's Intake Form*](#) is located on the shared document drive and includes the policies and procedures that focus on the child: Schooling (truancy history and whether to stay or change schools), special needs, child welfare involvement, and the assessment of what services mom wants the kids to be involved with in the Safe Haven (child care, behavioral health, afterschool program, summer camp, or other resources (outside referral). The case manager should review the policies and procedures that involve children and mother and complete the following:
- [*Releases of Information*](#) (ROI) – ROIs should be completed for children's medical records, school(s), and emergency contact(s).
- [*Trip Permission Form*](#) – Allows permission for children to participate in field trips.
- The [*Liability Form for Playground*](#) – Explain liabilities and responsibilities for use of WAA's playground.
- [*Child Goal Plan \(ISP\) or Goal Plan*](#) - The Individualized Service Plan is set up to ask for children's strengths and areas of support. The case manager should complete a separate plan for each child to address the following areas of need: afterschool services, daycare, health (medical and dental) needs and services, behavioral health needs and services, summer camp, extracurricular activities, and "other" which includes behavioral, social, and educational goals. As the mother indicates areas of need on the ISP, she checks off the boxes. Ideally, the mother and case manager will set about two goals per child in the areas of need that are indicated. The goals should be kept broad to allow for flexibility and creativity in what objectives are used to meet the goals. If the family is large, this may need to be broken into two meetings to be completed.
- [*Safety Plan*](#) – Children are encouraged to make their own safety plans to teach emotion regulation, provide safety, and support trauma resiliency. These plans should be short, clear, and straightforward for the children to be able to utilize them appropriately.
- [*Child Needs Assessment*](#) – The completion of this form may or may not involve the children being present depending on the children and the preference of the mother. This form reviews the family network and support system, developmental history, educational assessment, behavioral assessment, medical assessment, and legal situation or concerns. Some of the language in this form refers to goal setting as well as collecting information.

Case Manager then starts the paper file for the children and enrolls the children into the correct program in Client Track. The paper file must be kept up to date. The format and guidelines of the [*paper file*](#) and the [*instructions for Client Track*](#) can be found on the shared document drive as well. Paper files are kept in a locked file cabinet or desk in the case manager's office.



On-going Case Management

Clients may remain in the safe haven for 60 days with possible extensions to 75 or 90 days. Case managers should meet with the family weekly. Families will have a comprehensive review at 30 days, at which time the ISP can be updated. The 30 day review involves all case managers and clinical staff involved with a family.

WAA's goal is that 100% of children will have a plan, created with the mother, child (if age appropriate) and case manager, to identify and promote protective factors against domestic violence and homelessness. Including the child (ren) and mother in plan development, supports the **Empowerment** approach through recognizing that the client is the best expert on what will work for herself and her family. Placing control and decision making in the hands of the clients also meets the **Trauma-Informed Care** principles of encouraging client involvement in services, offering choices and options, partnering with the client, and assisting clients to voice concerns.

The **BSAFE Principles** support child services and protecting children from future homelessness, not only through rapid re-housing to minimize children's time in the safe haven, but also through addressing the unique needs of children. As stated in Part 1 of this manual, the needs of homeless children are often overlooked, especially in settings with limited resources. At a minimum,

- Child-specific services and child friendly settings must be provided. Services must be developmentally appropriate.
- Programs must help children access and succeed in schools.
- Medical, trauma-specific, and mental health services must be available for children. At WAA, this is done through collaboration with local medical providers and WAA's on-site clinical services.

At WAA safe havens, child services are on a separate case management track than adult services, but should be coordinated to ensure the whole family is being cared for in a seamless way. Child services focus on:

- | | |
|---------------------------------|------------------------------------|
| • Identification issues | • Safety and goal planning |
| • School supports | • Referrals to community resources |
| • Out of school time activities | • Behavioral Health care |
| • Emotion regulation | • Medical & Dental Health care |

Parenting after Domestic Violence can be difficult. Mom is trying to support her children while she herself is healing from trauma. Some messages that mom can be encouraged to **tell her kids about domestic violence** are:

It's not OK. *It's not your fault.* **I will help you stay safe.**

I will listen to you. **You can tell me how you feel.** Your feelings are important.

There is nothing you could have done to prevent or change it.

Documentation and Notes: Case notes for every meeting, contact, and significant event are kept in Client Track. Notes are a summary about what was discussed or accomplished in the meeting and may include plans for future meetings. Notes are recorded for every client contact, not just face to face meetings, or significant event (i.e. no-shows, cancellations, outreach, etc.). It is also important to document case manager efforts to reach out to clients, especially if there has been difficulty engaging the client. Notes should be concise, clear, and non-judgmental. Additionally, case managers should ensure that necessary items are updated in the file.

Skill building: Skill building with client will mostly focus on emotion regulation and school supports for children and emotion regulation and parenting supports for mothers. Emotion regulation skills are coached through the use of safety plans, modeling healthy and calm behavior, positive reinforcement, and boundary setting. Parenting skills are coached in much the same way along with providing tools to be used for positive parenting skills and for understanding child developmental needs. Many resources are available to the case manager on the shared document drive, in the [Children and DV Educational Packet](#).

Education support: Success in education is one of the leading protective factors for children against future poverty, homelessness, substance abuse, and violence. Factors that support school success are medical and behavioral health care to promote attendance and participation in school, protection from interruption of education (missing school, multiple school transfers mid-year, etc.), and out of school time supports (summer camp, afterschool services, homework support).

According to WAA's summary of education services, "WAA's preschool and school-aged programs provide a safe, nurturing environment with trauma-informed educational programs to enhance the holistic development of child residents and give them opportunities to grow, learn, and succeed while residing with WAA. WAA's children's case managers and children's education services staff work collaboratively to address the needs of children in WAA's residential programs. Therapeutic environments, including Bright Spaces, and early intervention assessments, such as the ASQ development surveys, are utilized to support parents and children in their healing and growth while at WAA. Additionally, incorporating the Sanctuary Commitments, using age-appropriate teaching methods, allows WAA's children to be supported and nurtured towards resilience."

Educational support services include Preschool supports, Afterschool Program, Summer Camp, and community partnerships including children's arts program, Mommy-Baby Wellness Music Group, Arcadia University story-time, and Drexel University College of Medicine tutoring program, among others.



Transition or Discharge

Children will be transitioned out of the program with their parents. Children being exited due to their mother's non-compliance or when the family is timing out and exiting the safe haven may need more support at transition time than children exiting to safe and stable housing. That support can come in the form of updated safety plans or referrals to on-going service providers.

Once the client has been transitioned out of the program, the case manager should write a final case note about the discharge in Client Track and complete a discharge summary form, print the case notes and referrals for entry into the paper file, close the paper file, exit the client in Client Track, and move the paper file to the closed file storage. Instructions for closing a file and exiting the client from Client Track can be found in the Operations Manual.



Sojourner House

Sojourner House, WAA's transitional housing program, provides transitional housing and supportive services to domestic violence victims. The program provides 15 family apartments for women and their children for up to 18 months. Supportive services provided include:

- Case management
- Individual and Group counseling (behavioral health services)
- On-site child care
- On-site health education
- After school and summer camp programs
- Financial management education
- Parenting and life skills education (individual and group)

Children's Services:

Case managers at Sojourner House and Safe at Home services should review the children's services description in the Safe Haven section of the manual for tips on serving the entire family.

Providing service referrals, support for emotional regulation and healthy boundaries, and educational support for children in WAA programs along with parenting support for mothers are key protective factors against future homelessness, violence, and poverty.

Transitional housing provides a critical stepping stone, after safe haven, toward safety and self-sufficiency for families who have become homeless as a result of domestic violence. Sojourner House provides a crucial link in the continuum of services for victims of domestic violence.

The ideal candidate for Sojourner House is a mother with at least 1 child, although the site has units for families as large as seven. A Sojourner House mother might not be earning income through employment at the time of move-in, but she should be ready to seek employment or return to school for more training within 3 months of entry into the program. Sojourner House clients are highly motivated to move towards greater economic advancement and are committed to saving money each month, paying their housing contributions on time, and increasing their income (through work or other sources) during their stay in the program. Clients must be goal oriented and need a safe, stable “home base” to get started on the next steps of their journey. Ideally, they are interested in being involved in a community, seeking supports and services for their children, and are committed to prioritizing self-sufficiency and safety for the 18 months of their stay at Sojourner House.

The main objectives of case management in Sojourner House are to assist the client in reaching self-sufficiency and finding stable housing for exit as well as furthering their healing process. Case managers are working with clients to achieve their goals in their goal plan. Case management services in Sojourner House incorporate the following elements:

- Identification of needs, including financial independence, employment, education, parenting, physical and behavioral health and other defined domains
- Establishment of a permanent housing plan, linking with identified necessary services and supports
- Completion of an individualized safety plan, utilizing the Sanctuary Model®/trauma informed approach, updating as needed
- Development of a service/goal plan
- Assessment of referral and service linkage needs, offering resources and assistance to client as needed
- Advocacy, encouragement and support on behalf of clients and their families
- Education and supportive counseling with emphasis on trauma informed care, safety and emotion management
- Focus on creating and supporting a healing recovery environment to restore a sense of hope for clients

All services should be delivered in a trauma-informed manner. Case managers should utilize language line if necessary to provide services in the instance of language barriers.

Intake

Clients can enter the transitional housing facility at the recommendation of the Office of Supportive Housing after staying in WAA’s Safe Havens or at another shelter in Philadelphia. Case managers receive clients through assignment by the supervisor, and the assignment is communicated via email or supervision meetings. The supervisor will forward the application packet and OSH approval to the case manager via email. The case manager is to have contact

with the client three to five days after assignment of the case. The client will still be in the safe haven when they start working with the Sojourner House case manager.

The intake is a multi-step process. In order to complete intake, the case manager does the following:

1. Arranges a move-in date and facilitates the client's move-in.
2. Provides client with items listed on Welcome Letter.
3. Schedules an intake appointment and follows up with client to complete all intake documentation with one week of move-in.
4. If client is from the WAA Safe Haven, then arranges to have the PW652 form sent from the safe haven to Sojourner and filed into the case file. If the client is not from the WAA Safe Haven, please have the client fill out a PW652.
5. Enrolls client in the program in Client Track.
6. Provides client with a Getting Started Checklist and Apartment Turnover form.
7. Completes Client Entries & Exits and distributes to all staff
8. Completes OSH admissions report and delivers to Case Manager Supervisor
9. Provides all Sojourner House staff with census information
10. When each of the policies has been reviewed with the resident, the client and the case manager will sign the bottom of the checklist.

First Meeting: The first meeting usually takes place in the safe haven, and the children may be present depending on the preference of the mother and the age and understanding of the children. Before starting intake paperwork, the case manager should have a conversation with the client about the program overall, including requirements, process, and expectations. Explain the case management process to the client so that she understands why you are asking for the information, how the information will be used, and the importance of shared decision making between case manager and client. Begin to explain community based services, referral options and potential linkages to explore what might be of interest to the client. During case management interactions, keep in mind case management models outlined in Part 1. Client engagement through use of trauma informed strategies is essential in building a solid, trusting working relationship.

