Envisioning a Coordinated Services Hub for Victims of Violence
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Introduction

As communities continue to grapple with increased gun violence, the need to coordinate services for victims of gun violence should be even more apparent. Continuing to view these victims as only requiring immediate medical intervention and legal intervention is just not accurate. Violence victims often have multiple needs that have accumulated over time. Yet, in spite of these needs, community violence victims are not only systematically excluded from institutions expected to help them, but they also must navigate providers that do not engage in trauma-informed practices. At a minimum, a trauma-informed approach would meet the victim's needs. Thus, developing a hub for victims of violence would establish a one-stop shop that coordinates services across multiple systems. A hub would also track participant progress and keep the individual engaged, while using trauma-informed principles (safety; trust and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender issues; CDC 2020).

This paper describes what is meant by coordinated services, anticipated goals, the types of services to be coordinated, potential challenges, the effectiveness, and examples of coordinated services. The target population for this hub are victims of community violence, generally defined as individuals who have been shot or stabbed as the result of a dispute or retaliation.

What is meant by coordinated services?

For victims of violence, specifically, it means that providers recognize the various contexts of service delivery and incorporate this knowledge into services that address victims' needs (Cambell and Ahrens, 1998). In practice, this looks like staff across multiple organizations working together to benefit their service recipients: victims and their loved ones. That is, providing direct services to clients across multiple providers. Activities that build up the capacity for coordinated services include cross-training, regular face-to-face meetings, developing polices and protocol, and communicating about victims (Allen 2005, Martin, 2005)

What is key is that providers recognize that violence victims have needs outside of their presenting problem. The main systems to coordinate for this population are: medical, legal, mental health, and public health. Providing coordinated services conveys to victims that the community cares and, in turn, violence victims report more positive experiences with these systems (Martin, 2005).

What is the goal of coordinated services?
The goals of coordinating services are to (1) decrease service fragmentation and (2) increase the quality of services for victims. Objectives (Gamache & Asmus, 1999) include:
   I.   Ensure victim safety
   II. Improve policies and practices in the institutional response to violence
   III. Increase communication and coordination across systems, and build in accountability
   IV. Increase public awareness and responsiveness

V.   Provide victims with the support they need

What kinds of services need to be coordinated for this population?

While this is not an exhaustive list, some of the potential services include:
- Emergency safe housing
- Dispute mediation
- Transportation
- Provision of resources to support meeting basic needs (food, clothing) during the time of crisis
- Support accessing resources, such as a peer navigator.
- Medical follow-up care
- Educational and employment support
- Advocacy
- Legal services
- Counseling
- Substance abuse treatment
- Long-term housing
- Community education and trainings (to educate community on violence)

How does coordination actually happen?

There are three common forms of coordinating: (1) one agency/organization takes the lead, (2) one staff member from each participating agency volunteers or is told to coordinate with staff in other organizations, (3) a task force or other similar group coordinates across services.

No matter which approach is used, it is critical that the council or team includes victims and people who work on the front lines, not just the decision makers, in developing the process. Partnership agreements should be developed that outline the roles, responsibilities, and steps taken when procedural issues arise. These agreements can be as formal as necessary and as granular as necessary. At the least, they should be documented, agreed upon, and referred to as necessary.

A major piece of coordination is sharing information about individuals, services, and opportunities. Data sharing protocols should be developed in addition to the general protocols and processes. The protocol should be clear about what is confidential, who has access, how the information is to be used, and why the information is shared. This should be conveyed to the person receiving services. This may mean investment in cloud-based databases or other software that allows information to be confidentially stored, shared, and accessed.

How effective is this approach?

Allen's (2005) examination of 43 domestic violence coordinating councils across Michigan found councils that fostered an inclusive environment and active participation were not only rated more effective by leaders and members, but also were associated with more positive changes in the criminal justice system. Another study also found that coordinating services between domestic violence and drug treatment providers was associated with positive outcomes for the participants (Benett & O'Brien, 2007).

The Urban Institute's Research Report: Engaging Communities in Reducing Gun Violence, identified four policy areas to reduce violence, with one of them directly related to coordinating services: "Promote Cross-Sector Collaboration with Meaningful Community Engagement." Examples of collaboration were more around data sharing and community input, but it points to the need for open communication and knowing what everyone is doing.

