PROJECT PEER CHARTER

Approved
by the
US Department of Justice
Office on Violence against Women

April 22, 2014

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WASHINGTON, DC COLLABORATION CHARTER III[1]

Updated for Continuation Award, 10/1/13 - 9/30/15

I. INTRODUCTION

This collaboration charter (Charter) represents the shared commitments of eight[2] community-based organizations in the District of Columbia. Individually, each of these organizations provides direct supports and/or advocacy services for people with disabilities and/or survivors of domestic and/or sexual violence, stalking and/or trafficking. Collectively, we have joined together to become the system of responsive supports that survivors in our community need and deserve. This 2014 version of the Project Peer's Collaboration Charter is a compilation of our two previously approved charters (2008 and 2011). We developed this version to incorporate the voices of our new partner, as well as new representatives from existing partners. It represents the shared expectations, responsibilities, and goals of our inter-connected services system. Our actions together, now and in the future, will breathe life into this Charter by strengthening our services for survivors with disabilities in the District of Columbia.

The partners in the Washington, DC, Collaborative (Project Peer) began to form a partnership beginning late in 2006 in recognition that the service needs we each address separately overlap and intersect in the lives of women with disabilities who are survivors. The Department of Justice, Office on Violence against Women (OVW) awarded our proposed Project Peer a cooperative agreement in October of 2007 (FY 2008) to end our artificially fragmented approach to supporting survivors, transform our daily practices, and change the awareness and operating cultures of our organizations. In 2010, we extended Project Peer for an additional, no-cost extension year, which concluded on September 30, 2011. After sustaining our efforts without OVW funding during fiscal years 2012 and 2013, we received a continuation award in fall of 2013 for fiscal years 2014 and 2015. Central to our planned outcomes for this award period is bringing on board a new anti-domestic violence partner, the District Alliance for Safe Housing (DASH). Our focus populations remain women with developmental disabilities and/or mental health issues,[3] who are survivors of sexual and/or domestic violence, stalking and/or trafficking.

II. VISION, MISSION, & CORE VALUES

A. Vision

In the District of Columbia, survivors of domestic and/or sexual violence, stalking and/or trafficking, who have disabilities, will live in safe environments, heal and have healthy,

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[1] This project is supported by Grant No. 2013-FW-AX-K001 awarded by the Office on Violence against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this document are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence against Women.

[2] This number includes new group member, District Alliance for Safe Housing (DASH). The Resource Opportunity Center (ROC), a self-advocacy partner in our first award, no longer exists.

[3] We are struggling with recent changes in the terminology professionals in our fields use for these disability groups and have chosen to follow the lead of the self-advocates involved in our project who have asked that we not use the terms intellectual disability and/or behavioral health because of the negative traits associated with their accepted definitions.

successful lives. They will have access to high quality, seamless supports that are person-centered, trauma-informed and responsive to each survivor's needs.

B. Mission

Together with survivors of domestic and/or sexual violence, stalking and/or trafficking who have developmental disabilities and/or mental health issues, we will:

- Increase physical and emotional safety,
- Facilitate healing, and
- Promote self-agency and support.

We are committed to raising our voices on a systems level against oppression in all its forms, especially with survivors who have been silenced because of their race, gender, ethnicity, socio-economic status, disability, immigration status, faith, and/or sexual and gender identity, by

- Transforming our system,
- Learning from survivors with disabilities,
- Prioritizing the needs of those survivors, and
- Building sustainable, trauma-informed practices that welcome and accommodate these survivors and meet their needs by creating focused partnerships to share our strengths.

C. Core Values

Accessibility: We think foremost about how to remove barriers and encourage the widest possible participation.

Accountability: We hold ourselves, and each other, responsible for our commitments to survivors with disabilities.

Believing Survivors: We take the stance of believing survivors and acknowledging that nothing justifies the use of violence and abuse as tools to maintain power and control.

Confidentiality: Survivors have the right to decide who knows their stories.

"Nothing about us without us": We vow to maintain full inclusion and partnership with survivors and women with disabilities.

People First: The voices and experiences of survivors with disabilities are at the center of our work.

Respect and dignity: We value all survivors, ourselves, and each other. We honor the decisions of all survivors. We show understanding and appreciation for our similarities and differences. We treat each other as we want to be treated.

Self-agency: Survivors make, act on, and take responsibility for their own decisions.

Self-care: We advocate for practices that help staff feel connected and supported to lessen the impact of vicarious trauma and burn out.

Sustainability: We remain committed to honoring our collaborative, staff, the people we serve and our vision, mission and values.

Trauma-informed Supports: We try to see through a trauma-informed lens, acknowledging the lasting impact of exposure to and/or experiences of trauma on all of us. We embrace practices that avoid re-traumatization through the following principles:

- Safety
- Collaboration
- Peer Support and
- Trustworthiness.

III. PARTNERS, ROLES & RESPONSIBILITIES

Our Collaborative includes the following member organizations:

- ***Anchor Mental Health*** **(Anchor)** has supported adults with mental health issues since our inception in 1958. Clinical supports include counseling and medication management; non-clinical supports are career development and adult education. In 2004, Anchor became a division of Catholic Charities of the Archdiocese of Washington.

- ***District Alliance for Safe Housing*** **(DASH)** is an innovator in providing access to safe housing and services for survivors of domestic and sexual violence and their families as they rebuild their lives on their own terms. We seek to strengthen and expand the local safety net for survivors by providing high quality, voluntary services that are responsive to their individual needs and by engaging lawmakers, community members, service providers and survivors in the movement to make safe housing more accessible in the short term and less necessary in the long term.

- ***DC Coalition against Domestic Violence*** **(DCCADV)** is the federally recognized coalition and bridge organization for all dedicated anti-domestic violence programs in the District of Columbia. We are a membership agency working to transform the experiences of survivors of domestic violence and address the urgent need to stabilize and expand existing services. The Coalition provides outreach, training and technical assistance, and policy and systems advocacy to our member programs, local government agencies, community-based organizations and the broader community.

