# Building Trauma-Informed Practices for Anti-Trafficking Housing Programs

Freedom Network USA

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**The purpose of this document is to provide a framework that anti-human trafficking providers offering housing services can utilize to build trauma informed, person centered and voluntary housing program for trafficking survivors.***

Throughout the document we will review the fundamentals of multiple philosophies to build foundational understanding as well as ways to implement these philosophies into programmatic operations and service provision. It is important that providers view housing services and housing needs on a spectrum and that each community evaluates the needs of human trafficking survivors, the housing options available in the community, and the types of victim service providers offering housing services. Providers and community members must take an active role in evaluating the current housing services available to human trafficking survivors and where there are gaps in services.

The information and references within the toolkit are focused on housing services and is intended for anti-human trafficking housing providers. We also acknowledge and encourage others to view this toolkit and utilize these practices and philosophies to inform other services serving survivors of trauma. Many of the theories and recommendations are applicable in non-housing programs and for non-survivors as well.

*We understand that service providers use various terms to refer to survivors of human trafficking, such as victim, survivor, or client. Freedom Network USA uses the word *survivor* as a term of empowerment.


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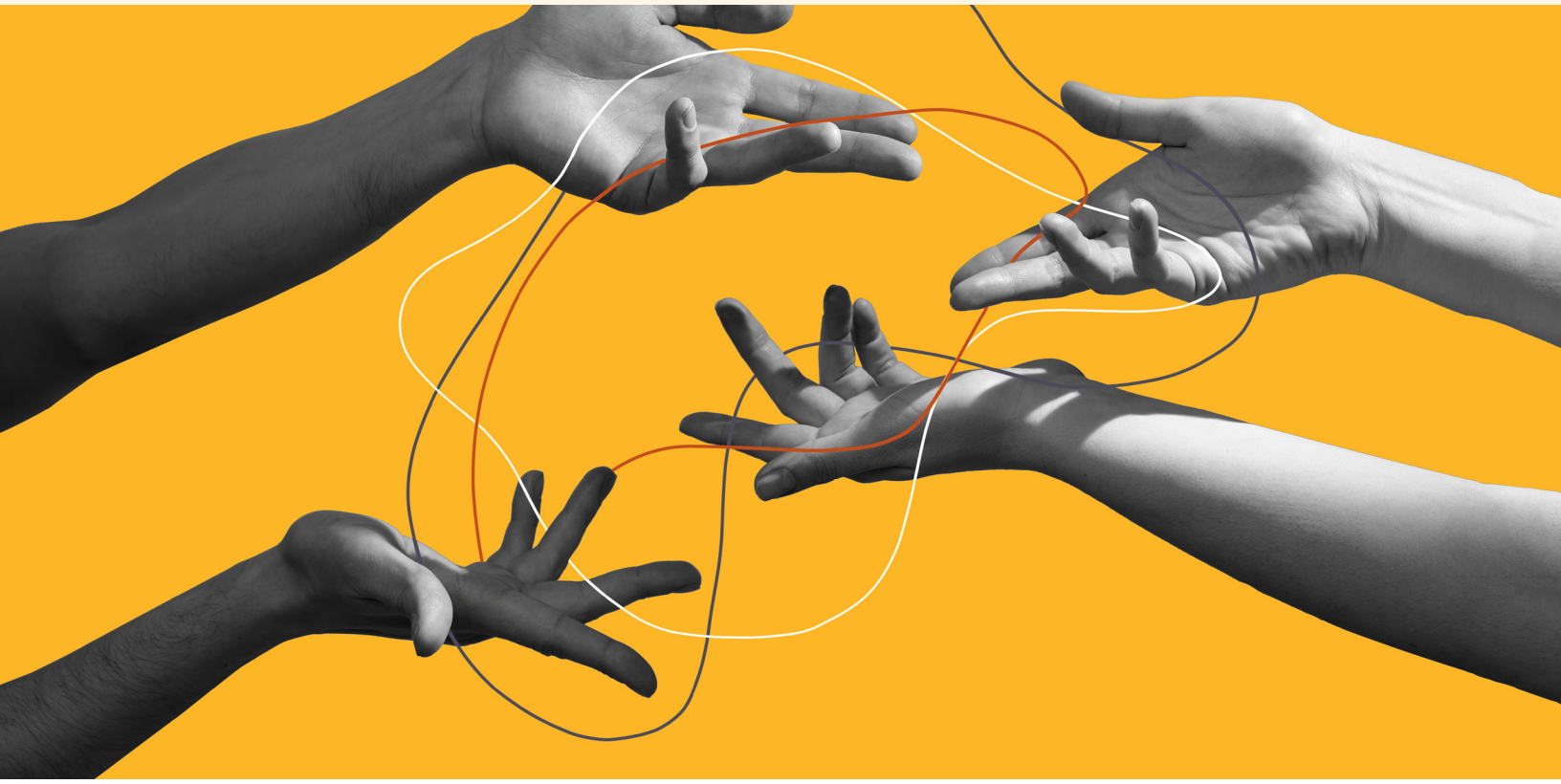
# Trauma-Informed, Voluntary, and Survivor-Centered Foundation



**Trauma-informed care empowers providers to:**

- realize the widespread impact of trauma;
- recognize the way in which trauma can appear in individuals, families, staff and others involved with systems;
- respond by integrating knowledge of trauma into policies, procedures, and practices; and,
- actively resist re-traumatization.

Recognizing and considering the above items is a way to build survivor trust, as well as understand where a survivor may be coming from. It is in the best interest of a provider to avoid actions that may mimic a survivor's perpetrator, and instead rely on survivor voice and choice to help advocate for appropriate accommodations.