1. Complete the [Pre-Enrollment Interview Checklist](#) located on the shared document drive. This is part of the final evaluation process for eligibility and appropriateness of placement into Sojourner House. In this conversation, the case manager can ask them how they think the case manager can help them: discussing goals, the case manager's role in assisting them in achieving their goals, and their ideas for being successful in housing, including whether or not their income is sufficient to support independent housing. Usually at this point the intake process will begin, the case manager will set a date for move-in, coordinate move-in, provide client with [Welcome Letter](#) and move-in items. During this meeting, the case manager is building rapport, going over policies, and answering the many questions the client will have about housing.

If at this point the case manager does not feel the client is appropriate for the Sojourner House program, the client should be informed of the concerns. If the client disagrees, then the supervisor must be brought in. The case manager will then inform the supervisor who will work with the case manager, client, and OSH to reassess the situation. This rarely happens due to the initial screening process. In the event that the client is refused admission after the case is explored with the supervisor, the client has an option to appeal that decision. Sojourner House [paper files](#) are kept secure by case managers and include intake paperwork and programming documentation.

Second – Fourth Meetings: The intake packet should be started in the first week after move-in and will be spread over three separate weekly meetings with the initial intake paperwork (steps 1-6) being completed in the first week. Once the initial intake paperwork is completed, the case manager will spend the next few meetings going through budgeting, goal planning, and safety planning with the client. In-depth discussion about each of these processes can be found in the third part of this manual and the forms are found on the shared document drive.

During the three-week “intake period,” clients may experience other crises and concerns that must be addressed, making intake challenging to complete. The case manager may want to consider scheduling the first few appointments for an hour.

Preparing clients for success and independence after transitional housing:

It is important to start talking about exit plans early with clients. Reminding clients regularly that they will need to move in 12 to 18 months and exploring options will support success.

1. [Getting Started Checklist](#) and [Move-in/Move-out Checklist](#) – Upon move-in, the case manager will go with the client to ensure that the apartment is clean and in good repair and that the welcome package of household items are there, will work with maintenance and property management to ensure that the fobs are activated, and will work with the safe haven case manager to ensure a smooth transition.
2. The case manager will receive a transition form from the past case manager, but will also complete an [Admission Form](#) at move-in.
3. Complete [Emergency Contact Form](#) and [Releases of Information](#) as necessary. Consider releases to assist in advocacy for children’s education (schools), medical care, and legal advocacy.
4. Complete Safety Zone Acknowledgement and [Visitors Policy](#) to ensure safety of all residents.
5. Complete [Mandatory Reporter Acknowledgement](#) Form to ensure client understands the case manager’s responsibility to report knowledge of child abuse.

6. Complete the [OSH Admission Report](#) for Compliance Department.
7. [Goal Planning Form](#) - Goal Planning should be done early in the intake process to identify areas of need, specifically identifying which areas the case manager can be of assistance. The Goal Plan is a form with preset goal areas and an open section for goals the client may have that do not fit into the preset areas. For Sojourner House, these goals usually surround housing, legal issues, financial, employment, child custody or child welfare concerns, and on-going healing from trauma. At this point, case managers should ask the client if she has identified future housing, where she is with the housing process, and whether or not she will need help with moving costs through PCADV and if so, whether she has already submitted an application for that assistance.

It is during the Goal Planning Process that the case manager also will start to review possible rental assistance and housing resources. Housing Resources are also available through the Safe at Home program.

2. [Budget Form](#) – The Budget Form is broken down into categories that include income, SNAP benefits (food stamps), renter’s insurance, cleaning supplies, utilities, etc. If the client is over budget, the case manager should ask guiding questions about how the client is actually making that work. Are family members assisting with bills? Are there expenses she is actually skipping some months? If she is struggling, consider some referrals for payment assistance, credit score repair, financial management, and benefits.
3. [DV Safety Planning Form](#) – The Safety Plan (differentiated from the Sanctuary Safety Plan) for Sojourner House is meant to assist the client in identifying and avoiding behaviors that are toxic or unsafe. It is best for the case manager to assist the client in personalizing the safety plan to meet her needs through finding healthy, simple activities the client can choose over unsafe responses to stress. Making a safety plan is a proactive approach to assist the client before issues arise that may lead to unwanted consequences for the client. ***In depth information on the types of safety plans and the distinction between them can be found in Part III of this manual.***

On-going Case Management

The client and the assigned case manager will meet weekly during the resident’s stay in the Sojourner House program. The assigned case manager helps families meet self-determined housing, financial, education, parenting, legal, community, and career goals. Residents participate in weekly on-site meetings that include life skills workshops on topics such as financial literacy and employment. Clients may also meet with an on-site behavioral health therapist to address the impact of domestic violence on psychological well-being. Staff provides children’s



education services for pre-school and school-aged children through day and after-school programs. Children at Sojourner House also participate in the Young Survivor's Summer Camp.

Clients' needs and progress are assessed through guided weekly meetings and case managers provide housing, financial and employment counseling to help women plan for long-term safe, affordable housing upon exit from Sojourner House. Case managers assist with identification of resources and provide general advocacy services for the client and their family. Children's services include addressing issues pertaining to education, health, social support, and behavioral health and developmental well-being.

In order to complete a case management session, the case manager reviews the following with the resident as appropriate: Triaging crisis situations (court and legal issues, welfare issues, mediation with other residents, etc.); weekly schedule; payment status of savings and contributions; answering client calls regarding need for assistance; group meetings or case management attendance; housekeeping reports; goal plans; budgets and payment plans; completing housing applications; furniture applications; job goals; education goals for mothers and children; financial goals; keeping clients motivated; and community referrals to meet needs.

Documentation and Notes: Case notes for every meeting and collateral meetings are kept in Client Track. Notes are a summary about what was discussed or accomplished in the meeting and may include plans for the future meeting. Notes are recorded for every client contact, not just face to face meetings, or significant event (i.e. no-shows, cancellations, outreach, etc.). It is also important to document case manager efforts to reach out to clients, especially when the client is difficult to engage. Notes should be concise, clear, and non-judgmental.

Additionally, case managers should ensure that necessary items are updated in the file. Updates to the Goal Plans, Budgets, and Safety Plans must be entered into the file at least every 90 days. Additionally, income updates (annually at a minimum, but preferably whenever there is a change), correspondence, referral applications, PFAs, medical documentations, ROIs as needed, legal info (custody, child support), etc. must be kept in the paper file and kept up to date.

Goal Plan, Budget, and Safety Plan Reviews:

Goal plans are reviewed informally in each case manager meeting for adherence to plan. Budget, Goal Plans, and Safety Plans should be formally reviewed and updated every 90 days (quarterly). In the review of the Goal Plan, the case manager should assess the need for ongoing assistance and support. The latest version of each goal plan will be brought to the case review session to be shared with the interdisciplinary team. Suggested strategies for the case management goal development process are:

- In developing goals with the client, incorporate more realistic goals that can be achieved within the expected/reasonable timeframe.

- As clients are able to build on successes, goal planning can involve larger goals, such as obtaining housing or gaining employment. Be careful not to overwhelm clients with goals that are not realistic or with too many goals at one time.
- Build on successes, work on identifying barriers and address challenges, remembering to use a trauma informed lens. Keep addressing and ensuring psychological and social safety.
- Prioritize goals with client, focusing on immediate and current needs. Provide support through periods of challenge and discouragement, as it can be difficult.
- Keep encouraging and coaching to identify and address barriers, normalizing experience and emotions along the way.
- Remember everyone has a different experience with structure, which may trigger trauma symptoms in client. Continually assess along the way, adapting strategies to meet client need.
- Engage client in importance of developing network of community resources. Educate regarding importance of engaging with community supports in client's success.
- Update and review each goal plan. Goals are an ongoing process and need to be revised quarterly.



Housing: The case manager will be assisting Sojourner House clients with maintaining housing in the program as well as obtaining new housing prior to exit. Skills in maintaining housing that the case manager may be able to help the client with or refer the client out for include lease education, landlord relations, tenant rights, housekeeping and maintenance basics, paying bills on time, neighbor relations, and setting boundaries with guests. See Part III of this manual for more information on this topic.

In the event that clients are in danger of losing housing while in the program, it may become necessary for the case manager to refer the client to legal assistance, help her negotiate ways for her to remain successful in housing (e.g. a safety contract), or referral to other housing programs or community resources as needed.

The case manager should discuss all housing options with the client including Safe at Home referrals. The client budget should also be considered and potentially revised to plan for moving costs, increased rent, application fees, and other moving related expenses.

To Help or Not To Help?

Advocating and assisting clients while empowering them to advocate for themselves and act independently can be a tricky balance. Different clients have different needs for assistance and advocacy. Case managers can try asking:

What is most appropriate

For
This client
At
This time
With
This issue
In
This situation?

Skill building: The case manager will be assisting clients with a variety of skills during their period of program participation. These include financial education (budgeting, teaching to save, researching best banks, going to banks with them, referring out, etc.), educational support (referrals to GED and diploma programs, school support for children, advice regarding affordable vocational and college programs, etc.), employment (resume writing, interview skills, referrals for vocational services, etc.), and parenting (positive reinforcement, referrals for child-gear services, etc.). See Part III of this manual for more information on some of these skill building functions.

Transition or Discharge

At each exit, the case manager should complete the [*Discharge Checklist*](#). Clients will transition out of Sojourner House services in one of three ways:

- Graduating or Completing the program – This is a voluntary, ideal reason for ending services and transitioning to independence. The process of transitioning out of services will begin when the goal plan has been achieved or three months out from exit date. The case manager should have a conversation with the client about exiting that focuses on what she has achieved and building positive self-regard and confidence for her future and ability to meet future goals. It is customary to give the client two to three transition meetings in which the client and case manager spend time reviewing the safety plan, budget, future goals, etc. This a great time for the case manager and client to prepare a resource packet together for client to use once she has been discharged that includes current resources being used, potential needs, and commonly used resources, such as crisis lines, support groups, utility assistance, etc. Ask client what info they want in the resource packet (current resources, potential needs, etc.). The case manager can also provide a completion of service letter if needed.
- Timing out of the program – This may be a voluntary transition due to program completion or may be involuntary if the client still identifies a great

need for support. In the case of the client timing out of services, the case manager should start talking to the client about transition six months prior to the end date of services and focus on what the client would like to achieve with the case manager in the time they have remaining as well as how the client would like to prepare for program completion, i.e. contact other service providers, make a plan for crisis situations, etc. The transition planning in this process will look very similar to the process of graduating as noted above.

- If a client needs to seek an extension to her stay at Sojourner House, a request for an extension must be filed with the Office of Supportive Housing, approved by OSH, and then forwarded to the State Housing Assistance Program for final approval. Extensions should be filed with Sojourner House staff no less than 30 days before scheduled exit, and should be for no more than an additional 90 days in the program. Case Managers will forward the extension request to the Client Services Director who will submit the request via email to WAA's program monitor at OSH. Extensions are generally granted for specific housing or safety related hardship.
- Termination of service due to non-compliance – This is generally an involuntary exit due to behaviors that are unsafe for themselves or others, non-participation with services, or other non-compliance with program guidelines. A client *may* be considered non-compliant if they are refusing to communicate with the case manager, missing meetings, or not engaging in goal/safety/budget planning. Any and all efforts should be made to engage client in an empowering way in the instance of non-compliance and disengagement. For the exit, the case manager supervisor and case manager will meet with client if possible and safe to have a discussion about the decision. If it is not possible for the staff to meet with the client due to the client not having contact with the case manager, the client will receive a letter with a two-week time frame to contact the case manager. If the client makes contact, the case manager can try to reengage the client or exit the client. If the client does not contact the case manager, they may be exited from the program. The letter to the client will include the steps for the client to appeal the exit decision.

