Cultural Competency in California's Domestic Violence Field

Ensuring Access to DV Services for All Californians

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RDP Consulting

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About RDP Consulting

RDP Consulting (RDP), based in Oakland, California, provides expert guidance and assistance to nonprofit community-based organizations that work to improve the life chances and circumstances of low-wealth Americans, their families, and their communities. Our consulting services include help with strengthening organizational practices and policies, developing and administering programs, fundraising and grantmaking, and research and evaluation. For more information, visit: http://www.r-d-p-consulting.com.

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Introduction

'I should have never said anything'

> "When I called the hotline, I was ready to get help to improve my relationship with my husband. However, no one was available who could speak my language. I had to wait for someone to call me back, but I was worried that my husband might pick up the phone. So I didn't give my number.
>
> "In the meantime, I decided to mention the situation to my doctor, and she immediately contacted the police. Now my husband is threatening to divorce me! This may mean that I'll be deported and separated from my children. I may never be able to find my way back.
>
> "I wish I could have talked with someone who understood that I can't leave my relationship and don't want to. I really was hoping that my husband and I could receive counseling. Instead, I'm now being told to move to a shelter with my children. How will this work for us? I can't find a job, I don't have a car, my family is far away.
>
> "I should have never said anything."

Those suffering from domestic violence are already a vulnerable population — and their chances for receiving the right kind of support are even more diminished if service providers do not have the adequate support, training, and resources to provide services that are responsive to a survivor's specific cultural and personal circumstances.

In California, domestic violence (DV) is no small problem. Nearly one out of every three California female respondents to the California Women's Health Survey reported experiencing a physical or sexual assault at the hands of an intimate partner in their lifetime (Bugarin, 2002).

How domestic violence is defined in this report

The National Center for Victims of Crime defines domestic violence (DV) as "the willful intimidation, assault, battery, sexual assault, or other abusive behavior perpetrated by one family member, household member, or intimate partner against another." While there are various forms of DV (sexual assault, elder abuse, etc.), for consistency, we will use the term "DV" specifically to mean intimate partner violence throughout this report.

Meanwhile, in the backdrop of a persisting economic downturn, decreases in funding to DV organizations have led to cutbacks in services and staffing at a time when high rates of unemployment have increased the very stresses among families that often lead to more demand for DV services (National Institute of Justice, 2009). Available data suggests that even the current number of hotlines, shelters, and supportive services do not appear to have the capacity to meet survivors' immediate needs. For example, on September 15, 2010, a 24-hour census of DV shelters in the U.S. found that of the thousands of women seeking services (including legal advocacy, shelter, transitional housing, and job training and skills), many were unable to access what they needed (National Network to End Domestic Violence, 2011). The California agencies that responded to the shelter survey reported serving more than 5,200 survivors, but due to limited capacity, over 600 requests for services in California were unmet on this day.

What do we mean by the high-need, underserved?

"High-need, underserved" populations are those who may experience higher rates of intimate partner abuse relative to the general population (as indicated by available statistics on reported incidences of such violence) but who may be less likely to utilize available services (as indicated by service records of various agencies or as told anecdotally). Identifying these groups is done best through information collected by local organizations, since data on those who need but do not access programming or services can vary by community and region.

Furthermore, studies and available data, which we will explore later in this report, suggest that certain populations may be considered "high-need." In particular, African Americans, American Indians, and, in some cases, Latinas and immigrants may experience higher rates of

DV than White women (Tjaden and Thoennes, 2000b; Rennison and Welchans, 2002). Against the backdrop of already stretched service providers, many of the “high-need” survivors from these populations mentioned may be even more “underserved.” For varying reasons, many do not access services that could improve their situation and keep them safe.

Why is this the case? One factor may be a lack of support and resources to promote and strengthen cultural competency among DV service providers. Based on a review of available literature and refined by interviews with DV leaders and experts, we understand cultural competency to involve developing and maintaining skills, knowledge, attitudes, values, and awareness necessary to effectively engage and work across various cultural groups inclusive of race, ethnicity, religion, socioeconomic background, sexual orientation, immigrant status, age, and English proficiency. Instead of a one-size-fits-all approach, cultural competency involves constantly asking and listening to the women and families themselves about what they need and how they can be best served and supported. This dynamic and adaptive process requires constant learning and responsive, continuous service improvement that results in authentic, accessible, comprehensive services. In sum, culturally-competent service provision is quality service provision (Bau, 2011).