Organizations that support survivors through case management, advocacy, and housing have the responsibility and opportunity to ensure that their practices are grounded in a trauma-centered approach, including voluntary engagement in supportive services. This toolkit will equip readers with an understanding of concepts of trauma-informed care as well as practical applications. Although each organization or program may have a different starting point, we hope this toolkit will provide creative ideas, actionable steps, and research-based guidelines as your organization is creating, evaluating, or revising program policies and procedures.

Before delving into the "what" and "how" of trauma-informed housing practices, it is important to recognize the "why" of this model. As mentioned above, organizations and practitioners that utilize a trauma-informed lens actively resist re-traumatization. When trauma triggers are minimized, the foundation of trust and assurance between residents and staff increases. Additionally, services are more efficient and effective when safety and collaboration are prioritized, which creates an environment conducive to the stability and healing survivors seek and deserve.

A trauma-informed approach ensures that the survivor is at the center of service provision, prioritizing their rights, needs, and wishes. This is done with clear recognition of an individual's right to self-determination and a humble attitude acknowledging and validating a survivor's history, culture, language, experiences, and preferences. The role of a service provider is to apply the appropriate mindsets, knowledge and skills to create an environment in which survivors can make informed decisions.

This can be difficult because housing programs don't exist in a vacuum. There are a number of complex systems (such as child welfare, juvenile justice, housing, etc.) and types of housing options and environments (program owned, independent living, institutional living) that require us to be navigators and advocates. This toolkit acknowledges the frustrations and challenges that come from interacting with systems that have not historically utilized trauma-informed practices.This toolkit is intended to support service professionals in identifying practical applications of trauma-informed and survivor-centered practices to increase the access survivors have to appropriate, accessible and quality services.

While it is common for organizations to expect that survivors engage in supportive services and/or programs, services that are identified and chosen by the survivor enable them to exhibit agency and are more likely to be successful and helpful long-term. Many survivors report that policies that mandate services, or otherwise make choices for them, mirror the experience of power and control exerted by their trafficker. It is important to critically assess the guidelines, expectations, or contracts of all programs and remove unnecessary guidelines or rules. Programs that proactively and intentionally provide choice in as many situations as possible return agency to survivors, which supports their physical and emotional healing.

# Trauma-Informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (https://bit.ly/3vVFfuh), defines individual trauma as a result from an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful or life threatening and that has lasting, adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma can be caused by many things including, but not limited to:

- Physical, sexual, or emotional abuse or neglect; including the threat of harm;
- Grief, loss, or abandonment of a loved one;
- Natural or manmade disasters;
- Interpersonal, generational, or domestic violence; or
- Being subject to coercive control.

Common impacts of trauma can include a decreased sense of safety coupled with increased/intense fear, psychological changes in a person's belief in themselves or the world around them, diminished ability to trust, hindrances in the ability to make decisions, and inhibited ability to organize and mobilize oneself to accomplish goals.

For example, survivors may present as lacking time management skills by missing or canceling appointments, or appear non-compliant with program expectations. A trauma-informed foundation helps to explore the cause of these challenges and to understand the underlying trauma that is impacting the actions, behaviors, and decision-making of a survivor. Trauma-informed care requires policies and procedures that anticipate survivors have experienced trauma and are designed to accommodate trauma responses.

Being trauma-informed asks providers to reconsider the way they do their work — including the language they use, the way they talk and write about survivors, and even the physical environment they create–. For a list of trauma-informed resources, please see: https://bit.ly/3Ffa7dx

# Trauma-Informed Care: Key Principles and Areas of Implementation

There are six key principles and ten areas of implementation suggested by the CDC and SAMHSA (https://bit.ly/3kBkUVO):

**Six Key Principles:**

1. **Safety** — the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.
2. **Trustworthiness and Transparency** — Operations and decisions are conducted with transparency with the goal of building and maintaining trust with survivors, among staff, and others involved in the organization.
3. **Peer Support** — Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and promoting recovery and healing.
4. **Collaboration and Mutuality** — Healing happens in relationships and in the meaningful sharing of power and decision-making. This is demonstrated in the partnering and leveling of power differences between staff and survivors and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators. Everyone has a role to play in a trauma-informed approach.
5. **Empowerment, Voice and Choice** — The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations and services are organized to foster empowerment for staff and survivors alike.
6. **Cultural, Historical, and Gender Issues** — The organization actively moves past cultural stereotypes and biases; offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols and processes that are responsive to the racial, ethnic, and cultural needs of survivors served; and recognizes and addresses historical trauma.

To learn more about taking a trauma-informed approach, please visit: https://bit.ly/3LGyJOJ.

# Housing First Is Trauma-Informed Care

A Housing First approach is widely embraced as best practice due to its effectiveness in ending chronic homelessness. Prioritizing housing for survivors quickly and safely is consistent with trauma-informed care. Speedy access to stable, permanent housing is the best platform from which survivors can pursue individual goals. People require basic necessities like food and shelter before they're able to focus on more complex goals, like getting a job, handling a budget, or furthering education.

Housing First doesn't mean housing only. Housing First programs provide participants with the support needed to maintain housing and avoid returning to homelessness. Although this model requires planning, coordination, and partnerships, successful outcomes related to housing retention, stability and overall recovery are well documented. Given the wide spectrum of needs expressed by survivors, incorporating key principles of the Housing First model is highly recommended.

Housing First principles:

- Homelessness is first and foremost a housing problem and should be treated as such.
- Housing is a right to which all are entitled.
- People who are homeless, or on the verge of homelessness, should be returned to or stabilized in permanent housing as quickly as possible and connected to resources necessary to sustain that housing.
- Issues that may have contributed to a household's homelessness can best be addressed once they are housed.

These principles upend traditional housing eligibility requirements. They also challenge formally accepted, case management approaches, shelter rules, and how providers build working relationships with survivors. Let's look at how these principles could integrate into a trauma-informed and survivor-centered approach.

