Illinois 2007 OVW Collaboration Charter
Preamble

The 2007 Illinois OVW collaboration is a multi-disciplinary team with a long history of cooperative work addressing the needs of survivors of domestic violence who have psychiatric disabilities. We respect and value each others' training, knowledge and expertise and keep the wisdom and experience of survivors who have had and/or are living with psychiatric disabilities at the center of our work. We have jointly carried out needs assessments, conducted focus groups, held conferences, provided technical assistance to one another and to local and state agencies and provided mental health/domestic violence cross-trainings to over a thousand professionals state-wide. Through this process, we have also come to recognize that the systems to which survivors turn are still unprepared to meet both safety and recovery needs. We are committed to developing collaborative models that incorporate principles of the domestic violence advocacy, mental health peer support/recovery and disability rights movements and to creating the local and ultimately broader systems change needed to address these critical gaps in services.

Our multi-disciplinary team is made up of the Domestic Violence & Mental Health Policy Initiative (DVMHPI), the Illinois Coalition Against Domestic Violence (ICADV), the Illinois Department of Human Services, Division of Mental Health (IDHS/DMH), The Growing Place Empowerment Organization (GPEO), Thresholds, and Life Span. We bring to this work our individual and collective experience as advocates, as people with psychiatric disabilities; as legal, clinical, domestic violence and peer support practitioners; as administrators, policy generators and educators, and as survivors.

Article 1: Vision & Mission

Partners of the 2007 Illinois OVW Disabilities Grant are committed to working with local service providers in selected IL communities to ensure that all survivors of domestic violence and other lifetime trauma who are experiencing psychiatric disabilities have access to the resources they want and need to achieve both safety and recovery. This commitment includes working with pilot communities to build collaboration, develop new service delivery models and create the system changes necessary to accomplish these goals. It also includes working to ensure that local providers and systems develop sustainable strategies for incorporating the following principles into their ongoing work:

- Recognizing the right of women with disabilities and survivors of DV to be treated with dignity and respect and to live lives free from violence, abuse, neglect and exploitation
- Treating all reports of violence, abuse, neglect or financial exploitation as legitimate.
- Respecting the right of women with disabilities and survivors of DV to self-determination

- Abiding by the legal rights of survivors of DV and women with disabilities, including the Americans with Disability Act, Section 504 of the Rehabilitation Act, and the Fair Housing Act.
- Preventing the disclosure of confidential information
- Ensuring that all survivors with disabilities have access to the services and information developed by the project and that services are welcoming and fully accessible as well as culturally-attuned, recovery-oriented and trauma-informed - in other words, services that are truly collaborative, survivor-defined, and non-retraumatizing; attend to safety and confidentiality and incorporate principles of inclusive design.
- Opposing all forms of stigma and discrimination, including discrimination against women, women with disabilities and women who are Deaf or Hard of Hearing

Our Vision

We **envision** new capacity and changed systems within local communities in Illinois that will meet the needs of survivors of domestic violence and other lifetime trauma who are living with psychiatric disabilities. As part of this vision, survivors will have access to the full range of services and resources they want and need to achieve the outcomes that are important to them, including safety, recovery, connection and self-determination.

Our Mission

The mission of our collaborative is to work with local communities in Illinois to develop their capacity to meet the needs of survivors of domestic violence and other lifetime trauma who are living with psychiatric disabilities by:

- Building collaboration at the local level among DV agencies, community mental health centers (CMHCs), state psychiatric hospitals and peer-support service providers;
- Building on existing peer-support service delivery structures in Illinois to develop new, sustainable service delivery models and tools;
- Providing ongoing cross-training, consultation and TA;
- Working with local partner agencies to change policies, practices and priorities so that they are empowering to survivors, providers and local systems; and
- Working with state agency partners to support new cross-sector service delivery models.

Article 2: Values & Assumptions

Values and Assumptions

We **believe** that:

- Women have the right to live free of violence, including the more insidious forms of violence such as stigma, objectification and discrimination.
- Survivors must have the opportunity to empower themselves by:
  - designing their own path to safety and recovery
  - determining how they want to live their lives
  - accessing all information they need and want,
  - making informed and meaningful decisions.
- Every person is inherently valuable and should be treated with dignity and respect.
- Everyone has the right to receive services that are delivered in a respectful manner.
- People's lives are affected by a complex variety of critical issues including:
  - culture,
  - immigrant/refugee status,
  - sexual orientation,
  - gender,
  - age,
  - socioeconomic status,
  - religion,
  - previous trauma,
  - strengths, resources & capacities.

Service providers must recognize and address these issues if interventions are to be meaningful for survivors.

- Consistency and transparency are critical for any type of collaboration, whether at the agency level, system level, or collaborative level
- The people and agencies that serve women who are survivors of domestic violence and other lifetime trauma and women who have experienced mental illness deserve great respect.
- People who do this work deserve the support, training, and supervision that will allow them to work compassionately, empathically and effectively
- Existing services should be expanded to be fully inclusive, appropriately comprehensive, and survivor-defined.