What is “cultural competency”?

Cultural competency is the providing of linguistically and culturally sensitive — and responsive — services. Put simply, it’s the understanding of how someone’s specific culture may require different approaches to care, whether that be speaking their language, adapting to religious or cultural customs and preferences, or generally focusing on their individual needs and concerns (Betancourt et al., 2002; Betancourt et al., 2003; Brach and Fraser, 2000).

Purpose and Methodology

Through reviewing available research and closely engaging Blue Shield of California Foundation grantees and other partners, RDP Consulting (RDP) learned that many organizations would like more support to address DV at the community level and to ensure that the direct services they provide are accessible and effective, particularly for high-need, underserved populations. In light of the current economic environment, RDP sought to understand and identify ways that organizations can continue to effectively engage and support those within their communities that are seeking services, while working to engage others who may be experiencing DV but not seeking help.

Content of this report

This report attempts to integrate multiple data sources, including a comprehensive literature review, to advance a perspective on responding to the particular needs of high-need, underserved populations, especially in California. This report will explore how a cultural competency framework could offer a more viable and useful approach to service provision and prevention efforts. To ground the discussion, the report begins with a brief review of the DV field's origins, summarizes its major successes, reviews the known data on DV in California (specifically among certain demographic groups), and discusses why these communities may not access services — and how a cultural competency framework could help address issues of accessibility.

The report concludes, based on research and interviews, with an overview of recommended approaches and best practices for leaders, organizations, and communities tackling DV to build on current assets to improve access and services for high-need, underserved populations.

Methodology

This report's findings and recommendations are based on 16 interviews with key DV leaders in California and nationwide, plus a comprehensive review of relevant literature. Those interviewed were selected based on their work in the DV field and their understanding of and commitment to providing and promoting cultural competency. Interviewees included executive directors and senior administrators at DV organizations in California; directors of county and state DV

prevention efforts, national coalitions, advocacy groups, and research institutes; consultants; and foundation program managers. All interviews were anonymous in order to encourage an open, frank discussion.

The Domestic Violence Field — Past and Present

History of the DV field

The DV field began to take shape in the United States during the early 1970s alongside other social activism of the times: civil rights, war opposition, and feminism (Lehrner and Allen, 2009). Early on, the field's goals were to end the oppression of women by framing such violence as a social and political issue, by pushing for fundamental social change, and by providing safety to survivors of abuse through establishing shelters and other services (Lehrner and Allen, 2009).

In the subsequent four decades, the efforts around DV continued to grow significantly, most notably with the passage of national and state legislation to combat DV, establish dedicated public funding streams through the landmark Violence Against Women Act (1994) and other laws, and the development of an increasingly professional field of DV service providers.

These advances have occurred in parallel to the examination of the forces shaping and influencing DV among not just women but also various groups of survivors, including same-sex couples, the disabled, immigrants, and the elderly. However, some argue that the focus on providing services may have come at the expense of advocacy, which was a foundational component of the DV movement's beginnings (Lehrner and Allen, 2009).

The data — and lack thereof — regarding DV in California

The growth and development of the DV field has occurred alongside dramatic demographic shifts in the country, particularly in California. While recognizing that DV survivors come from all cultures, socioeconomic backgrounds, races, and ethnicities, this report uses available information to start a discussion about which populations may be more vulnerable to DV (compared to others), and how the field can be supported in working to deliver more culturally-competent services to address these particular populations' needs.

What we mean by "culture"

It is important to note that "culture" should not be conflated with race or ethnicity. Culture is comprised of a number of factors, including familial, social, and economic circumstances, communication styles, value systems, and personal experiences that may affect an individual client or service provider's perceptions about the causes of DV — and how abuse should be addressed. The differing "cultures" of the DV survivor, the organization where services are provided, and the staff person providing the services present a confluence of factors that affect and shape how each acts and reacts. Similarities in culture do not necessarily ensure that each person will share common perspectives, values, or behaviors. Even if the clinician and client are members of the same community, ethnic or racial group, gender, or have similar socioeconomic backgrounds, each person's experience may be different (Warrier, 2005). At the organizational level, some agencies may have different perspectives on how to address the consequences of abuse: one agency may be more likely to focus on persecuting the abuser than another. Organizations and their partners must be prepared to successfully negotiate culture — those of their clients, staff, and their individual agencies — to provide quality prevention, advocacy, and direct services.