## Housing First Checklist For Anti-Trafficking Programs

The following checklist can help assess the extent that your program implements a Housing First approach.

- ☐ Access to programs is not contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, participation in services, saving money, or other similar conditions.
- ☐ Programs do not reject an individual or family on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions, or behaviors that are interpreted as indicating a lack of "housing readiness."
- ☐ People with disabilities are provided reasonable accommodations within application and screening processes and during their stay in the shelter or housing program, and units include physical features that accommodate disabilities. If utilizing federal funds, all housing must be ADA-compliant.
- ☐ Programs work with local partners to ensure that all survivors have access to quality housing and services by using an established referral process when the program is unable to meet all the identified needs of the survivor.
- ☐ Survivors should have access to culturally-appropriate and language accessible services. If utilizing federal funds, programs are obligated under federal civil rights laws to provide meaningful access to their programs and activities for persons with limited English proficiency.
- ☐ Housing and service goals and plans are survivor-driven.
- ☐ Supportive services emphasize building community and problem-solving over therapeutic goals.
- ☐ Participation in services or compliance with service plans are not conditions of receiving housing, but are reviewed with survivors and regularly offered as a resource.
- ☐ Services are informed by a harm-reduction philosophy that recognizes that drug and alcohol use and addiction may be part of some survivors' lives. Survivors may have exchanged sex for material goods or money. In other situations, the trafficker may have actively used substances as a form of control. In a harm-reduction model, survivors are addressed through non-judgmental communication regarding drug and alcohol use or other behaviors that a service provider may consider unsafe. In response, they are offered education regarding how to minimize risky behaviors and engage in safer practices, rather than being threatened with termination of services.
- ☐ Substance use in and of itself is not considered a reason for being exited from the program.
- ☐ Every effort is made to provide the survivor the opportunity to transfer from one housing situation, program, or project to another if tenancy is in jeopardy. Eviction into homelessness is actively avoided.

*Adapted from the United States Interagency Council on Homelessness: https://bit.ly/3Mmqqrz

# Building Procedures

Developing or revising an organization's policies and procedures can be challenging and often requires a commitment of time and a multi-tiered strategy. Start with a review of the organization. The goal here is to identify areas that can be prioritized and set up into achievable goals. To help with this, below is a list of key areas to evaluate. An organization may not have an answer for each item on this checklist.

| BARRIERS TO ACCESSING HOUSING | AREAS TO ADDRESS |
|---|---|
| Access: What pre-conditions does your program have, such as sobriety, minimum income requirements, lack of a criminal record, completion of treatment, etc. | |
| Screening in versus screening out: Programs do everything possible not to reject an individual or family on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions, or behaviors that are interpreted as indicating a lack of "housing readiness." | |
| Accommodations: People with disabilities, or individuals identifying language access or cultural needs, are offered clear opportunities to request reasonable accommodations within applications and screening processes and during tenancy. Housing units include special physical features that accommodate disabilities and cultural needs. | |
| **Voluntary Services** | |
| Are services voluntary? Are there expectations placed on the survivor in order to access services or maintain housing? | |
| Does the program provide a list of services offered to survivors and allow them to choose which they would like to engage with? | |
| Does the program mandate services such as drug treatment, therapy, case management, and/or religious activities? | |

| BARRIERS TO ACCESSING HOUSING | AREAS TO ADDRESS |
|---|---|
| **Trauma-Informed** | |
| Are staff focused on building relationships with survivors or on enforcing rules/good behavior? Are survivor leaders employed here? Survivor and staff interactions that emphasize engagement and problem-solving are more effective and empowering than those that seek to monitor behavior and enforce punitive measures. Relationships should include case managers setting balanced boundaries and reasonable expectations with survivors. The organization should also support staff in navigating boundaries and practicing self-care. | |
| Is feedback regularly obtained from survivors participating in your services? | |
| Does the program take away cell phones, implement strict curfews, drug screenings, and chores, which create an environment of power and control? | |
| What conflict-resolution policies are in place? Are multiple options available based on the abilities of the survivor? Are the policies reflected across the organization? | |

Now that you have identified your strengths and areas for development, here are some details on how to address each domain.

# Eligibility & Screening

Depending on the structure of your organization, the population of survivors being served by your housing program may be very broad (i.e. anyone experiencing homelessness) or very specific (i.e. domestic, female-identified, survivors of sex trafficking between the ages of 18-25). Lowering the threshold for entry into a housing program for these two examples will look very different. Additionally, no organization operates in a void — the community that you serve matters. Take time to consider the needs of your community in light of those being served by your program as well as those who may be marginalized within your community. Look deeply into the various systems that are connected around your survivor population.As you are developing or revising your screening procedures:

1. Clearly articulate who can be served through your program. For example, what age ranges does your program serve? What population of survivors? Is it able to serve both labor and sex trafficking survivors? What geographical region or jurisdiction does your program serve? What are options in the community for survivors who might not meet the eligibility criteria?

2. Eligibility criteria is critical to articulate. Eligibility should be focused on the needs of the survivor and the program's ability to meet them. Always look for ways to screen in.

# Intakes & Contracts

Initial meetings with potential survivors, or with new residents, can be time-intensive and overwhelming. A trauma-informed intake process is both welcoming and manageable and leaves the survivor feeling connected and invested in your services. Consider limiting intake forms and questions to essential information to meet eligibility criteria in order to provide housing quickly for the survivor.

For housing programs, the requested information should be limited and straightforward. Focus on what you “need to know” versus what’s “nice to know”. You may need their name, and how to connect with their case manager or advocate. Other information can be gathered in future case management appointments.

