
Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot

Chapter 5: Program Staffing

Fred Berman, Principal Author

Submitted to:

Sharon Elliott, Program Manager
Office on Violence Against Women
United States Department of Justice

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For more information about this report and related work, please address questions or comments to:

Fred Berman
Senior Associate
American Institutes for Research
The National Center on Family Homelessness
201 Jones Rd. -- Suite #1
Waltham, MA 02451
Telephone: 781-373-7065
Email: fberman@air.org

Barbara Broman
Managing Director
American Institutes for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007
Telephone: 202-403-5118
E-mail: bbroman@air.org

Note about the Use of Gendered Pronouns and Other Sensitive Terms

For the sake of readability, this report follows the example of numerous publications -- for example, by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)¹ and the Missouri Coalition of Domestic and Sexual Violence² -- and uses feminine pronouns to refer to adult victims/survivors of domestic and sexual violence, and masculine pronouns to refer to the perpetrators of that violence. This report also uses feminine pronouns to refer to the provider staff of transitional housing programs that serve survivors. The use of those pronouns in no way suggests that the only victims are women, that the only perpetrators are men, or that the provider workforce is entirely female. Indeed, the victims and perpetrators of domestic and sexual violence can be male or female or transgender, as can the staff that support their recovery, and the shortcut herein taken is merely used to keep an already long document from becoming less readable.

Although the terms "victim" and "survivor" may both refer to a person who has experienced domestic or sexual violence, the term "survivor" is used more often in this document, to reflect the human potential for resilience. Once a victim/survivor is enrolled in a program, she is described as a "program participant" or just "participant." Participants may also be referred to as "survivors," as the context requires. Notwithstanding the importance of the duration of violence and the age of the victim, we use the terms "domestic violence" and "intimate partner violence" interchangeably, and consider "dating violence" to be subsumed under each.

Although provider comments sometimes refer to the perpetrator of domestic violence as the "abuser" or the "perpetrator," this report refers to that person as the "abusive (ex-)partner," in acknowledgement of their larger role in the survivor's life, as described by Jill Davies in her often-cited [Advocacy Beyond Leaving](#) (2009).

Finally, although the Office on Violence Against Women funds transitional housing programs to address the needs of not only domestic violence survivors, but also survivors of sexual assault, stalking, and/or dating violence, the preponderance of program services are geared to DV survivors, the large majority of TH program clients are survivors of domestic violence, and much of the literature and most of the provider quotes are framed as pertaining to domestic violence. Consequently, much of the narrative is framed in terms of addressing "domestic violence" or "domestic and sexual violence," rather than naming all the constituencies.

¹ As stated on page 2 of the NCDVTMH's [A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors](#) by Warshaw, Sullivan, and Rivera (2013):

"Although many couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of "battering" is a form of gender-based violence characterized by a pattern of behavior, generally committed by men against women, that the perpetrator uses to gain an advantage of power and control over the victim (Bancroft, 2003; M. P. Johnson, 1995; Stark, 2007). Such behavior includes physical violence and the continued threat of such violence but also includes psychological torment designed to instill fear and/or confusion in the victim. The pattern of abuse also often includes sexual and economic abuse, social isolation, and threats against loved ones. For that reason, survivors are referred to as "women" and "she/her" throughout this review, and abusers are referred to as "men" and "he/him." This is meant to reflect that the majority of perpetrators of this form of abuse are men and their victims are women. Further, the bulk of the research on trauma and IPV, including the studies that met the criteria for this review, focus on female victims of abuse. It is not meant to disregard or minimize the experience of women abused by female partners nor men abused by male or female partners."

² As stated on page 2, of the Missouri Coalition's [Understanding the Nature and Dynamics of Domestic Violence](#) (2012)

"The greatest single common denominator about victims of domestic violence is the fact that the overwhelming majority are women. According to the most comprehensive national study by the U.S. Department of Justice on family violence, the majority of domestic violence victims are women. Females are 84 percent of spouse abuse victims and 86 percent of victims at the hands of a boyfriend or girlfriend. The study also found that men are responsible for the vast majority of these attacks—about 75 percent. (Durose et al., 2005) And, women experience more chronic and injurious physical assaults by intimate partners than do men. (Tjaden & Thoennes, 2000) That's why feminine pronouns are used in this publication when referring to adult victims and masculine pronouns are used when referring to perpetrators of domestic violence. This should not detract from the understanding that, in some instances, the perpetrator might be female while the victim is male or of the same gender."

1. Executive Summary

As described by many of the providers we interviewed, and consistent with the foundational research on trauma and recovery (Herman, 1992) and subsequent research on therapeutic alliance, the quality of the relationship between the advocate/case manager and the survivor is fundamental to the survivor's experience in a transitional housing program.

The advocate/case manager's ability to provide and coordinate the provision of trauma-informed support and services is understood as being critical to the overall effectiveness and success of program efforts to help survivors recover from the physical, emotional, psychological impact of domestic and sexual violence, and develop and implement plans for moving forward in their lives.

Chapter 5 examines the staffing in transitional housing (TH) programs operated by OVW-funded providers, addressing providers' ideas about appropriate caseload size; the types of staff positions they maintain; the attributes they look for in the people they hire; whether or not they prioritize having a clinician on staff and/or a staff person to specifically address the needs of participants' children; the importance they place on staff diversity and the tradeoffs with other attributes; their approach to training; their approach to supervising and supporting their staff, and how they work to prevent or address Secondary Traumatic Stress and burnout and; their use of volunteers, what they look for in volunteers, and how they train, support, and supervise volunteers.

Section 2 briefly describes the central role of the advocate or case manager; reviews the many factors that may influence staffing decisions (e.g., program capacity and funding, housing configuration and ownership, geography of the service area and where participant housing is located, demographics of the service area, size and capacity of the parent agency, etc.); presents a statistical summary from semi-annual reports of the use of OVW TH grants to pay for staffing; and presents a large sample of provider comments that illustrates the diversity of TH programs and the variations in their staffing patterns.

Section 3 briefly explores the pros and cons of staffing continuity from shelter to the TH program. On the one hand, being able to build on an existing strong relationship with staff gives a survivor a head start in the TH program, especially in a scattered-site program in which logistics and distance can complicate development of a new relationship between the participant and staff. On the other hand, TH programs that limit enrollment to survivors who have stayed in their agency shelter are at risk of unduly restricting access to the TH program.

Section 4 examines the criteria programs use in making hiring decisions -- the extent to which experience, education, personal attributes and attitudes, and knowledge and beliefs influence candidate selection.

Section 5 discusses provider perspectives about the pros and cons of hiring survivors to fill staff positions. Some programs take pride in being survivor-led, and see having survivors on staff as empowering for participants. Other programs seem more wary of hiring survivors; while acknowledging the credibility and perspective their life experience affords, and their commitment to the work, these providers worry about the difficulty survivors may have maintaining professional boundaries, and about their vulnerability to secondary traumatic stress -- particularly if their own experiences of domestic or sexual violence are "too recent."

Section 6 focuses on provider perspectives about the pros and cons of having a clinician on staff. On the one hand, given the trauma that survivors carry, and the not-infrequent co-occurrence of mental health or substance use issues, a clinician's knowledge and perspective can be useful. Also, clinical supervision can add an important dimension to the support and guidance that advocates/case managers receive, and a clinical supervisor is well positioned to recognize early signs and symptoms of secondary traumatic stress in direct service staff.

On the other hand, some advocates are wary of how a clinical focus can pathologize survivors, and of how diagnoses that should attribute a survivor's symptoms to the trauma and abuse she has experienced instead can result in enduring and stigmatizing labels that connote chronic mental illness.

Perhaps because of increasing understanding of the physiological and neurological impacts of trauma (and traumatic brain injury), the providers interviewed for this project seemed to broadly -- but by no means unanimously -- agree about the beneficial role that clinicians can play, and the advantage of having clinicians on staff who understand the impacts of domestic and sexual violence, as opposed to depending on external clinicians who may lack that perspective, and who may therefore have a less trauma-informed approach.

Section 7 focuses on provider attitudes about the pros and cons of having a children's advocate or other specialized child-focused staff. The providers that we asked about child-focused staffing and services, held a range of opinions about whether child-focused services should be a priority of a TH program. Some providers embraced their agency's role in working with children, citing the profound impacts on children of exposure to violence and the importance of primary relationships, like the mother-child bond, in promoting resiliency. They noted that often, work with children that begins when a family is in shelter can continue, even as families move on to transitional housing. Since OVW guidelines prohibit providers from using their TH grant to pay for children's services, other than childcare or ancillary services, any child-focused staff would have to be funded using other sources.

Other providers felt that survivors' children were not part of their primary clientele; asserted that a child's needs were best addressed by working with the mother, or with mother and child, but not separately with the child; stated that school personnel could address any child-related needs; and/or questioned whether there was a proper role for a child-focused staff person in a program that adheres to the voluntary services model, unless the gatekeeper parent had identified an unmet need that school-based personnel could not address.

Section 8 looks at staff diversity. Generally speaking, provider staff interviewed for this project embraced the idea that having someone on staff from the same ethnic, cultural, religious, and linguistic community as survivors strengthened the ability of a TH program to serve those survivors -- provided that such staff were otherwise qualified for the roles they would fill. In particular, there seemed to be strong appreciation of the importance of having the capacity to communicate with survivors in the language with which they were most comfortable. The diversity of staff, in terms of race, gender identity, and/or sexual orientation arose less frequently,³ and perhaps should be a topic for future exploration.

Section 9 examines provider approaches to staff training. Different providers have different training requirements, and use different curricula and training materials. At present there is no national standard, although one cited paper proposed such a standard, and outlined the content that the authors believed should be included. The narrative identifies key national organizations with websites that provide access to online trainings, curricula, forms, tools, and other materials that providers can utilize.

Section 10 address the approaches providers take, or may take, to supervise and support program staff, and to prevent and address staff burnout and secondary traumatic stress. The narrative discusses the costly nature of staff turnover, including both the monetary cost of staff replacement, and the adverse impact on survivors of losing a trusted helping relationship; the multiplicity of ways that programs can support and acknowledge staff, and provide opportunities and flexibility for them to de-stress; and three alternative approaches to supervision -- ranging from narrative and reflective to clinical -- all of which emphasize the importance of a safe, supportive, collaborative approach that supports a staff person's personal and professional development, and helps her avoid burnout and secondary traumatic stress.

In retrospect, our interviews did not adequately address the question of supervision, and we recommend that any future effort to explore the challenges and approaches to implementing specialized TH devote a portion of the conversation to the way that supervision is provided; the aspects of supervision that have been most beneficial; the type of personnel providing supervision; they types of issues that benefit from a clinical perspective, and how that perspective is offered; and whether and how supervision is used to

³ The one conversation in which the needs of LGBTQ staff were the primary focus was with non-TH program staff who were recommended by the Project Advisory Team, to help fill an information gap that the other interviews could not.

monitor staff for signs and symptoms of secondary traumatic stress. Because of the limited funding for staffing and the small size of some of the programs, the narrative suggests that providers may want to explore models of supervision that involve contracting with a local clinician who understands trauma and the adverse consequences of chronic exposure to domestic and/or sexual violence.

Section 11 explores the ways in which programs utilize volunteers, and Section 12 discusses provider approaches to screening, training, supervising, and otherwise supporting those volunteers.

2. Program Staffing Levels and Positions

(a) Central Role of the Advocate / Case Manager

As described by many of the providers we interviewed, and consistent with research on therapeutic alliance,⁴ the quality of the relationship between the advocate/case manager and the survivor is fundamental to the survivor's experience in a transitional housing program. The advocate/case manager's ability to provide and coordinate the provision of trauma-informed support and services is critical to the overall effectiveness and success of program efforts to help survivors recover from the physical, emotional, psychological impact of domestic and sexual violence, and develop and implement plans for moving forward in their lives.

Although [Jennings' \(2007, p.22\)](#) citation of Dr. Judith Herman's work in *Trauma and Recovery* refers to treatment services for children, it is broadly applicable to adult survivors, as well:

"All trauma-specific service models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections. The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992)."

Although the programs we heard about in our provider interviews varied dramatically, the central role of the advocate/case manager was common across all programs.

(b) Program Variation

OVW-funded transitional housing (TH) programs vary in capacity, focus, and budget; housing configuration; size and nature of service area; size, budget, and scope of parent agency; survivor demographics; and approach to services -- to name some of the key parameters. Some programs are operated by relatively small agencies whose only other program may be a DV shelter, while others are housed in large, full-service domestic violence/sexual assault agencies that operate multiple programs, including outreach and non-residential services programs, a shelter, a court-based program, a sexual assault nurse examiner program, children's program, employment program, and more. Some TH programs depend entirely or almost entirely on OVW funding, while others have multiple sources of funding, or exist in conjunction with other, differently funded TH programs. Some programs serve large metropolitan areas that include racially, ethnically, and linguistically diverse communities, while others serve sparsely populated, nearly homogeneous regions.

The TH programs operated by the providers we interviewed likewise varied, ranging from those that served under 10 survivor households to programs serving upwards of 50, 60, and even 70 households. Some of the programs relied entirely on congregate housing or clustered housing or scattered-site housing, and some operated programs using a mix of housing types. Some providers owned their own housing, some used leased housing, and many provided rental assistance to support survivors in leasing their own transition-in-place housing. Some were located in dense urban areas, some in sprawling rural areas, some in suburban areas, some covering a mix of geographies, and some on Native American reservations. Most were operated by agencies that focus entirely on domestic violence and/or sexual assault, but some programs were operated by agencies with broader missions, like a YWCA, a Salvation Army, or a Volunteers of America.

⁴ See, for example, [Frigo \(2006\)](#), the Butler Center for Research discussion about therapeutic alliance and treatment outcomes, and the [Martin, Garske, & Davis \(2000\)](#) analysis identifying therapeutic alliance as a consistent predictor of treatment outcome.

Not surprisingly, then, approaches to staffing and actual staffing patterns varied from program to program.

The continuum of program approaches to offering and providing services ranged from very hands-on to largely reliant on participant initiative to ask for help -- perhaps reflecting the sensibilities of the region or cultural community served, the geography or configuration of program housing, or the agency philosophy.

In some congregate or clustered programs, staff might be in daily contact with participants, and might offer regular group activities; in other such programs, staff might have a much lower profile. In some scattered-site programs covering large multi-county regions, staff might only see participants on a very occasional basis, might use phone or email for most communication, and might sponsor few or no group activities. In other scattered-site programs, staff might spend considerable time on the road, traveling to and from participants' apartments. And in other scattered-site programs whose units are spread over a relatively small geography, patterns of communication and group activities might resemble service patterns in a clustered housing model.

All these factors play a role in program staffing levels and composition. Also important is the organizational context of the program -- the other programs operated by the parent agency (e.g., shelter, non-residential services, counseling, outreach, etc.) and the availability of staff from those programs, and from partnering agencies, to supplement services provided by staff specifically funded by the OVW TH grant.

In some programs, a single staff person might wear multiple "hats," reviewing applications for program assistance; interviewing prospective participants; doing safety planning and supporting participants seeking court orders; working with participants on their goals and on developing individualized plans; helping participants with benefits and housing applications, with housing search, with job search, and with getting connected to community resources, including child-focused services like childcare/Head Start, Early Intervention, or school-based services; supporting participants with life/tenancy skills development, including budgeting and finances and credit repair; leading support groups; providing transportation; and offering follow-up services to participants who have left the program.

In other programs, some of these roles might be leveraged from other community agencies or from other programs operated by the OVW grant recipient (e.g., shelter-based counselors, shelter-based children's advocates, employment specialist, court-based victim advocate, etc.), or might be furnished pursuant to an MOU with a community agency, by interns from a local university, or by professionals on a pro-bono basis.

TH programs operated by full service domestic and sexual violence agencies that also operate a shelter and that use varied sources of funding to provide a mix of non-residential service programs and maybe one or two other types of transitional housing are able to offer a richer variety of services, and to employ a staff that better reflects the racial, cultural, and linguistic diversity of the victims/survivors in their service area than one- or two-person programs operated by small agencies with more limited resources.

That isn't to say that small programs can't provide effective transitional housing; they absolutely can and do. However, programs that primarily or entirely depend on OVW TH grants to pay for staff are likely more limited in what they can offer than more richly endowed providers in more service-rich communities, which can leverage the skills, expertise, and/or diversity of staff from other in-house programs or partner agencies.

What constitutes a best practice for a well-resourced program operated by a full-service agency that owns and leases units in a service-rich community might not be feasible for a small scattered-site program serving sparsely inhabited counties in a resource-poor state. Similarly, the staffing patterns that are ideal for one type of program may not work in a very different setting.

In developing and implementing its preferred approach to providing transitional housing and services, each program makes important choices about how best to use the resources at its disposal, and how best to leverage the opportunities and cope with the challenges posed by its operating environment. As explored in the pages that follow, the way staffing fits into that equation varies significantly from program to program.

(c) Statistical Snapshot of Program Staffing

As described in the program-wide summaries of the semi-annual reports submitted by TH grantees, OVW grant funding, on average, pays for a single FTE of staff, typically a person filling a case manager, advocate, or service coordinator role; a few hours/week of specialized or adjunct services; and a bit of administrative time.

What does the VAWAMEI Semi-Annual Report (a.k.a. Muskie Data) Tell Us?

Every six months, OVW-funded TH programs submit data on the OVW grant-funded housing and services provided and households served. The following is a summary of that data for the 24-month period (7/1/2012 - 6/30/2014) covered by four semi-annual report summaries available on the [VAWA MEI website](#).

On average, over the four reporting periods, 96% of projects reported using OVW TH grant funds to pay for staff. On average, each such project funded just under 1 FTE of staff, which, on average, paid for:

- .80 FTEs of positions providing case management-type services (e.g., case manager, program coordinator, housing advocate, transitional services advocate, victim advocate)
- .11 FTEs of positions providing specialized or adjunct services (e.g., counselor, child advocate/counselor, child care worker, support staff, legal advocate, attorney, driver, facilities/operations staff, IT staff)
- .07 FTEs of administrator time.