- ***The DC Rape Crisis Center*** **(DCRCC)** has been in operation for more than 40 years. As the Statewide Sexual Assault Coalition and only community-based advocacy organization specializing in trauma-informed care for sexual assault survivors in the District, we have considerable expertise in helping survivors heal in the aftermath of sexual violence through an anti-oppression lens. We offer a 24/7 hotline, counseling, support groups, and crisis intervention as a direct service to survivors. Prevention efforts include customized training and technical assistance to the community and prevention groups within the DC Public

Schools. Our coalition efforts include organizing survivor and direct service organizations, informing policy and reforming systems that impact survivors.

- ***Lt. Joseph P. Kennedy Institute*** **(JPKI)** was founded in 1959 as a special education school for children with disabilities. Over the years, we have expanded our services in DC and suburban Maryland to include early intervention, adult education, career development, employment and community living supports for people with developmental disabilities, as well as family support services. We have a longstanding, supportive relationship with Project ACTION! (see below). In 2004, JPKI became a division of Catholic Charities of the Archdiocese of Washington.

- ***Project ACTION!*** is a regional coalition of self-advocacy groups established by low-income adults with developmental disabilities in 1992. Our strong community of self-advocates shares personal experiences of living with developmental disabilities – training and encouraging peers to speak out on issues important to us – without regular financial support.

- ***Quality Trust for Individuals with Disabilities*** **(Quality Trust)** is Project Peer's lead organization. We are an independent catalyst for change, created to advance the individual and collective interests of people with developmental disabilities in the District. Our core activities include intervening on behalf of people with the services system and service providers (lay advocacy); monitoring the adequacy of services available in the city, including health, safety and welfare issues, and ensuring access to legal representation. Every person with a developmental disability living in the District is a member. Quality Trust serves as the fiscal agent for Project ACTION! (above) and provides in-kind support, including space, mailings, training and technical assistance.

- ***Ramona's Way*** provides holistic supports for women who are survivors of domestic violence and also have mental health issues (substance abuse) throughout the trauma and recovery process. Services, including case management, information/referral, crisis intervention and counseling, help women regain control of their lives and empower them with the support they need.

Consistent with the responsibilities set forth in the FY 2014 continuation award revised Memorandum of Understanding (MOU), these agencies and their representatives have made the following commitments to our work together:

<u>The eight partners in our Collaborative will:</u>

- Undergo an internal change process and serve as change agents
- Share agency and system specific expertise and knowledge
- Share field and movement expertise and knowledge
- Practice self-assessment and reflection
- Use our spheres of influence to advance the Collaboration's goals
- Share knowledge of our agencies' resources and our capacities
- Share our strengths

- Offer high quality services that are responsive to needs identified through our Needs Assessments
- Adhere to Project Peer's vision, mission and core values
- Support the Liaison System[4]
- Commit to ongoing problem solving and communication across partner organizations through the Liaison System and Project Peer's electronic medium for information sharing
- Commit to assigning specific staff to design and implement key change initiatives grounded in the Strategic Plan, using OVW's well-established work group model
- Collaborate through the Staff Knowledge Development work group to offer cross-field staff training and assign staff to attend and participate in this training[5]
- Encourage cross-referrals and inform our staffs not to limit survivors' opportunities to benefit from supports offered by more than one of our partner organizations – all of which offer high quality services responsive to survivors' multiple needs
- Commit to the ED of each partner attending quarterly ED meetings
- Continue to promote uniform and positive messages about our collaboration's members, mission and activities both internally and externally. This includes staff communications with the survivors who use our services
- Use and distribute practice guides, documents, and other materials that Project Peer has developed
- Share information on other opportunities to collaborate, including relevant proposals for funding, as a reflection of our collaborative spirit and respect for each other's specific field expertise

The Lead Agency will:

- Serve as the primary contact with the Office on Violence against Women and the Vera Institute of Justice
- Maintain compliance with grant requirements
- Serve as the fiscal agent and administer sub-contracts
- Staff the collaboration with a Project Director and Project Coordinator
- Contract with Principal Investigator to lead the needs assessment and conduct ongoing project evaluations
- Convene collaboration meetings

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[4] Each partner has identified and has available one or more liaisons as primary contacts to assist with answering questions, guiding referrals, and supporting staff of Project Peer partners, self-advocates, and survivors with developmental disabilities and/or mental health issues. Liaisons (who comprise the Steering Committee) attend scheduled monthly cross-partner meetings, any required teleconferences and regular meetings of the work groups to which they are assigned. Each liaison has received a Liaison System Resource Notebook, which details the roles of the liaison and contains background information on the collaboration, resources, and contact lists. (See "Project Peer Liaison System" in the Liaison Notebook for further description of liaisons' responsibilities.)

[5] This cross disciplinary training is vital to sustaining collaborative relationships among staff across our organizations and enabling effective cross referrals between partners.

- Research supplementary funding sources
- Maintain collective focus on long-term sustainability
- Monitor compliance with the MOU.
- Convene quarterly meetings of the executive directors of the partner agencies to assess the collaboration and reaffirm ongoing commitment to our work
- Conduct individual orientations to Project Peer for new executive directors of collaborative partners

Self-advocacy Partner (Project ACTION!) will:

- Contribute knowledge of barriers in services systems
- Serve as change agents
- Serve as the project's eyes and ears on the "front lines"
- Collect resources to share with the self-advocacy community
- Serve as liaisons between provider and self-advocacy communities
- Publicize Project Peer activities among female members and enroll women in the Women's Knowledge Development Training.
- Continue to encourage women to take the separate Leadership Training to become peer mentors, co-trainers and/or co-facilitators for the Women's Knowledge Development Training
- Back an informal, cross-field women's support group

Our individual roles and responsibilities are to:

- Advocate for change within our organizations
- Use the Liaison System to problem-solve with and encourage cross-referrals among our partners
- Participate and be fully present in collaboration meetings, trainings and activities
- Share project information with leaders and change makers in our respective organizations
- Keep collaboration team members apprised of important information from our individual organizations, disciplines and movements that could influence our work together
- Advocate with and support our team members and survivors with disabilities
- Challenge ourselves to confront our own biases and positions of privilege
- Question ourselves and our assumptions
- Listen and acknowledge the expertise of survivors and people with disabilities
- Be sensitive to people with disabilities – speak *to* them, not *down to* them
- Make sure we take care of our physical, emotional, mental and spiritual health so that we can be fully present and set healthy boundaries (self-care)
- Be the change we want to see

IV. DECISION MAKING

A. Decision-making Process

Our collaboration strives to achieve unanimous decisions about issues that affect us as a group. Consensus and equal representation in decision making promote trust and commitment among

our members. Consensus-based decision making also takes each individual organization's needs into account and results in solutions that work for everyone. To achieve consensus in individual decisions, we will use a gradient scale, so individual members can express support or opposition on a continuum, as opposed to a simple yes or no process.