The client is also considered to be non-compliant for aggressive or threatening behavior. If the client is being dangerous, safety precautions should be taken. The case manager supervisor should be brought in for all terminations of services due to non-compliance well before the situation gets to termination if at all possible. This may not be possible in the cases of dangerous behavior. For the exit, just as with termination due to non-compliance that is not aggressive or threatening, the case

manager supervisor and the case manager will meet together with client if possible. A letter confirming the decision and specifying the transition date will be sent to the client. The letter to the client will include the steps for the client to appeal the exit decision.

Once the client has been transitioned out of the program, the case manager should complete the [discharge checklist](#), write a final case note about the discharge in Client Track, print the case notes for entry into the paper file, close the paper file, exit the client in Client Track, and move the paper file to the closed file storage. Instructions for closing a file and exiting the client from Client Track can be found in the Operations Manual. Discharged clients should receive a follow-up phone call from case managers at 6 and 12 months post discharge. Utilizing the [Post-Discharge Client Survey Form](#), case managers should follow up with clients via phone or mail. These contacts should also be recorded in Client Track and any interest in volunteer, board, advocacy, or other future involvement should be forwarded to the appropriate WAA contact per the policy found on the shared document drive.



Safe At Home

Safe at Home Services offer support, safety and services for the community, in the community.

Safe at Home is an aftercare service that offers intensive case management, options counseling, advocacy, and education to individuals and families who are transitioning out of WAA's residential programs and moving into independent housing. Safe at Home case managers can help meet the goals that clients have in the areas of permanent housing, financial independence, employment, education, parenting, physical and behavioral health, and other domains. A Safe at Home case manager can be a support and advocate and can provide referrals and linkages to resources in the community. Safe at Home case managers also work with survivors of domestic violence who do not presently reside in WAA units, but do live within Philadelphia County and are seeking IPV/DV supports from their current home in the community.

To be eligible, clients must be moving into permanent supportive housing with a goal of renting on their own or moving into subsidized housing. Clients may also already reside in their own independent housing and may need support to sustain their current living arrangements. Clients in these situations are often referred to WAA from outside providers. The ideal candidate for

Safe at Home is a client who demonstrates the ability and readiness to live independently in the community. This client is able to afford the monthly rent on a market-rate apartment OR has a housing choice voucher (HCV) OR has another type of housing subsidy. The client should be willing to meet bi-monthly with a case manager to work on goals that support continued independence and healing. The Safe at Home program also supports clients with safety planning, budgeting, employment, career development, and connection to other resources to help clients maintain independence.

Referrals generally come through the Safe Havens or Sojourner House. Occasionally referrals come from outside case managers or OSH. The referral process involves completing the [application](#) and submitting it to the case manager supervisor. The supervisor will then screen for eligibility, conduct a phone screen with the client to assess appropriateness, and then, if the client is eligible, assign the client to a case manager. The case management assignment is based on caseload size, not by specialty or other factors. There are three case managers with up to 20 clients (households) per case load, with a family unit counting as a client, whether that unit consists of a single person or a parent and his/her children.

Further details regarding policies, procedures, and operations can be found on the shared document drive in Residential Services, Safe at Home folders.

Intake

Case managers receive clients through assignment by the supervisor, and the assignment is communicated via email or supervision meetings. The case manager is to have contact with Safe at Home client three to five days after assignment of the case. The client may still be in the safe haven or Sojourner House when they start working with the Safe at Home case manager who assists them with housing search and placement.

First Meeting: The first meeting usually takes place in the safe haven or Sojourner House, and the children may be present depending on the preference of the parent and the age and understanding of the children. Before starting intake paperwork, the case manager should have a conversation with the client about the program overall, including requirements, process, and expectations. This is part of the final evaluation process for eligibility and appropriateness of placement into Safe at Home services. In this conversation, the case manager can ask them how they think the case manager can help them: discussing goals, discussing how the case manager can assist them in achieving their goals, and how they think they can be successful in housing, including whether or not their income is sufficient to support independent housing. Usually at this point the intake process will begin.

If at this point the case manager does not feel the Safe at Home program is appropriate for the client, the client should be informed of the concerns and alert the supervisor. The case manager will then inform the supervisor who will work with the case manager and client to reassess the situation. This rarely happens due to the initial screening process. In the event that the client is

refused admission after the case is explored with the supervisor, the client has an option to appeal that decision by talking to the supervisor or the Client Services Director of the program.

If the client is admitted, the case manager will begin the intake paperwork. The entire intake may take up to four meetings, and will most likely take at least two meetings. All intake forms are located on the shared document drive, and there are five documents that must be printed for an intake: the Aftercare Intake form, Child Abuse Client Acknowledgement Form, Client Rights and Responsibilities, Program Participation Policy, and Termination and Appeals Policy. Other forms utilized for intake are Emergency Contact forms, Safety Plan, Goal Plan, and Budget. If at any time in the intake process the case manager has reason to believe that the client is having difficulty with language or literacy, s/he should take measures to read the forms to the client or seek support from language line as necessary.

1. [Aftercare Intake Form](#) – Since it is likely that the intake process will take at least two meetings, start with the Aftercare Intake Form. This form reviews non-cash benefits, cash benefits, budget, money management, credit, savings, medical concerns, mental health concerns, substance use, safety risks and concerns, PFA status, DHS status, family status, familial or social support, legal issues, citizenry, and where the client is in her/his housing search. There are also questions for the case manager on this form that address PHA Blueprint referral or Mission First Housing eligibility questions. While completing this intake form, the case manager is simultaneously assessing which services are most appropriate:

- Interim Services - 3-6 months of services; clients tend to be very independent/self-sufficient; client needs are low and s/he only has a few goals that are mostly involving transition assistance (i.e., enrolling kids in school and getting connected in community), or
- Self-sufficiency programming – up to two years of support; clients need more extensive services; client needs are higher and s/he has more goals that need the support of the case manager to achieve (i.e., more crisis situations and need assistance navigating community resources)

2. Policies – If there is time in the first meeting, start the policy forms. There is no set order to the forms, as long as they all get completed. Client must sign off on four separate policies:

- Child Abuse Client Acknowledge Form – notifying client that the case manager is a mandated reporter and must report suspected or disclosed child abuse in the past two years;
- Client Rights and Responsibilities – let clients know their rights regarding safety and dignity and responsibilities with regard to program requirements and expectations (i.e. goal planning, budgeting, and safety planning) including behavioral guidelines;

- Program Participation Policy – lays out WAA’s definition of what it means to be an active participant in the program; and
- Termination and Appeals Policy – lays out how client could be terminated from the program, the right to appeal, and what the appeals process is.

3. [Complete Emergency Contact Forms.](#)

4. Case Manager starts the paper file and enrolls the client into the Safe at Home program in Client Track. The paper file must be kept up to date with documented proof of income and current identification. The format for the six parts of the [paper file](#) and the [instructions for Client Track](#) can be found on the shared document drive as well. Paper files are kept in a locked file cabinet or desk in the case manager’s office.

If the case manager is able to get through all of this paperwork in the first meeting, it will usually take up the entire meeting. If there is time, the case manager should continue with the items outlined for the next intake meetings.

Second – Fourth Meetings: Preferably all meetings occur before the client moves out of the safe haven or Sojourner House. If any of the documents from the first meeting still need to be completed, complete them first. Once the initial intake paperwork listed above is completed, the case manager will spend the next few meetings going through budgeting, goal planning, and safety planning with the client. In-depth discussion about each of these processes can be found in the third part of this manual and the forms are found on the shared document drive.

Identifying current barriers to housing will be imperative not only in assisting clients in obtaining housing initially, but also in identifying areas for goal setting in the future to insulate clients from future homelessness.

1. [Goal Planning Form](#) - Goal Planning should be done early in the intake process to identify areas of need, specifically identifying areas in which the case manager can be of assistance. The Goal Plan is a form with preset goal areas and an open section for goals the client may have that do not fit into the preset areas. For Safe at Home, these goals usually surround housing. At this point, case managers should ask the client if s/he has identified future housing yet and where s/he is with the housing process as well as discuss whether or not s/he will need help with moving costs through PCADV and if so, whether or not s/he has already submitted an application for that assistance.

It is during the Goal Planning Process that the case manager also will start to review history of homelessness, possible rental assistance, and housing resources (these are outlined in the “On-going Case Management” section). Limited housing resources are available through Safe at Home. Permanent housing placements within the community are available to qualified, income eligible Safe at Home clients.

2. [Budget Form](#) – The Budget Form is broken down into categories that include income, food stamps, renter’s insurance, cleaning supplies, utilities, etc. If the client is over budget, the case manager should ask guiding questions about how the client is actually making that work. Are family members assisting with bills? Are there expenses s/he is actually skipping some months? If s/he is struggling, consider some referrals for payment assistance, credit score repair, financial management, and benefits.

The key to successful budgeting is making the budget manageable and accurate.

A tip from case manager Jessica Corey is to ask the client how s/he budgets. Just because the budget form is monthly does not mean that it cannot be altered to reflect the needs of a client who is used to budgeting per his/her paycheck, weekly, etc. The goal is to have the budget reflect the client’s needs and solutions regarding budgeting.

3. [Safety Planning Form](#) – The Safety Plan for Safe at Home is different from the Safety Plans at the Safe Havens and Sojourner House in that they are more geared for safety with regard to living independently and in the community. It addresses seven areas of need in seven sections with suggestions for safety in each area. It is best for the case manager to assist the client in personalizing it to meet his/her needs, but s/he may choose not to personalize his/her plan.

On-going Case Management

Clients may remain in Safe at Home services for up to two years. The clients who are initially put on the Interim Services track may have situations arise that necessitate an extension of their stay, but they generally only stay in services up to six months. During their stay, all clients are expected to meet with their case manager every two weeks at a minimum. Meetings can take place in the case manager’s office, in the client’s home, or out in the community. Case managers should work to be accessible to clients within the confines of healthy boundaries. For example, if a client is working and it is easiest for the client to meet at a place near work on his/her break, the case manager should try to accommodate. Willingness to work with his/her schedule and eliminate barriers to receiving services will encourage independence.

Community Maps are an ideal way to assist clients in building skills, identifying areas of need, setting goals, embracing creativity, and connecting to his/her own resources in the community. It also assists the client in thinking about self-sufficiency, independence, and transition planning.

Community Maps can be written, drawn, made as a collage, or any other number of creative iterations. Try starting with a basic wheel and spokes shape with the client in the middle. Ask the client to think of all the people or organizations s/he reaches out to and put them around him/her on the paper with who they are and what need they meet for him/her. Then ask the client to depict areas of need for which s/he does not have a contact, and work with him/her to fill those gaps.