Feel free to use the questions and practices below in training, on-boarding, and skill-building exercises with staff:

- What information are you currently requiring during intakes? It is worth evaluating each question to determine whether or not the information is vital to collect during the initial intake meeting. If you are unable to justify a clear and vital reason, it is likely the survivors are confused and overwhelmed. You may consider having an intake process during which you ask several questions over a series of several meetings. This strategy will minimize staff and survivors being overwhelmed and maximize the opportunity for relationship-building.
- It is important to be transparent with the survivor before an intake begins. Before the start of a meeting, share confidentiality and mandatory reporting protocols to communicate clear requirements and boundaries. Give the survivor an idea of what to expect during the intake, and how long the intake might take. Remind them that they can take a break if needed, and consider offering them a snack or a drink to make them more comfortable. Consider also providing comfort items, such as sensory items, coloring pages, or fidget toys to survivors during intake.
- Identify what information is necessary for you to provide services.
- Provide information about the organization and services available to the survivor so that they can make informed choices.
- Save time and start modeling what a collaborative partnership looks like by filling out information you already have prior to intake meetings. “I know this process can be a lot, so I’ve taken the liberty of filling out some of these forms based on information I had at the time. Will you take a look to see if I’ve gotten it correct? Then, we can take a few minutes to fill in the rest.”

  > “Feel free to look over the rest of the questions I’ll ask. Let me know if you have any questions or if something seems strange or out of place.”

- Be flexible in approaching each survivor and maneuver or re-arrange the components of your intake, as needed. It is important to be alert for signs of frustration, stress, exhaustion, confusion, or anxiety with the survivor, and to know which elements of the process can wait until a future meeting.
- As an organizational policy, note which critical pieces of information must be acquired right away, and what can be done at a later date in the survivor’s best interest. When in doubt, reflect what you’re seeing in your survivor and ask an open-ended question in a transparent and culturally humble manner.

  > “I’m noticing how tightly you’re holding yourself/your bag/jacket/chair, is there something that’s concerning you, or have I said or done something that’s worrying you? I want you to have all of the information you need to feel welcome here.” In some situations, it may be most appropriate to cease asking questions.

- Conversely, consider what information you are providing to your survivors during intake meetings. Are there specific points that are important for survivors to understand at intake versus information that can be processed later, at their leisure?
- Practice being transparent about the process and provide clear expectations ahead of asking survivors to sign anything.

- Consider presenting your intake materials in this way: **Say it, Share it, Sign it**.

    1. **Say it:** Information that should provided verbally to survivors — often individualized to the specific questions and needs of the survivor;

    2. **Share it**: Once information is spoken, share a hardcopy with the survivor in their preferred language– generally "good-to-know" or "nice-to-know" information such as workshops, schedules of events, community-based resources;

    3. **Sign it:** Information you say, share and need the survivor to sign — informed consent, victim rights, program policies and procedures, confidentiality & mandated reporting. Anything that requires the survivor's signature should be copied and added to a packet that the survivor takes with them, if it is safe for them to do so. It is essential that all of these forms are provided in the survivor's preferred language. It is essential that a survivor is not overwhelmed with paperwork at their initial intake — have the survivor sign only what is completely necessary. "I'd like to spend the next 20 minutes giving you important information that requires your signature. You have everything I'll be going over inside the folder I've given you. Please stop me at any time if you have questions. Anything you sign and date, I also sign and date. At the end, we'll both have a copy of everything."

**Avoid requiring the survivor to share their story of abuse and exploitation.** Survivors may be triggered when re-telling their story. This experience is counter to establishing trust and rapport-building as survivors enter your program. In fact, taking steps to assure the survivor that you do not need to hear details of the exploitation may create a more emotionally safe atmosphere, which will increase trust and potential engagement in services. Be especially aware of this when going through any kind of safety plan. Remind staff that doing a safety plan during an intake is simply to determine what may happen later in the day, or later that night — looking forward for future safety concerns, rather than looking in the past for what happened.

> "I'd like to spend about 8 to 10 minutes going through 5 questions about your safety for the rest of today and tonight/for the next 24 hours/for the next 2 days. None of these questions are going to ask you to tell me what happened to you or ask you about your past."

# Harm Reduction and Safety Planning

Let's review some terminology. **Physical safety**, generally, is the state of being safe. You are physically unharmed and there is no immediate or imminent threat to your being. **Emotional safety** is feeling safe. Sometimes a threat can be perceived by the survivor as either one or another, or sometimes it can be perceived as both at the same time. Others may label the drive to seek physical and emotional safety as psychological safety. Whichever term, or terms, you use to describe the way people seek safety, consider the impact of trauma on the ways survivors deal with feeling unsafe. Safety is a relative term that is different for every person. It's important to understand how tricky it can be to discuss safety with a survivor when there are many unknown factors as well as pre-existing assumptions about what is comforting or safe.

Housing First and trauma-informed principles embrace a harm reduction approach to safety. However, harm reduction and safety planning are two different concepts. **Harm reduction** involves helping survivors minimize — as opposed to fully eliminating — their own unsafe behaviors. **Safety planning** can be related to harm reduction and focuses on the survivors perceived safety. It's important to think of safety planning in terms of relative safety. The goal isn't necessarily to be "safe" but to be "safer." The harm reduction approach centers on the survivor and their definition of safety rather than the service provider's definition. What naturally follows is planning that focuses on what the survivor considers a safety concern and on what they believe will make them safer.