If we do not achieve immediate consensus, we will use the following gradient scale to assist in structuring our decision making. Individual members express support on a scale of one through five, with one meaning full support and five meaning a veto.

1: Yes. I fully support it.
2: Yes. I don't love it, but I can live with it.
3: I don't know. I need some more information.
4: No. But I'm willing to continue the discussion, and I'm open to the possibility of changing my vote.
5: No way. I do not support it, and I do not wish to move forward with further discussion.

When every member of our collaboration is a one or a two, we will move forward with a decision. We will continue the discussion, if any member is a three or a four. If anyone is a five, the group needs to engage in conflict resolution (see p. 10) to evaluate recommendations and alternatives that might lead to consensus. Once we achieve consensus, every member of the group agrees to reflect the group's decision in a positive light to our individual agencies and any external publics, as appropriate.

B. Decision-making Authority

For this project we will make decisions at three different levels: Steering Committee, the Executive Directors, and Full Group levels.

- *Project Director/Project Coordinator Authority*: The Project Director and Project Coordinator can make decisions independently about project logistics, when to reach out to our technical assistance provider or our Office on Violence against Women program officer for support, pace-setting for project implementation, and ways to hold the group accountable. The Project Coordinator works with the Principal Investigator to share findings from her evaluation activities with the collaboration.

- *Steering Committee Authority*: The project's Steering Committee includes at least one representative (Liaison) from each of the member organizations. This group can make decisions about the day-to-day work of the collaboration. The Steering Committee can also make decisions about the project's key priorities and issues, as well as offer recommendations about needed changes to agency policies and practices. Based on their knowledge of individual agency protocols, representatives to the Steering Committee also decide when to elevate decisions to the Executive Directors and/or the Full Group.

- *Executive Director Authority:* The Executive Directors approve decisions about changes to organizational policies and practices, changes with a fiscal impact and changes that impact public policy or agencies' public images. (For some organizations, these sorts of decision making also involve the full Board of Directors.) They also make decisions relating to crisis

media communication affecting Project Peer (see p. 13). Executive Directors select and support their liaisons through the Liaison System. Their involvement adds to the potential of real culture change. The Steering Committee often makes recommendations to the Executive Directors.

Our members agree to respect the boundaries among these three varieties of decision making.

C. Positive Conflict Resolution

Our members recognize that our organizations share common ground, but also bring differences of opinion, perspective, and priorities. These differences can teach us a great deal about each other and the work we do. They can also create barriers and challenges to effective communication and teamwork. We understand conflict is a natural part of relationship-building. We also recognize that our conflicts might impact people who do not participate in them directly, such as our respective organizations and the people we serve. Consequently, we seek positive solutions to our conflicts that are in the best interests of our organizations and the people we support. A positive conflict resolution process creates a context for the free exchange of opinions and ideas that are integral to our success. Our guidelines for positive conflict resolution include the following:

- We will trust each other enough to feel comfortable voicing disagreements;
- We will practice strong listening skills when we experience conflict and hear one another out before defending our own positions;
- We will pay attention to our body language and avoid eye rolling or other indirect forms of communication;
- We will separate problems from people and keep the focus on the issues that led to conflict, as opposed to personalities;
- We will allow time to hear each other out when we have disagreements; and
- We will seek solutions that promote self-governance and work for everyone.

If we are unable to resolve a conflict within the group, we will seek help, first, from the Vera Institute of Justice and, second, from the Department of Justice Office of Violence against Women. If support from these two sources does not lead us to a resolution, we will use local facilitators and/or mediation providers such as Mosaica or George Mason University.

V. INTERNAL & EXTERNAL COMMUNICATIONS

A. Internal Communications

<u>Ongoing Communication</u>

In all communications, our Collaboration encourages broad participation and welcomes alternative perspectives. We seek to minimize defensiveness in our interactions. We strive to listen carefully and respond respectfully to one another. Members of our Steering Committee (Liaisons) will continue to engage in direct and regular communication with one another through e-mail (using our closed Project Peer Yahoo group), phone, and face-to-face meetings (see "Project Peer Liaison System" in the Liaison Notebook). Steering Committee representatives

will continue routine updates to senior leadership in their organizations, as well as members of their Boards of Directors members, as appropriate. Liaisons will continue to update members of our organizations on our progress at staff, management, and Board of Directors meetings.

Meeting Guidelines

Our collaboration's Steering Committee will meet at least monthly for two hours each time. We will update each other between meetings with regular reports through our closed Yahoo group. We will rotate locations of our meetings among our member organizations. We will not hold meetings, however, at locations that are not metro accessible. We have committed to flexible scheduling of meeting times to accommodate the work schedules of our team members who are self-advocates and must use leave to attend our meetings. We will form smaller work groups to accomplish specific tasks; these groups will convene outside of our monthly meetings. These groups will report on their activities to the Steering Committee at meetings and using the closed Project Peer Yahoo group.

Within meetings, we continue to commit to the use of non-violent and People First language. We recognize that we will make mistakes and commit to having patience and learning from one another.

B. External Communication

Talking Points for the Second Award Period

We are engaged in our first continuation award. In response to inquiries about the project, we can speak from the following simple fact sheet (also available as a separate one-page document).

Who: "Project Peer" is a collaboration of anti-violence and disability support agencies/groups working together to share their strengths. It includes Anchor Mental Health Association, the DC Coalition Against Domestic Violence, the DC Rape Crisis Center, Lt. Joseph P. Kennedy Institute, Project ACTION!, Quality Trust for Individuals with Disabilities, and Ramona's Way. Late in 2013, the District Alliance for Safe Housing joined the collaborative.

What: Is an ongoing collaboration improving services for women with developmental disabilities and/or mental health issues who have experienced or been threatened with violence and/or abuse. It began with funding from the US Department of Justice/Office on Violence against Women (OVW).