Although the semi-annual reports provide data on the number of FTEs of staff funded by OVW, the numbers of survivors served by OVW-funded staff, the number of months assisted with OVW-funded vouchers, and the number of bed nights paid for in OVW-funded provider-owned or provider-leased housing, there are a number reasons why it is not possible to calculate average caseload sizes, including the fact that OVW-funded staff also provide services to survivors in TH units assisted by HUD grants or other funding sources, and the semi-annual report does not track length-of-stay data for survivors in those otherwise-funded units.⁵

Generally speaking, interview data indicated a staff-to-participant ratio of between 1:8 and 1:12, although some programs asked staff to handle higher or lower caseloads. By comparison, a survey of twelve TH programs some ten years before our interviews by [Correia & Melbin \(2005\)](#) reported similar or perhaps slightly lower caseload sizes:

"A full-time employee working only with participants in transitional housing serves anywhere from three to ten families simultaneously, with most programs citing eight to ten families as a typical caseload. . . . The number of families served at any given time by one employee is affected by the breadth of the staff person's responsibilities." (p.6)

⁵ In order to calculate a point-in-time caseload or the average caseload for a six-month period, one would need to know the number of FTEs of all program staff providing direct services, and not just the FTEs of OVW-funded staff. Likewise, one would need to know about survivors in units funded by HUD or other sources, who were served by OVW-funded staff. One would also need to know the number of survivors in the program at different points of time. While program-wide semi-annual reports provide data about the numbers of survivors served over each six-month period, they do not provide enough data to determine how long each survivor was served during any given six-month period. For example, while individual providers report on the amount of time in the program at the point of exit or termination, they do not report on the amount of time in the program for survivors continuing to receive services as of the end of each six-month reporting period. The semi-annual reports *do* include data on the number of bed nights or months of vouchered housing, but *only for units funded or assisted by the OVW grant*. Likewise, the data on exits and terminations only counts survivors that received OVW-funded housing assistance. OVW-funded staff often also provide services to survivors in TH units assisted by HUD or other funders, and there are no data about the how long those survivors were in the program.

The following provider comments offer a sense of the size and shape of programs, the number and type of staff, and the various program approaches to thinking about caseload size.

(d) Provider Comments about Overall Staffing Levels and Positions

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) I wouldn't make it any more than eight clients per staff member. Our families and single women need so many things besides housing. They're in debt collection, they need job training, they need to obtain birth certificates, they're in custody battles, they're working through immigration, they need child care, and they need transportation assistance. They need the same kind of case management as for homelessness, but they need even more support because of their trauma histories. Above 8 to 1 it would be overwhelming.

(#02) We have two OVW-funded case managers. You need one case manager for every six or seven families. Scattered-site housing becomes difficult when you have limited staff that has to drive a lot and to different areas. Clustered units are best if the housing is located outside your facility. Co-located units are the most easily managed program housing with limited funds and staffing.

(#03) We work with 15 new families per year. Right now, we have families in 17 different scattered-site units with 10 different landlords. We have one licensed social worker that does case management, advocacy, and housing advocacy. We also try to provide transportation as an in-house service. I'm the program director. My boss is the director of programs over the agency. All three of us are involved with day to day operations. A lot of appointments are done in the evening because some women are working and don't get home until after 5pm. We flex our schedule to see them after-hours. We don't do any weekends. There'll be an occasion where an emergency comes up where we need to see them, but we're not set up as an emergency program.

(#04) One full-time staff provides services to six survivor households in scattered-site, transition-in-place apartments. Six participants per staff seems the max, especially when survivors first enter the program. They have to try to find a job, apartment, work with the state Department of Social Services, find child care, etc.

(#05) Direct service is just me; there's also my manager and we have a Director, but for case management, counseling, advocacy, life skills, that's me. I provide counseling and advocacy for kids as well. We have counselors who see children in our outreach program, but for transitional housing it falls under me. I'm an LCSW so I play many roles with them - case manager, property manager, and therapist. I do home visits, maintenance requests, and handle emergencies.

(#06) I think having one designated full time person to every five adults is probably the most that it should be. And supported by other staff members for sure. But one designated person to be that go-to person who can go to the hospital when a participant needs them, can take them a food box when groceries run low, etc.

(#07) The OVW grant is the only source of program funding; it funds one half-time staff position, and some administrative support. However, we are an umbrella agency, and we have a domestic abuse resource center, with eight staff. We offer substance abuse prevention services, mentoring and family education.

(#08) We have a full time case manager plus part of a program manager's time for supervision and to act as the landlord. The house isn't staffed 24 hours a day. In addition to supporting current participants, the case

manager also provides six months of follow-up support to people who have left the program, as well as case management, safety planning, and crisis intervention for people on the wait list, so she's very busy. It would be better with more staff, but we make do. One to ten is the ideal ratio but when you add people who are waiting and people who've moved on, the workload gets bigger. A communal program like ours takes more staff time than a scattered-site program where participants only come in every so often to meet with you.

(#09) The OVW grant fully funds one full time direct line staff position and about 7% of a supervisor's time. I think our staff-to-client ratio (1:7 or 1:8) is pretty solid. It really depends on who is in your program and their needs. Everything is dictated by the individuals or families we're working with. Individuals could need just as much support as families.

(#10) There are two direct service staff -- an advocate and the manager; both of them do the advocacy and the counseling. The advocate position is 100% dedicated to working with the residents. The manager does some case management, but has other administrative responsibilities, program planning, and things like that.

Having two staff for 21 families has felt okay, because we have that structure, and because we are not the only two people working with these families: we have three childcare providers (who care for kids when we have meetings), we have volunteers doing different things, and we have collaborators, like therapists, so we have a big team -- maybe the equivalent of five full-time people. We decided that if we needed more help, we could define the need and then ask the community to help.

(#11) We have three full time family advocates. Half of one of the advocate's time is devoted to doing the intakes - meeting with anyone who is interested in applying for the apartments, and helping them get ready for the move-in process: the safety planning, their birth certificates, any money they need for the move-in. The other half of his time he provides our children's services. He does play therapy and family therapy with the children. We also have two family advocates, who provide the advocacy for the families who live in the apartments. They each serve half the families in the program, and they also have been trained to implement the Positive Parenting Program. They work individually with the moms, giving them parenting tips, looking at each child's behavior individually and talking about approaches that the parents can take. OVW pays for one of the three positions. The separation of roles helps keep it a little clearer and more like the real world.

We have three bilingual advocates who work with all the Spanish-speaking families that live in the apartment complex, as well as families from the community. We also house our legal department there, which includes full-time advocates that assist with protective orders. We have a grant which they use to find attorneys to help with contempt orders, child support enforcement, divorces, etc. Like the bilingual advocates, the advocates in our legal department assist both transitional housing participants and other DV survivors in the community, including a small number of families in scattered-site units who are working on their visas.

(#12) We have a separate grant-funded child advocate as well as our transitional living advocates. We also have an employment specialist - an MOU partner - who holds office hours at the house and leads monthly workshops. We also have a sexual assault MOU partner from a different program in that same agency.

(#13) I think having a coordinator -- someone on the ground to oversee the day to day activities works well. The way we have it divided up is one person is the landlord type to make sure the property is kept up, to coordinate ongoing maintenance, to check in with people, to collect the "rent," and things like that. And then, at least one person -- a caseworker or an advocate -- to work directly with the family on developing their action plan to meet their goals, and to help coordinate with other community services.

(#14) I'm here as the program coordinator and we also have a counselor that comes in to provide counseling services for our clients. My time, a part of the counselor's time, a part of the job developer's time, and part of our director's time are the only positions specifically funded for the transitional program. These are all agency staff who are funded under other offsite programs, whose services our transitional clients have access to.

(#15) Every participant receives advocacy support and is assigned a case worker. For our single-site 42-unit program, we have a team of five advocates, a program director, and a team of social work interns. Our scattered-site project has an advocate and a program director. Staff that support both those programs are an addiction specialist, and a clinical director. Although there are times when these clinicians step in and work directly with survivors, their jobs are to support the advocates in our programs so that they're able to address issues of addiction and mental health, and are fully trained and can feel confident working in the low barrier, voluntary services environment our programs maintain.

(#16) We have 16 units co-located in our shelter and four scattered-site apartments. We have two full-time advocate/case manager positions funded through OVW, along with a small percentage of their supervisor's time. Transitional housing participants are eligible to participate in all of our agency's comprehensive services -- our counseling groups and children's services, court advocacy services, civil legal representation, supervised visit and safe exchange program, and all the other programming funded through other sources.

(#17) We have an advocate who works mostly with children, and whose position is funded partly by the shelter and partly by the transitional housing. She develops a connection with some of the children while they're in shelter and then she goes on the home visits with the transitional program coordinator and provides activities and interaction with the children while the program coordinator meets with the adults. She also runs a group for the children while their parents are in workshops led by the program coordinator.

(#18) We have two TH programs, one funded by a HUD grant and one by an OVW grant. Each grant funds a fulltime advocate. As the OVW advocate, I also serve as the overall TH program coordinator. Our shelter has a Spanish-speaking staff person who helps guests with their applications for transitional housing and serves as a translator for Spanish-speaking participants in the TH program; a small portion of her salary is funded by the OVW grant. We have so many Latino clients that probably, if we had the money for an interpreter, we could do a whole Spanish speaking group and provide all our services in Spanish, as well as English.

Our agency has a full floor of therapists and intern therapists that lead free support groups and that offer free counseling (in English and Spanish) for anyone in the community that needs it (including TH participants). However there's more demand than therapists, so there's a waiting list.

(#19) (Not a current OVW grantee) Our HUD transitional housing grant pays for two part time case managers, or as we call them, resident support coordinators, and part of the salary of the program director/supervisor. It used to be that there was one full time position but we found it better to split that full time position into two part time positions, so we could accommodate clients with different languages, as well as clients with different schedules (e.g., working a late night shift).

Our agency has a clinician, an LICSW, who has two MSW interns every year that TLP clients can schedule meetings with. They can either speak with our clinician or her interns. We also have a housing advocate that offers the TLP clients support with their housing search, which is a big need in our region. Our housing advocate also works with shelter residents to who want help finding housing.

(#20) Our OVW grant funds a halftime case manager and rental assistance for the six units. All the other supportive services that residents access are leveraged, either through our agency or a sub-grantee, which sponsors children's programs, money management classes, and a program that can match participants' savings. Participants have access to all of our agency's counseling, life skills, advocacy, and children's services.

(#21) The OVW money helps to fund some of the staff positions in both of the counties we serve. We have a full time advocate in one county, and about 20 hours of her time is OVW funded. In our other county we have two part-time economic and housing advocates and one full time economic and housing advocate. We have my position as program director and a safe house advocate; each of these positions is partially funded through OVW and partially through HUD, plus we have other grant funding.

(#22) Our program staff includes a portion of my time as program director; a full time coordinator and a full time client advocate who provide direct services; and part-time staff, including a facilities person who maintains our building, a part-time childcare person who is with the children while the mothers are in our groups, and a part-time Spanish interpreter. In total, that's equivalent to three full-time staff positions.

Our counseling program, which can serve our transitional clients, has funding from other sources including the state and the county, and we have a child specialist and a children's counseling program. We receive other VAWA and VOCA grants from the state's criminal justice agency, so some of our transitional clients who are involved with Child Protective Services have met with that agency's domestic violence liaisons. And, we have staff at family court to assist victims in obtaining a temporary or a final restraining order.

We have an OVW-funded partnership is with an organization that assists clients with credit repair, financial education and budgeting, and with filing their taxes; they also have a loan program and an IDA program.

(#23) The main person providing services is our transitional housing case manager. There are a couple of accessory staff that have a little bit of funding, but our case manager really is the one who is going to sit down with clients, talk to them about their housing needs, talk to them about their history, work with them to identify housing that they're interested in, go out with them to get the housing, meet with them about budgeting, refer them to programs to help with furniture and things like that. She works about 30 hours a week to support our eight scattered-site participants.

(#24) Part of the salary of our transitional housing coordinator is paid from a HUD Continuum of Care grant and part from an OVW grant. She's the main support person for the adult in the family. We have a children's advocate who provides support and supportive services to kids in the family, if they request it. The children's advocate also provides parenting support to mom if she requests it, and we also have some child care. The OVW grant pays for 0.3 FTE of the children's advocate's time and for 0.25 FTE of the child care worker's time. The remainder of their funding comes from the grants that pay for shelter and outreach services.

(#25) (Not a current OVW grantee) Our case managers each maintain caseloads of 12-15 families. Ideally it's closer to 12. Services are very much a team approach. The team consists of a case manager, employment counselor, credit counselor, two child services staff, the deputy director, and myself. Sometimes the director of our children's program will join us, and we'll learn about what's going on with the littlest children, which will be an indicator of something we want to address with the family.

(#26) Four case managers handle the 60 to 70 transitional and rapid rehousing units. A CoC transitional housing grant through the County funds the on-site case manager at the 10-unit complex and a half-time maintenance man that does all the repairs and prepares the apartments for new participants. Our OVW funds pay for two case managers that serve the scattered-site participants, as well as for some services from a couple of community MOU partners. A CoC rapid rehousing grant funds the fourth full-time case manager.

(#27) Part of why we went to the scattered-site model was because we can ebb and flow with the funding. We can work with more families or fewer families depending on what our pot of money looks like and what our staffing looks like. As a general rule, our full time housing advocates would have a participant load of 8 to 12 or 14 households. That would include some folks that are well on their way and some folks who are new, because there's always a lot more time on the front end, especially when you're doing the housing search and trying to help somebody get settled somewhere. And then that tapers off.

Questions to Consider

1. Often, the level of direct services staffing and the staff-to-participant ratio are determined by the levels of funding for housing and personnel and the numbers of units of housing that can be financially sustained at any given time. In turn, the level of client assistance depends less on the amount and type of assistance that participants need, and more on the amount of time that staff can devote to program participants (which often exceeds the hours for which they are paid).

If program staffing levels were, instead, based on consideration of staff members' responsibilities and the service-related needs and interest of participants, how might the following parameters and assumptions be relevant in determining an appropriate staffing level?

- The role staff play in serving survivors on the waiting list (e.g., helping them prepare to search for the transition-in-place housing they will occupy while in the program, helping them address credit issues, apply for benefits, get on waiting lists for affordable housing or housing subsidies, etc.);
- The configuration of program housing, and what that will mean in terms of time spent onsite, traveling to meet with participants, etc.;
- The amount of face-to-face time versus communication by phone/email/texting;
- Participants' needs and barriers; interest and initiative in accessing assistance; and general level of engagement -- and the role of staff in reaching out to participants to help sustain their engagement;
- The extent to which participants independently address their own needs versus the extent to which staff "walk alongside the participants" and support their efforts;
- The extent to which staff provide follow-up services to participants that have left the program;
- The amount of time staff attend to other responsibilities (e.g., screening and interviewing program applicants, cleaning and preparing units that new participants will occupy, preparing for and running support group meetings and participant workshops on topics of interest, organizing other group activities, reaching out to landlords to find new units, doing data entry and preparing reports, etc.)

2. If certain staff responsibilities could be shifted to other persons -- other in-house staff, staff from partner agencies, volunteers -- what kinds of changes would most benefit the participant/staff relationship?

3. Promoting Continuity of Care - Overlap in Shelter and TH Program Staffing

(a) Overview

Given the importance of the relationship between the case manager/advocate/services coordinator and program participants, some of the agencies that operate both a shelter and a TH program are organized so that staff in the shelter who have developed supportive relationships with shelter participants continue

working with those participants as they transition into the TH program, and remain in partnership for the participant's entire stay in the TH program.

On the one hand, this continuity of care allows participants to build on and leverage the trusting relationship with their shelter case manager while they are in the TH program, rather than having to start from scratch with a new staff person who knows only what they've read in the casefile. On the other hand, as discussed in [Chapter 2](#) ("Survivor Access and Participant Selection"), programs that primarily or exclusively enroll survivors referred by their agency's DV shelter staff may be unduly restricting access to their TH program, and may even be at risk of violating fair housing or anti-discrimination laws, depending on the basis for staff referrals.

(b) Provider Comments about Overlap in Shelter and TH Program Staffing

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) We run our shelter and transitional programs together; our staff are actually really intertwined. We have a full time transitional coordinator, and I think that makes a big difference. She works directly with the women, so she ends up having a pretty small case load. Just whoever is in transition at the time or has recently left that she's doing follow-up with. If a woman is stuck, and if they've come into our transitional program from our shelter, they've had an advocate before that who they tend to have a good relationship with; we often bring their advocate in to talk to them because it's another voice.

They wanted to check in with somebody who knew their history. I think retaining staff helps in how long people stay connected to a program.

(#02) We have worked with the kids in the shelter, and they're usually the kids that go into transitional. So it's a natural progression for our child advocate to continue to work with the kids that are in transitional.

(#03) We do our staffing across all of our domestic violence programs. We have eight case managers. When a participant starts in our shelter and they get accepted into transitional housing, their case manager stays with them. We don't have separate staff for just our transitional housing program. We have DV program staff who follow participants from shelter to transitional housing. Since the case manager they had in the shelter is going to follow them into the transitional program, there's already a relationship.

(#04) We try to maintain continuity of care. We have heard from clients in our surveys that it's nice to maintain the same advocate throughout the programs, so we try to do that. Sometimes due to staff turnover it's not always possible, but that's our continuum of care practice.

(#05) One of the shelter clients was telling her how she really appreciated everything that she was doing for her in the shelter, and was afraid to leave the shelter. She was afraid to then go out into the community. She's made a connection with the program manager, and now she's going to have to go out and start over by herself. She'll have a transitional housing case manager, but it's somebody new. We're always looking for better ideas to improve services, and we really have been focusing on relationship building and the importance of that. It's hard to switch over to somebody else, and that might make them lose interest; I could see that side of things. We'd be interested in finding out about other programs whose case managers have stayed with clients from shelter to transitional housing, and how successful they've been.

(#06) I'm in the shelter and I'm the only one that works the transitional program. I interact with the shelter clients on a daily basis. I know their names, I know their family, I know their situations, and, with the help of that daily interaction, I know who is going to be a good fit for the program and who's not.

In turn, the clients who are enrolled into the transitional program know me, know my expectations, know that I'll be there to encourage, support, and help them, that I'm not somebody who's going to be against them. That knowledge motivates them to participate in more of our voluntary programs because they know we're here to support them. A lot of times a DV victim will be defensive, and our ongoing contact helps break down some of those walls, as they come to know that they can trust us and rely on us for services and support.

(#07) All of us on staff take back-up shifts for our crisis line through the month, so volunteers answer the phone but then if there's a problem there's a staff-person assigned for them to call.

Our staff functions as a team, so we have weekly staff meetings where we're in communication about what's going on in the shelter and what's going on out back in the transitional program. Our transitional advocate is pretty heavily involved with the shelter just in terms of being somebody that they know.

(#08) The transitional housing program coordinator is a fairly regular presence at our emergency shelter, so she has the opportunity to meet shelter residents and establish rapport with them. She also stays in weekly, if not more frequent, contact with our shelter advocates, and gets to know about the potential TH residents, and can have follow-up conversations with them when she sees them at the shelter about things they're hoping to do. By the time a resident enters transitional housing, they have a pretty high degree of trust in her.