The main objectives of case management in Safe at Home is to assist the client in reaching self-sufficiency, stability in housing, and continued healing from trauma. Case managers should, however, work through the client's goal plan to meet these objectives in an individualized, client-centered manner. Case management services in Safe at Home incorporate the following elements:

- Identification of needs, including financial independence, employment, education, parenting, physical and behavioral health and other defined domains
- Establishment of a permanent housing plan, linking with identified necessary services and supports
- Completion of an individualized domestic violence safety plan, utilizing the Sanctuary Model®/trauma informed approach, updating as needed
- Development of a service/goal plan
- Assessment of referral and service linkage needs, offering resources and assistance to client as needed
- Advocacy, encouragement and support on behalf of clients and their families
- Education and supportive counseling with emphasis on trauma informed care, safety and emotion management
- Focus on creating and supporting a healing recovery environment to restore a sense of hope for clients

Documentation and Notes: Case notes for every meeting and collateral meeting are kept in Client Track. Notes are a summary about what was discussed or accomplished in the meeting and may include plans for future meetings. Notes are recorded for every client contact or significant event (i.e. no-shows, cancellations, outreach, etc.), not just face to face meetings. It is also important to document case manager efforts to reach out to clients, especially when the client is difficult to engage. Notes for Safe At Home tend to be slightly more detailed than the notes for the safe havens, but still remain to be concise, clear, and non-judgmental.

Additionally, case managers should ensure that necessary documents are updated in the file. Updates to the Goal Plans, Budgets, and Safety Plans must be entered into the file at least every 90 days. Additionally, income updates (annually at a minimum, but preferably whenever there is a change), correspondence, referral applications, PFAs, medical documentations, ROIs as needed, legal info (custody, child support), copies of the lease, etc. must be kept in the paper file and kept up to date.

Goal Plan, Budget, and Safety Plan Reviews: At Safe At Home there are not currently regular team reviews of clients, but case managers can discuss challenging cases during bi-weekly team meetings or during bi-weekly supervision with the supervisor.

Goal plans are reviewed informally in each case manager meeting for adherence to plan. As previously stated, Budget, Goal Plans, and Safety Plans should be formally reviewed and

updated every 90 days. In the review of the Goal Plan, the case manager should assess the need for ongoing assistance and support. Suggested strategies for the case management goal development process are:

- In developing goals with the client, incorporate more realistic goals that can be achieved within the expected/reasonable timeframe.
- As clients are able to build on successes, goal planning can involve larger goals, such as maintaining or improving housing or gaining employment. Be careful not to overwhelm clients with goals that are not realistic or with too many goals at one time.
- Build on successes, work on identifying barriers and address challenges, remembering to use a trauma informed lens. Keep addressing and ensuring psychological and social safety.
- Prioritize goals with client, focusing on immediate and current needs. Provide support through periods of challenge and discouragement, as it can be difficult.
- Keep encouraging and coaching to identify and address barriers, normalizing experience and emotions along the way.
- Remember everyone has a different experience with structure, which may trigger trauma symptoms in client. Continually assess along the way, adapting strategies to meet client need.
- Update and review each goal plan. Goals are an ongoing process and need to be revised quarterly.
- Engage client in the importance of developing a network of community resources. Educate clients regarding the importance of engaging with community supports in the client's success.

Housing: Case manager will be assisting Safe at Home clients with obtaining and maintaining housing initially as well as re-housing if they lose housing during their stay in the program. Skills in maintaining housing that the case manager may be able to help the client with or refer the client out for include lease education, landlord relations, tenant rights, housekeeping and maintenance basics, paying bills on time, neighbor relations, and setting boundaries with guests. See Part III of this manual for more information on this topic.

In the event that clients are in danger of losing housing while in the program, it may become necessary for the case manager to refer the client to legal assistance to avoid eviction or for the case manager to meet with the client and his/her landlord to help him/her negotiate ways to remain successful in housing.

In the event that the client loses housing while in the program, it will be necessary for the case manager to assist the client in securing other housing. If the client was evicted and was not already connected with legal services, the case manager should make that referral. The case manager should then discuss all housing options with the client and refer the client to local shelters if necessary between eviction and securing new housing. If the client has a housing voucher, the assistance may simply involve locating a new unit and helping the client navigate

the transfer of his/her voucher to the new unit. If a new DV situation has occurred, the client may be eligible for an emergency transfer of site based housing assistance, emergency transfer of a voucher, or the client may need appropriate referrals to shelters. At this time, the client may remain with the Safe at Home case manager or may get services transferred to a shelter. This will be dependent on access to services and need to ensure services are available to the client without being duplicated. The client must remain in Philadelphia County to be eligible for Safe at Home services. When rehousing a client, the case manager should keep in mind the fact that clients are not eligible for moving assistance a second time, unless they have not used the full 2-year allotment of PCADV funds (\$1500/household). The client budget should also be considered and potentially revised to plan for moving costs, increased rent, application fees, and other moving related expenses.

Housing resources available through Safe at Home include:

- **Mission 1st Subsidized Housing** – Rental subsidies are available through our partnership with Mission 1st Housing. Permanent housing placements within the community are available to qualified, income eligible Safe at Home clients. Scattered site units and Safe Crossing placements are available.
- **Furniture Assistance-** Available through HAFI to help clients obtain beds, tables, chairs, dressers, and other essentials for their new homes. PHMC administers a fund through DHS which also provides furniture assistance to families only. The Safe at Home case managers can make a referral to PHMC for eligible families.
- **Security Deposit Assistance-** Security deposits and 1st month rent is available through PCADV for clients transitioning into permanent housing. A maximum of \$1500 is available (total) every 2 years to clients through this fund.
- **General Relocation Assistance-** Fresh Start Funds are available to clients who may need to relocate out of state or city and need support for transportation, travel, storage of belongings, or other needs not traditionally covered by PCADV funds.

Skill building: CM will be assisting clients with a variety of skills during their period of program participation. These include financial education (budgeting, teaching to save, researching best banks, going to banks with them, referring out, etc.), educational support (referrals to GED and diploma programs, school support for children, advice regarding affordable vocational and college programs, etc.), employment (resume writing, interview skills, referrals for vocational services, etc.), and parenting (positive reinforcement, referrals for child-gear services, etc.). See Part III of this manual for more information on some of these skill building functions.



Transition or Discharge

Clients will transition out of Safe at Home services in one of three ways:

- **Graduating or Completing the program** – This is a voluntary, ideal reason for ending services and transitioning to independence. The process of transitioning out of services will begin when the goal plan has been achieved or three months out from exit date. The case manager should have a conversation with the client about exiting that focuses on what s/he has achieved and building positive self-regard and confidence for his/her future and ability to meet future goals. It is customary to give the client two to three transition meetings in which the client and case manager spend time reviewing the safety plan, budget, future goals, etc. This a great time for the case manager and client to prepare a resource packet together for client to use once s/he has been discharged that includes current resources being used, potential needs, and commonly used resources, such as crisis lines, support groups, utility assistance, etc. Ask client what info they want in the resource packet (current resources, potential needs, etc.). Potentially, clients have the option to return for groups. The case manager can also provide a completion of service letter if needed.
- **Timing out of the program** – This may be a voluntary transition due to program completion or may be involuntary if the client still identifies a great need for support. In the case of the client timing out of services, the case manager should start talking to the client about transition three months prior to the end date of services and focus on what the client would like to achieve with the case manager in the time they have remaining as well as how the client would like to prepare for program completion, i.e. contact other service providers, make a plan for crisis situations, etc. The transition planning in this process will look very similar to the process of graduating, so the case manager should refer to that process.
- **Termination of service due to non-compliance** – This is generally an involuntary exit due to inappropriate behavior, non-participation with services, or other non-compliance with program guidelines. A client may be considered non-compliant if they are refusing to communicate with case manager, missing meetings, or not engaging in goal/safety/budget planning. Any and all efforts should be made to engage client in an empowering way in the instance of non-compliance and disengagement. For the exit, the supervisor and case manager will meet with client if possible and safe to have a discussion about the decision. If it is not possible for the staff to meet with the client due to the client not being in contact with the case manager, the client will receive a letter with a two-week time frame to contact the case manager. If the client makes contact, the case manager can try to reengage the client or exit the client. If the client does not contact the case manager, they

will be exited from the program. The letter to the client will include the steps for the client to appeal the exit decision.

- The client is also considered to be non-compliant for aggressive or threatening behavior. If the client is being dangerous, safety precautions should be taken. The Case Manager Supervisor should be brought in for all potential terminations of service due to non-compliance well before the situation gets to termination if at all possible. This may not be possible in the cases of dangerous behavior. For the exit, just as with termination due to non-compliance that is not aggressive or threatening, the case manager supervisor and the case manager will meet with the client together if possible and safe to have a discussion about the decision. If it is not safe for the staff to meet with the client, the client will receive a letter with the decision. The letter to the client will include the steps for the client to appeal the exit decision.
- The exit process is the same whether the client is on the Interim Services Track or the Self-sufficiency Services Track.

Once the client has been transitioned out of the program, the case manager should write a final case note about the discharge in Client Track, print the case notes for entry into the paper file, close the paper file, exit the client in Client Track, and move the paper file to the closed file storage. Instructions for closing a file and exiting the client from Client Track can be found in the Operations Manual.

WAA is committed to ensuring clients are living safely in the community following their discharge from WAA's residential programming. To honor this commitment, Case Managers from all residential programs request information from clients at their discharge on the [Client Exit Interview](#) to allow for ongoing follow-up. Case Managers ask departing clients during their exit interview if they want to be contacted by WAA after 6 months. Clients who consent to this outreach will be contacted by phone or mail to complete the [Post-Discharge Client Survey Form](#). Follow up will happen routinely at 6 months after discharge, and, if the client chooses, there will be a second follow up at the one year anniversary of discharge. The same form may be used at both 6 and 12 months, and case notes for the follow-up will be entered into Client Track following the completion of the phone call or receipt of the survey (if mailed). Case Managers will not need to re-enroll the client in Client Track; rather they will select the post-discharge option and record the note accordingly.

If a client indicates an interest in being involved in Advocacy efforts, Board or Committee efforts, Volunteering or other post-WAA (non-Client Services) activities, the Case Manager who recorded the interest will forward a copy of the exit survey to WAA's Public Policy Coordinator (if Advocacy related), to WAA's Development Assistant (if Volunteer related), or to the Executive Assistant (if Board related).

Part III

Critical Elements of the Case Management Processes

The functions of case management at Women Against Abuse are intricate and varied. This part of the manual provides more information on the Critical Elements of the Case Management Processes for the Safe Havens, Sojourner House Transitional Housing, and Safe at Home Residential Programs. The information in this section is an overview of the topics, and not to be considered all of the information case managers should know about each topic.