When: Now and ongoing. Project Peer's initial OVW award expired on September 30, 2011. Our partners remained committed to continuing our collaboration and key initiatives (see below). On September 30, 2013, OVW announced a continuation award to Project Peer.

Where: Across the District of Columbia.

Why: Women with developmental disabilities and/or mental health issues are especially vulnerable to violence and abuse. For example, women with developmental disabilities are 6 times more likely to be abused and up to 10 times more likely to experience sexual assault than

women without these disabilities (Sobsey, 1994). Despite their increased risk, there were limited outreach and services in our community for these survivors. As a result of our project, agencies that respond to violence and trauma and agencies that support people with disabilities are coming together to understand and collaborate to support women with disabilities who experience violence and abuse better.

How: With OVW support, Project Peer partners listened and learned from each other and survivors with disabilities. We are changing our own systems and services to improve quality and expand access to services for survivors with disabilities. Initiatives have focused on:

- ✓ Confidentiality: Building a shared understanding of best practices in confidentiality across our disciplines and practice settings to enable survivors to maximize control over their "stories".
- ✓ Collaboration Growth and Sustainability: Improving information sharing and building lasting partnership across our partners by developing a charter, cross-referral and liaison systems and annual memoranda of understanding to sustain our collaboration into the future.
- ✓ Staff Knowledge Development: Developing and piloting training to improve staff understanding of the four disciplines within our collaboration (developmental disabilities, mental health issues, domestic violence, and sexual assault) and do the intersecting work necessary to enhance survivor-centered advocacy, access and accommodations.
- ✓ Women's Knowledge Development: Developing and piloting trainings to increase what women with disabilities know about sexual and domestic violence, personal safety and how to heal and to build the leadership skills it will take for them to offer this training to other women with disabilities in the future.
- ✓ Policies and Procedures: Improving how staff of our partner organizations identify, respond to, and accommodate survivors with mental health issues and/or developmental disabilities.

We believe any woman with developmental disabilities and/or mental health issues who has been hurt will be able to get help from any of our partners as a result of this project.

Web Communications

Near the end of our first award, the DC Coalition against Domestic Violence established one section of its website as Project Peer's central online information depository for communication with stakeholders, the media and the general public. We will continue to explore the potential for a project website to which partners will link, if they have that capacity.

Stakeholder Communications

Our collaboration will coordinate any communications with key external stakeholders through the Steering Committee. Our several audiences and our secondary stakeholders will have different communication needs from our partners. Secondary stakeholders include, for example, members of Quality Trust and any private funders with which our collaborative as a whole, or individual partners, are involved. Strategies for communicating with these stakeholders might include community outreach through presentations.

This collaborative is committed to ongoing communication with self-advocates in our community. We recognize that these communications strategies will need to rely less, or not at

all, on electronic media. We will conduct more face-to-face and phone communications with them because many people with disabilities do not have regular access to computers and/or do not prefer written communications in general.

Media Communications

Media Plan

Our external communications strategies are designed to promote uniform and positive messages about our collaboration's mission, activities, and members, understanding that we are still focused primarily on being a "closed" system. We have different protocols for crisis and routine media communications (see below).

Routine Media Communications

Quality Trust houses the primary spokesperson for routine media communications, Judith Karsevar, who is Project Peer's Project Coordinator for the period of our continuation award. For routine (non-crisis) media communications, she will serve as a resource to the media and/or communication departments within each of the Project Peer partners, to ensure continuity of message – *i.e.*, that Project Peer is speaking "with one voice."

Crisis Media Communications

The following crisis communications protocols exist for our collaboration. ***This process is guided by the principle that all of our partners understand the importance of controlling the message and will not respond to crisis inquiries in haste.*** We recognize the potential to turn hostile questions to our advantage.

We have authorized Project Coordinator Judith Karsevar to be Project Peer's Primary Spokesperson, (or, if she is unavailable, the Executive Director of Quality Trust) to speak with the media on behalf of our collaboration in a crisis in consultation with the Executive Directors of all Project Peer partners. **All other members of the collaboration are *not* authorized to speak to the media on behalf of the group in a crisis.**

If any of our partner agencies receives a media inquiry about our collaboration in a crisis situation, that agency's Executive Director or media/communication department will confirm the organization's involvement with the collaboration and refer the reporter to the Primary Spokesperson. S/he will also immediately alert the Primary Spokesperson about this contact by phone and via e-mail. In turn, the Primary Spokesperson will convene a conference call with the Executive Directors of the Project Peer partners to strategize on how to proceed. Individuals from our collaboration who are not authorized to represent us to the media will state clearly to reporters that they only have authority to answer questions specific to their individual organizations, as opposed to our collaboration.

In addressing a Project Peer crisis media communication, at no time will any member of our group confirm or engage in negative comments about another project partner – *i.e.*, Anchor, DASH, DCCADV, DCRCC, JPKI, Project ACTION!, Quality Trust and/or Ramona's Way.

When fielding crisis inquiries, all of our agencies will avoid the use of the phrase "no comment" and will instead immediately refer the reporter to the Primary Spokesperson. In a crisis, the spokesperson for the collaboration and the Executive Directors will focus on "the whole story;" that is, on educating the media about the broader issues of violence against women with disabilities.

Protocol:

1. If a person who is not the Primary Spokesperson receives a crisis call, s/he will first refer the call to the Primary Spokesperson's office phone (202-459-4006). S/he will then contact the Primary Spokesperson via e-mail (jkarsevar@dcqualitytrust.org) with the subject line: "CRISIS COMMUNICATION: PROJECT PEER."

2. If the Primary Spokesperson is not available, the person who received the inquiry about the crisis will contact the Executive Director of Quality Trust (Tina Campanella) at her office phone (202-448-1442) and her e-mail (tina818@aol.com) with the subject line: "CRISIS COMMUNICATION: PROJECT PEER."

3. If both spokespeople plan to be out of town or otherwise unavailable, the Primary Spokesperson will appoint a third person to serve as the collaboration's media spokesperson. It will be someone familiar with dealing with the media.

4. The spokesperson will return the reporter's call, request his/her deadline, and commit to calling the reporter back, while indicating the need to double check the facts of the story first.

5. Next, the spokesperson will immediately notify all Executive Directors of the crisis contact via e-mail. The Executive Directors, at their discretion, can notify the appropriate people within their own organizations, such as Communications Directors, about the contact.