I truly believe that it's thanks to the rapport that's established with that staff person, first meeting her when they're at the shelter and then seeing the value of connecting with her and working with her when they're in the transitional program, to help clarify some of their goals and track weekly progress. I think we have been very discerning and extremely lucky in the two staff persons that we've put in that role. They are really gifted with client service and maintaining client rapport. For the past year and a half, all of our TH residents have either been enrolled in school or employed, and that's the first I've seen that in this three year period.

(#09) We have one full time transitional housing coordinator, who is based at our shelter location and she is constantly working with the women in shelter to see if they are eligible for transitional housing and where things are with the status of our units and any other transitional housing in our community. And that ongoing connection is important to supporting transitional housing participants' willingness to engage in services.

It is common for our youth advocates who lead groups for children in shelter to continue to have those children continue in their groups after they leave our shelter services.

We hire people within those communities, following our philosophy that you must be served by somebody from your community. It's respectful and it's critical to how we connect with a community - we are supporting employment within that area, rather than sending somebody there. And then a participant's connection to the advocate in their area is bridged with the transitional housing program.

(#10) (Not a current OVW grantee) Staff for the transitional/scattered-site program always overlaps with staff at the shelter, because we find that, most often, they'll form a bond with someone and it's really hard to say that "although you're in the same building, your former advocate only works in emergency shelter, so you can't work with her anymore; now you have to build a relationship with someone else." We found that that was another struggle when we had specific funding for specific positions. Now we overlap the staff and if you

began working with “Susie” and you formed a really good bond with her and you feel comfortable talking to her and you go from emergency shelter into transitional housing, you can keep working with “Susie.”

With the scattered-site program, it's different. We don't have enough staff that we can just send our shelter-based staff out to see the scattered-site participants; we only have one staff person who makes visits to scattered-site participants, but it's really up to the participants as to who they want to continue working with.

(#11) Although survivors might be assisted in their housing from different pots of funding, we try very much to have continuity for the survivor in terms of who she is working with. Frankly, a lot of the federal funds don't pay for staffing. We often are supporting the staffing from different pots of money than the housing dollars. We have ways to figure all that out, so that somebody who is working with an advocate can continue to work with that advocate. It's certainly more trauma-informed to not have to tell your story all over again and to not have to get to know a new person. Somebody who has been with you through other stages of what you've been working through can certainly jump in more easily. It's much more survivor-friendly.

Questions to Consider

1. Staff overlap between an agency's shelter and TH program offers the advantage of continuing a supportive relationship and avoiding the need for survivors to tell their story all over again.
 - What are the advantages and/or disadvantages **for survivors** in having the same advocate in TH as they had in shelter?
 - What are the advantages and/or disadvantages **for the agency or TH program** in having staff working in the shelter as well as the TH programs?
2. Elsewhere in this chapter, diversifying staff roles and balancing staff caseloads are suggested as possible strategies for preventing staff burnout and secondary traumatic stress.
 - Does dividing staff responsibilities between the shelter and the TH program accomplish that kind of diversification and caseload balancing, or is it likely to increase stress? What aspects of working in the shelter and/or the TH program determine whether a dual assignment helps or exacerbates staff stress?
3. How does the housing model -- congregate, clustered, scattered-site / transition-in-place -- impact the feasibility and logistics of a staff position that includes both time in the shelter and time with TH program participants?

4. What Providers Look for -- and Look Out for -- When Hiring Staff

(a) Overview

When asked about what they look for when hiring staff for their TH program, providers we interviewed mentioned a variety of attributes, often including:

- Traits like empathy, compassion, flexibility, and good listening skills;
- An understanding of domestic violence and what it means to be an advocate for a survivor;
- Being comfortable and culturally competent in working with survivors from diverse backgrounds and situations;
- Being able to provide services and support without letting judgments or biases get in the way; and
- An understanding of and commitment to a trauma-informed, survivor-centered approach to services, and to the voluntary services model.

Some providers mentioned looking for relevant prior work experience and/or a particular level of education, while other providers said they looked for proven ability to work with survivors, based on the assumption that participation in required trainings and on-the-job support and supervision would enable a staff person with the necessary sensibilities and aptitudes to perform well in their job. Some providers saw prior experience as a possible liability, if they were concerned that a prospective employee might retain old attitudes and old ways, and might have difficulty embracing their new agency's values and approach to working with survivors.

[Sullivan \(2006\)](#) asserts that questions about a job applicant's understanding of domestic violence should be supplemented by questions that get at their traits, work styles, and commitment to social justice. Questions about the causes of domestic violence, the reasons that some women stay with their abusive partners, and about an applicants' comfort with people from diverse backgrounds "deal with perceptions, and perceptions can change when new information is learned.... Work styles are directly connected to core personality traits, and both are much harder to change than are perceptions, even with direction and supervision. Therefore ... it is important also to ask about how organized they are, how well they communicate with others, how dependable they are, and whether they will be competent 'team players.'" (p.17-18)⁶

[SAMHSA \(2014\)](#) cites [Jennings' \(2007\)](#) recommendation that

"The system should prioritize recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. These staff or "trauma-champions" provide needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They advocate for consideration of trauma in all aspects of the system. There should be outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organizations, peer-led and peer support programs, consumer advocacy groups; other training sites)." (p.134)

[SAMHSA \(2014\)](#) cites [Hoge et al.'s \(2007\)](#) recommendation that programs seek to recruit a workforce of similar composition to the demographic served, including persons whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery, and to invest in their development through training stipends, tuition reimbursement, and professional mentoring. Speaking more generally about staff in a behavioral health program, rather than a DV/SA-focused transitional housing program, [SAMHSA \(2014\)](#) suggests that, "Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served." (p.175)

Provider comments reflect a range of opinions about hiring survivors of domestic violence or sexual abuse, and this topic is more fully addressed in the next section.

For a step-by-step discussion about the hiring process as it might apply to shelter staff (albeit with less of a focus on the qualifications discussed by Sullivan), see "[The Profession of Shelter Work: A Manual and Hiring Tools for Domestic Violence Shelters](#)" published in 2014 by the Provincial Association of Transition Houses and Services of Saskatchewan.

(b) Provider Comments about Hiring Staff

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) You can teach people how to listen, and you can teach clinical skills; but you can't teach advocacy. I've worked with young women trained as LCSWs or LCPCs who are very smart and well-versed in clinical skills, but

⁶ [Sullivan's \(2006\)](#) discussion about strategies for hiring and retaining staff (pp. 17-26) includes suggested interview questions for both direct services staff and supervisors.

the passion and compassion, advocacy and empathy – are just not there. And I've had women who graduated high school that I can teach how to listen and feel and what to look for, and they become better advocates.

(#02) I think it's important to screen your hires for their experience and their attitudes and their beliefs when dealing with people from different backgrounds. I think coming from the same demographic or cultural background as participants is an important factor, but that the training in dealing with different cultural backgrounds is probably equally or more important.

(#03) We look for staff who fundamentally believe in the voluntary services approach; it's something we spend a lot of time on in the interview process.

(#04) We focus on hiring staff who are accepting, trauma-informed, inclusive to LGBTQ, and committed to cultural competency. Most employees have a BA, but it's not a requirement. Definitely clinical supervisors need a clinical degree. We hire a lot in house. Many of our staff started as crisis line volunteers or interns. Many positions don't require a degree. Many have previous experience instead.

(#05) Some background knowledge in human services is helpful, or volunteering. School can be important; a lot of different factors weigh in. We ask for four year Bachelor's degree or five years' experience in human services. One substitutes for the other.

(#06) You need quality and qualified staff. You can have a lot of staff time budgeted, which is great for consistency and access, but if the staff are not grounded in trauma-informed services and the philosophy of voluntary services, and don't understand trauma and how it impacts behavior, they're won't get anywhere.

(#07) We require staff to either have a High School diploma or GED. We have deliberately kept our requirements at that level so we don't screen out potentially awesome employees.

(#08) I look for empathy and passion for the work that we do. You can't teach those. Good judgment is something you can't teach and that's important as well. The ability to work without a lot of direction is extremely important, so working autonomously and actually accomplishing something. Honesty is important but you can't really know about that from an interview, and leadership is important because, after all, we're trying to lead people on the path from victim to survivor. And the rest of it you can teach.

(#09) It can be very hard for staff who are working in a low barrier, voluntary service, trauma-informed environment to let go of some of the training that they came with, previous experiences at other programs, and to re-program them in this non-traditional context.

(#10) (Not a current OVW grantee) We try to keep a really positive environment because the one thing we don't give our staff is a set of black and white rules, and that can be really frustrating for everybody. So we've got to find staff that can roll with it, and meet people where they are. Most of us working in this field have probably been there and done that, so we know how important it is for staff to be nonjudgmental. I think participant willingness to engage with staff is more about using a non-judgmental approach than about coming from the same background.

Questions to Consider

1. How does the level of available supervision and the relative autonomy of the role for which a candidate is being considered impact the hiring decision?
2. How much and what kind of experience should a candidate for an advocate position have?
 - How important is having experience working with survivors of domestic or sexual violence?
 - How important is having knowledge of the community or region served, including familiarity with the service providers and other organizations whose assistance might be sought in supporting providers?
3. How much and what kind of experience should a candidate for a supervisory position have?
 - How important is supervisory experience?
 - How important is prior experience in residential victim services?
4. How important is a prospective advocate's understanding of and commitment to trauma-informed, survivor-centered services and the voluntary services principle?
5. Does an advocate working in a site-based program need different skills than an advocate that provides services to a scattered-site clientele?
6. How would the hiring decision be different for filling an advocate/case manager position in a relatively large program, where that advocate/case manager would have several peers and be part of a team versus a position in a program with few or no other staff?

5. The Pros and Cons of Hiring Staff who Are Survivors of Domestic/Sexual Violence

(a) Overview

Although it would be entirely inappropriate for a provider to ask a prospective employee whether they had ever experienced domestic or sexual violence, there was general agreement among the providers we interviewed that a candidate with personal experience as a victim would likely volunteer that information during the interview, if her interest in the position stemmed, at least in part, from her lived experience.

Generally speaking, the providers that addressed the topic (it wasn't part of each conversation) were willing to hire a survivor, as long as she was well qualified for the job. However, there appeared to be a continuum of opinions: at one end of the spectrum were providers that expressed pride at being survivor run and having paid and/or volunteer staff who were survivors. At the other end of the spectrum were providers that expressed a more cautious attitude about bringing survivors on board as staff or volunteers. One provider pointed out that given the prevalence of domestic and sexual violence, if a program did not employ survivors or utilize them as volunteers, its workforce wouldn't be truly representative of the larger community.

A number of providers commented that it could be empowering for participants to receive services from a survivor -- as long as the survivor's healing was "complete enough" to allow her to fully focus on addressing the needs of program participants and not her own trauma, and as long as she had good boundaries, knew when and how much to share of her own experiences, and knew never to compare or judge participants' experience against her own.

In fact, understanding and maintaining appropriate boundaries was seen as essential for any staff person (or volunteer), regardless of whether they had personally experienced domestic or sexual violence, and a session on boundaries was seen as an essential component of every paid and volunteer staff member's training.

(Another concern that was raised about employing survivors pertained to vulnerability to re-traumatization and secondary traumatic stress (STS). As discussed more fully in Section 10 ("Support, Supervision, and Efforts to Minimize Burnout and Secondary Traumatic Stress"), the research is not definitive on the question of

whether and under what circumstances a survivor of trauma is more vulnerable to re-traumatization and STS.) Provider #33 raised a concern about the possibility of a "dual relationship" if someone who had gone through the program came back as a staff member while staff that had previously worked with her were still part of the agency. Various perspectives on that topic are presented in a footnote to that provider's comments.

(b) Provider Comments about Hiring Staff Who Are Survivors

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) People who have survived or witnessed domestic violence can make the best advocates, but if they haven't healed they can make the worst.

(#02) Depending on her education, experience, and skills, I would hire a former participant to be a case manager, an advocate, or for a higher level position. Former participants could be considered for any position, as long as they have the qualifications we are looking for. I think it's important to hire survivors. But just because someone is a survivor doesn't make them a DV expert.

(#03) Our movement was started by survivors and it's a core value that people who have been there can often provide perspective and good support. Many survivors work at our agency, and within the program, offering the survivors a voice in shaping the program is really important to us.

(#04) I've learned over the years from interviewing people for different positions who open up and say, "I was a victim during my first marriage or during college." Sometimes those interviews turn into counseling sessions, because they haven't fully dealt with the abuse. I imagine some of our staff are DV survivors, but I don't know. People are employed for their experience, their skill set, and their ability to do a job.

(#05) We have survivors both on the board and on staff. It's defined as one of the areas that we look for. Sometimes you don't know whether someone is a survivor until after the fact, but when we do know, it's definitely taken into consideration. We value that.

(#06) We had an unwritten guideline that someone could not come back and volunteer or apply for a posted position for at least 6 months after they graduate, because we hoped that they would find their own stability before being overloaded with other responsibilities. But we're looking at that in different ways now, because that sense of connection and sense of giving back may fulfill a part of them that just expands into the rest of their life. And so, it's really a case by case basis. There may be someone who's ready and able to give back and maintain that healthy balance for themselves and the program after a couple months or after 6 months. And there may be someone who doesn't develop that stability in their lives for a year or two, or more.

(#07) If we were to hire a survivor, it wouldn't be a recent survivor; if they've been out of that situation for several years, it can work. I think the ability to help and relate would be great, but there can be transference or blending or boundary issues if it's very recent.

(#08) Our agency very much conforms to the NASW Code of Ethics for Social Workers, and we are very careful to avoid anything that looks like a dual relationship with our current or former consumers. The NASW Code of Ethics doesn't have a time frame addressing when the consumers were involved. That's not to say a former

client couldn't be employed. We would look at when they were involved with us, who was their advocate? Who was their therapist? Are those people still on staff? Would we create a dual relationship?⁷

(#09) I know that the women and children we work with can tell whether people are speaking from a level of, "I'm concerned, I'm empathetic, I care about you," versus, "I've been there." I think it's important, when possible, to have survivors doing this work. I think they can give a perspective that people who have only done the work can't. However, if there are unresolved issues, or if a participant is choosing a different path than maybe they chose, that can be a challenge.

(#10) We have a lot of staff who are survivors themselves, and the pros are that their level of empathy is higher. The cons are that if they aren't far enough away from the violent situation, there's a possibility that there are going to be triggers and they'll need some self-care to get past that.

(#11) (Not a current OVW grantee) In terms of the pros and cons of hiring staff that are domestic violence survivors: I'm prejudiced about that one since I am a domestic violence survivor, but I think it depends on

⁷ **Note:** The question of whether a "dual relationship" is inherently bad is still being debated in the profession. Much of the focus of the literature on the topic focuses on avoiding dual relationships that may exploit or harm (former) clients. Section 1.06(c) of the [NASW Code of Ethics](#) states that

*"Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a **risk of exploitation or potential harm to the client**. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)"*

In her article, [Respecting Boundaries — The Don'ts of Dual Relationships](#), [Dewane \(2010\)](#) explains that,

"A debate has emerged in the social work field.... On one side are those who support avoiding dual relationships at all costs. On the other side are those who say these relationships are situationally and contextually determined. They argue that being too dogmatic about avoiding dual relationships diminishes the essence and authenticity of social work."

In their paper, [The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions](#), Gutheil and Gabbard discuss the difference between "boundary crossings" and more problematic "boundary violations" -- harmful crossings or transgressions of a boundary. They note that the nature and context of boundary crossings -- the roles of the involved parties; the time and place that the interaction(s) occurred; whether money, gifts, and services were involved; clothing worn and language used; the extent, nature, and context of self-disclosure; and any physical contact -- help determine whether a boundary crossing was a boundary violation. (Note the focus on avoiding exploitation....)

Generally speaking, maintaining appropriate boundaries is likely to be part of every provider's training for paid and volunteer staff. However, as [Kaplan \(2005\)](#) notes in [Dual Relationships: The Challenges for Social Workers in Recovery](#), *"Agencies such as HIV/AIDS organizations, domestic violence shelters, rape crisis centers, and alcohol and drug treatment and prevention programs now staffed by professionals, emerged from grassroots movements of people in response to their own needs. Though these services may have started as peer programs, most evolved into organizations with blended staff consisting of volunteers, paraprofessionals, and professionals who were, or are, also consumers. [While] consumers-as-providers contribute to services in unique and positive ways because of their understanding of clients' personal experiences," . . . in order to protect clients and former clients from exploitation or harm, there is a need for discussions in supervision "about parameters of self-disclosure, privacy, boundaries, confidentiality, harm risk, and release of information;" . . . a need for "establishment of clear procedures to resolve clients' [and former clients'] concerns about dual relationships;" . . . and a need for "programmatically supports for agency and individual service providers [that] include skills and knowledge in working with nonsexual dual relationships that naturally occur in communities." (pp. 74-87)*

where people's heads are at. I think that our experience gives us a unique perspective. But sometimes we're too close. You need to have some distance before you begin doing this work, and it's a different amount of time for each of us to get to the point of being able to reflect back on it. But we can't and don't ask if you're a survivor during an interview; that's their own private thing.

(#12) It can be helpful to hire survivors because of their compassion and connection to the work. But it can also be difficult to separate one's own victimization from others'; they need to be good at setting boundaries.

(#13) Our staff is over 90% former residents. Some of the staff are second generation -- kids that grew up in our program and worked in our teen program, and now they're adults and have children and they work here.

(#14) This is a survivor-led agency, so there are survivors in many different positions. Our leadership team includes a survivor and then it just trickles down. We do internship programs where our survivors can work side by side with us. They get a stipend, usually an hourly pay and that's like a 12-week program so they can be part of that process. A lot of the survivor support really comes from our group and it's survivors working with each other in that setting, building trust in each other, vouching for the kindness or reliability of staff.

Three of our five staff are survivors so I can always refer to a survivor if they prefer, or if I've got to have a one-on-one with someone, I can bring in a survivor, who has most likely led a group because our survivor staff oftentimes leads our active participant and alumni groups, along with staff, but the survivors are the leaders.

(#15) (Not a current OVW grantee) I would say probably 80% of my staff are survivors themselves. We work with them to make sure they understand that when we share our story, it's more about strength and empowerment versus "Oh, I need your support." What we say is "If you feel like your story will benefit someone and will help them, you can share. But if you're sharing your story because you yourself are processing, that's not appropriate."

(#16) All of the staff -- house managers and family justice specialists / case managers -- are in recovery from substance abuse, so they speak from experience. I have to say it absolutely makes a difference to the women.

We have one of the largest resident advisory committees, I think, of any state, and it's the women who have been through the program and are in recovery that we develop our programming around. Even when women move out into permanent housing, the group continues, and they meet once a month. They help with fundraising, or they think of their own ideas to promote something in the community. To me, that's what success is; these women don't have to have anything to do with us and they keep coming back.