Article 3: Definition of Terms

***About our language**: Because our collaboration addresses a wide range of people, no single descriptor will be adequate. The way that we, as a collaborative, identify these groups is not as important as our commitment to make a new space that allows people to have, develop and define their individual experience, their own language relating to psychiatric disability, and to find responsive, open, and accessible services that meet their needs.*

General Definitions:

- **Accessibility:** Establishing a more inclusive environment and society in which everyone, regardless of ability, has equal opportunity to participate. This is broader than the ADA definition of accessibility (ensuring equal access and opportunity in public accommodations, employment, transportation, state and local government services, and telecommunications for people with disabilities and people who are Deaf or Hard of Hearing) and incorporates the new WHO definition of disability, described below. The concepts of universal access and inclusive design incorporate attitudinal and cultural accessibility, as well. Creating fully accessible, environments includes understanding and meeting our collective responsibility to provide equal opportunities for all; designing welcoming and supportive environments for the widest range of potential users and circumstances; providing individualized solutions to address individual needs and identifying community supports specifically for people with disabilities.[1]

- **Collaboration**: A working relationship involving critical individual and group responsibility, with collaborators adding to the value of the work of others to achieve a jointly determined outcome.[2] Collaboration is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone." Collaboration not only involves a commitment to shared goals and shared responsibility but also to creating a structure based on mutual accountability and trust, the sharing of resources, risks and rewards and a willingness to examine our own attitudes and practices in order to become the change we hope to create.[3]

- **Consumer**: A person who utilizes or purchases mental health services with the same rights and choices as others who choose to contract for services. While not everyone relates to this term, it reflects an important change from the more stigmatizing, dehumanizing, and identity-defining terminology of "mental patient" and from the more passive notion of "service recipient" to language that denotes a person who, in one aspect of their life, chooses to access a particular set of services. It recognizes choice and self-determination and challenges the acceptability of coercive mental health practices. Another definition is "a person who has or has had personal experience with major mental illness."

- **Disability**: Disability is an ordinary part of experience for all people; anyone may become disabled. The World Health Organization (WHO) defines disability as something that occurs outside of the person that is based on the interaction of the person, his or her functional abilities, and the environment. As such, one is more or less disabled based on whether physical, information, communication, social and policy environments are accommodating and welcoming of variations in ability. The prevalence of disability also corresponds to social and economic status. In other words, the experience of disability can be minimized by designing environments to accommodate varying functional abilities and providing individualized solutions

when needed, opening the door to a new approach to creating welcoming and accessible services for survivors. [4]

- **Domestic Violence (DV)**: A pattern of coercive behaviors designed to dominate and control a partner or household or family member through fear and intimidation. Partners may be married or unmarried; heterosexual, gay, lesbian, bi-sexual, transsexual, or questioning; living together, separated, or dating. Under the Illinois Domestic Violence Act (IDVA), a domestic violence perpetrator may also be involved in a care giving relationship with the victim (abusive tactics are used to gain and/or maintain control over a high-risk adult with disabilities who is under their care). Abusers may use a combination of tactics, some of which are described below, that result in physical and psychological harm to survivors and their children.

- **Economic Abuse:** The abuser controls or limits a survivor's access to money and other economic resources as a tactic of control. This can include preventing a survivor from finishing her education or obtaining employment, spending a survivor's money without her knowledge, or falsifying a survivor's name on financial documents.

- **Gender**: We mix gender-neutral and gender-specific terms in order to acknowledge the prevalence and seriousness of domestic violence and lifetime abuse in the LGBTQI community and the small percentage of men who are abused by a female partner and to reflect the experience of domestic violence programs – particularly shelters – that serve mainly women and children, as well as those research studies that are gender-specific. We recognize that rates of abuse are higher among men who have a disability than among men who do not.

- **Mental illness (MI)**: A broad range of mental and emotional conditions characterized by alterations in thinking, mood, and/or behavior. These health conditions are mediated by the brain and associated with distress and/or disruptions in functioning. The term "mental illness" is more generally used to refer to psychiatric or mental health conditions that are more chronic and cause greater disruption in functioning. We use the term "mental health conditions" or "psychiatric conditions" to refer more generally to symptoms or diagnoses that are less likely to cause long-lasting disability.

- **Neglect**: The failure to exercise the degree of care toward an adult with disabilities that a reasonable person would exercise under the circumstances. Neglect is the failure (whether intentional, careless or due to inadequate experience, training or skill) to provide basic care or services when agreed to by legal, contractual or otherwise assumed responsibility. Neglect includes but is not limited to:
  - The failure to protect a high-risk adult with disabilities from health and safety hazards.

- The failure to provide food, shelter, clothing, and personal hygiene to an adult with disabilities who requires such assistance;
- The failure to provide medical and rehabilitative care for the physical and mental health needs of a high-risk adult with disabilities; or
- The failure to take reasonable steps to protect an adult with disabilities from acts of abuse; the repeated, careless imposition of unreasonable confinement[5]

In the context of ongoing abuse and violence, neglect involves the willful disregard of a person's basic needs in order to exert control, elicit fear and create harm to that individual.

- **Person-First Language**: A standard promoted by the Americans with Disabilities Act of 1990 and the Disabilities Education Act of 1997 stating that one should look at the person first and their situation, experience, or disability only as relevant. For example, rather than saying, "a handicapped person" one should say, "a person who has a disability." Likewise, instead of referring to a person as "a schizophrenic," we would say, "a person who has or who is living with schizophrenia." The point of being conscious of how we use language is to ensure we are not inadvertently labeling, objectifying, or dehumanizing; in other words, defining other people through one particular lens or one aspect of their experience or identity. When considering the use of language, it is helpful to think about how it would feel to have a particular phrase used in relation to oneself or another person and whether it would feel objectifying, dehumanizing, disrespectful, and more importantly, not reflective of one's own personhood.