For this part of the manual, each section will refer back to the case study introduced in Part II:

Betsy is a 29 year old woman with two children, aged 5 and 7. Her long term boyfriend has been abusing her for the last three years. Before meeting him, Betsy and her children were homeless for a year, staying in a hotel in which she cleaned rooms in return for shelter after leaving the abusive father of her children. Betsy reports that her parents used to fight often when she lived at home, and those fights were very physical. When her parents split up, her stepfather abused both she and her mother until she left home at 17. Betsy has a high school diploma, and she is interested in going to school for nursing but thinks she may not be smart enough. She has experience working in hotels as a house keeper and waiting tables in a café, but her work experience is sporadic because she often loses jobs or quits due to issues with child care or missing work due to abuse. Her son, 7, is showing episodes of anger and is often withdrawn. He is struggling in school, and his teacher is concerned that he does not have many friends. There is an open case with the Department of Human Services from the last time he went to school with bruises that were self-inflicted, according to his mother. Her daughter, 5, is socially appropriate at school and seems to be doing well in kindergarten, but does not have all of her immunizations, as she has not been to the doctor in over 3 years. Betsy is estranged from her family, since she has not talked to them since she left home at 17. She does not identify any true friends, and reports feeling depressed. Betsy came to the shelter from the emergency room after a neighbor called the police during an especially loud fight with her boyfriend. The police were unable to arrest the boyfriend as he was gone when they arrived, and Betsy is afraid to tell them what happened to her. However, she was able to confide in a nurse at the hospital where the police took her to be treated.



Trauma Informed Approach to Case Management¹⁶

A trauma informed approach to case management “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization” (SAMHSA, 2015). Utilizing trauma-informed services helps clients heal from trauma through creating physical and emotional safety in order to build resilience.

A **trauma informed approach** includes the following tenets:

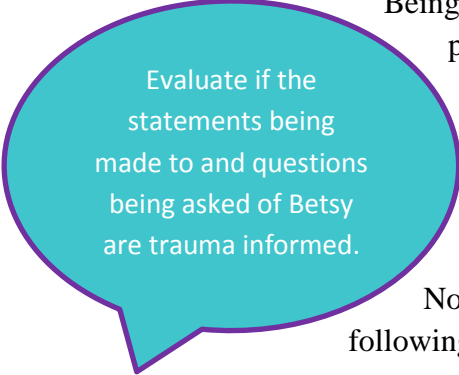
- Remember the client and family has experienced significant disruption in their lives recently. Explain some of the common responses to entering the safe haven (feeling overwhelmed, not remembering things, experiencing anxiety, being easily frightened) to the client if it seems appropriate. Educate to increase their sense of safety and control.
- Ensure that the environment is warm and inviting to the client and feels safe. Be mindful of your body language, volume, and tone.
- Privacy and confidentiality are essential to establishing an emotionally safe environment. Explain limits of confidentiality, due to ethical, legal or professional responsibilities. Ask client to clarify understanding.
- Focus on restoring a sense of power back to the person who has been abused and victimized. Set clear roles/boundaries that support collaborative decision making. Offer the client choices whenever possible, but be careful not to overwhelm.
- Show sensitivity about asking difficult questions and express empathy. Establish trust by normalizing feelings.
- Some clients may experience difficulty with moving forward and developing plans so quickly. Be aware of the client’s readiness to make changes.
- Address and respect cultural differences and diversity in all interactions with client.

For example, with Betsy’s case (page 69), it would be appropriate for the case manager to start by listening to what Betsy wants to share about her story, asking clarifying questions, but not pushing her to share beyond her comfort level (there may be particular exceptions to this which should be discussed with your supervisor). While listening to Betsy, the

How will Trauma Informed services look with Betsy? See the conversation tips below.

¹⁶ SAMHSA, National Center for Trauma Informed Care and Alternatives to Seclusion and Restraint. (2015). Trauma Informed Approach and Trauma Specific Interventions. Retrieved from <http://www.samhsa.gov/ntic/trauma-interventions>

case manager can offer encouraging words to validate Betsy's experience, including highlighting her strength in finding a way to provide for herself and her children through locating temporary housing and work the last time she had to leave a relationship and instilling hope that she can do it again. The case manager should avoid judging Betsy's choices to stay with her abusive boyfriend or to house her children in a hotel as negative, but look for an opportunity to applaud her problem solving skills and recognize that she made the decisions she could at that time. Furthermore, the case manager should validate Betsy's feelings of fear, depression, anger, etc., and act to normalize such feelings. Phrases such as, "I think most people would be afraid in your situation," "It sounds like you have worked really hard to keep your kids housed," "It's ok if you don't remember the answer to this question now. That is normal after experiencing trauma. We can come back to this at another time if you would like," and "Thank you for sharing that you feel overwhelmed. It is normal to feel that way, and together, we can find some solutions for you. You are not alone in this," are examples of trauma –informed responses for Betsy and other clients.



Evaluate if the statements being made to and questions being asked of Betsy are trauma informed.

Being transparent and clear about the intake process, service process, guidelines for behavior, and expectations of both Betsy and the staff, will help Betsy feel emotionally safe and empower her with information and clear expectations. For example, consider the following statement: "Betsy, while you are in this program you are expected to meet with case management regularly or you may be discharged." Now, to ensure the use of trauma informed principles, ask the following questions:

1. Is the statement clear? Not really, as "regularly" is open to interpretation.
2. Is the statement honest? In this case, the statement does seem honest. There is an expectation of regularly meeting with case management, and there is a possibility of discharge if the client does not participate in case management.
3. Is the statement kind, warm, and encouraging of emotional safety and does it take her experience into account? No. This statement seems to threaten Betsy with discharge if she does not obey a rule. Considering she may be fleeing a relationship in which she had to obey rules or face a punishment, this statement mirrors her trauma rather than helping her to recover from it.
4. Does the statement serve to empower and join with the client? No. This statement seems to put all the responsibility on Betsy to meet with case management rather than sharing the responsibility. Setting it up as though she is the one with responsibility to follow guidelines sets her below the staff and disempowers her.

Now, consider this statement: “Betsy, one of the parts of this program is case management services that will assist you in clarifying solutions, meeting your goals, and accessing services. To make sure that you get the full advantage of this service, it is expected that we pick a time once a week in which we will both be available to meet and focus on your service goals. What times might work for you?” In looking at the questions from above:

1. Is the statement clear? Yes. “Once a week” and picking an agreed upon time is clear.
2. Is the statement honest? Yes, the statement does seem honest. This time the case manager explains to Betsy why case management services are offered, and why they are offered weekly in a supportive and honest manner.
3. Is the statement kind, warm, and reinforcing/encouraging of emotional safety while taking her experience into account? Yes. As stated above, rather than threatening her with discharge for non-compliance, this statement serves to show her how the service will provide her with an opportunity to heal rather than setting up a dynamic of punishment. This is important considering many clients’ trauma is embedded with punishment dynamics.
4. Does the statement serve to empower and join with the client? Yes. This statement shares the responsibility of meetings with Betsy and the case manager by stating that the expectation is for both of them to be available to meet. This statement also empowers Betsy by letting her make the first offer of times that may work rather than being assigned a time. This statement also makes it clear that the case management time is set aside to work on her goals, not the goals that the case manager has for her.

Further empowerment will come from offering Betsy choices about how she handles her situation and educating her about a variety of options without judgment. For instance, if Betsy decides that she wants to try couple’s counseling with her boyfriend instead of finding her own housing, case management can educate her about potential recidivism in abusive relationships, educate her about the consequences of viewing abuse for her children, offer her other choices and options, and work with her to identify pros and cons of each option. The case manager may even want to express concern for her safety and offer to help her create a safety plan should she choose to return to the relationship. Please note that safety planning may be an important piece of decision-making, and should be done with the client at the decision-making stage. However, the case manager should not tell Betsy that she is wrong, being irresponsible, or “bad” for making that decision. Instead, trauma informed services recognize Betsy as being the expert of her situation, and trust her to make the decision that she believes to be best for her at this time. Trauma informed services also recognize that it is necessary for Betsy to be empowered to make her own decision and live with the consequences, positive and negative, of those decisions. Betsy needs to know that her choices are respected. If there is a decision that Betsy makes that the case manager does not agree with, the case manager can still make a statement that meets the trauma informed principles. For example, “Betsy, I understand your desire to make this

relationship work since you love your boyfriend. I also respect you for doing what you think is right for you and your children. I just want you to know that I am concerned about your safety with him. So, can we work on a safety plan for you and the children to create safety in this relationship and to have a plan for safety in case there is another episode of abuse? That way, you can move forward while enhancing your safety.”

A trauma-informed approach moves from asking the client, “What is wrong with you?” to asking “What happened to you?” Trauma-informed programs and interventions respect clients’ rights to be informed, connected, and hopeful and work collaboratively with clients to recognize the relationship between their trauma and their trauma responses and behaviors. Some helpful charts are included to remind case managers of trauma informed principles and values:

Traditional Paradigm	Trauma Informed Paradigm
➤ Clients are sick, ill or bad	➤ Clients are hurt and suffering
➤ Client behaviors are immoral and need to be punished	➤ Client behaviors are survival skills developed to live through the trauma but are maladaptive in normal society
➤ Clients can change and stop immoral destructive behavior if they only had the motivation	➤ Clients need support, trust and safety to decrease maladaptive behaviors
➤ Manage or eliminate client behaviors	➤ Provide opportunities for clients to heal from their trauma
➤ Staff should come to work every day at their best and perform to leadership’s expectations	➤ Leaders need to create strong organizational culture to combat trauma and stress associated with work with traumatized clients
➤ System of care should be created to minimize short term costs and contain immoral behaviors	➤ System of care invests in healing trauma, saving money over the long term

Another important piece of trauma informed care and services are respect for cultural differences and diversity. This may include the use of neutral language so as not to marginalize individuals or impose roles and stereotypes on them. For instance, using neutral language with Betsy’s children. If her children are going outside to play, a statement to her son such as, “You better protect your sister when you go outside,” serves to strengthen gender roles, diminish the sister’s ability to protect herself, and diminish the son’s need for his own protection. A better statement would be, “Be safe and watch out for one another.” This statement encourages shared protection and care for one another and safe family relationships without regard to gender. Another example of utilizing neutral language may be to refrain from assuming the abuser is a “he.”

Putting a client in the position of having to “out” him/herself as a homosexual by correcting your assumption can be disempowering. Additionally, if the client is a transgender person, be proactive and ask the client what pronoun they prefer to use, and make an effort to remember to use the preferred pronoun. Some transgender individuals prefer to use the neutral “e,” “they,” or “ze” pronouns instead of traditional gender-specific pronouns. These language preferences can be a barrier to service provision if the case manager does not discuss it with the client and work through any discomfort the case manager may experience in working with diverse clientele.

Further examples of respecting diversity occur when working with clients who belong to religious or cultural group with which the case manager may not be experienced or comfortable. All services should be geared to the client and the client’s comfort as much as possible. One example is a client whose religious or cultural views state that women are subservient to men. In trying to empower the client to leave an abusive male partner, it may be difficult to find ways to talk to the client about her rights and ability to set boundaries that are comfortable to the client. It is up to the case manager to remain neutral (not judging) and to work with the client to find ways in which she can remain safe and also adhere to her own beliefs and cultural identity. Seeking supervision in these times is crucial. In this example, a case manager may try talking to the client about other relationships that are not equal per se, but also not abusive: parent and child, teacher and student, or employer and employee to show her that subservience does not have to mean abuse. There are many more examples of diverse situations, and this manual does not provide an overview of all the situations a case manager may experience.