(#17) I would say that we just focus on the empowerment model and we always talk about employees being nonjudgmental, understanding, trying to walk in other people's shoes. We try to help every staff person understand their own trauma and trauma history; we don't ask people to disclose whether they are survivors. I know there's probably more survivors on our staff than report. It's more about having an environment that is survivor-driven, empowerment-based, and in which we create a culture of respect for every survivor.

(#18) Sharing personal experience is not part of the case management model that we promote. Definitely empathy and motivational interviewing, but that doesn't include talking about your own experiences as a victim of violence. Also, that might set up a "you should" dynamic: "If I did it, you should be able to do it." That doesn't mean we haven't hired survivors, because we have. They have to have really good boundaries

and good supervision. One in four women become victims. If our staff excluded survivors, we'd be missing a whole population that could be very effective.

We have former clients serving on our board of directors. We've had former clients come back and share with current clients about how they're doing now, and what that experience was like. And we offer a support group where they can interact with people in different places in the leaving and healing process.

Questions to Consider

1. Should an agency that employs survivors in staff positions provide any different or additional kind of training, supervision, or support for those staff: (a) to address the possibility of re-traumatization or secondary traumatic stress? (b) to address boundary-related issues?
2. Are there reasons not to hire otherwise qualified survivors to fill direct service positions?
 - (a) What are the pros and cons of establishing a uniform requirement regarding the length of time that must have passed since a survivor's experience of abuse, before they can be considered for employment?
 - (b) Is there an inherent contradiction in, on the one hand, embracing an empowerment, survivor-centered approach to services, and, on the other hand, refraining from hiring survivors, or imposing a uniform waiting period before a survivor can be considered for hire?

6. The Pros and Cons of Having a Clinician on Staff

(a) Overview

Having a clinician on staff is a financial decision, as well as a reflection of the philosophy, priorities, size, and scope of the agency. A full-service domestic violence / sexual assault services agency is more likely to have a clinician on staff who can serve participants in the agency's TH program and provide supervisory support to the staff, than a small, less-well-funded provider.

A staff clinician can offer convenient in-house access to counseling or other clinical services that participants might be reluctant to travel to or access from a person or organization they have not met. An in-house clinician can provide consulting support or supervision to case management/advocacy staff for handling challenging situations and/or for addressing or preventing vicarious trauma.⁸

Unlike clinicians who work in medical settings and must document their patients' diagnoses in order to be able to bill insurance for their time, an in-house clinician whose position is funded from grants and donations can provide services without having to attach a potentially stigmatizing clinical diagnosis to the survivor (or her children). Fear of being labeled as having a mental illness is a common barrier to accessing adult or children's mental health services.

Also, unlike clinicians in other settings, who may not have an understanding of domestic or sexual violence and how the experience of trauma might affect survivors and their children, an in-house clinician will presumably have been selected for their understanding of violence and trauma, and will have participated in the customary staff training, and so, will understand and embrace the program's approach to working with survivors. In particular, a clinician who understands the nature of domestic and sexual violence will recognize that symptoms which might otherwise be attributed to an organic mental illness diagnosis might, instead, be the result of chronic and complex trauma, caused by longtime experience of abuse and violence. With clarity about the nature of the problem, there is less of a stigma, because the survivor can be assured that the

⁸ As discussed in Section 10 on "Support, Supervision, and Efforts to Minimize Burnout and Secondary Traumatic Stress," clinical supervision is seen as an integral organizational strategy for minimizing Secondary Traumatic Stress.

symptoms are 'not her fault.' Moreover, "survivors who were once confused by their symptoms and who despaired of ever receiving understanding and assistance now have the opportunity to receive effective treatment, to heal, and to get their lives back and on track." ([Courtois, 2010](#))⁹

Even with the potential benefits of being able to select and train a clinician who might better understand and embrace the survivor-centered empowerment approach, a few providers expressed significant reservations about involving clinicians, who they felt, would be likely to pathologize survivors of domestic violence, displacing the proper focus on advocacy and empowerment with a focus on diagnosis and treatment.¹⁰

The appropriate balance between advocacy and empowerment and clinical services is the subject of a longstanding debate, and the legacy of years of misdiagnosing survivors as, for example, having a 'borderline personality disorder,' which "carrie[s] enormous stigma in the treatment community, where it continues to be applied predominantly to women clients in a pejorative way, usually signifying that they are irrational and beyond help." ([Courtois, 2010](#))

Complicating matters, the cost of a clinician can be prohibitive for a small program with limited funding, as compared to a large, full-service victim services provider. If a provider can leverage trauma-informed clinical services from a community agency or pro bono services by supportive professionals, that may be more appropriate than bringing a clinician on staff, at the expense of using grant funding to add other valuable services, particularly if the caseload is small, and likely to require only a few hours.

(b) Provider Comments on Including a Clinician on Staff

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) In the treatment team meeting, the counselor/therapist who does the first assessments - a bio-psycho-social and then an assessment that screens for problem resolution - tells us what we need to know about the client's history. Because we're not just dealing with the crisis that has happened right now; we're dealing with that whole person and her whole experience, whether it was trauma when she was a child or in her first marriage. Her work informs all of our case management and the practices that we implement with the client.

Our counselor not only does assessments with new people. She also does treatment and so her schedule is packed every day. We need another one of her -- or we need some of our social workers to have the training and to develop the experience to be able to do similar assessments. But I do think it's helpful to have a separate person, who has that counseling relationship, that therapist relationship, because I feel like the assessments are more authentic and there's a foundation for the rapport and for further treatment.

Our therapist has extensive history with alcohol and drug treatment and inpatient mental health care experience so she has been a godsend. Addiction is an issue that comes up probably 50, 60 percent of the time with our clients, either their addiction or their abuser's addiction.

⁹ See the section on "Disabilities" in [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence" for more information on serving survivors with mental health-, substance use-, trauma-, and traumatic brain injury-related issues.

¹⁰ An Issue Brief by the [National GAINS Center \(2006\)](#), "After the Crisis: Trauma and Re-traumatization," based on work by [Kammerer & Mazelis \(2006\)](#), affirms that concern:

"The impact of experiencing traumatic events includes responses such as isolation, hypervigilance, substance abuse, dissociation, self-injury, eating disorders, depression, anxiety, hearing voices, risky sexual behavior, and other psychological reactions that begin as coping mechanisms and end up as compounding problems. Too often, coping responses to experiencing trauma are pathologized and designated by mental health diagnoses--including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, panic disorders, personality disorders, obsessive compulsive disorders, psychotic disorders, and eating disorders--without a full understanding of their interrelation with trauma. Immediate, intermediate, and long-term support, including peer support, for trauma survivors that fosters connection is essential to the healing process."

(#02) Our case manager does not have clinical skills. If the people we serve have needs in that area, we can refer them to other agencies, or right now, we have a clinician next door, should they request that.

(#03) I would say it's not very important for TH programs to have in-house staff with clinical skills. If there's a mental health provider in the community, that's where the service should be provided. It might make more sense for congregate programs or programs with a lot of units clustered in an apartment building to have a designated clinician available. It wouldn't make sense for a program with only eight participants.

(#04) We can't afford the cost of having a clinician on staff, but we do a great many referrals to clinicians in the town where our main office is. There are a couple of licensed clinicians and psychologists that we can make referrals to that are very good with children. Many of our clients are on Medicaid or the state's children's health assistance program, so some of the counseling costs can be covered. Once you get to the outlying counties, clinical resources are more limited.

(#05) I think it's really important that we have a clinician one day a week, because it gives the moms an outlet. People are dealing with a lot of trauma, and sometimes they just need to be able to process with someone other than their case manager, because case management is more task-oriented. Meeting with the clinician is a time to sit back and think about what she needs to do for herself.

(#06) If we could afford it, I would love to have a clinician on staff. What we do have is a medical team that comes in and provides medical support; it provides onsite medical personnel. We have a substance abuse counselor that comes in and provides services to everyone, whether they're in the shelter or our transitional housing. So whereas we don't have a clinician on staff we can make referrals for on-site clinical support.

(#07) If the funds allow it, I think that's great to have a clinician on staff. I guess I don't see it as the most essential. But if someone offered us a free clinician, I would take it.

(#08) We have an LPC family therapist. I think having a clinician on staff is important -- especially a clinician who is aware of and experienced with DV and sexual assault, which not all clinicians are -- so clients don't have to go elsewhere. When you provide on-site resources, clients are more apt to utilize them.

(#09) It's absolutely important to have a clinician on staff. We've had an amazing clinician; some of the ladies take advantage of her services and some don't. It's important for not only the moms but for the kids too; the kids have experienced trauma just as the moms have, and they have so many needs. The kids may understand it in a totally different way, or they may not understand it at all, but I think it's important to sit and talk with them about what they've seen, how they feel about what they've seen, and remind them that it isn't their fault -- so they can become healthy young children.

(#10) I think it's important to have a clinician on staff or available as a consultant because there are going to be crises, and a clinician might have different information or a different perspective than direct care staff.

(#11) (Not a current OVW grantee) I think it's very important to have a clinician on staff or contract. Everybody's got issues, including staff. A clinical supervisor can help staff step out of their patterns and

examine what's going on; or she can orchestrate our sitting together as staff and communicating about what would be best for a participant.

(#12) (Not a current OVW grantee) The director of our non-residential services is a licensed marriage and family therapist. She's a clinical social worker and she does the clinical supervision for all the therapists. We've usually had to contract that out and have somebody outside the agency do that clinical supervision for our therapist. But, now we're able to offer it in-house; and she's made a lot of great improvements to the organization. She helped spearhead the trauma-informed philosophy coming into our programs. I know that the therapists and advocates that do individual counseling feel more supported, and appreciate being able to get her feedback on cases so quickly.

(#13) The clinical piece is important but there also needs to be an understanding of domestic violence, and that's something clinicians don't always have. If they don't have that understanding, they may think that a woman should just leave a relationship, but that's not the way the woman is experiencing it. Our clients don't have a lot of options, or don't feel they do, and if there's not that understanding, we're blaming the victim.

(#14) We have a certified trauma therapist, who is in private practice, but she has contracts through various state agencies. Our participants can access her services here on site.

(#15) We're fortunate to have a licensed counselor and a part time licensed counselor on staff right now

(#16) (Not a current OVW grantee) Our DV-certified case managers are also [CADAC-certified](#) so they can provide addiction treatment services directly to participants. And we have a nearby residential resource center where they can access behavioral health services. There's a therapist that comes in every other week and a physician from Health Care for the Homeless that comes every other week. We have a dentist that comes to our PSH program site once a month, and we can get transitional housing participants to all those sites so they can access services.

(#17) When we identify that there's a more serious clinical or mental health or substance abuse issue, we involve people on our staff with that specialty. We have psychiatrists, psychologists, social workers, as well as the peer advocates -- formerly battered women from different cultures that are just as effective in their own way. Also, in our community there's a family and children's health and mental health services program, and we work very closely with them. At times, we've had to transfer people to their program when they were acting out to the point where people couldn't sleep and/or the moms were afraid for their kids. When there's acting out that's not dangerous to the residents, we have staff from that program come here to help the families function better within a house, and to assist them with their challenges. Having those relationships and having people on staff that are specialists in that area is really wonderful.

(#18) We don't have any clinical services available to participants, but we do have supportive services. Our case manager is the main support person for the adult in the family, and our children's advocate provides support and services to kids in the family and parenting support to mom, if she requests it.

(#19) (Not a current OVW grantee) Our therapist is a marvelous woman, warm and engaging and smart and she does groups on wellness. People meet her as the instructor on wellness and so already they know her, and so if they want to talk to somebody about the trauma in their life, they think, "I want to talk to Susie." We

introduce them to the person who can help them in a way that is very gentle and non-stigmatizing. She's not Dr. Guilty; she's Susie.

Sometimes, there's still a stigma; if your child needs mental health services, somehow you're a bad parent. That's especially true for people from certain cultures. To get a child into counseling, it can sometimes take months of conversations before a parent says, "you know what? I think that's the right thing."

(#20) I think clinical support needs to be available for a TH program serving survivors of trafficking. We don't readily have that in our house, but we have therapists and psychiatrists we can send you to that we have great references for. Whether you offer that onsite or not probably depends on how big your program is: if it's four units, you wouldn't, but if it's 12 units, it would be very helpful if the provider came onsite.

(#21) One of the things we've seen over the years, in addition to women getting screened out of programs, is how many labels are put on battered women unnecessarily -- and clinicians are a direct link to that, because a lot of domestic violence shelters now bill insurance companies which need a diagnosis to cover treatment services. So they have clinicians on staff saying "They're bipolar," or "They're this and that." That's appalling to me: To me, nobody should be diagnosed within the first six months of them getting clean and sober because their behaviors -- that's a good average time for them to really get it out of their system. Because once they're labeled with those diagnoses, that's going to follow them everywhere. I'm personally opposed to all the labels and medication that so many battered and sexually abused women are diagnosed with in the initial stages -- even if they're not an alcoholic or drug addict. Because if you interview a woman the day after her crisis versus six months later, you can see the difference without her having had any medications.

(#22) We have three full-time clinicians and one part-time clinician. That's where our embedded clinical program comes into play, because our advocates work in concert with our clinicians all the time, and clients are very willing and open to working with the clinical staff to address the needs of their families. Our clinical team is trained in evidence-based treatment interventions that address the needs of children who've experienced domestic violence. In addition to such interventions provided directly for the children, we work with children and their parents together, and directly with the mothers to address both their own trauma and how they as parents/caregivers can support their child, given the trauma that each experienced. We also offer a four-part workshop for parents once or twice a year that addresses the impact of trauma specifically on their ability to be a parent; the workshops are very successful with clients, because it's a huge issue for them.

My experience is that our staff is successful in engaging participants in clinical interventions because from the get-go, we create a climate of mutual respect and a nonjudgmental environment. We don't wait for parents to find a way to tell us that they think there's a problem, or to share with us that their child is struggling. We set a precedent from the very beginning that "your child will probably struggle and that's a normal reaction to what they've experienced, and we're here to help you. Nobody sets out to experience domestic violence in their life, but when you do, there's a range of things you may feel, or behaviors you may engage in, or things you may experience that are all a totally normal reaction to this abnormal experience of domestic violence. We are here to help you with that."

We don't bill health insurance companies, and because of that, there's broad flexibility in the interventions our clinical program is able to provide. We're not locked into a certain number of sessions. The frequency with which we see clients isn't predetermined by an insurance provider. We don't have to go through the process of diagnosing according to the DSM-5. Of course our clinical staff uses their understanding of mental health diagnoses to inform our interventions with clients, but we don't have to label people in order to provide that intervention. For us, it's about really building a trusting relationship with them, normalizing what they've experienced and what they might expect going forward, based on those experiences, and providing gentle interventions that don't feel overly clinical or scary to clients.

(#23) We don't have clinicians. That's something we leverage through referral and partnership. We've got a list of therapists that we know are trained in domestic violence -- many others are not. We don't do clinical services, therapy, and treatment in-house. We're very advocacy-based rather than treatment-based.

Questions to Consider

1. In what ways could a clinical perspective complement a program's strengths-based approach to services and support, and in what ways could it undermine that approach by pathologizing survivors?
 - (a) What strategies might a provider use to leverage a clinical understanding of trauma and its consequences without compromising the strengths-based orientation of its services and support?
 - (b) Does "normalizing" some of the lingering impacts of trauma and abuse -- for example, depression and exhaustion -- undermine or support an empowerment approach?
2. If a program wants to provide clinical services, but cannot afford to bring a clinician on staff, are there ways of providing access to mainstream clinical services -- particularly clinical services that are billed to Medicaid or other insurance -- that avoid the diagnostic labeling that might follow a survivor or her children for life?
 - (a) If a participant is on the fence about whether or not to seek clinical services for themselves or a child, where can they get objective information about the pros and cons?
 - (b) What are the ethical issues to consider when contemplating accepting funds that require a clinician to diagnose participants in order to be reimbursed? When, if ever, is it worth accepting such funds?
3. Clinical supervision can help advocates/case managers understand some of the trauma-related feelings and reactions of survivors and their children, and can also help direct services staff address the impacts of secondary traumatic stress that come from their day-to-day exposure to the details of the violence that survivors lived through, and from witnessing and hearing about the impact of that violence.
 - (a) If a program cannot afford to bring a clinician on staff, are there ways to offer clinical supervision, as is recommended for staff who work directly with trauma survivors?
 - (b) Are there reasons, aside from cost, not to offer clinical supervision?

7. Staffing for Children's Services¹¹

(a) Overview

Identifying and addressing the adverse impact of a child's chronic exposure to traumatic violence is critical to a child's future healthy development. The earlier the intervention, the better the outcome. As described on the [Supporting Children, Parents & Caregivers Impacted by DV](#) webpage of the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH),

"Children's experiences of domestic violence are individual, widely varied, and unique. Some children do well and may not need additional supports as they grow into adulthood. Others, particularly children living in homes where they have experienced domestic violence from an early age and/or exposure to severe and prolonged violence, are at greater risk for developing trauma-related responses that may impact their growth and development. The traumatic impact of experiencing domestic violence may affect children and their non-abusive parents/caregivers as well as their relationships with each other, and the primary relationships within families that children rely upon for safety, nurturance, and protection from harm. Based on the research about resilience and with more than 30 years of practice wisdom, we have learned

¹¹ The topic of children's services is addressed more fully in [Chapter 11](#) ("Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children").

that the single most important resource for children in fostering resilience and healing from the traumatic effects of experiencing domestic violence is a secure attachment relationship with a loving parent or caregiver over time."

As explained in [National Scientific Council on the Developing Child \(2010\)](#), early childhood exposure to the intense fear and anxiety caused by traumatic situations such as physical or sexual abuse or exposure to violence can adversely impact the development of a child's brain, impairing emotional, social, and cognitive development, compromising their ability to acquire language skills, make and follow through on plans, focus attention, manage impulsive behaviors, and form healthy relationships.

And as described in [National Scientific Council on the Developing Child \(2015\)](#),

"[The more extensive the exposure to] "adverse experiences in childhood, the greater the likelihood of developmental delays and other problems. Adults with more adverse experiences in early childhood are also more likely to have health problems, including alcoholism, depression, heart disease, and diabetes. . . .

Early intervention can prevent the consequences of early adversity. Research shows that later interventions are likely to be less successful—and in some cases are ineffective. For example, when the same children who experienced extreme neglect were placed in responsive foster care families before age two, their IQs increased more substantially and their brain activity and attachment relationships were more likely to become normal than if they were placed after the age of two. While there is no 'magic age' for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting."