- **Physical Abuse:** Physical violence is only one of many tactics batterers use to harm their victims, to undermine their autonomy and sense of self, and to keep them isolated and entrapped. Physical abuse includes punching, beating, kicking, biting, burning, shaking, hair-pulling, spitting, or otherwise harming a person physically or intentionally causing a person physical injury or pain. Physical abuse also includes any unwanted physical contact.

- **Psychiatric Disability**: A normal part of the human experience that occurs when mental illness significantly interferes with the performance of major life activities, such as learning, thinking, communicating, and sleeping, among others. Trauma and mental illness (MI) can cause psychiatric disability but do not always do so. Psychiatric disability occurs when the effects of trauma and/or MI significantly interfere with the performance of major life activities. Psychiatric disability may come and go, remit, or be more persistent. Safety and support can reduce psychiatric disability.

- **Psychological Abuse**: Whenever there is physical or sexual abuse, psychological abuse is invariably present and may be quite severe. This often takes the form of verbal intimidation and threats, ridicule and humiliation, destruction of property, threats to significant others, stalking and monitoring a woman's activities, and

controlling her access to money, personal items, and contact with friends, family and children. It includes calling her names, making cruel and unfair comments, and engaging in other conduct that causes emotional pain and harm. Accusations about sexual infidelity can be particularly humiliating. Emotional withdrawal, threats of abandonment and threats to harm or take away the children are also used as tactics of control. Abusers also use mental health issues to undermine, isolate and control their partners. Psychological abuse also includes threats to harm the survivor, her children, family members, friends, pets, or the abuser him or herself (suicide).

- **Psychological trauma**: Trauma is the unique individual experience of an event or enduring condition in which the individual experiences a threat to life or to their psychic or bodily integrity and the individual's coping capacity and/or ability to integrate his or her emotional experience is overwhelmed. Cultural and historical trauma can impact individuals and communities across generations[6]

- **Sexual Abuse**: Sexual abuse is any form of nonconsensual sexual activity and encompasses all unwanted sexual acts, including touching a person in an unwanted sexual manner, engaging in sexually threatening and/or degrading behavior, or forcing a survivor to watch sexual acts. Sexual abuse is designed to humiliate, intimidate, control or instill fear in another person. It can be committed by the use or threat of force or under circumstances in which a person is incapable of consent. Most often, the perpetrator is someone who is known to the victim.

- **Stalking:** Stalking has two components: a threat of violence, and two acts of surveillance and/or following. Stalking can include behaviors such as appearing at the victim's home or place of work, laying in wait for the victim or making unwanted and frightening contact with the victim through phone, mail, email and/or other technologies or through a third person. Stalking must include explicit or implied threats to harm the victim or the victim's children, relatives, friends or pets. A stalker can be a stranger or someone the victim knows including a partner, an ex-partner, or a family member

- **Stigma**: Stigma is the use of negative labels to identify a person living with mental illness, the fear of mental illness, and the resulting discrimination that discourages individuals and their families from getting the help that they may want or need. An estimated twenty-two to twenty-three percent of the U.S. population experiences a mental disorder in any given year, but almost half of these individuals do not seek treatment. Stigma also keeps women from accessing DV services. Stigma is not just a matter of using the wrong word or taking the wrong action; rather, it is disrespect.

- **Systems Change:** Systems change is the intended outcome of collaborative work that attempts to influence "a group of key individuals and organizations that interact to produce a benefit or to improve ways of living, working and relating."[7] Desirable systems change influences a group of individuals and organizations in

ways that achieve both sought-after and unexpected improvements in how stakeholders live, work and relate. Systems change in the context of this project also means enhancing the capacity of individual communities, providers and public systems to address the needs of survivors of abuse and violence who are living with psychiatric disabilities and/or experiencing the traumatic effects of abuse.

- **Victim/Survivor**: A person who has lived through the experience of domestic violence and/or other types of trauma. For some women, the term "survivor" is preferable to the term "victim" and is used specifically to convey strength, experience, empowerment, wisdom, positive self-image, and hope for the future. For others, the term "victim" is preferred as a way to acknowledge the harm that has been done by another person (or persons) and the fact that their human rights have been violated. In criminal justice system context, the term victim is used to communicate that a survivor is also the victim of a crime.

- **Willful deprivation**: Willfully denying a person who because of age, health or disability requires medication, medical care, shelter, accessible shelter or services, food, a therapeutic device, or other physical assistance, and thereby exposing that person to the risk of physical, mental or emotional harm, except with regard to medical care or treatment when the person has expressed an intent to forgo such medical care or treatment.[8]

Provider Definitions:

- **Certified Recovery Support Specialist**: A certified recovery Support Specialist (CRSS) is a mental health consumer who has been trained and certified to help other consumers identify and achieve specific life goals. The CRSS assists consumers in cultivating their own abilities to make informed, independent choices, and in gaining information and support from the community to make their goals a reality. As a CRSS, an individual accepts and agrees that his or her experience as a mental health consumer will be known by his or her colleagues, consumers and others with whom s/he may share that s/he has achieved this certification. Additionally, CRSS's actively seek to role model mental health recovery in their lives and work and to follow the "Model Code of Ethics" outlined in the Illinois Certified Recovery Support Specialist Model.