A note of caution on the data presented below: Most statistics are drawn from national data collected during the 1990s to the mid-2000s. Besides being dated, researchers used a number of different methods, questions, approaches, and perspectives (e.g., criminal justice versus personal safety issues), making it virtually impossible to agree on the prevalence and incidences of DV (Tjaden and Thoennes, 2000a).

Prevalence is defined as the percentage of people within a particular demographic group who experience abuse during a defined period.

Incidence is the separate and distinct occurrences of abuse experienced by members of a certain demographic group.

While there is clearly a need for more data, what we do know is telling — and troubling. For example:

One-third of California women have experienced physical or sexual violence

California women report experiencing substantial rates of DV. Nearly one-third of respondents to the California Women's Health Survey reported experiencing a physical or sexual assault at the hands of an intimate partner in their lifetime (Bugarin, 2002). In 2009, over 167,000 separate incidences of intimate partner were reported statewide (California Department of Justice, 2010).

But those numbers only paint a partial picture. The reality is that many DV survivors do not report abuse or access services. For example, undocumented immigrant women may never report abuse or seek services — even if they know about and need them — for fear or threat of deportation (Family Violence Prevention Fund, 2009; National Resource Center on Domestic Violence, 2006). To underscore this problem of underreporting, consider the following:

Survivors are hesitant to report their abuse

In California, Department of Justice statistics indicate that about one-third of DV incidents were reported to law enforcement. For many survivors, seeking help may be hindered by a number of factors: shame and embarrassment, an inability to speak English, the limited number and type of available services within their communities, and fear and mistrust of existing service systems. Immigrant and refugees may not seek help because of language barriers, inexperience and unfamiliarity with the legal system, fear of removal from the country, isolation, and lack of cultural and community awareness about — and comfort with — discussing DV (Family Violence Prevention Fund, 2009). In spite of the efforts to shift norms and raise awareness about DV, the stigma of abuse remains and may keep many survivors from accessing available services.

Many victims either don't know about services or won't use them

More than one in four women (29 percent) neither sought help nor had knowledge of available DV services in their communities (Bugarin, 2002). Even among those Californians who did know of local programs, only one in five (21 percent) sought help (Bugarin, 2002). White and U.S.-born women were significantly more likely to seek help in general, possibly as a result of being more knowledge about and comfortable

with mainstream services. Among White women, common sources of support were law enforcement and regular medical providers. Women of color were more likely to seek out friends or go to a hospital for emergency medical assistance (Bugarin, 2002).

Data and Assumptions about High-need Populations

Higher rates of DV among women of color

Based on a review of several reports, the available data on the incidences and prevalence of abuse among women of color suggest that American Indians, African Americans, and, in some cases, recent immigrants (including women of Hispanic/Latina and Asian/Pacific Islander descent), may experience higher rates of DV than their White counterparts (Tjaden and Thoennes, 2000b; Rennison and Welchans, 2002). Below we explore these data further.

Native Americans/American Indians

National data indicates that Native American/American Indian women may experience much higher rates of intimate partner violence than women of other racial groups (Tjaden and Thoennes, 2000; Centers for Disease Control and Prevention, 2008). For American Indian communities in California, qualitative research studies seem to corroborate national findings that indicate that DV is a major issue. Over 100 respondents to a survey examining violence in California tribal communities (Inter-Tribal Council of California, Inc., 2009) reported that:

- Domestic violence was the most frequent type of family violence;
- Most forms of family violence were not reported to police, with DV being the more frequently underreported form of family violence, followed by sexual assault (both within an intimate relationship and outside of a relationship) and teen dating violence;
- More than 80 percent of DV survivors did not tell someone about their abuse;
- When asked, most respondents did not feel they were treated fairly by law enforcement, child protective services, or probation when dealing with issues of family violence; and

- Lack of culturally-competent services for victims of family violence was seen as a "big problem" for the large majority of the respondents.

However, American Indians living on reservations, unlike those living in urban communities, may have to navigate sovereignty issues that stipulate who has legal jurisdiction over DV matters, which can complicate interactions with mainstream service providers and the legal system (Bachman et al., 2008).

African Americans

When compared to women of other ethnic and racial groups, African American women report significant rates of DV — and its consequences. Studies reveal:

- 35 percent higher rates of DV than White females, and nearly 2.5 times greater than other women (Rennison and Welchans, 2002); and
- African American women are more likely to die as the result of violence directed at them from family members than are women from other racial groups (Institute on Domestic Violence in the African American Community, 2011; Tjaden and Thoennes, 2000b).