Although the OVW makes other discretionary grant funding available to address the impact of domestic and sexual violence on children and youth, primarily child-focused services are considered "Out-of-Scope" for recipients of OVW TH grants. The [annual OVW solicitation for Transitional Housing Assistance grants](#) explains:

"Applicants may not use grant funds to provide direct services to children, including children who witness domestic violence or are survivors of child abuse, except where such services are an ancillary part of providing services to the child's parent who is a victim of sexual assault, domestic violence, dating violence or stalking, such as providing child care services while the victim receives services." (p.10)

That is, any staff providing child-focused services other than such "ancillary" services must be funded by sources other than the OVW TH grant. In other words, providing more extensive children's services in conjunction with that transitional housing becomes a significant financial decision, dependent upon the priorities, size, and scope of the provider agency, and the configuration of the program housing.

A full-service domestic violence and sexual assault agency is a lot more likely than a small, less-well-funded provider, to have the funding to employ staff who can offer children's services that TH program participants can take advantage of. And a congregate or clustered housing program or a scattered-site program with units within a relatively small geographic range is more likely to offer children's services than an agency serving participants who live in widely scattered apartments who only occasionally, if ever, travel to a central location, and whose children don't necessarily come into contact with program staff.

On the one hand, these services could be crucial to the future wellbeing of impacted children; on the other hand, in order to provide them in conjunction with its TH program, a provider agency must make a serious commitment to fundraise the separate cost of those services, and program staff must recognize and be able to effectively communicate the importance of leveraging those or other community-based services to address the adverse impacts of child exposure to traumatic violence before the damage becomes irreparable.

Among the providers that we interviewed about child-focused staffing and services, there was a mix of opinions about whether child-focused services should be a priority of a TH program. Some providers embraced their agency's role in working with children, citing the profound impacts on children of exposure to violence and the importance of primary relationships, like the mother-child bond, in promoting resiliency.

They noted that often, work with children that begins when a family is in shelter can continue, even as families move on to transitional housing. Since OVW guidelines prohibit providers from using their TH grant to pay for children's services, other than childcare or ancillary services, any child-focused staff would have to be funded using other sources.

Other providers felt that survivors' children were not part of their primary clientele; asserted that a child's needs were best addressed by working with the mother, or with mother and child, but not separately with the child; stated that school personnel could address any child-related needs; and questioned whether there was a proper role for a child-focused staff person in a program following the voluntary services model, unless the gatekeeper parent had identified an unmet need that school-based personnel could not address.

(b) Provider Comments on Including Child-Focus Staff and Offering Children's Services

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) I think it's important to have separate staff to focus on children. All our staff should be able to work with kids. We need staff trained on children's issues to advocate for them at the table, because sometimes we forget. We're so caught up in the adults, but the children need to have a voice.

(#02) We don't assess participants' children for developmental delays or the impact of trauma. If the need for an assessment is identified in the shelter or by the parent, we help make a referral to counselors in the community. We make referrals to and work together with one of the local hospitals that has a healing and trauma unit with counselors that specialize in trauma and children's issues. It's the shelter identifying the needs, or the parents saying, this is what I'm seeing; can you assist?

We work with the school -- regular staff, McKinney Liaison, or special needs program -- when asked by the parent. We don't want to overstep our boundaries with the parents. We encourage parents to do it on their own, and if they need help, we step in.

(#03) I wear many hats -- it's just me providing therapy, case management, life skills, etc. Ideally there'd be a separate provider to do activities, a group, and counseling for the children, and someone else for adults.

(#04) We have an intern -- she's actually a veteran social worker working on her specialist certification for play therapy, and she comes in and works with some of the children. While the work that she does is great, what we find is better is when we have a person designated to engage with the entire family, because they can address the family dynamic, not just what's going on with the child. Working with a child will provide minimal, short-term benefits, but for sustained, long-term success, you have to engage the entire family unit.

(#05) I've noticed that a lot of our participants' children seem to have speech delays; they're three years and still not very verbal. Quite a few have had behavior issues once they've moved into stable housing, and the moms don't know how to handle it. Maybe because they feel safe enough to express themselves. They know life isn't going back to how they thought it would be. When we see something like that, we refer the child to our agency's children's program or to other community resources, because staff funded under our OVW transitional housing grant are not supposed to provide direct service to children. If the referral doesn't need to come directly from us, if the mom just needs to call the provider, I give them the info and follow up with them to see if they've done it. I empower the mom to make the kid's appointment herself.

(#06) We don't do any child-specific assessments. We do have a child advocate in our shelters, but her primary responsibilities are really more around providing respite to mom. She will do an intake with moms, but it's more about, "Tell us about your kids and what we need to know while we help watch them." And we do everything we can to give mom a break and some time off to get stronger so that she can step back in.

So those really aren't assessments. We do have, in our shelters, children's therapists that come in and meet with moms and meet with kids; they're catching things that really need to be addressed. And then those services are always in place for any of our transitional housing participants, as well, if they haven't already gotten that started when they were in shelter.

(#07) We have a youth advocate, a youth coordinator, and a play therapist on staff. The youth advocate does the children's assessment with parental permission. They also go on the home visits. (Our program advocate does the assessment on the adults.) We work very closely with the school's Title X McKinney program, which serves homeless children. However, we don't play a role in IEPs for children having trouble in school. That's between the parent and the school.

(#08) Children's services are an integral part of our family support services. When a family gets on our wait list for transitional or permanent housing, they get assessed as to what the family might need; a case manager and clinician work as a team with the families to make sure that the child's needs are taken care of in the classroom as well as at home.

(#09) It's not very important for a program that serves families to have separate staff that focuses on children. I don't think a program like ours could have funding to support separate child staff in addition to our case manager. And honestly, our case manager does it all, and we're comfortable with that.

(#10) We don't have a child advocate. We do have a children's group that operates at the same time as our women's groups do, and sometimes things come out there, but we do not have funds for a child advocate.

(#11) When we started, we just had the shelter and we didn't have a child advocate; so there was no one there specifically for the kids. I think it's really important to have someone specifically for the children. We say it's the kids' case manager, but the kids don't know that. They just see her and they're happy it's playtime, -- she's really great with kids -- and they're able to talk to her. I think it's critical to give kids the opportunity to say what's on their mind because there's a lot going on with them too and just witnessing the abuse was very difficult for a child, so it's good to have someone neutral they feel they can talk to, and who can act as a middle person for the mom if they have something really important they need to say but are afraid to say it -- to work with the advocate to say how are we going to tell mom this?

(#12) I definitely think it's important for a program that serves families to have a separate staff that focuses on the children. Sometimes, in focusing on the adult victim and what they dealt with, I think we miss how the DV affects the children. The emotional effects of DV are, I think, just as great as the physical. Even if a child has been in a situation where they witnessed domestic violence, but weren't physically involved.

(#13) Most of our families come from our shelter and have already been engaged in the children's program. Once they go into the transitional housing program, the children can still engage with the children's program.

There's also a licensed therapist that can work at no charge with the family or individually with head of household or with the children.

(#14) We could really use more staff to work with the children, even though we have a good number of staff working with the transitional housing. We have 130 children on the property now, and I have only one part-time child advocate. I'd say that the number one challenge for this program is more staff to work with the children. Every mom here has an advocate. The children do have some resources, but what we see is that you can provide therapy to the children, but if you're not working with that family unit -- mom and the child and how they interact -- you're not really meeting that holistic need. We want to implement more services as far as the parent-child interaction and how they work together as a family and how they communicate.

(#15) We don't provide direct service to children, but we've been able to outsource to different community partners, child therapists, and make referrals for parents struggling with some of those issues. We also work with Title I school services, which pretty much takes care of the transportation needs for children attending public school. Assessment is one of the things we outsource to other providers. If we recognize a behavior, we'll share our concerns with the parents and offer support, tell them about services that are available, and ask if they would like help in accessing those services.

(#16) Trying to give kids a chance to be themselves -- to run around and play, because that's what kids do. It's important to have children's services that can allow for that. And to have a trained professional who can observe what's going on with the kids, and see how that measures up to what's going on with mom.

That's a service that most funders don't want to pay for -- because those are not the outcomes we're measuring for. How did Johnny do in school this year is not really how we're going to end homelessness or end violence. But how they did in school is going to be a real indicator for the stress level that mom's experiencing -- and her sense of whether she made the right decision in leaving. A lot of our parents take a huge amount of pride when their kids start to thrive again, and you can tell that it's boosting their self-esteem again -- that they did the right thing in leaving, or that they made good decisions. As opposed to when their kids are struggling, and they're thinking, "Maybe I should just go back."

(#17) We have a child advocate that provides direct service to the kids in both the shelter and the transitional program, and I think that is imperative for both kids and parents.

(#18) We believe that domestic violence is generational and it's important to reach the children because they don't have a voice. And so our policy has always been that mom has an advocate and so do the children.

(#19) It's absolutely important to have a clinician on staff. We've had an amazing clinician; some of the ladies take advantage of her services and some don't. It's important for not only the moms but for the kids too; the kids have experienced trauma just as the moms have, and they have so many needs. The kids may understand it in a totally different way, or they may not understand it at all, but I think it's important to sit and talk with them about what they've seen, how they feel about what they've seen, and remind them that it isn't their fault -- so they can become healthy young children.

(#20) Having staff to focus on kids is very important in a domestic violence family program. We know that the male children are three times as likely to grow up to be batterers and the female children are more likely to

select a batterer for their significant other. Having someone with the skills to deal with the children is extremely important, so that domestic violence isn't perpetuated in the next generation.

(#21) We serve families, but we don't offer counseling services to children. Children and other dependents are usually secondary clients, you could say, because they benefit from the rental assistance we provide. But we don't really see them one-on-one. We do, however, partner with other agencies that address children's needs. A lot of clients are either already seeking counseling or may want to get their housing situation under control and then focus on mental health. So if they want their children to receive counseling services, we link them with counseling agencies or domestic violence agencies that offer counseling to children. Although we always encourage counseling services for both the primary participant and their children, it feels like the mothers are more likely to have their children receive services and less likely to focus on the services that they, themselves, need. Mothers usually put their children's needs before their own.

(#22) (Not a current OVW grantee) We have a child advocate but he is primarily based at the shelter. It would have been good to have someone for the transitional living program but I think it would be more difficult for them because there would be a lot of travel back and forth between apartments. They would need to come into people's homes and sort of observe. It's not like they have an office and they're in the background; they would have to insert themselves into people's homes and say, "I'm here; show me how you play with your child."

(#23) Our transitional housing is very adult focused. There's definitely a service gap when it comes to children. The child's needs get assessed if the mom says there is a need and wants it addressed, and that's when they would get referred to our children's therapy program.

(#24) We don't have anyone on staff that focuses on the children, I'm sorry to say, and I think that's a huge gap. We don't have a children's advocate. We receive funds to do teen work because that's the big thing these days. But we don't receive funds to do children's work. (#080) I'm really sorry to say that our program does not have anyone that focuses on children, or any partnerships with Early Intervention or other such programs, and I think it's a huge gap. We receive funds to do teen work because that's the big thing these days, but no funds to do children's work.

(#25) We don't have any services specifically focused on the children. The way that we support children is through supporting mom. If mom was having problems with parenting, we would refer out for help, but we could definitely talk with her about it. When I'm in a participant's home, I don't give my suggestions about disciplining or parenting. I just support them in working through their frustration and then ask them what I can do to help.

(#26) There are a couple of different ways that we work with children. If a mother chooses, the child can engage with the art therapist on staff, who works with children who've been traumatized. We talk to mothers about education and the impact that trauma can have on children; we talk about some of the behaviors they might be seeing that are a result of that trauma -- how it can interfere with functioning and development, and what can be done to try to address some of those things, so they're able to move forward. And we offer to connect them with on-going support and resources if the child could benefit from something more comprehensive and long-term than art therapy.

(#027) (Not a current OVW grantee) We have children's advocates on staff, some of whom work with the residential clients, and some of whom work with the children of families that don't need shelter, but who still need counseling or therapy. If we feel that a family in the transitional needs a referral, we offer to make it; or if they're already working with somebody when they come into our program, that continues. Our small transitional program has served a few parents who were in denial that the abuse had affected the children, but I don't think any parents were flat out reluctant to engage their children in services. So, we provide education around DV and its effects, how it might affect the children and maybe some warning signs, like acting out in school.

(#28) We have an amazing child advocate. The children just love her and look forward to the activities she leads, from the time they are in the shelter until the time their families move on from transitional housing. The assessment process happens during the time that the children spend with her, and then she can make appropriate referrals.

Originally, our children's advocate's services were entirely child-focused, but we realized that it was really important to engage the parents -- giving them the opportunity to take back the decision-making power that they need as parents -- and she invited and encouraged them to participate in and observe those activities, and she really earned their trust and confidence in the program and in our staff. In turn, building that relationship made it possible for her to discuss the kinds of things she might be seeing, and to help parents understand that they were not to blame if their child had a developmental delay or other setbacks due to witnessing or experiencing the violence, that it was the perpetrator, and that by working together now to address those issues, they could prevent more significant problems and setbacks later.

(#29) Our family advocate is basically our case manager. We also have a children's advocate, who works exclusively with the children in the transitional program. Our intention is not only to serve the women, but we want to help the children develop the understanding and skills to create healthy relationships. We want the cycle of violence to end with them. So we concentrate on the children's wellbeing as well as the moms'. The reason we staff the way we do, is that mom, who is stressed and at rope's end may be unaware of the needs of the children. Mom will say "Yes. They're fine. Everything's going good" and this other observer can pick up on things; and so we have someone assisting the children and assisting mom in meeting their needs.

(#30) (Not a current OVW grantee) Technically speaking, the children are not our participants, but if, as part of the assessment process, the parents have identified that their child has special needs -- for example, if they have PTSD or they're struggling in school and will need an IEP -- we'll put it in the service plan, so that we can support them in getting services for the child. Because if their children aren't stable, the parents aren't going to be stable.

(#31) When families come into the shelter, they meet our children's advocate and the staff member who provides our childcare, and if they go into transitional housing, the kids' needs continue to be met by those two staff.

(#32) I think it's critically important to have a child-focused staff person available to our TH program. In our program, that staff person is a male whose background is in child and family development, and that's added an interesting element for us. The children develop a great rapport with him. Families usually come through the shelter, so they establish a relationship with him while they're there. And because we invite TH program residents to join us for some shelter activities after they leave the shelter, there's still that connection.

(#33) We work with a couple of other organizations to offer services for the kids that live with us, but that is an area I feel like we need to do a better job with and offer more services ourselves. I feel like that is a real gap. We don't have the funding, of course, but, in the meantime, we work with two organizations that work with children and so they're able to go to group activities or a daycare that specializes in working with kids who come from homes where there's been domestic violence or abuse.

(#34) We're working to enhance the services to children exposed to violence; to replace some of the children's coping mechanisms, so that we're not repeating this violent dynamic; and to expand the trauma informed counseling services for victims. In all the years I've done this work, civil legal services was always our number one requested service, but I can tell you, hands down, in the last two years since we have expanded our counseling interventions and our trauma informed model for both children and adults, the trauma informed counseling is clearly our number one requested service.

We find that survivors really want to understand the trauma. They want to heal from the trauma. They want to change that dynamic in their lives and they definitely want to not see it repeat with their children, so we have increased the number of trauma counselors we have on hand; we have expanded our services to children to include trauma services for bilingual children as well as children with disabilities.

(#35) Working with children who have witnessed violence is a very big issue for us because there are very few services in these rural areas. We have a person that comes in and works with the children, and we do some art therapy. Not all parents want their children in these services. We can also refer them to counseling programs within their schools, depending on what their parent wants and what kinds of services are available to the child. When the parents are resisting services for their children, we suspect that somebody's trying to hide something. And a lot of times, it's the fact that a child's been sexually abused and the mother's aware of it. Depending on what the service is and how a parent reacts usually is an indication that there's a skeleton in the closet, and we do what we can to try to flush it out so that the child gets the services that he or she needs; even if it results in social services having to step in. But the child needs to have a safe environment as well, especially if they're going to be going back to the family situation they left on the reservation.

Questions to Consider

1. If a program does not offer children's services, what might be the role of the advocate/case manager in recognizing and calling attention to signs that a child was adversely impacted by exposure to violence?
 - How would that role be different if the child is old enough to be attending school versus if the child is not yet old enough to attend school?
 - How would that role play out if a parent was unhappy about the way school-based programs are or are not providing services? What if the child is unhappy about how services are being delivered?
2. Parents are the gatekeepers of services for their children, particularly in a program that operates with a voluntary services model. Providers have found different ways to help parents recognize a developmental delay or problematic behavior that they might not otherwise perceive, but there are occasional instances when a parent simply does not want their child to receive specialized services, perhaps because they are concerned about the stigma attached to receiving services, or because they don't know or trust the provider, or because, as one provider suggested, they are concerned about what the child might reveal about what went on in the household.
 - What should a TH provider do if they recognize a significant developmental delay or dysfunctional behavior that the parent does not acknowledge and/or is unwilling to seek services to address?

8. Staff Diversity¹²

(a) Overview Part 1: Diversity of Survivors in OVW Grant-Funded TH Program Units

The degree of racial and ethnic diversity of the clientele -- and the potential clientele -- varies from county to county and state to state; in some regions, a small one- or two-person staff can largely reflect the diversity of the population served. In other parts of the country with more of a demographic mix, larger programs and programs that can leverage other in-house staff or staff from partnering providers are in a better position to reflect and address the diversity of the communities they serve, and better able to offer services in the native language(s) of at least some of their limited-English-speaking survivors.

The four semi-annual VAWAMEI reports covering the period 7/1/2012-6/30/2014, indicate that Black or African American survivors (28%), Hispanic or Latino survivors (18%), American Indian or Alaska Native survivors (6%), Asian survivors (5%), and Native Hawaiian / Pacific Islander survivors (2%) constituted a combined majority of adult program participants. Fourteen percent of adult survivors during that period reportedly had limited English proficiency and 13% were immigrants, refugees, or asylum-seekers. Although Muskie data doesn't capture data about the languages spoken, provider interviews hinted at that diversity.

We recommend that the data set for the semi-annual reports be expanded to capture information about the primary/preferred language spoken by the survivor.

The Muskie data set does not capture information about survivors' sexual orientation or gender identity (apart from standard male/female data), so the VAWAMEI reports do not indicate the extent to which LGBTQ survivors are utilizing OVW-funded TH programs; however, few programs mentioned serving that subpopulation, and only one or two providers mentioned having LGBTQ staff.

According to the [National Intimate Partner and Sexual Violence Survey \(NISVS\) 2010 Findings on Victimization by Sexual Orientation](#), 43.8% of lesbian women, 26% of gay men, 61.1% of bisexual women, 37.3% of bisexual men, 35% of heterosexual women, and 29% of heterosexual men reported experiencing rape, physical violence, and/or stalking within the context of an intimate partner relationship at least one in their lifetime. This translates to an estimated 714,000 lesbian women, 708,000 gay men, 2 million bisexual women, 711,000 bisexual men, and 38.3 million heterosexual women and 30 million heterosexual men in the United States.