- **Clinician**: A person who provides mental health treatment.

- **DV Advocate**: A person who provides support and information to survivors of domestic violence and who helps survivors become aware of options. Advocates also interact with various governmental agencies and systems on behalf of individual survivors and promote policies, procedures, and protocols that impact survivors in a positive way.

- **Mental Health Consumer Advocate**: Independent mental health consumer advocates are not employed by state mental health agencies. They are usually part of the overall consumer movement, and may be aligned with one or more consumer run organizations. They advocate with administrators, state bodies, and legislative government bodies and volunteer to sit on various local state and national mental health and disability boards and similar bodies as appointed members. Consumer advocates assist in writing legislation. As free agents consumer advocates are free to voice the perspective advocate for consumers of mental health services to influence practice and policy.

- **Mental Health Provider**: A professional or paraprofessional who offers diagnostic, treatment, case management, and/or preventive care services to help people who have mental health symptoms and/or a psychiatric condition or mental illness optimize their physical and emotional well-being.

- **Mental health worker**: Someone who provides non-clinical mental health services, case management, outreach, and support.

Service Definitions:

- **Trauma-informed Services**: Services that are designed to prevent retraumatizing of survivors and to promote dignity, respect, collaboration, recovery, empowerment and choice.

- **Universal Access / Inclusive Design**: Ensuring the maximum flexibility to reduce the experience of disability and to universally enhance experience and performance. This includes social, cultural, and economic accessibility as well as physical/environmental accessibility.

Article 4: Individual and Organizational Roles and Responsibilities

4-1 Collaboration Structure

Our project structure is simple: all partners' voices are equal; we all have a stake in the collaborative process and in its outcomes. The responsibility to fully participate in all phases of the project is clearly shared in equal measure by all partners. Though each partner brings special skills and expertise to the project, it is anticipated that the work load will be distributed fairly. As the lead agency DVMHPI will manage the finances of the grant, will function as the administrative center of our work and coordinate communication between the project and OVW and the Vera Institute.

4-2 Partners and Roles

The nine individual people in this systems-change collaboration are part of an established group of colleagues and co-workers who have long-standing professional ties, some dating back to the late 1970s and who, since the 1990s, have worked to address the mental health needs of survivors of domestic violence in the state of Illinois. These nine people are stakeholders within their respective organizations and, along with individual knowledge, skill and commitment to the vision of this collaborative are able to draw on both formal and informal resources within their respective agencies in support of the mission of the collaborative. Each individual member serves as an ambassador and 'champion' for the work of the collaborative within her own agency, and in her broader professional network.

Agencies

This collaboration involves five nonprofit agencies and one publicly funded state mental health authority. These agencies have committed the time and resources of these individuals in support of the vision and mission of this project. In addition, each agency has committed specific expertise, resources, access and networks to the success of the collaboration. Furthermore, as specific collaborative strategies or initiatives are devised, the partner agencies are committed to respond in a timely way and to participate as requested by the collaborative.

Each partner agency is committed to participating in every aspect of the planning and implementation process, including the creation of a collaboration charter, the development of a needs assessment plan, conducting the needs assessment and generating the needs assessment report, generating a strategic plan and overall project implementation. Each agency is also committed to a process of deepening collaborative relationships among partners, evaluating and revising its own policies and practices, and working to create meaningful and sustainable systems change.

Domestic Violence & Mental Health Policy Initiative is a non-profit, non-governmental organization with a significant track record of providing training, technical assistance, and policy development in the area of building advocacy- and trauma-informed service systems for survivors of domestic violence (DV) and other lifetime trauma and/or psychiatric disabilities. DVMHPI is currently engaged in several multi-year capacity building efforts that provide a strong foundation for this project. Each involves the development and testing of collaborative service delivery models, the production of curricula and informational materials and the provision of training and technical assistance, with a long-term goal of system and policy change. Since 1999, DVMHPI has been successful in fostering collaboration between domestic violence and mental health service providers both locally and nationally. DVMHPI also brings the expertise and resources of its DHHS-funded National Center on Domestic Violence, Trauma & Mental Health, its national partners and other in-house expertise to this initiative, including legal, practice and policy guidelines for DV programs on responding to survivors experiencing psychiatric disabilities (including compliance with ADA and Fair Housing Act); guidelines for mental health providers on responding to survivors of DV; recommendations for

creating DV- and trauma-informed services; strategies for supporting the parenting capacity of domestic violence survivors; and ongoing work on culturally-specific responses to trauma and domestic violence.

DVMHPI commits staff and resources to this project to provide the following: project direction; fiscal management; logistical support for meetings and other activities and provision of meeting space. DVMHPI will also maintain records and data related to the collaborative and train and support members in the use of our web-based communication tool (BaseCamp). Both DVMHPI's Executive Director and Adult Trauma Specialist have over 30 years of experience in addressing these complex issues.