> "The challenges facing a group do not equal culture. For example, more African Americans are poor. So is the issue race or poverty? Culture or social context? We focus on the wrong issues when we confuse social context challenges with culture... Culturally-competent practice involves understanding the client's values, how they define help, understanding of their social context, help-seeking behaviors, barriers to service delivery, and service needs."
>
> **—Executive Director, national DV organization**

However, these results should be viewed with caution: Looking at race alone does not paint a full or accurate picture. Other factors, such as economic status, can play a critical role in the rates of abuse among African Americans (Benson and Fox, 2004; Institute on Domestic Violence in the African American Community fact sheet, 2011).

Latinas/Hispanics

Available data have not provided conclusive findings about DV among Latinas/ Hispanics. For example:

- One survey of Latinas in California uncovered that eight in 10 had experienced DV (Vázquez, 2009);
- Other research suggests that 20 to nearly 60 percent of Latinas suffer DV (Alianza, 2010), and that certain groups of Latinas may experience greater rates of abuse (Kantor et al., 1994); and
- In one national study between Hispanic and non-Hispanic women, few differences in rates of DV were found, although Hispanic women were more likely than their non-Hispanic counterparts to report that they had been raped by an intimate partner (Tjaden and Thoennes, 2000a).

Not enough research has been done to decouple the data on various subgroups of Latinas to determine what factors might affect reports of abuse and use of available services. For example, there may be differences in how various groups experience and address DV depending on their immigration status, how long they have lived in the U.S., their English proficiency, and economic status (Family Violence Prevention Fund, 2009). All these factors should be explored to have a true understanding of how best to engage and support survivors.

Asians/Pacific Islanders

Similarly, research on abuse among Asian/Pacific Islander women presents prevalence rates that vary widely. For example:

- One national study reported that Asian/Pacific Islander women had significantly lower reported rates of DV than other ethnic counterparts (Tjaden and Thoennes, 2000b); but
- A literature review found that between 41 and 61 percent of Asian respondents in the highlighted studies had reported DV in their lifetime (Yoshihama and Dabby, 2009).

> "Asian women were not accessing services in [our region]… They don't feel comfortable with mainstream [services]. Here, we allow women to bring their children — if not, they're not going to come. We provide food for them and for the volunteers; they bring women in who need help. We try to operate more like a family. We can't operate like an institution."
>
> **—Director, DV service provider in California**

Immigrants and Refugees

Few studies have been conducted to determine differences in the prevalence and incidence of abuse for various groups of immigrant and refugee women. The World Report on Violence found that a review of surveys targeting specific groups of immigrants and refugees indicated that 10 to 69 percent of respondents reported at least one incidence of physical abuse at the hands of a male partner (World Health Organization, 2002). However, little is known about how various social, cultural, political, and economic factors influence how these different groups experience and address DV (Family Violence Prevention Fund, 2009). Data on immigrants and refugees continue to be limited in how useful it can be in informing the design and implementation of relevant DV services for different populations (Family Violence Prevention Fund, 2009).

Again, these seemingly contrary findings highlight the need for more research that examines the differences in the incidence and prevalence of abuse for various Asian subgroups. In fact, the disparate and often incomplete data on all of the above groups underscore the need for much better research on DV among different ethnic groups.

That should not, however, delay anyone from taking action. Enough statistics exist to confirm that DV providers can prioritize high-need populations in order to more fully, inclusively confront the problem of abuse within our communities.

Why some high-need populations may not access services

Blue Shield of California Foundation's DV program, Blue Shield Against Violence (BSAV), collects grantee reports from its Core Support Initiative. From the reports submitted between 2005 and 2010, BSAV has learned that DV service providers in California have experienced challenges in providing appropriate services to meet the

needs of specific high-need populations, especially in light of cuts in public funding. BSAV's work with grantees and other partners, combined with research and conversations with DV leaders and experts, suggest that for many DV survivors, especially those of color, services may need to be redesigned and restructured to effectively reach and engage these populations. It is important to look at the various structural, programmatic, and personal barriers for these high-need populations. There are many reasons why those experiencing DV do not access services, and it is critical to take these multiple layers into account in order to remove these obstacles. Some factors include the following:

Institutional

- Fear of deportation or concerns regarding immigration status
- Realities of discrimination, racism, sexism, etc.
- Policies around child custody

Logistical

- Language barriers
- Transportation
- Physical isolation
- Limited services

Safety and security

- Threats from an abuser
- Economic dependency
- Losing a job or being unable to find work
- Losing housing

Family and social norms

- Pressure from family to "make it work"
- Seeing abuse as a "private issue"
- Desire to preserve "sanctity of marriage"
- Perception that women must "obey" men

Personal

- Shame
- Mental illness
- Addiction
- Hope that an abuser will change

The above factors greatly affect whether someone will decide to seek help, remain in an unsafe situation, or leave an abuser. For many women, leaving the abuser may not be the right solution, meaning DV service providers can only truly help if they take an individual, open-minded approach to each person — and then match the services with that survivor's particular needs (Benson et al., 2004; Correia, 2000; McCaw, 2009; National Resource Center on Domestic Violence, 2006; Yoshihama and Dabby, 2009).

The path to cultural competency — and a stronger DV field

While changing mindsets and practices to deliver more culturally competent care may not happen overnight, there is an emerging roadmap to follow. Blue Shield of California Foundation grantees and experts interviewed for this report reveal how cultural competency can and has helped — and realistic steps to take to achieve this higher level of service.

A multi-level response

The approach that available research and DV leaders and experts alike recommend is a multi-level response to building and maintaining cultural competency (Betancourt et al., 2002; Brach and Fraser, 2000; Marjavi and Ybanez, 2010; Warrier, 2005).

> "That's where trust is so important. It's a dialogue. It's not just doing whatever the community says but engaging the community in the interface between what the DV field knows and what the community knows… The key to getting at that level of understanding is to reach the leaders who really understand DV in their community — who will be champions of those issues."
>
> **—Executive Director, DV service provider in California**

The community level

At a community level, cultural competency involves understanding the context in which services are being provided:

- What are the social norms in the community about DV — do community members see such violence as a community problem, a personal family issue, or something else?
- Where do community members go to seek help (if they seek help) to deal with physical and mental health issues, obtain a restraining order, or pursue criminal prosecution of the abuser?
- Are DV staff linguistically and culturally reflective of the people who will need their services?
- What are the key mechanisms for communicating important information regarding health and mental health services in the community?
- What types of messages and images resonate with community members when discussing issues related to DV?

The organization level

For organizations, cultural competency involves a commitment to assessing, supporting, and evaluating an agency's ability to effectively meet the needs of the community in which it works. Assessment should examine who is being served and who is not; what services are requested or needed; and whether the services offered really made a difference. Questions for organizations to consider include (Betancourt et al., 2002; Brach and Fraser, 2000; Office on Violence Against Women, 2008):

- How is culture defined?
- Is there a common definition and understanding of cultural competency?

- Can staff articulate how cultural competency can enhance service accessibility and quality?
- What are current or former clients saying about the services they received?
- What could be done to improve clients' experiences?
- Are there groups within the community that are not seeking services but may need them?
- If so, what data are collected to inform how the organization could adjust or enhance its approach to delivering services to reach these survivors?
- Has the organization identified advocates that can speak certain languages or that are representative of the groups that are less likely to access services?
- In what ways can community representatives help to inform and support more culturally competent practices?
- What other community-based organizations are willing to partner to meet the community's complex DV service needs?

After addressing these questions and needs, organizations should consider the best strategies to increase — for all community members — awareness about DV and DV-related services: radio, print, and TV ads with language-media outlets; presentations at places of worship and wherever else community members congregate; and informational materials that are responsive to language and literacy levels — and that include images representative of the target community (Warrier, 1997).

The individual level

Once a DV survivor seeks services, the quality of the service is affected by the service provider's and the client's cultures (see "what we mean by 'culture'," above). Experts also suggest being conscious of the power dynamics at play when staff at DV organizations first engage with clients. The person seeking help may feel they have little control, while the service provider has the knowledge and connections to help the client respond to a very difficult, stressful, and disempowering situation. Cultural competency at this level requires being sensitive to and aware of these differences, so that providing any service (e.g., housing, advocacy, counseling, medical assistance, and job training) is appropriate and appropriately received (Dabby and Autry, 2005).