Listed below are pitfalls to avoid when implementing trauma-informed or survivor-centered practices for housing programs serving survivors of human trafficking. Please note that this is not an exhaustive list. Reviewing the following will hopefully spark conversation and evaluation within your organization.

| Pitfalls | Why Does This Happen? | How Can We Avoid This? |
|---|---|---|
| Limiting self-determination during safety planning.<br>• "I really think you should [specific action] ..."<br>• "I don't think you understand how serious this could be..."<br>• "That's really not a good idea, let's do [this] instead, it's safer..."<br>• "I don't think my survivor is in the right frame of mind to make that decision because of [reason]." | • Providers prioritize their own sense of urgency or definition of safety for the survivor.<br>• Providers use a narrow approach in assessing for concerns or in creating a safety plan, often due to a sense of limited options within the community.<br>• Providers deem a survivor incapable of making choices around safety; i.e. substance abuse, trauma-bonding, emotional attachment to trafficker(s). | • Practice identifying whether your thoughts, feelings and actions around a safety concern reflect what you're observing in the survivor or if you are reacting to what the survivor is saying. Maintain ethical and professional boundaries, even when presented with safety concerns that are unique and alarming. Trust that survivors are experts of their own safety and are best positioned to identify what is/isn't safe for them.<br>• Review harm reduction models around substance use, even if your current program doesn't use it. Consider skills and techniques that can complement what you already do/use, or even replace them.<br>• Remember, the right to self-determination exists for everyone, including disabled individuals, individuals using substances, and people struggling with mental health issues. As providers, it is essential to avoid processes like 72-hour psychiatric holds or rehab as a way to "protect [survivors] from themselves" whenever possible (unless mandated by state statutes or court orders). |

| Pitfalls | Why Does This Happen? | How Can We Avoid This? |
|---|---|---|
| Requiring a report to law enforcement, or pushing a survivor to contact law enforcement for any reason<br>• "You need a police report in order to access [resource]..."<br>• "You should get a restraining order..."<br>• "Oh, our contact at [law enforcement department] is great, we work with them on all our cases..." | • Providers believe a police report is the best/only way for the survivor to feel safe or achieve justice.<br>• Providers may be unaware of implicit biases that exists in the criminal legal system.<br>• Providers may be placing their own ideals or wishes on the survivor, rather than providing the options available to the survivor. | • Never require, suggest, or imply that access to housing, services, or resources are contingent on survivors reporting or contacting law enforcement (unless the survivor is eligible for a T-visa or crime victim compensation). In this case, be open and honest about what the police report is required for, and what type information may be requested.<br>• Ask the survivor to define what justice means to them and then describe options for achieving that. |
| Taking away cell phones/limiting cell phone use; setting curfews. | • Providers feel there is no other way to keep an undisclosed location safe.<br>• Providers believe doing so increases a survivor's safety and the safety of others.<br>• Providers may be unaware of how these rules mimic the control and manipulation of traffickers. | • Understand that these rules rarely increase safety for survivors or their community within a shelter. A survivor may need access to communication in order to stay in touch with family (for example, child custody), work, and/or support systems, and therefore should have access to their devices.<br>• Curfews often convey disempowering messages and do not recognize the need of some survivors working night/evening shifts. Curfews should be avoided. |

# Safety Planning: shifting from "safe" to "safer"

Using a harm reduction approach means approaching safety with an attitude of humility; it is the recognition that survivors are the experts of their own lives and have implemented successful safety strategies that have kept them alive for a long time. A survivor may describe actions or behaviors while working on safety plans that seem unsafe to you based on your own experience. It is beneficial to begin safety conversations by asking the survivor what strategies they rely on for safety. This both acknowledges their agency and also provides insight to staff on what resources they may share in the future to increase their safety options. The truth is that the only thing that can keep a victim 100% safe from the trafficker is the actions of the trafficker. Safety can be defined within a continuum of actions and behaviors. Therefore, creating strategies based on the survivor's knowledge of the trafficker and the strategies they have successfully utilized in the past is an important place to begin.

Honoring a survivor's right to self-determination, especially when it seems to directly conflict with their safety, is difficult to do at times. Remember that no one service provider or organization can be responsible for keeping survivors safe 100% of the time. We can assist in creating a plan, looking into resources, and gathering information, but the survivor is ultimately responsible for their actions. To extend yourself beyond this role is likely overstepping your ethical and professional boundaries.

Safety planning and harm reduction aren't always solely about survivor safety. Staff and organizations benefit from creating safety plans as well. This can sometimes lead to competing priorities, especially when a survivor's actions or circumstances directly impact the safety of staff and/or other survivors. It is important to consider each situation as unique as each survivor is unique, and with the least amount of restrictions as possible.

## A Harm Reduction Philosophy and Substance Use

Through a harm reduction philosophy, service providers recognize that substance use and addiction are significantly correlated with trauma. Survivors are addressed in non-judgmental communication regarding drug and alcohol use and are offered education and information on how to avoid risky behaviors and engage in safer practices. In a Housing First program, substance use in and of itself, is not considered a reason for eviction. Reflect on the following questions to evaluate the programmatic practices you have in place and the direct service staff supporting the program.

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**Questions to Address in Your Program:**
How are staff trained to address safety?
What happens when a safety plan is activated or goes awry?

### Case Study: Organization QRS

Organization QRS runs harm reduction-based drop-in facilities for homeless adults in a large, urban city. Survivors can meet with a case worker, have a meal, and take a shower. With the recent opioid epidemic, the center's staff have been seeing an increasing number of survivors with opiate use disorder. For the first time since opening this program, staff were responding to overdoses at such a high rate that staff received training from medical centers on overturning overdoses.

LH is a young man who utilizes the center's services regularly. His drug use is frequent and staff have called emergency medical teams to respond to LH at their center multiple times. The staff are concerned that medical care is not always available quickly enough for LH, and that the repeated overdoses were triggering for other survivors who were committed to sobriety. This led QRS to consider LH's progress at the center, staff well-being, and the safety of other survivors. They eventually agreed that while access to services at the center have had positive outcomes, the severity and frequency of LH's drug use required a new safety plan.