Illinois Coalition Against Domestic Violence (ICADV) is an independent, non-profit, non-governmental domestic violence victim services organization representing 53 local domestic violence programs in the state of Illinois. ICADV commits staff (Executive Director/Associate Director) and resources to this project and is committed to participating in every phase of project activities. ICADV also brings knowledge and expertise about domestic violence and about DV programs, activities and policies in the state of Illinois. ICADV has a longstanding track record in addressing service accessibility issues, fostering community partnerships and developing innovative strategies for addressing unmet needs (for example child trauma services). ICADV is committed to building on these achievements to develop, pilot, and broadly implement new collaborative peer support/advocacy models for addressing the needs of survivors dealing with both domestic violence and psychiatric disabilities. It will communicate to its member programs about the collaboration on a regular basis and will encourage and support participation among potential project sites. In turn, the ICADV board which is compromised of the executive directors of its 53 member programs is committed to ensuring the success of this project. ICADV commits the time of its Executive Director and Associate Director as well as the provision of CEUs, as needed for any training activities generated by the project.

Illinois Department of Human Services, Division of Mental Health (IDHS-DMH) is the state mental health authority, which operates nine psychiatric hospitals, funds 160 community agencies and supports a statewide network of Recovery Support Services. IDHS-DMH commits the time of its Mental Illness and Developmental Disabilities Services Coordinator, as well as the participation as indicated of its Associate Director of Hospital Operations and Recovery Support Services. IDHS-DMH will act as a liaison to ensure participation of state-funded mental health agencies and facilities (hospitals) and will encourage and support potential project sites and their staff to participate in activities proposed by the collaborative. IDHS-DMH will also contribute by facilitating the involvement of state-funded Recovery Support Specialists in our collaborative work. In addition, IDHS-DMH will arrange for space, audiovisual equipment, and videoconferencing, as needed. IDHS committed to this collaboration via the Director of the Division of Mental Health and will utilize its regional managers and Associate Director for Hospital Operations as well as its Director of Recovery Support Services to assure resource commitment in the pilot sites.

The Growing Place Empowerment Organization (GPEO) is a non-profit, non-governmental mental health consumer advocacy organization, with statewide expertise in training and technical assistance on peer-driven recovery supports. GPEO will commit the time of its Project Director; and will provide expertise to the project on empowerment-based peer support recovery models and links to consumer advocacy groups throughout the state to ensure active involvement of mental health consumers and mental health consumer groups at all levels of planning, implementation and evaluation. GPEO will also play a key role in the development of any new consumer-generated peer-support tools, educational materials and collaborative service models that may be developed by the project. GPEO has been instrumental in building support to establish mental health consumer-directed and operated Wellness and Recovery Centers throughout Illinois and will build on this commitment to ensure the success of the project.

Thresholds is a non-profit, non-governmental mental health and psychosocial rehabilitation agency with 105 sites that annually serves approximately 6,000 individuals with psychiatric disabilities throughout metropolitan Chicago. It is a leader in recovery-oriented services and established an award-winning peer-run Recovery Drop-in and Resource Center that was the first of its kind in the state of Illinois. Thresholds will commit the time of its Trauma Committee Chair and Program Director of McHenry County as well as a consumer/trainer staff member with expertise in consumer-run recovery services. In addition, The Thresholds Institute, a leader in mental health training and research, will offer consultation and the use of its "Hearing Voices" curriculum. Thresholds will also provide expertise on psychosocial rehabilitation, creating trauma-informed programs and peer-support recovery models. Thresholds will share all effective assessment and implementation tools related to information collection and analysis and will assist in developing the needs assessment plan and analyzing the results.

Life Span is a non-profit, non-governmental domestic violence victim services organization distinct experience and staff expertise in the legal concerns and issues surrounding advocacy for survivors of domestic violence. Life Span will commit the time of its Executive Director to provide broad perspective on issues of domestic violence, including the perspective of domestic violence advocates and survivors, as well as legal expertise on issues of confidentiality, record keeping, and other legal issues involving providing services to survivors of violence with disabilities. Life Span has provided services to domestic violence victims in Cook County for more than 30 years. This agency combines domestic violence counseling, criminal court advocacy, and legal services to offer their clients a unique perspective and comprehensive response to their services needs. Life Span has been involved in several strong, effective collaborations, including OVW funded projects. The experience of its Executive Director in working with partners with disparate interests toward a common goal will help our collaboration to achieve its mission and goals.

Individuals

Representatives from the Domestic Violence & Mental Health Policy Initiative:

- **Executive Director** (serving as grant Project Director) will be responsible for general oversight of the project and for ensuring that project requirements and goals are met. She will provide guidance on the development of materials developed by the project and will contribute expertise on domestic violence, trauma, mental health and psychiatric disabilities and on building cross-sector collaboration.
- **Project Manager** (serving as grant Project Manager) will serve as the primary administrative liaison to the collaborative, maintain records and submit all required progress reports; provides day-to-day fiscal management, and serves as the central point for communication within the collaborative
- **Adult Trauma Specialist** will provide trauma/domestic violence expertise as well as expertise on training and supervision, on working with survivors who experiencing cognitive disabilities in the context of trauma and mental illness, and on strategies for improving provider and agency practice.

Representatives from the Illinois Coalition Against Domestic Violence

- **Executive Director[9] and Associate Director** will jointly provide the following: statewide organizational knowledge, voice and expertise on domestic violence; representation of the collaboration to local domestic violence programs and their communities; and facilitation of communication about this project with the state agencies with which ICADV regularly works—Office of the Illinois Attorney General, Illinois Violence Prevention Authority, Illinois Criminal Justice Information Authority, and the Illinois Department of Human Services, Office of Domestic and Sexual Violence Intervention and Prevention. In addition to grant-funded activities, they will also engage in state-level policy activities and in developing and implementing standards for Illinois DV programs on addressing domestic violence, trauma, mental health and mental illness, and providing services for DV survivors with psychiatric disabilities.