Be a "negotiator" of cultures

Field experts emphasized that it is absolutely critical for DV providers and advocates to understand how to be culturally sensitive negotiators. Practitioners need to ask a survivor how she wants to be treated, and to support her choices (e.g., not prescribe or assume that leaving the batterer is the solution for her and her family). Those interviewed said what is acceptable for one individual from a particular group, even if suggested by actions of other group members, may not be best for another, so providers must be willing to ask: "I want to be helpful to you. What would you like to happen? Please let me know what's appropriate."

> "Consider using a scale of cultural proficiency. It's not a static skill that you simply learn. It's an ongoing process. Really it's a lifelong, challenging process… It's about cultural negotiation."
>
> **—Director, DV service provider outside of California**

That's sound advice, and the DV leaders and experts we interviewed offered these first-hand insights about other cultural competency dos and don'ts.

CULTURAL COMPETENCY BEST PRACTICES FOR DV PROVIDERS	
Dos	**Don'ts**
➪ Extend a safe and welcoming environment by having staff or volunteers that are from the local or target community.	**X** Don't promise too much. Ask what the survivor needs and wants, and then be honest about what you can provide.
➪ Work with clients to change their behavior given where they're coming from.	**X** Don't stereotype or confuse socio-economic background with culture.
➪ Get to know her. Each person has a different background and story.	**X** Don't assume that leaving her abuser is what she wants — or is the solution.
➪ Build relationships and trust between the clients and DV organizations — and between DV organizations themselves.	**X** Don't underestimate life experiences that may include war, displacement, disability, or a lifetime experience of violence.
➪ Go to where women go (not just DV organizations but also community-based groups and other service providers, such as CalWORKs offices, libraries, ESL classes, Bible study groups, community clinics, and community-based organizations).	**X** Don't think that cultural competency can be attained by attending trainings, classes, or one-time events; it is a life-long process.
➪ Be inclusive of how she self-identifies (race, ethnicity, religion, age, sexual orientation, physical ability, among others).	**X** Don't assume all cultures have the same appreciation and understanding of cultural cues (e.g., physical cues, sense of time).
➪ Pay attention to the messages sent in shelters (e.g., what hair products are available, the TV stations watched, foods considered to be comforting, and other cultural preferences and practices of people from different backgrounds).	**X** Don't assume that if they can't describe the abuse well (in English) that it didn't happen or wasn't that serious.

Cultural competency — as a practice — takes time

Incorporating and improving cultural competency within organizations and across the field does not happen quickly or end after any particular milestone. Some organizations are just beginning the conversation about how to support and build a culture of cultural competency. Others are finding ways to institutionalize it naturally and seamlessly into all aspects of their work.

Within a community, levels of cultural competency will vary. Often the individual level is the first place that cultural competency takes root and is maintained. Change at the organizational and community levels may take more time and investment, but it can have broader impact.

Experts agree that cultural competency requires safe spaces where administrators, staff, and the community can discuss the current and, in some cases, historical contexts that influence the prevalence and incidence of DV in their community — and how it can be addressed and prevented. At individual, organizational, and societal levels, the stages of cultural competency will ebb and flow with changes in staffing, community demographics, and the availability of resources.

A constant focus on these skills and approaches will help to ensure both consistency and improvement over time. And because this is an ongoing endeavor, DV leaders and experts recommend the following three strategies to strengthen and broaden cultural competency practices.

Supporting staff in a way that promotes and rewards self reflection

In culturally competent organizations, supervisors create safe environments where staff can and are expected to step back and examine their practice. On-going, regularly scheduled supervisory meetings — where staff are expected to discuss what they have done well, what they could have done better, and how culture affects their effectiveness — helps to create a norm where practice stays relevant and appropriate (Warrier, 2011).

Supporting survivors holistically — as long as they need help

When a DV organization first encounters a survivor, naturally the first priority is ensuring that person's safety and addressing immediate needs: shelter and/or transitional housing, involving law enforcement (in some cases), etc. However, our interviews with DV experts suggest

that this is just the first step. Once physically but temporarily safe, many women and their children are faced with rebuilding their lives.

> "We may do a three-way call to help with language issues between the client, an interpreter, and the service provider… We continue to follow up with the women after they access services, help monitor their legal services, [and] help them apply for benefits. We are always the point of contact, even after women leave the shelter."
>
> **—Executive Director, DV service provider in California**

Rebuilding can require a holistic set of supports: mental health counseling, legal advocacy, job placement, vocational training, and transportation assistance, among others. Some DV organizations must help clients' children cope with the abuse of their mothers. Others work with women who maintain an emotional connection to their abuser. (Physical distance may not be enough to break these bonds; one expert described how even incarcerated batterers continue to harass and threaten — sometimes through family members — their victims.) And some survivors will leave one abuser and enter into another unhealthy relationship.