6. In strategizing the collaboration's response to a crisis at hand, the spokesperson will convene a conference call with the Executive Directors to discuss the allegations, gather information as necessary, and decide on their key talking points for the return call. They will then arrange a teleconference for the return call to the reporter and determine any other additional actions to take.

7. Information about survivors is confidential. Spokespeople/agencies will neither confirm nor deny whether a specific survivor is receiving services from any of our partner agencies. We cannot share this information or connect survivors directly with the media under any circumstances in a crisis.

8. Spokespeople for the collaboration will use People First and non-violent language in communicating with the media. They will also avoid victim blaming in any stories that involve violence or abuse. Spokespeople will make positive statements about our project and each collaborating organization.

VII. CONFIDENTIALITY

Our collaboration believes survivors' rights to confidentiality are born of their rights to self-agency. We recognize any limitation of confidentiality concurrently limits self-agency. We believe survivors have the right to implement their own choices on their own terms. Our actions together will, therefore, maximize the survivor's right to confidentiality, to the fullest extent allowable under DC and federal law. In DC Adult Protective Services law, the following professions must report abuse against a vulnerable adult: conservators, guardians, court-appointed intellectual disability advocates, health-care administrators, licensed health professionals, police officers, bank managers, financial managers, humane officers enforcing animal cruelty laws, and social workers.

A. Information Shared in Meetings

If collaboration members share personal or sensitive agency information in our meetings, this information is not shared with anyone outside the group. Team members are not at liberty to repeat information shared in these meetings with anyone. We take notes during and/or record our meetings to prepare meeting summaries and document progress. These summaries will not contain personal or sensitive agency information shared during a meeting. Any meeting tapes are the property of the Principle Investigator; she is not a mandatory reporter.

B. Survivor Information

We agree to protect confidential survivor information gathered during our needs assessments to the fullest extent allowable under DC and federal law. We will be transparent about any limitations of confidentiality imposed through agency regulations or local or federal law. We will attempt to state the consequences of disclosures before any survivor shares personal information in the presence of a mandatory reporter. We agree to respect boundaries and any differences among our agency protocols for confidentiality. For example, some agencies within our group mandate that all employees report abuse and neglect, even if they are not mandated reporters under DC law. We agree to respect these protocols, even when they are grounded in organizational policies rather than local law.

C. Organizational Information

We understand the importance of honest and open sharing of organizational information for the best possible collaboration among us. We also understand that in the process of assessing our services, we learned/will learn about both the strengths and weaknesses of our organizations. We will limit the availability of information that demonstrates organizational challenges to members of the collaboration. We will not disseminate information outside of our group that is potentially sensitive or damaging to our reputations as service providers. Confidentiality with respect to our organizational challenges will promote both trust and change.

D. Mandatory Reporting

There are members of our group who are mandatory reporters under DC law, *e.g.* social workers and counselors. These members are open about their obligations under the law and the potential

consequences of disclosure. Should we want to guarantee confidentiality in any of our activities, we will not include our mandatory reporters directly in those activities. Furthermore, some individual agencies in our collaboration have more stringent mandatory reporting expectations for staff members than what local law requires.

E. Project Peer's Confidentiality Principles[6]

Our partners have revised their policies and procedures consistent with the following principles:

Our partnership:

- We use our project's core values (see above, pages 3-4) and these confidentiality principles to explain to our staffs the importance of respecting survivors' privacy and limiting the information we share about the people we support. We are their allies.

Practices that do not re-traumatize survivors:

- We understand and use person-centered decision making: We encourage survivors to make, act on and take responsibility for their own decisions.
- We provide survivor-centered supports: We make every effort to support survivors in the most responsive and sensitive ways.
- We choose the least invasive and least restrictive responses to survivors, even though some of us must report "unusual incidents". When we must report, we only report to those who really need to know.

Respect and dignity:

- We meet survivors where they are in their healing process. We honor survivors' ownership of their own stories. We respect and do not try to influence or judge survivors' decisions about sharing their stories when and with whom they choose.

Upholding privacy and confidentiality:

- We understand and acknowledge survivors' concerns about their privacy and the confidentiality of information about them and the services they are seeking or using.
- We do all we can to maintain confidentiality. We are aware of and guard against recording too much confidential information ("over documentation") and oversharing information.

Accountability:

- We are responsible to survivors to assure that we respect their confidentiality as much as possible. At the beginning of the service relationship, we explain any limitations to confidentiality, including mandatory reporting, in sensitive, clear and understandable language.
- Some of us must share files/other information among staff or across providers. We explain this information sharing to the survivors we support. We honor their rights to time-limited consent forms that describe in detail the specific information we are able to

[6] Each of our original partners has approved and adopted these Principles, one of the products of our first OVW award. During DASH's implementation phase, it will consider these provisions and adopt them outright or suggest possible changes for the other members to consider.

share with specific service providers. We let them know whenever we do have to share information about them under this consent.
- Staff who must report offer survivors the choice of speaking with someone who is not a mandatory reporter. This might include making a referral to a partner organization.

Self-agency:
- Our staffs understand the limited scope of authority of most guardians and family members over the lives of survivors aged 18 and over. They are prepared to question a guardian's/family member's authority and insist on seeing court or other documentation before they permit guardians/family members to speak on behalf of or limit survivors' access to services and supports.
- We offer services and resources that create the greatest opportunities for survivors to feel empowered to take control of confidentiality issues in their own lives.

Access and accommodations:
- We provide our services in environments that survivors find safe and welcoming. Survivors have described these as the product of trust. We respect the sensitive nature of any information survivors share with us. We have private conversations in private spaces, whenever possible.
- When using an interpreter, we use professional interpreting services rather than using family members, caregivers or guardians, to ensure survivors' safety and control over their stories.

VIII. GLOSSARY OF KEY TERMS

Our collaboration adapted this glossary from the Accessing Safety Initiative's website at www.accessingsafety.org. We reviewed this glossary of terms one-by-one to determine which were most relevant to our collaboration and excluded those we thought were less important. We adapted some of the terms to represent our collaboration's identity and values; we also included some of the terms without modification. Finally, our collaboration added several terms that the original glossary did not include.