Representative from the Illinois Department of Human Services, Division of Mental Health (IDHS-DMH):

- **Mental Illness and Developmental Disabilities Services Coordinator**: will provide statewide knowledge about publicly funded mental health services in Illinois; represent the collaborative to IDHS/DMH; advocate for the collaborative with state psychiatric hospitals, community mental health agencies and IDHS-DMH administration; provide systems knowledge about the integration of recovery support programs and strategies within the state-funded mental health system; maintain communication within IDHS/DMH agencies and local mental health agencies; keep additional IDHS/DMH stakeholders informed about the project and solicit their participation as needed in various stages of the work (e.g., the Associate Director of Hospital Operations and the Director of Recovery Support Services)

Representatives from the Growing Place Empowerment Organization (GPEO):

- **Project Director of GPEO** will provide statewide knowledge about recovery-based empowerment strategies and programs; advocacy for the collaborative with mental health consumer organizations; formal expertise as a certified trainer for empowerment-based wellness recovery planning for people with psychiatric disabilities and facilitation of communication about the project within the peer recovery self-advocacy community.

Representatives from Thresholds:

- **Program Director of McHenry County/ Thresholds Trauma Committee Chair will** be the point person for coordinating Thresholds' involvement in the project. She brings her expertise on trauma and psychiatric disabilities, and in providing recovery oriented services in both rural and urban communities. As chair of the trauma committee, she has taken the lead in moving Thresholds toward responding more effectively to survivors of domestic violence and other lifetime trauma.
- **Thresholds Research and Training Department: Training Associate** brings her experience as a longtime consumer of mental health services, her personal experience as a trauma survivor and her expertise in peer support recovery and advocacy. **Research Director**: brings her expertise to assist the collaboration in the development and implementation of the needs assessment plan and in generating the needs assessment report.

Representative from Life Span:

- **Executive Director** will provide both national and statewide perspective and expertise on the legislative and policy structures that underlie services to survivors of domestic violence as well as her years of experience in the provision of services to domestic violence victims and as a supervisor and manager of an agency of 30 counselors, advocates and lawyers. She will also provide expert knowledge about civil legal matters related to psychiatric disabilities and to survivors' accessing safety and recovery. Life Span's Executive Director is known for her innovative work on issues of domestic violence and mental health in the legal system, and has represented many battered women with mental illness in family law matters and on appeal. She has published an article on this issue, and trained numerous national audiences on the issues of confidentiality, record keeping, and strategies for successful litigation in these cases.

Ad Hoc Advisors

- As our work progresses, we will solicit information and expertise from our broad networks of people/organizations outside of the core collaborators. As such situations arise we may engage these individuals and agencies at the level of *ad hoc* advisors to inform our work.

Article 5: Work Schedule, Policies, and Practices

5-1 Partner Meetings

DVMHPI will call and coordinate at least one monthly two-hour conference call and one half-day in-person meeting. When needed the group may engage in longer calls or convene more frequent meetings.

Each member will make every attempt to participate in every meeting. The discussions and work completed during the meetings will be captured and documented by one or more members of the collaborative, and will be made available to all collaborative members. The responsibility of planning meetings is the responsibility of DVMHPI unless the work indicates otherwise (for example if a meeting will be held at a partner agency).

5-2 Decision Making Authority

We operate from a consensus model, therefore any decision impacting the vision, mission or core activities of our collaboration must be made by the full collaboration. The majority of our collaborative members are also key decision-makers for their agencies and/or organizations (DVMHPI, Life Span, ICADV, GPEO). Collaborative members who do not have ultimate decision-making authority within their agencies or organizations (e.g. Thresholds, in some instances IDHS-DMH) will engage appropriate decision-making authorities (for example, Agency Directors, Boards of Directors) as needed to further the work of the collaborative. For example, for Thresholds, the collaborative called a special meeting with the CEO and Chief Clinical Officer to specify the "systems change" aspect of the VAWA grant following the St. Louis meeting. Information regarding the collaborative project is reported on each month through the Trauma Committee chair and grant partner, Julie Gibson, to the agency Clinical Operations Committee chaired by the Chief Clinical Officer. For IDHS-DMH, Sandra Houghlund, who is the Mental Illness and Developmental Disabilities Services Coordinator, has considerable seniority within the division and has consistently been able to assist the collaborative in navigating within DMH in order to ensure that stakeholders and decision makers are apprised of the work of the project and its expectations, and to ensure access to necessary resources, Division involvement and approval.

With regard to decisions involving collaborative partner agencies and/or organizations when the key decision-maker is not at the table, the following steps will be taken:

For Thresholds: Trauma Committee chair and grant partner, Julie Gibson, will discuss any decisions affecting her agency with the Clinical Operations Committee chaired by the Chief Clinical Officer. Strategies will be developed and presented to the agency's CEO. Involvement of additional collaborative members will be sought as deemed appropriate.

For IDHS-DMH: Sandra Houghlund will discuss any decisions involving IDHS-DMH with appropriate decision makers for their input and approval. Involvement of additional collaborative members and other key stakeholders will be sought as deemed appropriate.