Key Elements of Trauma-Informed Practice...

Key Elements	Descriptions
Cultural Competence	The extent to which policies, procedures, staff, services and treatments are sensitive to the cultures, traditions and beliefs of the families and youth who are involved with the agency
Youth and Family Collaboration	Policies and practices that encourage empowerment and partnership/participation, as well as strength-based and community-based approaches
Trauma Competence	The extent to which policies, procedures, staff, services and treatment are aware of and are sensitive to the unique experiences and needs of trauma survivors.
Physical and Emotional Safety	Factors that assure both the physical and emotional safety of consumers such as secure reception or waiting areas, non-judgmental treatment, and flexible scheduling.
Trustworthiness	Factors that foster trust between a service provider and the child and family such as consistency, accessibility of staff and interpersonal boundaries

Goal Planning

Clients should not be labeled or blamed for their situation, per the trauma informed lens of The Sanctuary Model®. Encourage clients to set goals, recognizing and building upon their strengths, per the Empowerment Model.

Every plan needs to be individualized and based on the client's personal goals and preferences. Plans are to be completed with the client present and engaged and with the case manager utilizing strategies to increase engagement, such as motivational interviewing techniques, empowerment strategies, etc. Goal plans should include goals in all relevant life domains. Each goal should be broken down into objectives, or smaller steps, that are specific and measureable and provide a benchmark against which to measure progress.

How might it look to create a goal and service plan with Betsy?

Utilizing Betsy's case study (page 69), goals that should be at least discussed are employment (she indicates having work experience), education (she identified wanting to go to school to be a nurse), counseling for her children (she stated that her son is exhibiting possible signs of trauma), medical care for her and for her children (she was referred by the emergency room and her daughter is in need of a medical visit and vaccinations), school support for her children (she indicated that the teacher is concerned about her son), legal (she has an open DHS case and may want to pursue charges against her boyfriend), mental health (she indicated being depressed), social relationships and/or community connectivity (she reports being estranged from her family and not having any friends), and obtaining housing (she has no place to live currently). Betsy may not be able to attack all of these goals while in the program, but may be able to work on them over time as she makes progress in her healing.

One example of a goal she may identify is to attend college for nursing. She may need some motivational assistance since she had identified that she does not think she is smart enough for nursing school. If her overall goal is nursing school, the case manager may want to add an objective to the goal that includes exploring her options for school and financial assistance that includes a living stipend that allows for her children's care. For example, if the goal reads, "Attend and graduate nursing school," the objectives might be "1. Research 3 nursing programs in the area for cost and financial assistance packages. 2. Attend a consultation with the financial aid office of top 2 preferences for nursing school within one month." If it is determined that the client cannot qualify for or afford to go to nursing school, then the case manager can meet with Betsy to discuss other routes to her goal. For example, the goal may be changed to "Obtain employment training in healthcare field to help prepare for nursing school" with objectives "1. Apply to the Medical Assistant program at the community college 2. Complete financial aid paperwork with case manager within one month." The important part is that Betsy is part of any decision regarding her goals and objectives.

Goal plans are assessed regularly and are living documents that can be updated to meet the client's changing needs. Suggested strategies for the goal development process are:

- In developing goals with the client, incorporate more realistic goals that can be achieved within timeframe of the program.
- Start with short term goals, sometimes as little as an hour, a day, a week, etc. Clients in crisis can have difficulty organizing and planning effectively to meet broader expectations.
- Accomplishing short term, smaller goals will help clients build competency and confidence in their ability to achieve. It helps in feeling productive and in control.
- As clients are able to build on successes, goal planning can involve larger goals, such as obtaining housing or gaining employment. Be careful not to overwhelm clients.
- Build on successes, work on identifying barriers and address challenges, remembering to use a trauma informed lens. Keep addressing and ensuring psychological and social safety.
- Prioritize goals with client, focusing on immediate and current needs. Provide support through periods of challenge and discouragement, as change can be difficult.
- Keep encouraging and coaching to identify and address barriers, normalizing experiences and emotions along the way.
- Remember everyone has a different experience with structure, which may trigger trauma symptoms in clients. Continually assess goals and plans along the way, adapting strategies to meet client's needs.
- Update and review each goal plan regularly as appropriate for the programs and services being delivered (i.e. every 15 days, monthly, biannually, etc.). Goal planning is an ongoing process and needs to be revised on a regular basis in order to be current, meaningful, and in pace with the client's changing situation.
- Engage client in importance of developing network of community resources. Educate clients regarding importance of engaging with community supports in client's success.



Goal planning for trauma informed care emphasizes the importance of choice for clients. Create a predictable environment for goal planning, focused on the future. This helps clients build a sense of efficacy and personal control over their decisions and life. Acknowledge and utilize skill building along the way to further develop and increase resiliency.

Safety Planning

Safety Planning is a significant component of working with clients experiencing domestic violence because of the very real dangers they face in their close personal relationships and the emergency measures they may have to take to keep themselves and their children from harm. Focusing on safety as an ongoing concern is vital.

Clients who have experienced domestic violence can have trouble identifying what is safe behavior. Those challenges in anticipating future events may lead them to have difficulty in anticipating the consequences of unsafe behavior. In the Sanctuary Model® when we use the word “safety” we are referring to four all-encompassing domains of safety: physical, psychological, social and moral. Safety Planning requires attending to all four domains simultaneously and coming up with a plan for avoiding danger.

Safety plans are similar, yet not identical, across the safe havens, transitional, and after care services. There are three types of safety plans utilized at WAA: The DV Safety Plan, The Sanctuary Safety Plan, and The Sanctuary Self-Care Plan. Templates for these plans can be found on the shared document drive. Each of these plans have different purposes and structures:

1. [Sanctuary Safety Plan](#): a tool for managing emotions in the moment
 - Sanctuary Safety Plans are meant to triage moments where we become overwhelmed by our emotions in particular situations and our capacities to cope are limited (we can go into fight, flight, and freeze modes). That’s why we plan ahead of time by identifying the 4 to 5 things we can do immediately, in the moment, to help manage our emotions.
2. [DV safety plan](#): safety planning with survivors of domestic violence; a tool to enhance safety for survivors in DV crisis situations
 - The DV safety plan is specifically focused on enhancing safety in domestic violence crisis situations by planning ahead (e.g. what rooms to go to that are safest, what documents to have on hand in case a quick escape is needed, etc.).
 - Distinction: The Sanctuary Safety Plan is more general and can be applied broadly to situations in which our capacities are overwhelmed.
3. [Self-care plan](#): a tool to help us create a healing context and environment in the long-term
 - Tool to help us create a healing context and environment for ourselves and those around us so that we can prevent being vicariously traumatized and hopefully reduce the number of times we go into crisis mode (fight, flight, freeze) or get caught up in re-enactments
 - Distinction: The Sanctuary Self-Care Plan is broader and more comprehensive than the Sanctuary Safety Plan- It’s a long-term plan that focuses on future. It

does this by having us reflect on different, specific areas of safety in our lives (moral, social, physical, psychological) and develop a long-term plan for how we can take care of ourselves in each of these areas. It also includes areas for our professional development and how we can engage with our organization and society in a way that empowers us and where we can set up a support system for ourselves.

The Sanctuary Safety Plan and The Sanctuary Self-Care Plans are built on The Sanctuary Model® concept of the SELF (safety, emotional management, loss & future) and the use of Sanctuary Model® tools. The Sanctuary Model® covers four domains of safety:

- **Physical Safety:** being physically safe from harm.
- **Psychological Safety:** ability to keep oneself safe in the world - includes self-discipline, self-esteem, self-control, self-awareness, and self-respect.
- **Social Safety:** ability to be safe with other people in relationships and in social settings.
- **Moral / Ethical Safety:** ability to maintain a set of standards, beliefs, and operating principles that are consistent, that guide behavior, and that are grounded in a respect for life.



Using the Sanctuary Model® as a foundation for safety planning, physical safety is one of the first areas to address with a client. For example, a physical safety plan that might be used while at the safe havens or Sojourner House, to keep the location a secret, considers the following:

- Encourage client to change their phone number.
- Discuss use of a post office box rather than their home address.
- Educate about cancelling previously held bank accounts and credit cards, especially if the client shared those resources with their abuser. When client is opening new accounts, advise to use a different bank.
- Discuss sexual safety planning with client, including family planning options, medical health assessments, ob/gyn care, risk of sexually transmitted diseases (including HIV/AIDS), etc.

Another important consideration in physical safety planning is stalking. Ask whether the client believes that they are being stalked. Consider the following questions: Does the abuser seem to always know where the client is, e.g., showing up at appointments? Does the abuser refer to information in communications with the client that the abuser should not know?

- If the answer to either of these questions is “yes,” discuss how the abuser is obtaining information about the client, including low-tech methods (e.g., physically following the

client after leaving court) and high-tech methods (e.g., installing spyware on the client's cell phone). Help the client look for patterns in the abuser's stalking to identify the source of information. For example: If the abuser only shows up at appointments that the client has referred to in text messages, then the abuser may have installed spyware on the client's cell phone.

- Discuss the risk of escalation before cutting off lines of communication with the abuser. For example, it may be safer to allow the abuser to continue posting to the client's social media account rather than blocking the abuser, which may trigger the abuser to find other avenues of communication, such as a face-to-face confrontation.
- Encourage the client to keep a log of all stalking incidents, including the date, time, and what happened. Also, encourage the client to preserve evidence of stalking, for example, by taking screen shots of threatening or harassing text messages.
- Encourage the client to change passwords for various accounts, including email, "cloud" services (e.g., iCloud, Google Drive, etc.), and social media (e.g., Facebook), bank accounts, and credit cards.

Physical safety planning encompasses a wide range of concerns and new skills, including:

- take a new route to work;
- avoid places where abuser might think to locate you;
- change any appointments the abuser may know about;
- find new places to shop and run errands.

Psychological, Social, and Moral/Ethical safety are largely connected to emotion regulation and identifying what behavior is safe behavior in all domains and designing a plan to avoid danger. Safety plans should be simple enough to be usable, and should be assessed regularly to meet the current and changing needs and status of clients in trauma recovery. Additionally, plans should be culturally appropriate and incorporate strengths, resiliency, and sources of support, per the empowerment model.

In the safe haven and residential programs, safety plans can be used as an empowering way to address behavior that may otherwise lead to client exit from services or put the client in danger in the community. By allowing for behavior planning, choice, and accountability, clients are empowered to take control and responsibility for their own outcomes.

What are some possible ways to talk to Betsy about safety planning for physical safety?