The NISVS findings do not address violence against transgender persons. A [2015 report on Intimate Partner Violence against LGBTQ and HIV-Affected Survivors by the National Coalition of Anti-Violence Programs \(NCAVP\)](#) indicated that 7% of the 2,166 LGBTQ and HIV-affected survivors who experienced IPV and sought support from one of 16 member organizations 13 states were transgender persons. (The [2015 NCAVP report](#), containing data from 18 NACVP member organizations in 17 states, indicated that 10% of the 2,697 LGBTQ and HIV-affected survivors reporting IPV victimization in 2013 were transgender persons.) Since these are very limited datasets, they may not be representative of the overall population of LGBTQ and HIV-affected survivors. However, the reports suggest that significant numbers of transgender survivors are not being counted in the national statistics.

We recommend that the dataset for the semi-annual reports be expanded to capture information about the gender identity and sexual orientation of survivors, and that, as described in greater detail in the section of [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence") on LGBTQ survivors, training be offered on strategies for better serving LGBTQ survivors and on how to ask the necessary demographic questions.

¹² Challenges and approaches to serving diverse subpopulations are more fully addressed in [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence").

(b) Overview Part 2: Staff Diversity of TH Program Providers

There are no published data about the diversity of OVW-funded TH program staff, and we did not inquire as to the demographics of the person(s) we were interviewing or their program colleagues.

There was almost universal agreement about the importance of cultural and linguistic competence and about the advantages of participants being able to work with people whom they can identify with and who speak their language. Communication is an essential part of the healing process, the safety planning process, and the process of identifying and addressing the barriers to achieving the survivor's stated goals and objectives.

Much of the conversation about diversity and cultural/linguistic competence focused on communication between program staff and survivors whose native language -- and the language they are most comfortable speaking -- was not English. Providers' opinions about the use of interpreters or a telephone language line varied somewhat, with some providers appearing to view those options as fully adequate, while other providers saw them as less adequate than a staff person from the same linguistic community. There was general agreement that having to communicate with a staff person who has only a rudimentary grasp of the language spoken by the survivor -- or having to converse in English if that is not the survivor's language of choice -- deprives the survivor of the full benefit of the program, because they are unable to adequately communicate their experiences, feelings, needs, and priorities, and because they are unable to fully appreciate whatever information or perspective the provider is sharing with them.

Apart from programs targeting specific ethnic or cultural communities -- in particular, Native American and Alaska Native survivors and Asian survivors -- which stressed the importance of having staff who come from and understand those cultures, there were fewer comments about staff diversity and cultural competence as it relates to religious and ethnic subpopulations, and still fewer comments about diversity and cultural competence with regard to race or gender identity/sexual orientation. (Interview #126 was with two providers we sought out, because of their focus on addressing IPV in the LGBTQ community; they are not affiliated with OVW-funded TH programs.)

The degree to which staffs reflect the diversity of the communities/regions they serve varies from program to program. The smaller the program and the smaller the staff, the more difficult it is for staff to match that full diversity. Quite a few of the providers we interviewed emphasized the primary importance of hiring qualified staff even if that comes at the expense of diversity. The ability to listen without judgment, awareness of white privilege, and training in cultural competence were described as necessary and acceptable substitutes when it isn't possible to hire staff who reflect the demographics of a target constituency.

(c) Provider Comments on Staff Diversity

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) When we hire social workers and case managers, we really look at what their experience is in the helping field. Coming from the same demographic or cultural background as participants is an important factor, but that training in dealing with different cultural backgrounds is probably equally or more important. Our staff used to better match our clients' demographics; however, our current staff have more experience and training dealing with different cultures and backgrounds, and we have had even more success with the clients we are currently serving, maintaining relationships, improving contacts.

(#02) People feel more comfortable being served by providers that represent them in some way. We try hard to avoid the "us versus them." Our community is very diverse, so it would be very difficult to find one case manager who represents every demographic that we serve.

(#03) It's important if possible to hire staff from the same demographic or cultural background as anticipated clients. An effort to be culturally competent and trauma informed is good. We do that and adjust for cultural differences and needs.

(#04) Qualification is the number one thing, but it helps if staff are culturally competent.

(#05) We've committed to making sure that we always have one full-time Spanish-speaking staff member. If somebody has a different role in the agency and they speak a different language, that's a huge plus for us. If we don't have what women need to address their cultural needs, we do our best to find it.

(#06) As a general rule, we try to hire people that are representative of the people we serve. If the people we hire don't come from that demographic, it would be essential that they recognize their own privilege and know how that privilege has shaped their lives and how they can use that to help others.

(#07) It's very important to have staff with similar ethnic or cultural background to the participants. If the clients view us as a part of their community, as opposed to outsiders, that makes it easier.

(#08) I think it's important that the people you're helping see somebody like them. It's smart to have staff that have experienced some of the same things or at least understand what participants have experienced.

(#09) Having staff diversity is extremely important so that we can make that connection and build trust. We're all more likely to open up to someone that's like us.

(#10) (Not a current OVW grantee) I think it's really important to have staff who look like, share a similar background, and speak the same language as clients and potential clients. We don't have staff from all those cultures; we have some: we have Spanish speakers and a Vietnamese speaker. It's very hard to attract people with language skills, given the wages we pay.

(#11) If you had a small staff and they're primarily all from one particular background, I think it would be very challenging. Even if they were all from one particular demographic, I think you'd look to hire staff that are open minded and that are super positive and that enjoy meeting people from different backgrounds. People that just naturally are the kind of staff that would be a positive force, regardless of where they've come from or who they might be helping.

(#12) Of our agency's 15 staff members, four are bilingual Spanish speakers. It's huge for us because this is a communication-heavy program, and having bilingual staff means our clients feel more confident that they are being heard. We reduce the risk of miscommunication and residents feeling isolated, and increase our capacity to serve a more diverse community.

(#13) I have been very intentional about bringing on staff that come from communities of color, and have given them a lot of training so that they're advancing. I try to create an empowered work force because I truly believe that staff can't empower survivors if they don't feel empowered themselves. We build teams, and allow staff to make decisions about their own programs, including spending money.

(#14) Where staff are in safe situations, we can model for participants that, "I'm part of the LGBTQ community and happy to be who I am in the world." And my colleagues can say, "We're really happy to have her on our team." And our marketing materials and our policies can affirm that the organization celebrates the LGBTQ communities. And we can confront homo-, bi-, and transphobia in the support groups that participants attend, in interactions among staff, and by being involved in public policy issues, like fighting discrimination in employment and housing, and by inviting participants to join us in those efforts, without pushing any individual to accept a label or identity that they're uncomfortable with or not ready to embrace.

Some of us have the privilege of working in states and organizations that are relatively affirming. But that's not true for all LGBTQ advocates across the country; there is a huge challenge for some LGBTQ staff, and for TQ advocates in particular, in maintaining their jobs and moving forward and being mentored and cultivated for leadership positions, and in maintaining those leadership positions, if they get them. So I'd want to really empower staff to keep themselves safe first, because if you can't keep yourself safe, you can't do anything for the folks you serve. Which ties in to the importance of making it safe for survivors not to answer the question.

Personally, when I've been able to be out with survivors, I feel like it's been very appreciated. It could be by just having a rainbow sticker on my water bottle; people would come out to me all the time because they'd see that -- and I don't think they would have told me otherwise. I think it's fantastic if a staff person feels comfortable being out -- it can be so helpful to survivors who identify in similar ways. But while staff should be allowed to be out, they should never be forced to be out.

Questions to Consider

1. What does "staff diversity" mean for a small (1 FTE) program that serves a racially and ethnically diverse region? What, if anything, can such a small program do to enhance staff diversity?
2. Is cultural/linguistic competence enough, in the absence of staff diversity?
3. Can programs more effectively serve demographic segments of the survivor community that are under-represented on the staff by utilizing volunteers from those demographics? If so, should persons serving in that role be paid, given the importance of effective translation in facilitating communication?
4. If communication between staff and participant is compromised by a language barrier, what can staff do to ensure that participants are adequately understood and feel confident that they have been heard?
5. How can a victim services provider collaborate with community-based organizations that serve segments of the population that are not demographically represented by agency staff, and that have not tended to seek survivor services from that agency?
6. As noted in the text, few comments addressed race or gender identity / sexual orientation (with the exception of LGBTQ-focused providers that we reached out to in order to fill the project gap in information relative to addressing the needs of LGBTQ survivors).
 - (a) How important is it to have one or more African Americans on staff, if the program hopes to be seen as a resource to African American survivors?
 - (b) How important is it to have a lesbian or gay or transgender person on staff if the program hopes to be seen as a resource to LGBTQ survivors?
7. How important is the socioeconomic status of the provider staff as compared to the clientele? If provider staff are college educated, middle class women and program participants are primarily working class women, are class differences likely to create a barrier to engagement? If so, how can that barrier be transcended?

9. Staff Training

(a) Overview of Resources and Current Training Practices

All providers interviewed for this project indicated that their programs require new staff to participate in an intensive training, typically 20-40 hours long, offered by their agency or their state coalition.¹³ Some agencies have annual training requirements; others don't. Even where providers did not mention annual training requirements, they did say that throughout their employment, staff are encouraged to attend on-line and in-person trainings and conferences, including trainings sponsored or conducted by their state or national coalitions, subject to availability of funding, if there is a cost attached. (OVW requires grantees to include funds for travel and attendance at its mandatory trainings.)

The direct service providers we interviewed cited the value of the networking and the sharing about common concerns and promising approaches that takes place at these trainings and conferences. Staff who attend such trainings and conferences are encouraged to share their learning and the results of their information-gathering with agency colleagues, although day-to-day responsibilities and crises sometimes preempt that kind of sharing.

For examples of the kind of basic trainings that state coalitions provide, see: the curriculum outline in Appendix D (pp. 506-517) of the [Illinois Domestic Violence Guidelines Services Manual](#); the various lists of training requirements in the [Iowa Victim Advocate Certification Manual](#); a [new service provider training agenda](#) from the Michigan Coalition to End Domestic and Sexual Violence; in "Training" and "Dual Training" outlines in the Missouri Coalition's [Service Standards and Guidelines for Domestic Violence Programs](#) and their [Service Standards and Guidelines for Sexual Violence Program](#); the description of the North Carolina Coalition's [Advocates' Institute](#) for new staff; the [training curriculum developed by Northnode](#) for Massachusetts providers; the detailed [section on training standards](#) (pp.32-40) in the Oregon Coalition's Domestic Violence and Sexual Assault Program Standards Self-Assessment Tool; and the Tennessee Coalition's [Best Practices Guidelines for Sexual Assault Response Services \(for adult Victims\)](#).

State coalitions maintain websites providing online access to an abundance of excellent resources which may be used alongside trainings or as supplementary references, for example: the Alaska Network's [toolkit for serving survivors with multiple issues](#) ("Real Tools: Responding to Multi-Abuse Trauma"); the Arizona Coalition's [Best Practices Manual](#); the Missouri Coalition's publications on "Understanding the Nature and Dynamics" of [Domestic Violence](#) and [Sexual Violence](#); the Ohio Violence Network's [Trauma-Informed Care Best Practices and Protocols for Ohio's Domestic Violence Programs](#), and their [manual for DV Child Advocates](#) ("When Fear Has No Voice" **Note:** under revision as of Jan. 2018); the Tennessee Coalition's [Cultural Competency Resource Manual](#) and their curriculum on youth and sexual assault ([Tough Issues: Youth and Sexual Assault](#)); and the Washington State Coalition's [template for training mainstream housing and homeless providers on serving DV survivors](#), and training manual on DV advocacy for persons with disabilities ("[Enough and Yet Not Enough](#)").

The [Simmons College School of Social Work \(SSW\) Domestic Violence Training](#) (Thomas, et al., 2017) is an online, free training for providers and other interested persons that seeks to provide an "overview of the essential knowledge about domestic violence that has been amassed through decades of advocacy and research." The training's seven units explore types and prevalence of violence; the impact of violence on individuals, children, and communities; appropriate responses and best practices for working with survivors; strategies for working with people who use violent and coercive behaviors against partners; the legal framework; and resources for additional information. Although the authors and primary contributors are based in Massachusetts, the training materials were intended for a broad geographic audience, occupying a variety of roles in which they might encounter and serve perpetrators and/or survivors of violence. As noted

¹³ See, for example, NNEDV's [listing of state coalitions and their contact information](#)

in the introductory unit, the training is intended as a “starting point,” rather than a comprehensive curriculum. Persons successfully completing the training and accompanying quizzes can obtain Social Work Continuing Education Credits from the Simmons School of Social Work. For info, contact dvtraining@simmons.edu.

In addition, the following national domestic violence- and sexual assault organizations maintain websites with extensive online resources for training or reference; for example:

- NNEDV maintains an [online Transitional Housing toolkit](#) with links to resources on a multitude of topics, including economic justice/financial literacy and technology-related privacy and confidentiality issues.
- The National Resource Center on Domestic Violence (NRCDV) maintains an [online training calendar](#) and sponsors the VAWnet National Online Resource Center on Violence Against Women, which includes [publications of the NRCDV](#) and [publications of the National Sexual Violence Resource Center](#), as well as a host of online webinars, podcasts, training materials, and printed resources.
- The National Center on Domestic and Sexual Violence maintains an [online training calendar](#) and a [webpage providing online access to a host of resource materials](#).
- The National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH) maintains an [Online Training and Resource Center webpage](#) featuring access to downloadable web-based trainings, tip sheets, and more extensive written materials addressing both individual practice and organizational strategies. Currently featured are a series of webinars and print materials on "Creating Trauma-Informed Services and Organizations;" online trainings and print materials for mental health and substance abuse treatment providers who want to better serve survivors of domestic and sexual violence; materials supporting training on addressing the combination of substance abuse and trauma related to domestic and sexual violence; materials addressing support for parents/caregivers and their children; and more.
- The [Battered Women's Justice Project](#) maintains an extensive online library of webinars (click on "Resource Type" = Webinar Recording), tools and guides, promising practices, etc., which are nominally intended for staff whose work brings them into contact with civil and criminal justice systems, but which are, in many cases, applicable to other domestic and sexual violence providers.

New resource materials and trainings are constantly being developed, and many of the aforementioned state and national organizations provide links on their websites to those publications, webinars, podcasts, and presentation materials.

The Substance Abuse and Mental Health Services Administration (SAMHSA), an office of the US Department of Health and Human Services (HHS), is increasingly focused on supporting trauma-informed services, and its publication "Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol #57" (hereinafter [SAMHSA \(2014\)](#) contains a wealth of information about implementing a trauma-informed approach in delivering behavioral health services. Given the importance of a trauma-informed approach to services for victims/survivors of domestic and sexual violence, and given the fact that the survivors served by transitional housing programs not infrequently have co-occurring mental health and/or substance abuse issues, the SAMHSA recommendations seem important to include, beginning with the recommendations in [SAMHSA \(2014\)](#) regarding the need for training in providing trauma-informed care:

"Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of re-traumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person." (p177)

[SAMHSA \(2014\)](#) cites of [Jennings' \(2007\)](#) recommendation that "All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences of trauma. (p.135)"

[SAMHSA \(2014\)](#) further recommends that,

"All clinical and direct service staff members, regardless of level of experience, should receive more in depth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid re-traumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace." (p.177)

[SAMHSA \(2014\)](#) encourages staff training in motivational interviewing,¹⁴ which it describes as "a client-centered, non-pathologizing counseling method [that] can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance. Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients." (p.180)

Some of the staff interviewed for this project reported having been trained in motivational interviewing, some had heard of it but had not been trained, and some had never heard the term. NNEDV has provided several trainings on Motivational Interviewing, and we recommend that such trainings continue to be offered, given periodic staff turnover and the need for refreshers.

At present, there are no national training standards for advocacy/case management/service coordination positions in shelters and TH programs for survivors of domestic and sexual violence. While adoption of such standards and the kind of national certification that [Stover and Lent \(2014\)](#) recommend would be highly controversial, disruptive, and expensive -- and would involve an investment that might be better directed to building the housing and services capacity of the existing system -- the curriculum outline (see pp. 12-15) underlying their proposed 180-hour training framework is worth examining for ideas about topics that might be added to existing staff training programs.

Finally, a few providers mentioned that their staff left the program to attend university classes to acquire additional knowledge, skills, and credentials; in some cases, those staff returned to the program with their enhanced competencies. While providers may not have the budgets to help staff attend higher education, their positive references may be helpful to staff competing for some of the limited program slots and the scholarships that make attendance possible.

(b) Provider Comments on Staff Training

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) Training is provided through the state Coalition. We contract a supervisor from the local mental health agency to do training and clinical supervision. We do staff development once a month and have a local agency talk about things related to the work we do.

¹⁴ See discussion about Motivational Interviewing in [Chapter 9](#) ("Approach to Services: Providing Basic Support and Assistance").

(#02) With a very limited budget, we do what we can to try to find a webinar, a book, or any opportunity for growth. You can never do too much to address safety and confidentiality, and things are always changing, so if we had the opportunity to arrange additional trainings, it would include those topics.

(#03) There is an initial 40-hour domestic violence training, including legal, community resources, dynamics of domestic violence, technology safety, safety planning. Even the administrative and cleaning crews do the 40 hour DV training. Staff who work directly with clients receive more training though. We have a four-month orientation period for new employees with ongoing training and shadowing by a supervisor and pairing with a peer. Training is ongoing. The last few months we've been working on Trauma Informed Care.

(#04) All staff, volunteers, and interns must attend our 36-hour crisis intervention training before they can participate in any agency activities. We have two different clinical therapists that come to our offices monthly to do clinical supervision for staff and to lead discussions about relevant issues. Our focus lately has been on cultural competency; we've been consulting with other agencies on helping transgender and underserved populations, including older survivors -- how to reach them and making sure we're culturally competent.

(#05) Every year, we do an extended staff training. It's 16 to 24 hours. And once a month we do training. We sponsor an annual conference in partnership with the state university. We probably average between 110 and 130 attendees every year. The state DV Coalition will provide training that our staff will attend. They'll bring in people from NNEDV and other national organizations. There's a trauma-informed conference in our state capital in September that the Coalition is paying for all executive directors to go to.

(#06) We're part of the regional network and the state network, we're part of our state DV Coalition and they provide trainings to our staff and administrators. We're required to and we attend a lot of the OVW sponsored trainings. If staff are interested in and ask to attend any of the community or regional trainings that are offered, and if we have the funding, we'll send them. One or another of us has attended the OVW orientation, the training for volunteers, for the supervisor, the LGBT training, the HIV training, the technology training, and the financial literacy training. We're looking for more training in technology - how abusers use or misuse it (for stalking, phones, etc.). It's constantly changing and we need to understand it.