Abuser: Someone who uses tactics and behaviors of domestic or sexual violence to control another person. In domestic violence, also referred to as a batterer or a perpetrator.

Accessible: The absence of physical, environmental, and attitudinal barriers, so that the widest possible participation is encouraged.

Accommodations: Generally understood as modifications or adjustments to a program, work environment, or job description that make it easier for a person with a disability to participate in the same manner as other people, Project Peer focuses beyond physical access to other person-centered adaptations that might be crucial to the meaningful participation of a survivor or a person with disabilities. These include, but are not limited to, reading documents with survivors; becoming familiar with and using different methods of communication, such as making available interpreters unrelated to the person; honoring survivors' preferences about staff gender; altering the length and time of appointments, intake, or counseling sessions; and allowing staff from our partners to accompany survivors who want their support during intake and initial counseling

sessions. Hotlines can accommodate survivors by having staff slow down the conversation, use plain and understandable terms, check with the survivor to be sure the information being provided is understood, and set up appointments to speak face-to-face. (See also Universal Design.)

Accountability*: The quality or state of being responsible; willing to accept responsibility of one's obligations.

Adaptive equipment*: A device or devices that someone with a disability or functional limitation will use to adapt the environment in which s/he lives or works in an effort to overcome the barriers it poses. Adaptive equipment could be a wheelchair, cane, electronic equipment, or other assistive devices.

Addiction: A disease with genetic, psycho-social, and environmental factors influencing its development and manifestations. This disease is progressive and can be fatal. It is characterized by continuous or periodic impaired control over the use of alcohol or other drugs, preoccupation with drugs or alcohol, use of drugs or alcohol despite adverse consequences, and distortions in thinking, most notably denial. Addiction is a treatable disease and long-term recovery is possible.

Assault: An action, threat or attempt to harm another person. It can be physical, verbal, or sexual in nature.

Barrier*: Something that blocks, prevents or hinders participation, action, movement, or passage.

Caregiver: A person who provides direct supports to another, either formally, such as a paid Personal Assistant, or informally, such as an unpaid family member or friend. The term is often used to denote a person who assists people who are very young or elderly, or people with disabilities. Many people with disabilities prefer the term Direct Support Staff to caregiver; they require support and assistance from their staff, and caring from their natural support networks.

Charter: A document that reminds group members about the commitments, plans, and goals they have agreed to for their work on this project, as well as how they will work together.

Civil Protective Order (CPO): This District-specific term refers to a court order that directs the abuser ("respondent") to stop being abusive. It can require the abuser to stay away from and/or have no contact with the survivor ("petitioner"), specify terms of custody, require the abuser to leave and stay away from the household and/or give up firearms or other property, including pets. CPOs are in effect for one year. A judge can extend or modify a CPO at the request of the survivor.

Collaboration: A well-defined team or group that is working together to achieve the same goals. The members share their workloads and resources. Their relationships include mutual authority and accountability for success.

Confidentiality: An ethical or professional duty not to share information with another. We create and use confidentiality principles, policies and procedures as a best practice to help decrease outside access to information about the people we support

Consensus*: General agreement among the members of a group or community, each party of which has a responsibility for decision making and follow-up action.

C**ultural competency*:** The ability of certain people of one culture (often a dominant one) to acknowledge, consider, respect and include the needs and interests of other cultures.

Culture*: The values, traditions, norms, customs, arts, history, folklore, and institutions that a group of people, who are unified by race, ethnicity, language, nationality, sexual identity or orientation, or religion, share; the way of life shared by the members of a group.

Cyberstalking: The use of technology or electronic means, such as the internet or e-mail, to stalk or harass a person. Stalking may include monitoring, gathering information, identity theft, or damage to or tracking of equipment. Harassing may include false accusation, threats, or threatening behavior or unwanted advances. Cyberstalkers often target victims by sending threatening or obscene e-mails or text messages, hiding cameras, spamming, tracking computers and internet activity, or tracking movement through GPS in cell phones.

deaf*: Individuals with severe to profound hearing loss. The lowercase "d" reflects a physical, medicalized or audiological perspective.

Deaf*: Individuals who identify with and participate in the language, culture and community of Deaf people, based on sign language. The capital "D" reflects this socio-cultural point of view.

Deinstitutionalization: The process of moving people, especially those with mental health issues and/or developmental disabilities, from large, hospital-like, congregate-care living situations ("institutions") into small-scale or family-centered environments which do not segregate people from neighborhoods or the community and then permanently closing the institutional setting. In DC, people with developmental disabilities transitioned out of Forest Haven from 1978 through 1991, when the institution was formally closed. People with mental health issues continue to transition into the community from St. Elizabeths[7] Hospital.

Developmental disability: We have struggled with recent changes in the terminology professionals in our fields use for this disability group and have chosen to follow the lead of the self-advocates involved in our project who have asked that we not use the term intellectual disability because of the negative traits they associate with its accepted definitions. A severe, chronic disability, which: (1) is attributable to a mental or physical impairment or a combination of mental and physical impairments; (2) is manifested before age 22; (3) is expected to continue indefinitely; and (4) results in substantial functional limitations in any three of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Examples of developmental disabilities can include: autism, behavior disorders, brain injury, cerebral palsy,

[7] The institution spells its name without an apostrophe.

Down syndrome, fetal alcohol syndrome, cognitive disabilities, and spina bifida. People with developmental disabilities benefit from comprehensive long-term supports and are able to continue developing as active, productive, and independent participants in their communities.[8]

Disability: The limitation or loss of opportunities to take part in community life because of physical and social barriers. Attitudes, beliefs, and environments disable people.

Disclosure*: The act of sharing personal information which might, under other circumstances, be kept secret.

Discrimination: Treatment based on a person's membership in a group, class, or category rather than their individual qualities or merit. It usually involves excluding or restricting members of one group from opportunities available to another group.

Domestic violence: (1) A pattern of coercive behaviors used by a batterer to gain or maintain power and control over another person with whom the batterer is in an intimate, dating, family, or caregiver relationship[9]; (2) When someone repeatedly hurts you or tries to control you; that person is either someone in your family, a boyfriend or girlfriend, a formal support person or an informal caregiver. They might hurt you by yelling at you, hitting you or putting you down. They might also hurt you by keeping you away from your family or making you do things sexually that you don't want to do. They try to control your behavior in a way that makes you feel unequal and unsafe.[10]

Ethics*: A sense of, or system of, morals and values.