Staff met with LH to discuss how to move forward in a safer way. A case manager offered to meet him outside the center as a way to keep LH connected to desired resources and services. Together, LH and the staff identified a safe location where he could use, and was closer to the medical center where EMTs could bring him when he overdosed. This new plan was not about cutting LH off from the center because he was using so heavily; rather, it was about finding a new way to support a survivor's recovery — using the least amount of restrictions as possible — while also maintaining a reasonable level of safety for LH, center staff, and other program participants.

# Voluntary Services

Low-barrier and voluntary service models, guided by values of justice and access, encourage survivor-centered practices among staff and promote survivor autonomy. Staff who implement voluntary service policies are able to focus on supporting survivors instead of "policing" behaviors. Enforcing disempowering rules undermines the work staff members put into building relationships with survivors, a key component of successful outcomes. When asked to describe how a program could start implementing voluntary services, most programs emphasized building relationships with survivors.

Service providers may also be challenged by the inevitable power dynamic between staff and survivors that often create barriers to establishing trusting relationships and moving towards successful outcomes identified by the survivor. Some solutions are easier to implement than others. The language and labels service providers use, or the authority providers hold by virtue of their position, may impede a survivor's progress.

There are other power dynamics that can affect a survivor's progress towards establishing independence.

**Case Study: Organization Flower**

Organization Flower is a large NGO with grassroots origins in a large city. Organization Flower was established to meet the needs of a specific ethnic population. This identified population struggled to connect to available community-based resources. There were language and cultural barriers that created difficulty in bridging this gap. To address the situation, Organization Flower hired bi/multilingual staff and helped local NGOs build relationships using a culturally humble approach. Over time, Organization Flower grew and evolved in response to the growth of the population they served.

The Organization Flower emergency housing program experienced proportionate growth. Although Organization Flower embraced Housing First principles, a combination of the city's strict housing laws and a long list of criteria that made survivors ineligible for housing, quickly became a barrier for many Organization Flower survivors. Denials were based on criminal records, no social security number, past evictions, low credit scores, or the lack of a high school diploma. Survivors felt frustrated and doubted that the system could work for them. Organization Flower advocacy efforts began with city officials and housing coalitions in the city, but these efforts were slow-moving. Staff understood that Organization Flower leadership was contesting entrenched, systemic problems. In the meanwhile, program staff focused on making changes within the program.

> Organization Flower staff began to talk openly with survivors about the problems within the city's housing systems. Staff shared their knowledge of the housing system, and acknowledged that aspects of Organization Flower's own housing program, which was bound by the laws and policies of the city, were neither trauma-informed or survivor-centered. Organization Flower staff worked with survivors to figure out what, if anything, worked for the survivor's situation. Some survivors opted to leave the city, some decided that Organization Flower was not a good fit for their situation and were referred to another housing provider, and some stayed and engaged the housing system as advocates.

There are many power dynamics at play within every request for housing. No one can address them all. Helping survivors navigate this system is part of what service providers do. Service providers can work to make sure that even if the system is problematic and re-traumatizing, that interacting with it doesn't have to be.

# Person-Centered Services

Being person-centered (also referred to as being survivor-centered or survivor-informed), requires organizations to engage survivors in a meaningful way and at multiple levels within the organization. Apart from the type of engagement that is implemented within a program, this section focuses on the ways your organization may connect with survivor voices across the organizational spectrum. Consider these three principles of survivor engagement:

1. Survivors are more than their lived experience.
2. Engaging survivors as partners requires intentionality.
3. Supporting partnerships with survivors requires commitment and investment of resources.

Survivors are all unique within their experiences and trauma; each survivor may have needs, wants and focused areas of expertise and interest that are specific to them. When engaging, or partnering, with a survivor on a project, there is much front-end work to do in order to identify a good fit for the partnership. For example, it is important to focus on building a safe and comprehensive relationship to get to know the survivor and their preferences of contribution within the partnership and specific projects. As we strive to be trauma-informed and survivor-centered, consider concrete ways in which survivor feedback and input can be successfully utilized. For example:

**Case Study: Organization JKL**

JKL is a Housing First program for transitional-aged female-identified survivors of sex trafficking ages 18-22 in a large city on the west coast. When the program first opened, many new staff had experience working at group homes and brought a “group home mentality” to JKL. This didn’t work for many reasons, including the creation of a power and control dynamic between survivors and staff that mimicked the trafficking experience. JKL’s director and staff utilized current research on Housing First models and trauma-informed best practices to revise policies and procedures. After a few iterations of revisions, the director and key staff held a meeting with current residents of the housing program. They shared both current and revised versions of policies, forms, documentation. They discussed sensitive topics of safety, substance use, and harm reduction. They engaged the residents and asked for thoughts, feedback and suggestions.

The residents responded with their own definitions of safety for the housing program. They revised questions on intake forms that they felt could be triggering. They asked for education and training on how to use social media safely and how to use technology in safer ways. They proposed limiting access to the house to only social workers, staff and residents. Community drop-off/pick-up points were designated. A security system was installed — but only for the

outside, no cameras on the inside. Instead, the security feeds looped into screens that the residents could easily see and monitor. The residents recognized the need to take ownership of the safety of their house, instead of relying on staff.

Both residents and staff felt an increased sense of ownership and responsibility after these changes were implemented. This led to a decrease in triggers experienced by residents and increased communication with staff. Staff shared that they were able to focus on fostering skills with residents rather than feeling like an enforcer.

**Please note — this particular case study was chosen to reflect survivor engagement — not to highlight specific safety measures.*

This is a clear example of utilizing participant feedback to improve survivor services and improving policy alignment with trauma-informed practices. At times, it can be frustrating to seek survivor input only to feel like the organization can't utilize what you obtain. Try to be more specific in these circumstances. What exactly makes the feedback frustrating or not usable? Are there more nuanced questions, information or context that could help? At a minimum, remind yourself that you are providing an opportunity for survivors to have a voice which can be affirming in itself.