Effort should be spent determining what success looks like for the coordination services hub. Is it retaining participant engagement for 3 months? Is it participants keeping up with their medical care? Is it regular case review meetings across service providers? This needs to be decided prior to the collaborative going live, otherwise how do we know that this is making a positive impact on the participants? Further, without clear indicators of success, it becomes vulnerable to political influence: as a tool made to either raise up some agency/person or tear them down (read: scapegoat).

What are some examples of coordinated services?

While there are not many known models of coordinated services for victims of community violence, the domestic violence field has many examples of coordinating services for survivors. This includes the Sexual Assault Response Teams (SART) that respond to hospitals when someone has reported a sexual assault. The team includes a domestic violence advocate and counselor. Another example is the Family Justice Center in Indiana. This agency provides services to survivors of domestic violence, and serves as a "one-stop shop" to meet their needs. In this example, they coordinate with non-profits and governmental agencies, and are physically located in one building. This way, families only have to go to one location. Services include crisis intervention, childcare/children's play space, resource room, civil legal assistance, information on protective orders, and advocacy.

While many examples are rooted in coordinating services for survivors of intimate partner violence (aka domestic violence), HUD's Continuum of Care (CoC) is another potential model to draw on. The CoC must develop a charter and establish a board that acts on behalf of the CoC, typically representatives from various agencies and systems serving the homeless. The CoC is then responsible for operating the CoC, designating and operating a Homeless Management Information System (HMIS), and conduct planning. This model is so imbedded in HUD that communities are required to measure how well their local homeless system performs as a

coordinated system (HUD Exchange). Another Federal Agency, the Administration of Children & Families Office of Planning, Research, and Evaluation, recently published a report assessing models of coordinated services. In this report, the hub model is described as a model that coordinates services with the goal of increasing participants' access to services. The focus is not only on getting these individuals into services, but also retaining their engagement throughout their service life course. Strategies include no "wrong door" for intake, co-location, and joint case management (p. xi). Of note, their analysis found that the majority of coordinated services approaches that fell within the "hub" model tracked clients using a combined data system.

How is this different than a NYS Health Home?

Health Homes are screened at the individual level, focusing on supporting the individual, not pushing systems to coordinate at a higher level. Health Homes also have eligibility criteria (Medicaid recipient, 2 + chronic conditions or serious mental illness significantly impairing life) which all violence victims will not be eligible for. However, one potential avenue is to leverage the Health Home model. Relatedly, community health workers may also be an appropriate position to coordinate services for these victims. This is a hard-to-reach population, so constant engagement will be required. This will require active, accountable point persons between the victims and service providers.

What are some important considerations when implementing coordinated services?

The first issue to address is: Who *owns* the problem? Who *owns* community violence locally? Is it the police? Public Health Department? Violence Prevention CBOs? Medical Providers? The City's Office of Neighborhood Safety? For the police, this is one of many problems they address, which is also true of medical providers. So, what organization, agency really owns community violence prevention in Rochester? Is there one?

Recognize that victims of community violence typically have needs that do not just fall within one domain (e.g., medical intervention). For example, victims may have legal issues, lack well paid jobs, need mental health counseling, or need emergency housing. It is important to not assume the needs, but to also ask this question to violence victims. This will help to build out all the services to be coordinated.

Another consideration is, where is the entry point? Is it centralized to one location (e.g., a local health center), multi-locations, virtual or phone-based (call number or complete online form), "no wrong door" – every provider can link to the service hub thru assessment, or does a specialized team come out to identify participants? Accountability must be built into the process so individuals to not slip through the cracks. Everyone who is part of the services should be able to quickly identify "how" someone gets into the violence victims hub.

What are some of the potential challenges with coordinating services?

- Distrust: One of the biggest potential challenges to getting this work done is organizational suspicion or distrust. It is common for different agencies to be skeptical of others, which can quickly lead to assumptions.
- Work Overload (Martin, n.d.): Adding coordination as another job duty for staff while not taking away other job duties is one way to facilitate staff burnout and/or turnover.
- Poor Communication (Martin, n.d.): Different communication styles and approaches can impact providers across systems. For example, one group may be comfortable conducting all work electronically, while another provider may prefer handwritten notes, and another may not be responsive to phone calls.
- Competing Beliefs (Martin, n.d.): Competing beliefs should not be ignored, especially when serving a population that is consistently treated as "other," with many blaming the victim for getting shot or stabbed. There may be providers who have racist attitudes or are scared of this population, while there may be others constantly giving this population the benefit of the doubt and not questioning them. Likely to be the biggest belief hurdle is how "deserving" this population is of dignified, comprehensive service delivery.