(#07) There is a good amount of funding for training in our grant. The voluntary services training is mandatory for anyone in this grant. I do a lot of webinars about housing protection and a lot of state-sponsored trainings. It's definitely an open field as far as what I'm allowed to reach out to for training.

As a coalition, we provide guidance to our programs around what good victim advocacy services looks like and how to provide it, especially in terms of what needs to be offered and how the program works, including use of the voluntary services model. We have to help develop the capacity of our programs to provide services that are good for survivors. We've provided a number of in-person trainings and webinars to help our programs understand the trauma informed approach. We are also doing some pointed work right now around LGBTQ communities and again that work is being done with the trauma informed framework.

(#08) For domestic violence, we have designed a training program that includes the basics of domestic violence and the trauma informed approach, training on voluntary services and empowerment, burnout prevention, all that stuff. We invest greatly in training and the OVW grant has been very generous in providing

training and webinars and topical trainings, so we have the opportunity to connect with other providers and have conversations with other programs and see what they are doing.

(#09) The State has a 40 hour advocacy training requirement and the Coalition has developed a training module that's research-based, and based on current best practices. Trauma informed philosophies and practices are incorporated throughout the entire 40 hour module.

(#10) We make sure to do trainings on all the different types of populations to make sure that our staff are aware of the differences that may occur in an LGBTQ domestic violence situation, an African American DV situation, or a Latino DV situation. We try to educate our staff on all of those different cultural pieces, so they're aware of how those populations may experience domestic violence and homelessness differently.

(#11) Initially all of our staff goes through a 20 to 30 hour certification training, which is aligned with our state statutes that insure privileged communication between the victim and staff. We also go through fundamentals of trauma informed services, our empowerment based model, looking at the client's strengths, and a lot of role playing. There's also training on the hotline, on policies, procedures, confidentiality, mandatory reporting, etc. We send staff to trainings by our state coalition, which run the gamut: legality assessment trainings, nuts and bolts of advocacy, working with immigrant populations, a dynamite collection of different trainings and support. And then of course we also attend the OVW mandatory trainings.

(#12) We provide a 40 hour training and orientation to all new employees that covers basic information about domestic violence, sexual assault, and the different community resources available. A big focus of that initial training is communication and listening skills, trauma informed care, and the impact of adverse childhood experiences on adults – so, just giving them a good understanding of trauma. We require all of our staff to have at least 20 hours of community education every year. We provide at least that much in-house. Most of our staff has far more training than that. Staff members gravitate towards training in areas that interest them. We have some staff that specialize in children, others specialize in sexual assault or DV. We try to support people's individual interests as long as they fit our mission. I'd like to be able to offer more training on housing and economic security issues, which are the biggest barriers facing our clients.

(#13) We do in-house training when staff members are new. The state Domestic and Sexual Violence Coalition holds a regional conference once a year, and also has a lot of basic advocacy training. We send our staff to lots of local trainings; any time there's a good relevant training, my supervisor has me sign up.

(#14) (Not a current OVW grantee) We give our staff as much training as we possibly can. They get a lot of on-the-job training, including something that's like a DV-101, 30-hour training. Staff get at least 20 hours of shadowing someone in their position. We are about to have certification training for everyone who is not already Red Cross- and CPR-certified, which is something I've been trying to do for a long time. A lot of them get legal training through agencies that offer free training about public benefits, Social Security, etc. There are a lot of webinars through our state agencies, including trainings about LGBTQ. Staff are constantly updating their skills. In this era of webinars it's much easier. We try to have staff who have attended trainings tell others about what they've learned, but sometimes, something will come up that usurps the time we were going to share with our colleagues, and then all of a sudden, it's three weeks later, and not as fresh. It would be great to have more training on working with participants with co-occurring mental health and substance abuse issues.

(#15) Trauma-informed care training and training in feminist style peer counseling are important. Empowerment philosophies and understanding system depression and how they're all linked is really important. I think being able to set aside your values and still know that you have those values, even as you are supporting someone who's doing the complete opposite of what you would do.

(#16) I really like the annual extra technical support around the issues that we may not see on a regular basis like the very technical details of stalking and technology.

(#17) When we got started, there was a lot of cross-training that had to happen between people who work in geriatrics and the domestic violence case workers, who were used to serving younger people, and who needed to learn some of the ways for working with older victims that are a little different than how they work with a 25-year-old. Now, elder abuse education and awareness has become part of the training that happens for all the staff throughout the two domestic violence agencies we partner with. And the DV trainers that go out and talk to staff at hospitals and other community organizations now include an elder abuse piece in it.

(#18) We train all of our staff in trauma-informed care and emphasize relationship building. The goal is that relationship building will increase the number of people who voluntarily choose to participate in services. Sometimes it works, and sometimes not. I think it helps for our staff to have an understanding of trauma, and why people don't follow through. By helping staff understand how trauma may impact participants' decisions, by minimizing the hierarchical nature of our relationships with clients, and trying to be more of a partner with them, we hope to maximize the number of people who engage with the many services that we can provide.

(#19) We have ongoing training that the therapists are constantly going to; trainings on trauma informed care and cognitive behavior therapy. I would say we are probably a model for the therapy that we use.

Questions to Consider

1. In addition to OVW's mandated trainings for TH grantees, are there other trainings that should be mandatory for all OVW-funded TH program staff?
2. How do TH program staff learn how to support participants in finding and accessing housing? Is there training that could help?
3. Given the limited resources for travel and accommodations, how could OVW or state and national coalitions facilitate more regular networking between and among programs that face similar challenges, operate in similar settings, and/or serve similar or overlapping populations?
 - Would a regular schedule of online facilitated peer-to-peer workshops and discussion groups be a helpful adjunct to the less frequent in-person training and networking opportunities?
4. Especially in programs with limited budgets, there is a temptation to utilize as many online trainings as possible, rather than sending staff to conferences and trainings that involve more travel and cost.
 - How can programs create opportunities for staff to process what they heard in online trainings, so as to strengthen the learning and build shared understanding?
5. Sometimes, staff attending a training hear new and exciting ideas, but implementing those ideas require changes in policies and procedures that other staff who didn't attend the training don't understand or support. If nothing comes of their efforts to introduce such new ideas, staff may start to question the value of trainings or their agency's interest in new ideas.
 - What can a program do to encourage fresh ideas, if it can't afford to send multiple staff to trainings?

10. Support, Supervision, and Minimizing Burnout and Secondary Traumatic Stress (STS)

(a) Overview

Survivors of domestic and sexual violence in specialized shelters and TH programs may carry the scars of serious physical and sexual violence, as well as emotional, psychological, and financial abuse. They have navigated difficult and often dangerous circumstances to get to where they are. Yet with a clock ticking down on their temporary housing, or time-limited housing assistance, unsure of what their abusive (ex-)partner might do next, facing a range of barriers to a stable future, and facing potential homelessness if they cannot address some or most of those barriers, survivors experience added stress and anxiety, on top of the cumulative trauma that already weighs them down.

Their case managers/advocates, who walk alongside and support them as they address these and other challenges and risks, who hear the terrifying stories about the violence and abuse, who hear the fear and anxiety in survivors' voices, and understand the harsh realities they face, are, not surprisingly, vulnerable to secondary traumatic stress (STS) and burnout.

The providers we interviewed address secondary traumatic stress and the threat of burnout in different ways -- with paid time off, so staff can step away and decompress from the work; with wellness packages, including gym memberships and free counseling; by teaching and encouraging self-care; through supervision; by providing staff with the time and opportunities at regular meetings or periodic retreats to provide and receive peer support in dealing with difficult situations, and for open communication about work difficulties and challenging emotions; and by teaching and supporting staff in setting appropriate boundaries.

Monetarily, according to the [American Management Association](#), the cost of losing and having to replace an employee adds up to approximately 30% of their salary, including lost productivity, and staff time hiring and training new personnel. [Sullivan \(2006\)](#)

For a TH program serving survivors of abuse, in which participant engagement is closely linked to the quality of the staff/participant relationship, the adverse impact of staff turnover is potentially much greater than merely the cost in dollars. Staff turnover undermines continuity of care. At best, it engenders the loss of a trusted relationship; at worst, it is experienced by the participant as a trauma-inducing betrayal of trust by the departing staff person. In some cases, participants are able to build a strong new relationship with the replacement advocate/case manager; in other cases, the loss of trust resulting from staff turnover cannot be overcome. Abusive partners use the unpredictability of their emotions and violence to hold power. To counter that stress-inducing instability, staff work to create a sense of predictability in their program, and to demonstrate their reliability as allies and supports. Staff turnover undermines that predictability and reliability, and instead, can become a source of stress or trauma for the participant. As [SAMHSA \(2014\)](#) states,

"Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors." (p.197)

[Sullivan \(2006\)](#) asserts that an investment in competitive wages and benefits, including a flexible work schedule are more than justified by the ability to retain skilled and dedicated staff. Sullivan also emphasizes the importance of effective training and ongoing weekly positive supervision to highlight what is going well and to provide support for addressing areas in which staff are experiencing difficulties; doing the little things that acknowledge staff efforts, celebrate successes, and make a workplace fun; and providing opportunities for staff to grow, be challenged, and exert meaningful control over how they do their jobs.

[SAMHSA \(2014\)](#) echoes some of Sullivan's suggestions regarding the need for competitive wages and benefits, including adequate time off and other benefits that support staff wellbeing; providing regular, consistent

(clinical) supervision and support ...; and allowing staff to offer input into the policies that directly affect their work experience. [SAMHSA \(2014\)](#) cites [Hoge et al. \(2007\)](#), which endorses those same kinds of working conditions, as well as, "clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (p.177).

Importantly, [SAMHSA \(2014\)](#) also talks about the importance of "reasonable caseloads" and the need to acknowledge secondary or vicarious traumatization, and in particular, to **normalize the stress reactions of staff who work with seriously traumatized clients, and to treat it "as systemic -- not the result of individual pathology or a deficit on the part of the counselor."** (p176) In creating such a supportive work environment, the provider agency "demonstrates a level of respect for the [staff] (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma." (p.177)

Summarizing findings from their survey of staff support practices in 30 domestic violence programs and 15 programs serving refugees and survivors of torture, [Phillips et al. \(2015\)](#) cited some of the same approaches:

"All programs shared that staff support is foundational to a program's ability to adopt and sustain a trauma-informed approach. . . . Many programs described using approaches to supervision, including reflective supervision, that support staff self-awareness, offer guidance about challenging interactions, engage staff in working through situations that are triggering to them, build on staff members' individual strengths and talents, and focus on supporting their success. All programs described efforts to manage caseloads, and many allow staff some input and flexibility in determining their own schedules. Several programs ... provide childcare on-site, or welcome staff to bring in their babies and breastfeed.

[Other] practices to support staff well-being and reduce the risk for vicarious or secondary trauma and burnout [mentioned by survey respondents included]:

- *An informal open-door policy among staff members*
- *A supportive, democratic, and collegial atmosphere*
- *A focus on open and respectful communication between staff members, including when challenging issues arise*
- *Supporting staff through good benefits, Employee Assistance Programs, opportunities for advancement, hiring from within the organization, and competitive salaries*
- *A commitment to staff members' professional development and fulfillment, such as through training and networking opportunities, membership in statewide committees, or collaborative work with local anti-oppression groups*
- *Having designated onsite clinical staff to provide support to advocates and other staff members*
- *Having onsite peer support groups for staff members, with a goal of reducing the likelihood of vicarious or secondary trauma*
- *Regular staff appreciation events, thorough orientations for new employees, and recognition of employment milestones*
- *Ongoing wellness programming, such as walking clubs, reading groups, yoga and other mindfulness-based activities, crafts, remedy teas made by a traditional herbalist, and fitness and healthy eating challenges.*

All programs emphasized the importance of staff self-care, and they actively encourage and support staff members to do personal work to maintain emotional well-being and reduce the likelihood of burnout. Many programs emphasized the importance of fun, laughter, and staff social activities where work is not discussed. In addition, several programs described trauma-informed trainings and supports available to

peer and lay workers, including training on working as part of a cross-cultural team, assessing problems, understanding mental health concerns, and supportive actions." (pp.6-8)¹⁵

(b) Three Perspectives on Supervision

"We have the time for those things for which we make the time. Supervision is not something that should ever end for any employee." [Sullivan, 2006, p.22](#)

(i) Reflective Supervision

In her [no longer downloadable] July 2014 training on "Advancing Trauma-Informed Services through Reflective Supervision," Dr. Terri Pease of the NCDVTMH¹⁶ likens the principles and underlying approach taken in reflective supervision to the principles and underlying approach taken as part of survivor-centered, empowerment-focused advocacy: It is non-prescriptive, requires and supports a high level of engagement, is non-hierarchical, and provides safety for the participant. In the same way that survivor-centered advocacy focuses on the priorities and matters of concern to the program participant, reflective supervision begins with the advocate/case manager's sharing of a question or concern, or their description of a work experience that they would like to process.

The supervisor's role in reflective supervision is facilitative, helping the staff member reflect on what they were trying to achieve, what they did, how it worked/the consequences/how the survivor reacted, how they feel about what they did, what they could have done additionally or differently, what they can learn from the experience, and how that will influence their future efforts. The safe, non-judgmental space of reflective supervision makes it possible to consider situations from alternative perspectives, with an ultimate focus on improving service quality and enhancing the staff member's skills and job satisfaction. Reflective supervision thus creates a space for staff members to be acknowledged for their successes, their capacity for continued growth, and their valued role on a solution-focused team that helps the program/agency achieve its mission.

In its [Reflective Supervision Guidelines](#), the Minnesota Association for Children's Mental Health distinguishes reflective supervision from administrative supervision and clinical supervision, based on its focus on shared exploration, and parallel process, that is, its "attention to all of the relationships ... including the relationships between practitioner and supervisor [and] between practitioner and [program participant] ... [and] how each of these relationships affects the other." Reflective supervision "attend[s] to the emotional content of the work and how reactions to the content affect the work, [and places a] greater emphasis on the supervisor's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor."

In her aforementioned July 2014 training, Dr. Pease cites Dr. Joy Amulya, formerly Assistant Director of the Massachusetts Institute of Technology's Center for Reflective Community Practice, and a leader in reflective practice and learning. In her 2004 brief on [What is Reflective Practice](#), Dr. Amulya describes reflection as "an active process of witnessing one's own experience in order to take a closer look at it ... to take perspective on one's own actions and experience -- in other words, to examine that experience rather than just living it. . . . [Reflection] allow[s] the possibility of learning through experience ... before, during or after it has occurred." [Amulya \(2004\)](#) observes that reflective learning can come from exploration of struggles and challenges, experiences of uncertainty, and experiences of success and fulfillment. She states that "reflective practice is

¹⁵ To view a July 2013 webinar on "Sustaining Ourselves in the Work: Trauma-Informed Approaches, Self-Awareness, and Self-Care," see [Cave, Pease, & NCDVTMH \(2013\)](#).

¹⁶ To view part 1 (August 2013) and part 2 (October 2013) of the webinar, "Concrete Strategies for Reflective, Strengths-based Supervision: Organizational Supports for Trauma-Informed Domestic Violence Services and Organizations" by Dr. Terri Pease and Cathy Cave, Senior Training Consultant for NCDVTMH, visit [Practical Strategies for Creating Trauma-Informed Services and Organizations](#).

driven by questions, dialogue, and stories," that is, on "narrative accounts of experience," similar to an individual's process of journaling.

Also in that July 2014 training, Pease notes that "reflective practice is simply creating a habit, structure, or routine around examining experience." A cornerstone of reflective supervision, then, is "regularity."

[Amulya \(2004\)](#) notes that "for many practitioners, doing swallows up learning. Even staying aware of what we are doing does not itself create learning. Learning is a purposeful activity, although not a complicated one. Recognizing the necessary role of reflection in excavating learning from experience and becoming familiar with the basic elements of a reflective practice will allow practitioners to begin to act on the notion that knowledge is embedded in the experience of their work, and to realize the importance of this knowledge in furthering their practice."

(ii) National Association of Social Work: Best Practice Standards in Social Work Supervision [NASW \(2013\)](#)

The [NASW's 2013 guidance on supervision](#) begins with the notion of accountability, and which incorporates elements of collaboration, but which depends more heavily on the capacity of the supervisor to guide and inform the process. Although the term "social work" may seem too clinical or hierarchical with respect to the work of advocates/case managers in TH Programs, the NASW's supervision principles offer useful perspective:

"Professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process.

Supervision encompasses several interrelated functions and responsibilities.... During supervision, services received by the client are evaluated and adjusted, as needed, to increase the benefit to the client. It is the supervisor's responsibility to ensure that the supervisee provides competent, appropriate, and ethical services to the client....

Ideally, the supervisor and the supervisee use a collaborative process when a supervision model is selected; however, it is ultimately the responsibility of the supervisor to select the model that works best for the professional development of the supervisee. The supervisory relationship is built on trust, confidentiality, support, and empathic experiences. Other qualities inherent in the supervisory relationship include constructive feedback, safety, respect, and self-care....

Some areas of knowledge, and the application of that knowledge to [serving] clients, can only be translated during the supervisory process. Supervision provides guidance and enhances the quality of work for both the supervisor and the supervisee and, ultimately, the client.

The activities of supervision are captured by three primary domains that may overlap: administrative, educational, and supportive.

- **Administrative:** *Administrative supervision is synonymous with management. It is the implementation of administrative methods that enable social workers to provide effective services to clients. Administrative supervision is oriented toward agency policy or organizational demands and focuses on a supervisee's level of functioning on the job and work assignment.*
- **Educational:** *Educational supervision focuses on professional concerns and relates to specific cases. It helps supervisees better understand social work philosophy, become more self-aware, and refine their knowledge and skills. Educational supervision focuses on staff development and the training needs of a social worker to a particular caseload. It includes activities in which the supervisee is guided to learn*

about assessment, treatment and intervention, identification and resolution of ethical issues, and evaluation and termination of services.

- **Supportive:** *Supportive supervision decreases job stress that interferes with work performance and provides the supervisee with nurturing conditions that complement their success and encourage self-efficacy. Supervisees are faced with increasing challenges that contribute to job stress, including the growing complexity of client problems, unfavorable physical work environments, heavy workloads, and ... vicarious trauma. Supportive supervision is underscored by a climate of safety and trust, where supervisees can develop their sense of professional identity.*

The combination of educational, administrative, and supportive supervision is necessary for the development of competent, ethical, and professional social workers."