The magnitude of the challenges that survivors and their children face may require a relationship with the organization for months or years, as these families create new social networks and support systems that promote empowerment and self-sufficiency. Building long-term and strong networks and collaborations with many partners within the community will be necessary to help many survivors address the consequences of their abuse.

Creating and supporting partnerships

The complexity of culture and the challenges facing survivors leads many agencies to work collaboratively with others (such as healthcare providers and law enforcement) to offer the breadth and intensity of support that survivors may need.

> "We work with other agencies… We are part of a coalition to end domestic violence. There are 10 members: other direct service agencies, prevention organizations, health services, mental health services, and legal outreach."
>
> **— Executive Director, DV service provider in California**

Interviews and review of research suggest that partnerships are also important for reaching populations that DV organizations might normally not encounter. For example, Blue Shield of California Foundation grantees and experts interviewed noted that women from specific racial, ethnic, and cultural subgroups in their communities were not accessing services. They hoped to better reach African Americans, American Indians, and recent immigrants (Afghans, Ethiopians, Hmong, Mien, Somalis, and Southeast Asian women). Some described developing outreach and services to target these groups, and others worked to partner with organizations already serving them to create a network of services.

> "[We] do trainings with law enforcement to help them understand the link between immigration and DV. We also do training for mandated 'reporters' — doctors, healthcare workers — so they take into consideration what the clients want. A man going to jail may lead to financial challenges — may be the woman's only source of income. Instead of automatically reporting in all cases, we would prefer that mandated reporters call us."
>
> **—Executive Director, DV service provider in California**

These efforts are often hindered by the small number of organizations serving these populations, the limited availability of culturally and linguistically-competent staff, the isolation of these individuals, and often a mistrust of longstanding or emerging programs. Below, we summarize promising practices from field leaders about supporting DV survivors in culturally-competent ways.

Recommended next steps

For nearly all of the DV leaders and experts who were interviewed, cultural competency was one of the top five challenges named in engaging and serving high-need, often underserved populations. Fortunately, we also heard repeatedly that field leaders recognize that cultural competency (from finding linguistically appropriate staff and partners to providing ongoing trainings and assessment) is a required component of effective outreach, prevention, advocacy and direct services for survivors with the greatest needs. Below is a summary of other steps and recommendations that we discovered in our research and interviews. They include:

- Service providers embracing cultural competency as a way of being — to integrate it into its core organizational DNA — so that all planning, approaches, services, staffing decisions, trainings, and assessment reflect the need to respond to the specific needs of their clients;
- Constant and continuous recognition of the various hurdles to accessing services or seeking help for high-need populations;

> "Rather than being a static skill that either you have or you don't, cultural competency is a developmental process that requires regular and ongoing assessment, evaluation and knowledge, and capacity building.
>
> Being culturally competent is a process of engaging diverse communities as equal partners to inform and reflect your programs and services, staff, and leadership. Cultural competence is not a one-time event, a certificate to be achieved, but a constant and ongoing process to assure relevance of programs that acknowledges changing demographics and to be based in the culture(s) of that community."
>
> **—Director, national DV organization**

- Improving outreach (individually and through partners that are trusted in high-need communities) to meet potential clients where they are, and to ensure they know that services are available and will be delivered in a culturally sensitive manner;

- Asking the questions that allow for new types of services — beyond shelters and criminal prosecution (e.g., pairing elders

with youth as part of teen violence prevention, integrating faith-based practices into support groups, offering home-based counseling services, collocating services at other agencies within the community, or focusing on healing as part of individual or family counseling sessions); and

- Providing a platform for DV organizations and non-DV partners to collaborate on a committed, sustained effort to offer culturally competent, relevant, and sensitive prevention, practice, and advocacy. This includes sharing best practices so that others can replicate and build on these successes — and furthering the overall expectation that cultural competency is the rule, not the exception.

While there is much work to do, California's DV field is poised to build on its current successes. A greater understanding of and commitment to cultural competency will lead to improved services, best practices, and, ultimately, less domestic violence. While the DV field aims to create a more positive, productive, and welcoming experience when the most high-need Californians come through their doors, the real vision shared by many is that, one day, they won't need to at all.

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