Additionally, be prepared to provide compensation. For example, when pulling together a two-hour focus group for survivors to provide input on trauma-informed housing policies, offer a flat stipend, a gift card of their choice, and/or transportation costs. Contracting with survivors, as with any partner, requires foresight and preparation. Have short-term contracts at hand. Ask survivor consultants about their rates for service and mirror rates that are similar to consultants in professional fields. If a survivor is unfamiliar with consultant fees in the area or new to this form of engagement, work with them to determine a fair rate. Survivors are experts in their lived experiences and expertise and should be compensated accordingly. Be clear and proactive regarding project expectations and timelines. Refer survivors interested in becoming involved in advocacy to training courses, whenever possible, to build their confidence and skillset and offer mentors to support their progress.

Access the practical guide on survivor-informed services for more information: https://bit.ly/3Pp9PFJ

# Language Access

Regardless of whether or not you serve Limited English Proficient (LEP) survivors, or receive federal funding, all programs should create clear policies and procedures for a) allocating funding and resources for such services, b) identifying resources for language assistance, and c) training protocols for staff on using language assistance resources. Some questions to consider:

**Who must provide language access?**

Anyone receiving federal funding, even indirectly, is required to comply with Title VI of the Civil Rights Act of 1964 and Executive Order 13166 for language access requirements. Moreover, this applies to the entire organization, even if it is only partially funded through federal funds.

**What must I do to comply?**

You must take "reasonable steps" to ensure that LEP survivors have "meaningful access" to their activities and programs. This means that the language assistance provided is accurate, timely and effective, and is at no cost to the LEP survivor.

Please refer to the FAQ link here (https://bit.ly/3G8KiMV) as well as in the references below for additional questions around language access. Please note that using a survivor's family member or friend to provide either translation or interpretation is not appropriate. All vital information (say it, share it, and sign it) should be provided in the survivor's preferred language.

# Cultural Humility

An important element of cultural humility is becoming conscious of blind spots on an interpersonal and professional level. Service providers have been involved in institutional practices in the past that are now considered insensitive to cultural difference. Social service providers, at times, have supported practices of discrimination. We still struggle with implicit bias, unintentional and intentional injustice.

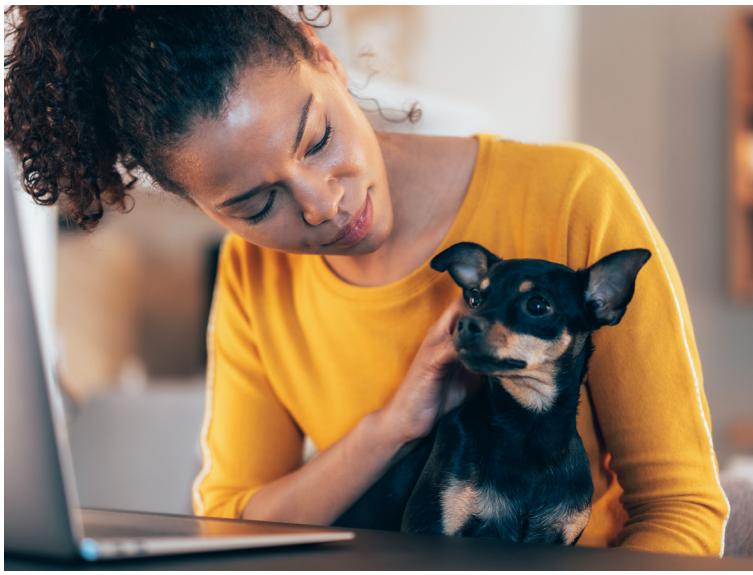
Cultural competency is a term that has been challenged for its failure to account for the structural, and systemic forces that shape individuals' experiences and opportunities. In contrast, the concept of cultural humility considers the fluidity of culture and challenges both individuals and institutions to address inequalities. Approaching this work from a stance of cultural humility offers the best chance at acknowledging power differentials between provider and survivor and challenging system-level barriers. We move away from a focus on mastery in understanding ‘others’ to a framework that requires personal accountability in challenging systemic barriers that impact communities put at risk of harm.

**Case Study: Organization XYZ**

XYZ is a nonprofit organization out of California who are working to end domestic violence, human trafficking, and violent crime. While working to create programs for survivors of crime in the community, XYZ recognized that male survivors, and Latino men in particular, needed a place to go and a community to be a part of. In order to create a space that was welcoming for Latino male trafficking survivors in the community, XYZ first took a look at ways that they could create a culturally competent space for the survivors. In doing so, they considered culturally appropriate language, food, activities, and services for these survivors, as well as thought through challenges that could be specific to male-identifying survivors.

# Service Animals, Emotional Support Animals & Pets

As housing service providers, there will be situations in which a potential survivor has a service animal, emotional support animal, or a pet. This section reviews what makes an animal a service animal, an emotional support animal, or a pet. We will explore possible reasonable accommodations as well as how to advocate on behalf of a survivor who requires a service animal.



Service animals are defined in Title II and Title III of the Americans with Disabilities Act (https://bit.ly/3z1WWLQ) (ADA) as any dog that is individually trained to do work or perform tasks for the benefit of an individual, the handler, with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Please refer to this one-pager (https://bit.ly/3G8Khsl) for a quick snapshot about service animals and the ADA. Refer here (https://bit.ly/3wnQtJJ) for more information about accommodations in the context of education, transportation, and employment as this toolkit will not cover this information.

Emotional support animals, comfort animals, and therapy dogs are not service animals under Title II and Title III of the ADA. Some states have laws defining therapy animals. These animals are not limited to working with individuals with disabilities and therefore are not covered by the ADA.