For Betsy (see case study on page 69), a physical safety plan may include seeking a restraining order or a plan to call the police if she sees her boyfriend, changing the school the children attend so that her boyfriend cannot find her there, changing her phone number, and avoiding social locations where he may look for her. Betsy will be able to best identify threats to her safety and know how to plan for physical safety, but due to trauma effects, she may need guidance and ideas from case managers. It is not the job of the case managers to decide how

Betsy should keep herself safe, but rather to help her generate ideas since this may be a new skill for her. For instance, rather than using the statement, "Betsy, I am adding

‘changing your phone number’ and ‘changing your children’s schools’ to your safety plan since you did not press charges on your boyfriend,” which is a disempowering and judgmental statement, consider the following possible conversation:

Case Manager (CM): Betsy, something that many domestic violence survivors find helpful is safety planning for physical and emotional safety. So, considering physical safety, how do you think you can stay safe and keep your children safe this week?

Betsy (B): Well, um, I think I plan on just staying in the shelter this week. No one knows where this is, right? Should I worry about him finding me here?

CM: Betsy, we try very hard to keep our location a secret and we also make sure that there is staff here to keep you safe. I think that in times of trauma it is very normal to want to stay safe through remaining in a safe place all week. That is a good instinct for yourself and your family. I do think that it may be hard for the kids to miss school this week. Do you think they should miss school so that you can all stay in the shelter all week?

B: I don’t know. He knows where their school is, and I don’t want them to miss school or go to school. I am not sure what to do.

CM: Well, there are some options. We can work on a way to keep the children safe at school and to keep you safe while dropping them off and picking them up, or we can contact the school to see what ideas they have, or we can see if their school can be changed. Do any of those ideas work for you?

B: I am not sure, but I think that they are close to their teachers, so I would like to include them in the conversation.

CM: That is a good idea. I appreciate how much you care about the children’s attachment to their teachers. We can see about having the children’s case manager reach out to you and the school. Would you like to talk to their case manager about that or would you rather call the school yourself and let us know what you decide?

B: I see their case manager in an hour, so I will talk her.

CM: Great, I think we can add that to your plan when you decide. And what about the things you will need to get done this week outside of the shelter? Are there some steps you can take to keep yourself safe while working on your goals?

B: I just don’t think I need to leave this week, so I can’t think of anything.

CM: Ok. So, some other clients have found that changing their phone numbers, or making a list of social places to avoid – places where your abuser might look for you, or even changing bus or car routes helps to keep them physically safe. Do any of those ideas work for you?

Of course, this is an abbreviated conversation, but it demonstrates how a conversation that includes suggestions, ideas, choice, and encouragement rather than prescriptions, dictates, and judgment might look. Actual conversations with clients will vary greatly, but as long as the case manager is open, honest, supportive, and willing to provide realistic options for the client, the safety planning will be trauma informed. Notice the skills the case manager used in this conversation: applauding the client's strengths and ideas through recognizing the client's good intent (isolation in the shelter may not be the best idea, but the client's intent is to stay safe, which is a positive intent), encouraging the client to be realistic (isolating in the shelter would mean that the children miss school and the client may not be able to make progress on her own goals, so the case manager gently reminded her of that through asking her opinion), educating about some strategies that are often used on safety plans, and offering choices so that the client is empowered to be in charge of her own safety and the safety of her children. What might a conversation look like with the children regarding their own safety? How might that be balanced without scaring them or creating paranoia? Consider some clients you have worked with in the past and how this conversation may have gone with them.

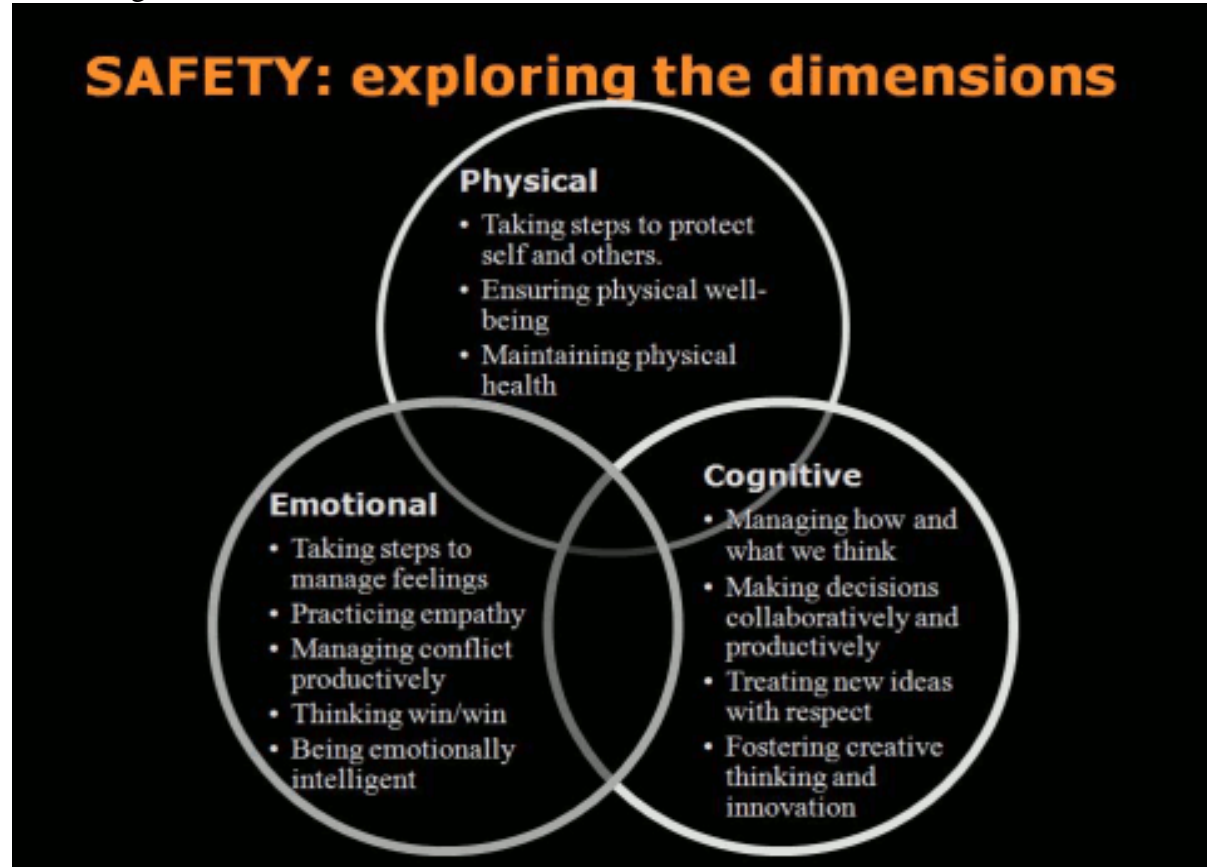
What are some possible ways to talk to Betsy about safety planning?

Psychological, social, and moral/ethical safety planning with Betsy will look similar to the skills used by the case manager: applauding strength and recognizing good intent, encouragement to be realistic, educating about strategies and ideas, and offering choices. The same skills will be used whether the safety plan is an initial safety plan to work on emotion regulation or if it is a safety plan to address ineffective behavior, though the intent and purpose of the safety plan should be made clear to Betsy. For example, an initial safety plan for emotional safety may include asking Betsy, "What does it look like when you feel scared, stressed, or unsafe emotionally?" and following up with, "What are some strategies you can use to avoid (name negative behaviors)?" For example, Betsy may start by stating that she yells at her children when she is scared. The case manager may then say, "Some clients find that taking a deep breath and silently repeating, 'I am just scared, not in danger' is helpful to keep from yelling. Do you think this may help you or do you have some other ideas about how to keep yourself from yelling when you are scared?" Even defining what triggers Betsy to feel scared and inserting her triggers into the sentence may be helpful.

If the plan is in response to unwanted behaviors, such as screaming at her children when she is feeling scared, the conversation may start differently. For example, the case manager may say, "Betsy my observation is that you are yelling/screaming at your children sometimes, even though I know you are a very loving and supportive mother. When you yell at your children, you are not appearing to be living up to who you say you are as a mother, and it seems to happen when you appear stressed or fearful. Is this what you observe about yourself?" The conversation may continue as, "I want to assist you in not yelling at your children and being the mother you have told me you want to be all the time, and ensure that you are getting support in following our guidelines about treating your children with emotional safety so that your family can be successful in the program. So what things are making you stressed?.....What actions can you take, such as deep breathing, taking a time out, giving your children a hug, or counting to ten, in

order to not yell?” Again, there are many iterations of such conversations, but being clear, honest, supportive, encouraging, appreciative of her efforts, and offering choices will be a good, trauma informed strategy for safety planning as a way to support behavior changes.

Another way to conceptualize safety planning, though it uses alternative language, can be found in the diagram below:



Housing Plan and Housing Stability

Housing is a basic human need. Case managers need to be aware of all community resources and provide essential assistance in developing a solid, realistic housing plan (i.e. encourage clients to find a safe place that is 50% of income or less).

B-SAFE, as a case management model, is supportive of rapidly rehousing families as quickly as possible, minimizing their time in the shelter environment. Linking housing with needed supports and services, especially in times of intensive service need, is encouraged. **Domestic Violence**

Informed Safe Housing (DASH)

necessitates case managers build safe housing capacity by working with other community based organizations and increasing community linkages. Both models require extensive knowledge of community resources and the ability to seek out and actively engage in community partnerships. The **WAA Theory of Change** supports the development of a continuum of housing options.

For example, with Betsy (see case study on page 69), the case manager will want to start working on a housing plan with her early in her shelter stay (BSAFE and Theory of Change), and link her to supports that will encourage housing stability, such as income assistance or employment assistance (BSAFE and DASH models). Her housing plan should include a range of options if possible. For Betsy, she may need a housing subsidy, but also may be able to get a job waiting tables that will pay for market rent for an apartment. She also may want to look for a roommate and get a larger apartment. Creativity and being open to her desires for housing will be important, while encouraging her to be realistic about her housing goals. She may also find a job that includes housing: if she gets into a nursing program with financial assistance for family housing, a job at an apartment complex that includes housing, or a job at a hotel which matches some of her experience and includes housing (if appropriate for her family), may be options she can and wants to explore.



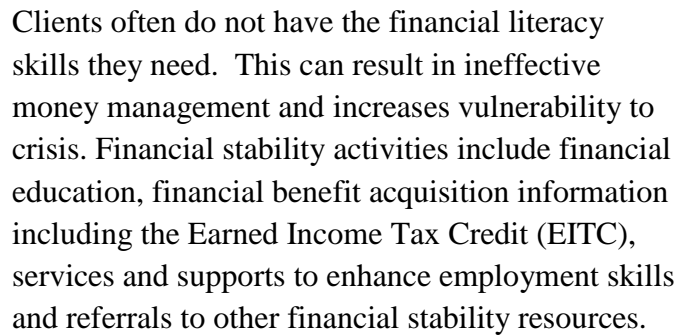
Housing plans when domestic violence is present may require:

- Lower rent - Clients can be less financially dependent on abusive partners and have more money to meet basic needs.