Decisions regarding the management of the day-to-day activities of the collaborative group, including but not limited to: grant reporting, meeting and conference call planning, travel arrangements, coordination of communication, etc., are the responsibility of the project director and project manager. In addition, the project director and project manager will make decisions regarding the fiscal administration of the grant, with clear consideration to what will benefit the larger collaborative. Input will be solicited from all collaborative members.

5-3 Internal Decision Making Process

We commit ourselves to principles of ethical communication among ourselves and in our dealings with other organizations and individuals. As such we agree to approach our decisions with an attitude of flexibility and adaptability. When a formal decision making process is needed, we will follow the consensus process detailed below.

Introductions

- Clarify the process
- Present a proposal or issue
- Ask questions to clarify presentations and issues

Level 1: Broad Open Discussion:

- Convene group discussion
- *Call for Consensus*
  - If consensus is not reached, move to Levels 2 & 3

Level 2: Identify Concerns

- List any concerns
- Identify group related concerns
- *Call for Consensus*
  - If consensus is not reached, continue to Level 3

Level 3: Resolve Concerns

- Resolve group concerns
- Restate remaining concerns
- Ask questions to clarify concerns
- Limit discussion to resolving one concern at a time
- *Call for Consensus*

Alternative Closing Options:

- Stand aside
- Send to Committee
- Declare block and make an alternative proposal

5-4 Conflict Resolution Process

Our years of experience of working with each other and developing a respectful process for resolving philosophical differences and conflicting opinions and perspectives that has evolved into a shared vision, mission and goals gives us confidence that conflict at this point in our collaboration will be an uncommon situation. We view our collaborative as a "continual learning organization." Hence, given our deep respect for each others' knowledge and experience, we assume that when differences of opinion or conflicts of interest arise, there are good reasons for that to be the case. When we listen carefully to each other, we each learn from the experience. Through this process, we have been able to come to resolutions that respect each of our needs and concerns. We will apply these lessons as we move forward with our pilot sites. As we work with the pilots, we will strive to establish the trust, commitment, shared vision and respect necessary to listen and learn from each other. This process, which mirrors that of our collaborative, will, in turn, lead to new collaborative strategies to achieve our overall goals while respecting the needs and concerns of each member.

We also believe that our collaboration will benefit from a structure to resolve conflicts within our group, should they arise as our work moves forward.

We will use the following process to resolve conflict.

Basic Premises

- All participants in this collaboration have equal power and value.
- All participants agree to treat each other with respect and courtesy at all times.
- Each participant may have requirements in relation to this collaboration that are unique to their agency or organization.
- A goal of the collaboration is to retain all participants.
- A goal of the collaboration is to develop policies, procedures, and substantive products that are not in conflict with any participant agency's values, mission, or goals.

Conflict Resolution Procedure:

The collaboration will use the Conflict Resolution Procedure (CRP) when two or more participants cannot reach an agreement about an issue involving the collaboration's policies, procedures, substantive issues, work products, or any other matter of importance to the functioning of the collaboration. Any participant may ask to make use of the CRP when that participant believes that internal discussion and efforts to resolve the conflict have not been successful. The Conflict Resolution Policy assumes that the CRP will be needed by the collaboration in very rare circumstances, and that most disputes and conflicts will be resolved through respectful and thoughtful discussion within the collaboration. The Conflict Resolution Policy mandates that all resolutions of disputes will be in harmony with the overarching goals and policies of the collaboration as a whole.

- The participants who are having a conflict will be identified.
- The issues which cannot be resolved will be identified and described.
- Identifying the Issues: The participants having a conflict must agree that the issues are described accurately before the process can go forward. The participants may suggest changes to the issues statement so that the participants all believe that the issues are stated accurately. Any of the participants in conflict and/or any member of the collaboration can assist in identifying the issues.
- Mediation: All participants agree that, if they cannot resolve a dispute or conflict, that the participants who are in conflict over that issue will mediate their dispute with a neutral mediator. The Vera Institute may be utilized to provide mediation as a part of the technical assistance services provided to this grant. Locally, the Center for Conflict Resolution is a nonprofit agency that may also be utilized, and which does not charge for its services. Participants will make every effort to mediate the dispute to a resolution with which each participant can agree.
- In the event that the participants' efforts at mediation are not successful, we will consult with OVW for their input and suggestions.

Article 6: Communication, Confidentiality & Mandatory Reporting

6-1 <u>Internal Communication Plan</u>

In an effort to maintain consistently clear and open channels of communication, our collaborative group will use many methods of internal communication including:

Twice monthly collaboration meetings

- Conference call once per month: 2+ hours
- In-person meeting once per month: 4 hours - 1 ½ days
- Email communication
- Individual telephone communication
- Paper based (mail) communication

In addition to the above means of communication, our collaboration is utilizing a secure online project management website (BaseCamp) that allows the sharing of information, documents, calendars, and timelines.

<u>Communication with Collaborative Member's Organizations</u>

Each collaborative member will report back to and share information about the work of the collaborative with her respective agency, and will share information about her individual agency with the larger collaborative group on a bi-weekly basis, as well. We will share information about this project through existing mechanisms such as regular staff meetings, newsletters and board of directors meetings.

6-2 External Communication Plan

Communication with the Vera Institute and OVW

The project manager will maintain regular communication with our Vera program Associate, but any member is free to communicate directly with her. The Vera program associate will participate regularly in collaborative conference calls. The collaborative will also benefit from face-to-face meetings with our Vera associate during all-site meetings. Similarly, the project director will be the appointed representative to maintain communication with OVW.