Flashback*: The vivid reoccurrence in the mind of a past, usually traumatic, incident.

Harm Reduction Model: A set of practical strategies that reduces negative consequences of drug use, incorporating a spectrum of strategies from safer use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing the conditions of use along with the use itself. This model calls for a non-judgmental, non-coercive provision of services.

Institutionalization: The act of placing someone in a congregate setting, usually as the result of formal commitment proceedings, where s/he lives, eats, works, in return for the expectation of receiving medical and other services, such as training, rehabilitation, etc. In DC, many children and adults with disabilities were institutionalized against their will at Forest Haven, and many children and adults with mental health issues were institutionalized against their will at St. Elizabeths Hospital.

Interpreter: A person who forms a connecting link between the users of different languages. When using an interpreter, we use professional interpreting services rather than using family members, caregivers or guardians, to ensure survivors' safety and control over their stories.

[8] From Project Peer's Staff Knowledge Development Curriculum.
[9] From Project Peer's Staff Knowledge Development Curriculum.
[10] From Project Peer's Women's Knowledge Development Curriculum.

Intrafamily Offense: The legal term in the District of Columbia for an act of domestic violence. See D.C. Code §§ 16-1001 *et seq.*

Justice: A survivor's ability to sleep at night. This can occur, for example, when an abuser is held accountable by the law for the crime(s) he/she committed, and the survivor feels there has been just action.

Mandatory reporting: Laws that require members of certain professional groups to report certain instances of abuse and/or neglect to law enforcement, social services and/or other regulatory agencies. In DC Adult Protective Services law, the following professions must report abuse against a vulnerable adult: conservators, court-appointed intellectual disability advocates, guardians, health-care administrators, licensed health professionals, police officers, bank managers, financial managers, humane officers enforcing animal cruelty laws, and social workers. Some human services agencies have more stringent expectations and policies regarding mandatory reporting for their staff than local laws require.

Mental Health Issue: We are struggling with recent changes in the terminology professionals in our fields use for this disability group and have chosen to follow the lead of the self-advocates involved in our project who have asked that we not use behavioral health because of the negative traits associated with its accepted definitions. Mental health issues are a disruption in a person's thinking, feeling, mood and socialization. Mental health, mental hygiene, behavioral health, mental illness, and mental wellness are all terms used to describe the state or absence of mental health issues. Some examples of mental health issues include: Anxiety, Bipolar Disorder, Dissociative Disorders, Dual Diagnosis (MHI and Substance Abuse), Eating Disorders, Major Depression, Obsessive-Compulsive Disorder (OCD), Panic Disorder, Post-Traumatic Stress Disorder (PTSD), Risk of Self-Harm, Schizophrenia and Seasonal Affective Disorder. Some psychiatrists find the cause of mental health issues in organic/neurochemical causes that can be treated with psychiatric medication, psychotherapy, lifestyle adjustments and other supportive measures, but it is important to note that we really don't know what causes mental health issues. The battle between "nature" and "nurture" has gone on for years; we still don't know enough about the nature of mental health issues to understand what people might inherit (a result of specific genes) and what might be the result of a person's unique environment, including trauma experiences. Advocacy organizations have been trying to change the common perception of mental health issues, which are frequently seen as signs of personal weakness and something to be ashamed of. Instead they compare them to physical diseases, like the measles.[11]

Non-Violent Language: The deliberate omission of words and phrases that reference violence in communication. For example, the avoidance of common phrases such as "take a stab at" or "target" population.

People-First Language: The use of respectful language in reference to people with disabilities, as mandated by the District of Columbia's *People First Respectful Language Modernization Act of 2006*. This law requires the following: (1) Avoidance of any use of the following terms: "afflicted," "cripple," "crippled," "defective," "feebleminded," "handicapped," "handicap," "idiot," "lunatic," "imbecile," "insane," "invalid," "maimed," "moron," "suffering," "wheelchair

[11] From Project Peer's Staff Knowledge Development Curriculum.

user," or "wheelchair bound"; (2) Use of "person," "people," "individual," "individuals," "adult," "adults," "child," "children," or "youth" in sentence construction so that the language refers to individuals: (A) With disabilities or with conditions that result in disability; (B) Who have disabilities or who have conditions that result in disability; or (C) Who use or who need assistive technology.

Perpetrator: A person who executes criminal behavior. Our collaborative uses this term to refer to people who commit domestic violence, sexual violence, and/or rape. (See also "Abuser".)

Person-centered decision making: Listening to what survivors say, and respecting and supporting them to take responsibility for their choices. Helping them take and keep control over their stories and their lives.

Post-traumatic Stress Disorder (PTSD): A complex, long-term response that can develop as the result of experiencing or witnessing a traumatic event that causes a person to feel an intense fear, horror or sense of helplessness and/or relive the situation in the mind in response to specific stressors. Anyone can develop PTSD – men, women, children, young and old alike – and it can cause them severe problems at home, work or school and/or in their interpersonal relations.

Privacy has two definitions. It means being alone, away from other people. It also describes a right to protection from public attention, *e.g.*, to have a one-on-one conversation in a space where others cannot overhear.

Rape Trauma Syndrome (RTS)*: A complex, long-term emotional response to the extreme stress experienced by the survivor of sexual violence. RTS is a response to the profound fear of death that almost all survivors experience during an assault. RTS is a sub-set of Post-traumatic Stress Disorder (see above).

Safety: Freedom from the risk or threat of physical and/or emotional harm. It is the stillness or desired feeling that a survivor experiences in her mind when she feels safe from physical and emotional abuse.

Safety Plan: (Adapted in part from the Kansas City collaborative's *Guide to Safety Planning*.) A written or verbal plan that helps a victim or survivor of domestic violence think ahead about what to do when facing danger. The plan consists of action steps a person can take to keep her/himself and/or her/his children safe, when violence takes place or to stop violence from happening. With informed consent, a survivor might want to include a family member, friend or agency staff in the planning process.

Safety plans can be used for a variety of situations. For example, when someone lives, works or is in contact with a person who is abusive; when a survivor feels afraid for his or her safety; for staying safe after ending an abusive relationship or when someone is being harassed or stalked.