While Title II and Title III limit service animals to dogs, entities must make reasonable modifications in policies to allow individuals with disabilities to use miniature horses if they have been individually trained to do work or perform tasks for individuals with disabilities.

The handler is responsible for the care and supervision of their service animal. If the service animal behaves in an unacceptable way — i.e. uncontrolled barking, jumping on other people, running away from their handler, etc. — or poses a direct threat to the health and safety of others, the housing program does not have to allow the service animal into their facility. However, fear of animals or

allergies are not valid reasons to remove a service animal from a facility.

When supporting survivors in leasing housing, it is important to know that the Fair Housing Act (FHA) requires landlords and homeowner's associations (HOAs) to provide reasonable accommodation for individuals with disabilities. The FHA also requires reasonable accommodation of emotional support animals. Additionally, a no-pet rule or a pet deposit may be required to be waived as a reasonable accommodation — service animals are not considered pets.

Under the FHA, it is inappropriate to require a request for accommodation in writing. The housing provider can ask for a request to be in writing, but they will still be required to accept it if it is not in writing. A housing provider cannot ask for confirmation of a disability or need; if the disability-related need is obvious then a housing provider cannot ask for any proof. An example of this would be a blind person needing a service dog. If a disability is not obvious, a housing provider or landlord can ask a third party for enough information for a confirmation of a disability. A typical trustworthy third party could be a doctor. For more information, please see the DOJ-HUD Joint Statement on Reasonable Accommodations Under the Fair Housing Act, numbers 12, 15, 17, and 18. (https://bit.ly/3wo3Vg) For service providers assisting or advocating on behalf of a survivor with a service animal, this document might be worth preparing in advance with the survivor rather than relying on the landlord/HOA to provide one. It's important to note that in shelters and certain housing contexts, such as student housing, the ADA applies and requiring documentation or certification would not be permitted with regards to a service animal.

For housing service providers, please refer here (https://bit.ly/3FRylLn) for a list of inquiries, exclusions, charges, and other specific rules related to service animals. Of note, staff are only permitted to ask two questions when it's not obvious what the service animal provides. Additionally, staff cannot ask about the individual's disability, require medical documentation, require a special identification card or training documentation for the service animal, or ask that the animal demonstrate its ability to perform the work or task.

What does this mean for housing service providers? Perhaps intake forms and intake procedures will need to be revised to include the two questions allowed by the ADA. Within communal shelter settings, it is beneficial for all policies and procedures to include protocols regarding how to work with dog allergies or how the physical space of a shelter could be adjusted to increase accessibility for a survivor with a service animal.

Although emotional support animals and pets are not covered under the ADA, many service providers recognize the impact of such animals on the health and well-being of their owners. Housing providers should be familiar with state and city laws around emotional support animals and pets in public accommodations. Perhaps emotional support animals can be allowed access to the shelter on a case-by-case basis, along with the acknowledgement of the responsibilities the survivor would bear as the owner. Housing providers should also develop partnerships with local veterinarians, animal boarding or kenneling organizations, animal sanctuaries, and animal fostering programs to provide short-term care and housing, as needed.

# Long-term Commitment

Creating trauma-informed policies and procedures is an important commitment and long-term process. It will take time for practices to be implemented in the day to day work of the organization. Continued training for your staff, as well as feedback from survivors, will be critical in ensuring that the intended shift not only happens on paper, but it is reflected in practice. Consider including survivors on your board and within your staff. Additionally, hold regular team meetings to strategize, and consider reaching out to community partners for in-kind donations of self-care resources for staff and survivors.

There are many programs that have engaged in this process and revised their policies and procedures to ensure that they are practicing from a trauma-informed approach. We encourage you to seek out support and resources as you engage in this process. You can visit Freedom Network USA's Resource Library for tools, training, and resources at http://freedomnetworkusa.org/resource-library.

# Resources


1. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-48 Rockville, MD: Substance Abuse and Mental Health Services Administration, 20 https://bit.ly/3PDbcRk

2. Project Trust. Trauma Informed Care Resources: https://bit.ly/3Ffa7dx

3. Project Trust. Applying a Trauma-Informed Approach: https://bit.ly/3LGyJOJ

4. Ward, J. Caring for Survivors Training Guide. UNICEF (2010) https://bit.ly/3sG7CvA

5. Caswell, M. Toward a survivor-centered approach to records documenting human rights abuse: lessons from community archives. Arch Sci 14, 307–322 (2014) doi:1007/s10502-014-9220-6

6. National Alliance to End Homelessness. (2009). Organizational Change: Adopting a Housing First Approach: https://bit.ly/3yGQZ6Y

7. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-48 Rockville, MD: Substance Abuse and Mental Health Services Administration, 20 https://bit.ly/3PDbcRk

8. Nnawulezi, N,. Godsay, S., Sullivan, C. M., Marcus, S., & Hacskaylo, M. 20 The Influence of Low-Barrier and Voluntary Service Policies on Survivor Empowerment in a Domestic Violence Housing Organization. American Journal of Orthopsychiatry. Advanced online publication. https://bit.ly/3Nf4sY7

9. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-48 Rockville, MD: Substance Abuse and Mental Health Services Administration, 20 https://bit.ly/3PDbcRk

10. Migration Policy Institute, FAQs on Legal Requirements to Provide Language Access Services https://bit.ly/3wkkREK

11. Fisher-Borne, M., Cain, J. M., Martin, S. L. (2014). From mastery to accountability: Cultural humility as an alternative to cultural competence. Social Work Education, 34(2), 165-1 https://bit.ly/3FTAnug

12. Project Trust. Implementing a Victim-Centered, Trauma-Informed Program for Survivors of Human Trafficking: https://bit.ly/3FVzMs7

13. NNEDV, Transitional Housing Toolkit: https://bit.ly/3LIMth2

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