- Mobility – The ability to relocate to be near supportive family or friends, near employment, etc. can be essential to a successful housing plan.
- Clean, well-kept housing with adequate space – Housing that is clean, maintained and provides sufficient living space can be challenging to find.
- Safety Plans – Clients and their families need to be in environments where security is a key feature with secure window and door locks, good lighting, window bars, etc.
- Schools Safe & in Proximity – Children are often impacted by the need to change their school in domestic violence situations. Schools that are close to a client's residence can be a vital element for an effective transition.
- Stability in housing options – Clients and their families can find themselves experiencing short stays in a variety of housing situations, requiring frequent moves.
- Financial resources – Educating about the need for money management skills, understanding financial benefit acquisition and enrolling in and qualifying for housing assistance programs are needed

Research shows that the five areas of skills and connection that best insulate individuals and families from future homelessness are: Financial education and stability, Education access and support, Access to physical and behavioral health care, Community involvement and support, and Housing stability. Skills in maintaining housing that the case manager may be able to help the client with or refer the client out for include lease education, landlord relations, tenant rights, housekeeping and maintenance basics, paying bills on time, neighbor relations, and setting boundaries with guests. Any case management skill building and community activities that promote these skill areas will be beneficial to housing stability. Betsy may need community referrals for employment support, education/ job training support and programs, public assistance (food stamps, TANF, etc.), child care, lease education and renters' rights, medical and mental health care for herself and the children, school support for the children, and social networking.

To remain successful in housing, Betsy will benefit from being linked to community resources that support housing success in the five areas that protect her from future homelessness.



Providing timely information to enhance financial stability is a critical activity of case management. Financial stability is not an end point but rather a continuous process of gaining the information needed when it is most relevant. Case management staff needs to be aware of the demands and challenges facing residents in order to individualize the information presented to meet their changing needs and circumstances. (ibid)

Benefits

Employment

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services at any of these three stages and may move between employment stages while in programming.

Employment readiness and training: It is imperative to assess clients' strengths and challenges as they relate to becoming employed. Necessary training may need to be accessed in the form of GED classes and tests, certification programs, vocational programs, and college education, including finding financial assistance if free help is not available. Many clients with learning disabilities or low literacy may not qualify for free or reduced fee services for GED classes due to the length of time it may take them to obtain their GED. In these cases, obtaining financial assistance will be necessary. Case management should coach clients in conversations about employment readiness in such a way as to support the clients' employment goals while being realistic about those goals and offering multiple options in order to help the client gain self-sufficiency and maintain autonomy in the process.

Employment readiness may also include accessing resources for business attire if the client had to leave without her clothing or has not been in the workforce for an extended period of time, obtaining transportation, obtaining child care that is safe so that she is free to work, and mental health care to ensure she is ready to return to the workforce.

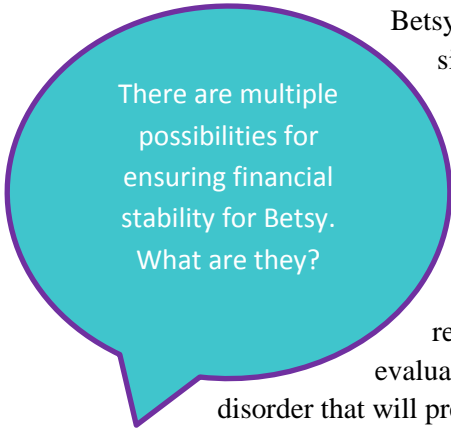
Obtaining employment: Once clients are ready for employment, ensuring they have skills and support in applying to, interviewing for, and accessing (e.g. transportation, uniforms, clothing, supplies) employment is important. There are many resources to assist women in gaining employment, including employment that will be understanding of clients who may have legal barriers or challenges in employment history, such as Career Wardrobe (<http://www.careerwardrobe.org>) and Women Employed (<http://womenemployed.org/>).

Employment support groups, supported employment (employment with on-site/off-site intensive case management or job coaching to support success), resume writing support, and mock interviews are ways in which case managers can support clients in obtaining employment.

Maintaining employment: If clients recently gained employment, assisting clients in maintaining employment should include problem solving around safety, child care, and transportation; supportive employment if necessary (supportive employment refers to service provisions wherein people with disabilities, including intellectual disabilities, mental health, and traumatic brain injury, among others, are assisted with obtaining and maintaining employment).; and skill building around employment and interpersonal skills. If clients enter the program with employment, employment maintenance services should include education on the client's rights regarding employment (namely paid sick days, FMLA rights and regulations, and ADA protections if the violence has resulted in disability) and supportive services such as transportation assistance and safety planning with regard to employment.

Safety plans are also helpful in assisting clients to maintain employment. Clients who struggle with emotional regulation and healthy, safe behaviors due to trauma responses can struggle with

social skills in the work place and navigating the difficult interactions and stress of employment. Case managers can support clients through encouraging use of safety plans.



There are multiple possibilities for ensuring financial stability for Betsy. What are they?

Betsy (see page 69 for the case study), as with most clients, has a unique situation that will need to be assessed in depth and discussed with her to develop a financial stability plan (included on the goal or services plans) to best meet her needs. On the surface, it looks as though Betsy can work or apply for school, or both. She reports having an employment history, including employment in more than one industry. However, depending on the additional information the case manager will seek during the intake and regular meetings with her, the case manager may refer her for an evaluation to see if she can still work or if she has a trauma-related disorder that will prevent employability. Perhaps the case manager and Betsy both feel that she can work if she gets support for child care during work and behavioral health care to manage her trauma responses. Perhaps she is in need of job training to obtain more gainful employment, and that is the referral the case manager will make. What would you do if were her case manager? In the event she is not ready for employment, what benefits are available to her for income? Would she qualify for SSI benefits for Post-Traumatic Stress Disorder? If she can work, will she need supplemental benefits such as food assistance or child care subsidies?

Further considerations have to do with Betsy's ability to manage her financial resources once she has them. Does she understand budgeting? Does she need help fixing her credit to be able to pass a credit check for an apartment? Will she need to go into transitional housing while she works to repair her credit or can she obtain mainstream housing with employment? If she can find employment, will she need ongoing support to maintain employment considering she does not have a history of long-term employment? Each of these questions will need to be answered with Betsy, and each option should be presented to her with focus on both the positives and negatives of each possible solution.

Education

Educational support is necessary for both adult clients in need of education and training as part of their self-sufficiency skill-building and employment support. Assisting clients in finding GED and diploma programs, affordable technical and vocational education, or obtaining grants for post-secondary programs and schools (i.e. Pell grants or education reimbursement programs popular with nursing and teaching programs) are a few ways in which case managers can support clients in the educational life domain. Additionally, case managers can assist clients in obtaining affordable computers, computer trainings, access to library resources, and managing childcare while in school.



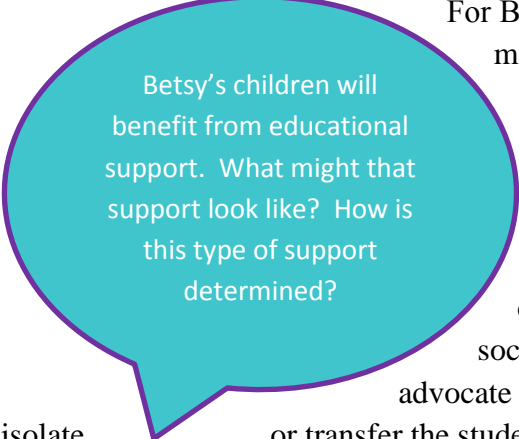
For children in shelter and housing programs, the McKinney-Vento Act states that every student experiencing homelessness is entitled to:

- A free, appropriate public education
- Education in a mainstream school environment
- Participation in the school food service program
- Prompt resolution of disputes regarding educational placement
- No isolation or stigmatization due to their homeless status
- Placement in their school of origin the entire time they are homeless, and until the end of any academic year in which they move into permanent housing
- Consideration of parent's requests regarding placement at the school of origin or the zoned school
- Educational, social, athletic, and recreational services offered to other students

In order to be successful, students and their parents who are experiencing homelessness or displacement due to trauma need assistance to

- Stabilize their basic needs for food, clothing, shelter, hygiene, and transportation (especially if they remain in a school in proximity to their residence).
- Work with school staff, including teachers and social workers, to meet any specific needs the child has regarding trauma, gaps in education, safety measures, etc.
- Access enrichment and tutoring services if needed
- Coordinate awareness and sensitivity with school staff as needed

Additionally, out of school time support that is sensitive to the needs of traumatized children, including their developmental needs, such as summer camps, afterschool activities, preschool support, and appropriate childcare services to augment their education is imperative.



Betsy's children will benefit from educational support. What might that support look like? How is this type of support determined?

For Betsy's case (see page 69), her educational needs will most likely be addressed when considering her financial stability since she has a high school diploma and is in greatest need of employment and education or training that supports living wage. However, her children have some identified needs for educational support. For example, her son is struggling with isolation and outbursts of anger, and his teachers are concerned about social difficulties and his performance in school. An advocate may want to ensure that the school is not trying to

isolate or transfer the student due to his behavior, since he has a right to mainstream education. The children may also need help accessing food assistance programming and afterschool care. Furthermore, the children may need support to participate in social activities at school through access to financial aid for uniforms for sports, etc. Other forms of educational support for Betsy's son may include tutoring or behavioral health care; and for her daughter, support in obtaining current vaccinations. Consider what other questions a case manager might ask this family or need to consider when working with this family? What techniques might be useful? What referrals will be best? For instance, should Betsy's son be referred to mainstream afterschool activities or will he benefit from trauma-specific activities? How might a case manager include Betsy on decisions regarding her children in a manner that supports healing rather than instilling guilt and shame?

Legal Issues

“Lack of understanding of the criminal and legal systems can become significant barriers to victims of domestic violence in establishing safety. Legal advocacy is often the deciding factor in whether a victim will successfully leave an abusive relationship.”
– WAA website

In Philadelphia, the majority of clients needing legal action to protect themselves cannot afford appropriate attorney representation. The Legal Center at WAA (phone 215.686.7082) offers free legal advocacy and representation for both males and females dealing with relationship violence-related legal matters to assist with the complexities of the legal system, including:

- Protection From Abuse (PFA) orders
- Child Custody and Child Support
- Legal Options Counseling
- Safety Planning
- Court Accompaniment and Advocacy
- Attorney Representation
- Telephone Outreach

It is imperative that case managers offer options for legal services to clients including protective orders, dissolution of marriage, housing and property, child custody, and any charges that that may have been filed against the victim. At WAA, clients have access to free legal advocacy and support through the WAA Legal Center. Case managers can support clients by encouraging their engagement in legal services, providing support at court and other legal proceedings if possible, and assisting with transportation to appointments.

Betsy may have more and evolving legal concerns than initially revealed

Betsy may have more and evolving legal concerns than initially revealed

Considering what we know at this moment about Betsy's case (see page 69), a case manager will at least refer Betsy to legal counsel for her open DHS case. However, the case manager may also want to ask Betsy how she is feeling about pressing charges for her assault or filing for a protection from abuse (PFA) order. Since these are often scary decisions, talking to legal counsel to thoroughly understand options and possible outcomes of each option will be empowering and a way to support her in making a decision that is best for her and her family. Additionally, she may have lingering legal issues concerning custody or child support from her previous relationship, which she indicated was also abusive and thus may be more difficult to navigate. It will be helpful for the case manager to ask open-ended, supportive questions to help Betsy identify her need for legal counsel, but the case manager must refrain from offering any legal guidance. The role of case management is to refer for legal assistance, not to offer legal advice.