It is important to recognize that a victim or survivor is not able to stop the abuse nor is s/he responsible for the abuser's behavior. Safety planning is an option to help survivors cope with stressful and scary situations by drawing on resources they have identified in a time of crisis.

Self-agency: The ability to make, act on, and take responsibility for one's own decisions.

Self-care: (Adapted from our Staff Knowledge Development curriculum.) Hearing survivors' stories can take an emotional toll on our well-being. Self-care is how we make sure we take care of our physical, emotional, mental and spiritual health so that we can be fully present and set healthy boundaries.

On the journey to wellness, it is important each one of us develops our own "buffet" of self-care practices that works well for us. It is an individual menu. Self-care – specifically focusing on taking care of ourselves – includes a daily routine of resting enough, eating well and exercising. It's also important to take good care of our emotional, spiritual and mental health, e.g., finding ways to connect to ourselves, such as daily meditation, prayer or contemplation are good forms of spiritual care. Connected to people who share our journey and are caring friends are good forms of emotional health.

Project Peer partners and the project's committees, subcommittees and work groups make every effort to integrate self-care into our culture to ensure that all staff and other group members have access to someone they feel safe with to debrief and process difficult feelings that arise from our work. We recognize and acknowledge the necessity of being fully heard and supported as essential to true collaboration and allow space for this at every level of our project.

Self-Esteem: The knowledge that one is important to oneself and others, that s/he matters and has value. The identification, understanding, and validation of self.

Sexual harassment: A form of sex discrimination. According to the Equal Employment Opportunity Commission, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when submission to or rejection of this conduct explicitly or implicitly affects an individual's job, unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment. Sexual harassment is not limited to the workplace and can also happen in public spaces, domestic situations, and recreational spaces. (See also "Cyberstalking" and "Stalking".)

Sexual violence: (1) Any unwanted sexual activity forced on one person by another[12]; (2) Sexual activity when one person is not in control due to drugs or alcohol; (3) Being forced in anyway (manipulation, coercion, blackmail) to go further sexually than one person wanted to; and/or (4) being made uncomfortable or being hurt as a child by any type of sexual contact.[13]

Shock*: The impact or effect of a violent or jarring experience. A state of being depressed, disturbed, or scared.

Socio-economic status: Of, relating to, or involving a combination of social and economic factors, such as income, education, and occupation.

[12] From Project Peer's Women's Knowledge Development Curriculum.
[13] From Project Peer's Staff Knowledge Development Curriculum.

Stalking: When one person follows, contacts, or harasses another person, or contacts the other person's friends and family members many times after being told to stop. Examples include repeated or unwanted phone calls; following a victim; sending unwanted gifts; destroying or vandalizing property; or tracking another person over the Internet, on cell phones or pagers. (See also "Cyberstalking".)

Substance Abuse: A destructive pattern of use of drugs and/or alcohol, which leads to significant social, occupational, and medical impairment or distress. When a person begins to exhibit symptoms of tolerance and withdrawal, it is likely that the person has progressed from abuse to dependence, or addiction. (See also "Addiction".)

Survivor: A person who has continued to live, prosper or remain functional after a traumatic event; considered an empowering term preferred by the violence against women movement for people who experienced or are experiencing domestic violence, sexual violence, and/or stalking.

Sustainable*: Lasting; a program is sustainable when it can continue over the long term.

System*: A group of organizations that works together to provide services.

Systems change*: A system is a group of organizations that works together to provide services. When the system isn't working, people change it to become better for others. This is systems change.

Trafficking: Victims of human trafficking can include (a) children involved in the sex trade, (b) adults age 18 or over who are coerced or deceived into commercial sex acts, and (c) anyone forced into different forms of "labor or services," such as domestic workers held in a home or farm workers forced to labor against their will. What each of these situations has in common is elements of force, fraud or coercion used to control people. That control is then tied to encouraging someone into commercial sex acts, labor or services.

Trauma: Reacting to an event that is upsetting or causes injury or stress to a person's physical or psychological well-being. There are different kinds of trauma – from trauma that a person gets over quickly, to traumas that are harder to deal with, to traumas that are so horrific that their effects can last a long time and can overwhelm a person's life. Examples of lasting traumatic events include sexual violence, domestic violence, child abuse, stalking, and fighting in a war.

Trauma-informed Supports: This is the hallmark of effective programs to promote healing and safety through support from peers, survivors and providers. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities of or triggers of trauma for survivors that traditional service-delivery approaches might exacerbate, so that they can be more supportive and avoid re-traumatization.

Trauma-informed supports address the consequences of trauma and facilitate healing by recognizing the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding her/his own recovery

- The interrelationship between trauma and symptoms of trauma (e.g., eating disorders, depression, anxiety, substance abuse, "behaviors," etc.)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services or anti-violence agencies.

Traumatic Brain Injury (as it relates to DV): A type of damage to the brain that can result when the head (a) hits a stationary object (e.g., slams into a wall or table); (b) is hit (e.g., with a blunt object, like a baseball bat or lamp); (c) is penetrated (e.g., by a gunshot or knife) or (d) is violently shaken (e.g., severe whiplash, shaken baby syndrome).

Temporary Protection Order (TPO)**:** This District-specific term refers to a court order that is very similar to a Civil Protective Order (CPO; see above) except that it is in effect for a period of two weeks and leads to a CPO Hearing. *It is protection in the interim.* A judge can extend it. To get a TPO, the survivor ("petitioner") must show that s/he fears immediate danger from the abuser. A TPO directs the abuser ("respondent") to stop being abusive. It can require the abuser to stay away from and/or have no contact with the survivor, specify terms of custody, require the abuser to leave and stay away from the household and/or give up firearms or other property, including pets.

Universal Design*: A framework for the design of places, things, information, communication and policy that opens them to use by the widest range of people, operating in the widest range of situations without special or separate accommodations. Most simply, Universal Design is human-centered design of everything with everyone in mind. (See also Accommodations.)

Victim/survivor: Words that recognize two perspectives on the experiences of people who have experienced domestic violence, sexual violence, stalking, and trafficking. While some agencies might refer to someone as a victim, others prefer to use a word that feels more empowering to them – "survivor".

Wellness: The quality of being healthy in both mind and body through deliberate effort.