Communication with Other Stakeholders/Pilot Sites

Communications (e.g., written, spoken, and electronic interactions) with individuals and organizations outside of the Project Team will be utilized to develop relationships with new stakeholders in Illinois and to create state-wide awareness about the progress of this project.

The project team's external communication plan will include but not be limited to the following:

- The team will identify stakeholders throughout the time period allotted for this project and determine the best method of sharing project information.
- All formal external communications will be approved by the collaborative
- Any media inquiries will be referred to the Project Director

6-3 Media Plan

We will maintain a set of talking points for responding to media inquiries and/or requests for information from the 2007 State of Illinois grant collaborative members related to information about this project. Talking points will be revised and updated by the collaborative as needed.

All media inquiries in any form (phone, fax, in-person, electronically, or by any other means of communication) will be directed to the Project Director who will refer to these talking points. For questions and/or requests for information beyond the scope of the talking points, the project director will draft a response that will then be sent to all available collaborative members for review and approval within a 48-hour time frame.

6-4 Confidentiality

The 2007 State of Illinois collaborative will not be providing direct services to individuals. Collaborative members will share information about systems, rather than about individuals. However, there may be rare occasions when identifying information about individuals becomes known as we carry out the work of this project. Under these circumstances, any information revealed will be kept confidential within the group.

With respect to agency-related confidentiality:

All collaborative members agree that, in order for our collaboration to be successful, members need to keep discussions held during meetings confidential. The results of discussions will be reported out as agreed by the collaborative members. In specific, information that is shared by or about individual collaboration members will be kept confidential.

With respect to the confidentiality of individuals:
All survivors require confidentiality in order to be safe, to be in control of designing their own path to safety and recovery, and to determine how they want to live their lives. When the project solicits information from survivors, we will develop a formal protocol for ensuring confidentiality and obtaining appropriate releases of information. We are committed to maintain the confidentiality of any survivors' information; however we acknowledge that some collaboration members are mandatory reporters of child abuse and neglect or the abuse and neglect of persons with disabilities. We will work to ensure that survivors who become involved with the collaboration are aware of that mandate to report.

As the project moves forward into the needs assessment phase that may involve survivor participation as well as individual agencies and their staff, the collaborative and all agencies involved will develop and submit an IRB application to the Hektoen Institute, LLC, and any and all work conducted as a part of this grant project will comply with IRB standards for the involvement and protection of agencies and individuals. In addition the collaborative and agencies will implement confidentiality procedures, and will ensure that each individual participating has given complete informed consent.

6-5 <u>Mandatory Reporting</u>
Team members will review the implications of mandatory reporting at each point in the project. Survivors will be informed about mandatory reporting. Their rights of confidentiality and self-determination will be considered at every juncture.

Reporting abuse and neglect:
Information about specific collaborative member and pilot project agency policies, practices, and events may be obtained or observed in the course of our project work. Some collaborative members, IDHS/DMH staff in particular, are mandated to report abuse and neglect in IDHS facilities to the inspector general. Some collaboration members are mandatory reporters of child abuse and neglect or the abuse and neglect of persons with disabilities. We will work to ensure that survivors who become involved with the collaboration are aware of that mandate to report.

Article 7: Work Plan

Phase I: **Collaborative Charter: To build/strengthen collaboration by developing knowledge and understanding of other member organizations; develop mission & goals**

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Develop knowledge of other members/orgs										
Develop vision, mission, and goals										
Determine how your group will work as a team										
Deliverable - Collaborative Charter										

Phase II: **Identifying Focus: To identify initial focus/areas of interest, which will shape your needs assessment**

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Identify Pilot Sites										
Explore site interest and commitment level										
Secure commitment of sites										
Secure commitment of decision makers										
Deliverable - Memo Outlining Focus										

Phase III: *Months* **Needs Assessment: To identify strenghts & needs of collaboration; identify strenghts and**

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Develop methodology for needs assessment										
Deliverable - Needs Assessment Proposal										
Carry out assessment										
Analyze data										
Draft report of key findings										
Deliverable - Final report of key findings										

Phase IV: **Strategic Planning: To define your collaboration's goal; outline activities for implementation; include key partners, timeline, budget, & plans for**

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Review findings from needs assessment										
Agree upon priority areas										
Develop strategies for change										
Draft and finalize plan										
Deliverable - Strategic Plan										

*The estimated times for completion are based on OVW and Vera Institute estimates

[1] World Health Organization, Adaptive Environments, Vera Institute
[2] Source Engineering Council of South Africa
[3] Fieldstone Alliance http://www.fieldstonealliance.org/client/client_pages/articles_tools/Article-4_Key_Collab_Success.cfm
[4] World Health Organization (www.who.int.), www.adaptiveenvironments.org, www.accessingsafety.org.
[5] Adapted from Illinois Domestic Violence Act (IDVA
[6] Sidran Institute and DVMHPI
[7] Michael Winer and Karen Ray *Collaboration Handbook*,, Fieldstone Alliance, 1994, p129.
[8] From Illinois Domestic Violence Act (IDVA)
[9] In addition, the *Executive Director* has participated as a collaborative member in the project since its beginning, and will continue to do so until her tenure with the organization ends mid-summer 2008.