"To maintain objectivity in supervision, it is important to

- *Negotiate a supervision contract with mutually agreeable goals, responsibilities, and time frames*
- *Provide regular feedback to supervisees on their progress toward these goals*
- *Establish a method for resolving communication and other problems in the supervision sessions so that they can be addressed*
- *Identify feelings supervisees have about their clients that can interfere with or limit the process of professional services."*

"Supervisors must ensure that all client information be kept private and confidential except when disclosure is mandated by law. Supervisees should inform clients during the initial interview that their personal information is being shared in a supervisory relationship. Supervisors also have an obligation to protect and keep the supervisory process confidential and only release information as required by the regulatory board to obtain licensure or if necessary, for disciplinary purposes."

"Documentation is an important legal tool that verifies the provision of services. Supervisors should assist supervisees in learning how to properly document client services performed, regularly review their documentation, and hold them to high standards. Each supervisory session should be documented separately by the supervisor and the supervisee. Documentation for supervised sessions should be provided to the supervisee within a reasonable time after each session. . . . Records should be safeguarded and kept confidential."

(iii) Clinical Supervision

Note: *While some of the following guidance may be primarily applicable to clinical supervision, other concepts will be applicable to the kind of non-clinical supervision that is more routinely provided in TH programs, given the universal importance of a trauma-informed approach, and the reality that nearly all program participants carry trauma and that at least some participants may be experiencing co-occurring mental health and/or substance use issues. In any of the directly quoted text that follow, the reader may find it should helpful to replace the term "clinical supervisor" with the term "supervisor" and the term "counselor" with the term "advocate" or "case manager."*

[SAMHSA \(2014\)](#) defines three possible supervisory approaches, and observes that a model that allows the supervisor to take on whichever role is needed by the supervisee "may be particularly useful in working with counselors in TIC [trauma-informed care] settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment." (p. 191) The three possible roles that [SAMHSA \(2014\)](#) discusses are:

- **"Teacher:** The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.

- **Counselor:** The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- **Consultant:** The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors." (p.191)

[SAMHSA \(2014\)](#) advises that "Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations [i.e., teacher versus counselor versus consultant] are clearly defined in an informed consent process similar to that used in the beginning of the counselor-client relationship and in which exploring the nature of boundaries in both client-counselor and counselor-supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship."

"Supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' [experiences of trauma and the impacts of that trauma]
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors." (p.193)

(c) **Secondary Traumatic Stress (STS) and Staff Self-Care**

(i) **Background**

In addition to the general stressors often associated with social service work, the experience of listening to stories of participants' trauma and witnessing the ongoing pain of those who have experienced trauma poses unique risks to the physical and emotional health and well-being of the advocate, case manager, or counselor providing supportive services. These effects go well beyond what is traditionally referred to as the "**burnout**" that occurs across human service professions.¹⁷ Service providers who work with trauma survivors are at risk of experiencing post-traumatic responses that parallel those of the individuals and families they serve and that "compromise their professional functioning and diminish their quality of life." ([NCTSN, 2011; p.1](#)).

Secondary traumatic stress (hereinafter STS) is the set of trauma-related stress reactions and physical, psychological, and cognitive changes and symptoms that staff may experience when they work with clients with histories of trauma. Although STS and PTSD have similar symptoms, secondary trauma is distinguished from PTSD because it arises from contact with persons with traumatic experiences, rather than from direct exposure to a traumatic event. STS (also known as **compassion fatigue**) can affect behavioral health staff

¹⁷ [NCTSN \(2011\)](#) describes "**burnout**" as "characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically." Although often used interchangeably with secondary trauma, NCTSN notes that the term "**vicarious trauma**" focuses less on the provider's trauma *symptoms* and more on the adverse cognitive changes that s/he experiences following cumulative exposure to another person's trauma narrative and symptoms.

across all kinds of care settings and across diverse categories of providers who work with trauma survivors (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers, etc.). [SAMHSA \(2014\)](#)

[Slattery & Goodman \(2009\)](#) state that,

"Like a diagnosis of posttraumatic stress disorder (PTSD), an STS reaction is considered to be a normal response to exposure to victims of traumatic events rather than an abnormal or pathological reaction (Figley, 1995; Herman, 1992). Indeed, Munroe (1999) called STS an occupational hazard for those working with trauma survivors."

"Symptoms of STS parallel those of PTSD and include re-experiencing the client's traumatic event through thoughts, feelings, and imagery; avoiding or feeling numb to emotions that remind one of the event; and persistent arousal such as heart palpitations, sweating, or sleep disturbances (Figley, 1995; Figley, 1999)."

The [webpage on "Self-Care for Providers" of the International Society of Trauma Stress Studies \(ISTSS\)](#) states,

"Indirect trauma, also known as vicarious trauma (VT), compassion fatigue (CF), or empathic strain, is an inevitable byproduct of working with trauma survivors. It isn't the "fault" of survivors, any more than occupational stress in air traffic controllers is the fault of pilots or airline passengers. Indirect trauma is the cumulative response to working with many trauma survivors over time.

The signs and symptoms of indirect trauma resemble those of direct trauma. Treaters may experience intrusive imagery and thoughts, physiological arousal, avoidance, or anxiety. Treaters may also experience disruptions in their personal or professional relationships, in managing boundaries, and in regulating their emotions. They may withdraw from others, become hopeless, have nightmares or difficulties sleeping, overeat, overuse alcohol, and so forth."

[NCTSN \(2011\)](#) adds that,

"Individuals affected by secondary stress may find themselves re-experiencing [their own] personal trauma.... They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes: hypervigilance, hopelessness, inability to embrace complexity, inability to listen, avoidance of clients [whose trauma triggers these reactions], anger and cynicism, sleeplessness, fear, chronic exhaustion, physical ailments, minimizing, and guilt. (Van Dernoot Lipsky, 2009)" (pp.1-2)

Over time, the cumulative effect of working with traumatized survivors can lead to negative changes in how staff view themselves and others vis-à-vis trust, safety, control, esteem, and intimacy. This phenomenon, known as **vicarious trauma**, may manifest as increased difficulty leaving work at work, poor boundaries, increased irritability with co-workers, diminished energy and patience, and doubts about professional impact and capabilities. (Pearlman & Saakvitne, 2005; Van Dernoot Lipsky, 2009). These effects can extend into staff members' personal lives in ways that include feeling disconnected from family and friends, avoiding activities they used to enjoy, and having less empathy and emotional availability for others (Van Dernoot Lipsky, 2009).

Given the adverse impact of STS and vicarious trauma on the quality of care -- and on staff turnover ([Bride, 2007](#)) -- there has been much interest in the personal and organizational/environmental risk factors for experiencing STS, and the protective factors and strategies for preventing and addressing its occurrence.

(ii) Are Staff that Have Experienced Domestic or Sexual Violence More Likely to Experience STS?

[Slattery & Goodman \(2009\)](#) observes that, "Two of the most commonly explored individual level contributors to psychological distress among trauma workers are degree of exposure to traumatized clients and personal trauma history." (p.1360) The authors reviewed a number of published studies, some of which appeared to confirm and some which appeared to undercut the importance of those factors, and hypothesized that these

"mixed findings" might be due to "environmental factors at work, such as accessibility to supervision or degree of coworker support." (p.1361)

Building on prior research,¹⁸ [Slattery & Goodman \(2009\)](#) conducted a study of advocates in domestic violence programs to determine whether certain organizational conditions -- workplace coworker support, the quality of the relationship between staff and their clinical supervisor, and staff sense of shared power (i.e., level of autonomy, mutual respect, participation in decision making related to their work) -- might be protective factors vis-à-vis STS -- and whether their absence might increase the risk of STS. The study also sought to assess the relative impact of these work environment factors compared to staff members' personal experience of violence and the amount of direct service exposure to program participants with trauma.

[Slattery & Goodman \(2009\)](#) found that all three workplace variables -- coworker support, quality of the staff relationship with the clinical supervisor, and shared power -- were inversely related to STS (i.e., the less support, the more likely the experience of STS; the lower the quality of the relationship between staff and clinical supervisor, the more likely the experience of STS; and the less the worker's sense of shared power, the more likely the experience of STS).¹⁹ However, when the authors looked at the three workplace variables together with measures of staff survivor status and level of direct contact with trauma survivors, the two variables that explained the most variance in STS were survivor status and shared power. (pp.1364-68)

The authors speculated that the lack of a statistically significant relationship between level of exposure to trauma and STS may have related to the **type** of exposure (e.g., exposure to telling and re-telling of the details of the traumatic experiences versus less trauma-inducing encounters with survivors); the study only measured the **amount** of exposure (e.g., hours of direct service).

The [Slattery & Goodman \(2009\)](#) study also did not explicitly address the tenure/level of experience of the workers. [SAMHSA \(2014\)](#) cites [Newell & MacNeil \(2010\)](#) finding that "being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions" can also be a risk factor for STS. (p.195)

(iii) Secondary Trauma and Staff Self-Care - Recommendations in the Literature

Although some factors may be more definitively linked to STS than others, the body of research on secondary trauma points to steps that **all individual workers providing services to trauma survivors and the organizations employing them** can take to reduce the likelihood of STS.

[SAMHSA \(2014\)](#) states that, "Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation," (p.196).

¹⁸ Cited in [Slattery & Goodman \(2009\)](#), for example, are (a) House & Kahn (1985), who found that work-related sources of support appear to be more valuable than support from family and friends in addressing workplace stresses; (b) Moos (1988) and [Repetti, Matthews, & Waldron \(1989\)](#), who found a significant relationship between social support in the workplace and the physical and mental health of the employee; (c) [Wasco, Campbell, & Clark \(2002\)](#), who studied rape victim advocates and found a relationship between organizational support (including but not limited to coworker support) and advocates' use of self-care routines; (d) [Ullman & Townsend \(2007\)](#), who found vicarious trauma related to poor supervision as a significant problem for advocates; (e) [Iliffe & Steed \(2000\)](#), who found that domestic violence counselors identified debriefing and peer support as the most important factors that helped them to deal with the work; (f) Pearlman & Saakvitne (1995) and Rosenbloom, Pratt, & Pearlman (1999), who found that good supervision can normalize a trauma worker's feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in identifying transference and counter-transference issues, and reveal feelings or symptoms associated with the trauma; and (g) Kanter (1993), who proposed that the behavior and attitude of individuals at work are determined in large part by their positions within the organization and their relative access to power. (1361-63)

¹⁹ Not coincidentally, the underlying principles for creating a trauma-informed organization (e.g., safety, control, choice, shared power, and effective communication) for survivors are also the underpinnings of a trauma-informed workplace.

[Volk et al. \(2008\)](#) reminds direct service workers that, "Self-care should be a preventive measure, and not something one does when feeling completely overwhelmed. It is not always easy to take care of ourselves. Demands from work, family, and friends can relegate self-care to the bottom of your "to-do" list. Self-care is not a sign of weakness. It is a way of making our bodies and minds stronger, thus enabling us to continue leading the lives that we do.... [You] cannot take care of others unless [you] first take care of yourself." (p.7)

[SAMHSA \(2014\)](#) suggests that,

"A self-care plan should include a self-assessment of current coping skills and strategies, and the development of a holistic, comprehensive self-care plan that addresses the following four domains: (1) Physical self-care, (2) Psychological self-care (includes cognitive/mental aspects), (3) Emotional self-care (includes relational aspects), [and] (4) Spiritual self-care.

Activities that may help behavioral health workers find balance and cope with the stress of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996)." (pp.206-07)

Of course, practices like attending workshops, balancing caseloads, managing a work schedule, taking breaks and vacations, and looking to professional colleagues for support all depend on the workplace culture. [Volk et al. \(2008\)](#) provides an **Organizational Self-Care Checklist** (pp.36-37) covering training and education, support and supervision, employee control and input (i.e., shared power), communication, and work environment.

Building on a host of research findings, [SAMHSA \(2014\)](#) frames some very similar recommendations as organizational strategies to prevent secondary traumatization:

- "Normalize STS throughout all levels of the organization as a way to help [staff] feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.²⁰
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and non-trauma-related [staff] caseloads.²¹
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and [staff] training that focuses on

²⁰ [Slattery & Goodman \(2009\)](#) note that "As Catherall (1995) suggested, it is critical that administrators actively create and encourage an environment where advocates are able to share their reactions to the work, discuss their own values and visions, and respond to each other in a positive manner. Evaluating possible obstacles to social support may be a first step. Yassen (1995) recommended an assessment of the physical environment, value system, expectations, and cultural characteristics of the organization prior to the development of any type of intervention plan to prevent STS. A cultural system that prohibits the expression of emotion, for example, may prohibit discussion of individual reactions to trauma work and discourage the type of personal disclosure necessary for the development of trust and sympathy between coworkers. Only by acknowledging these kinds of obstacles can real progress be made. In addition, it should be recognized that sharing case material may also potentially increase the risk of further secondary traumatization among advocates and, therefore, group consultation and supervision should provide the necessary support and structure to minimize this possibility." (p. 1372)

²¹ Of course, **every** participant in a TH program for survivors of domestic and sexual violence has experienced trauma, and in a small program with one or two staff, there may not be a way to "balance" caseloads. Not surprisingly, some staff mentioned that working in the shelter was more stressful than staffing the TH program; although shelters may have a broader mix of clients, including some who are largely private and seeking only temporary respite from the abuse, by and large, the trauma and pain for shelter guests is more recent, and so, more intense and raw.

understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for [staff] to engage in these activities.²²

- Provide regular trauma-informed clinical supervision²³ that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes staff members' professional and personal development. Supervision limited to case consultation or case management is insufficient to reduce the risk for secondary traumatization and promote [staff] resilience.²⁴
- Provide opportunities for [staff] to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from [staff] on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the [staff] to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting [staff] to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization." (pp.197-198)

Several of the providers that we interviewed indicate that their organizations try to implement the recommendations from [Laura van Dernoot's book on Trauma Stewardship](#), which emphasizes the importance of self-care and self-awareness, so that staff and volunteers providing care and support can continue to be fully present and capable in the work that they do to help people who have experienced trauma. Interested readers can hear a [TED Talk by Ms. Van Dernoot](#).

From its more clinical perspective, [SAMHSA \(2014\)](#) encourages clinical supervisors to "be familiar with the manifestations of STS in their [staff] and [to] address signs of STS immediately." (p.198) "Clinical supervisors and [staff] should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions." (p. 204) The authors cite the [Professional Quality of Life Scale](#) which is a free, downloadable validated scale for measuring secondary trauma, burnout, and compassion satisfaction²⁵ that "can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for [staff] to check in with themselves on their levels of stress and potential signs of secondary traumatization." (p.199) However, they caution that,

²² The Homeless Resource Center's Homelessness and Traumatic Stress Training Package ([Volk, Guarino, & Konnath, 2007](#)) suggests that large group trainings are helpful forums for initial staff education, but that such trainings alone are insufficient. It recommends the use of supervision and team meetings as smaller settings in which information can be clarified and follow-up information can be conveyed. Smaller meetings provide a forum for open communication, peer support, and additional training and education. Individual supervision by someone who is trained in and understands trauma is essential to meeting the individualized needs of each staff member by enabling them to learn how to apply learned concepts to real life work situations and to their responses to those situations.

²³ Provider comments in the portion of this section devoted to the merits of having a clinician on staff suggest that only a small minority of providers are able to offer clinical supervision to direct service advocates/case managers.

²⁴ [Slattery & Goodman \(2009\)](#) likewise emphasize that, "Applied to trauma workers and domestic violence advocates, in particular, this result [the inverse correlation between the quality of clinical supervision and the occurrence of STS] lends much-needed empirical support to the assumption so pervasive in the clinical literature that clinical supervision is essential to managing and alleviating the more direct and painful effects of trauma work." (p.1369)

²⁵ Compassion satisfaction measures the intrinsic satisfaction that a worker feels in helping their clients. [SAMHSA \(2014\)](#) observes that "The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people..., despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives.

"Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances. If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team, if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them."

Of course, not all programs offer clinical supervision, and, as noted elsewhere in this document, there is concern among some providers that a clinical orientation may pathologize survivors. Whether or not a program utilizes clinical supervision, there should be no question about the importance of being watchful for and quickly responding to signs of Secondary Traumatic Stress (or burnout) among staff.

(d) Staff Safety

A home visit with a program participant may be unsafe, if the participant's (ex-)partner is potentially onsite and volatile. To address this and other safety-related issues, Volunteers of America Oregon's Home Free program has created a [fact sheet on home visiting safety](#) that advises advocates and case managers to have an "open and honest conversation with the participant" regarding any safety-related concerns (for both the participant and the advocate/case manager).

In addition to its other recommendations, the fact sheet advises advocates/case managers to periodically check in about safety, and to "determine the appropriateness" of each home visit (versus meeting with the participant in a more public location, like a coffee shop or the library) any time there is potential concern that the abusive partner may be present or around. The fact sheet suggests that staff call the participant when they leave the office and again when they arrive at her building, to provide the participant with "an opportunity to let you know in advance if it might not be a safe time for you to visit." The fact sheet concludes with what it describes as "the most important guideline of all" -- trust your instincts:

"If at any point before or during a visit you feel that your safety may be compromised, listen to this feeling and do what you need to do. This could mean rescheduling the visit for another time, leaving in the middle of a visit with promises to call later, or moving the visit from the participant's home to a safer venue."

(e) Provider Comments on Staff Supervision/Support and Preventing/Avoiding STS or Burnout

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) It's that much harder because this kind of work is not well-paid; my staff is not handsomely compensated for the very hard work that they do, and we have individuals working for us who are working poor, and living very close to the federal poverty level themselves, while they're struggling to do the work and meet the mission, and help other people who are themselves struggling.

(#02) Clinical supervision has helped. With the residential team, we try to do things together to build the team. I encourage people to take time off. With limited staff and funding the schedule can get tighter and our executive directors focus on coverage, but I try to be flexible and say, if you have the time, take it. I'll worry

about coverage. It's not really feminist and worker-centered when people have to stress about their vacation. If we could, I would offer more self-care training, perhaps involving art therapy or body work/massage.

(#03) A large part of how we avoid burnout is our treatment team model, having weekly meetings and being able to maintain awareness of what's going on with the cases and also with our staff, being able to pick up the slack when needed, and to provide some relief. This summer, on Fridays we get a half day off. A couple of times a year, we have a retreat with everybody to press the reset button. Our executive director encourages family involvement, and is very sensitive to the importance of having support not just here, but also at home.

(#04) To avoid burnout we have our Employee Assistance Program with free counseling. We also discuss vicarious trauma to normalize it. A clinician comes in twice a month and provides optional group sessions for staff, focusing on vicarious trauma and grounding techniques and self-care, and recognizing and addressing signs of vicarious trauma and burnout in yourself. It's well utilized, and staff look forward to her coming. We also have a general wellness program that focuses on things like staff emotional wellness, healthy eating -- we do fun prizes, offer days off, etc. to make it fun and incentivize people in helping each other stay well.

(#05) Having clinical supervision helps prevent burnout and minimize vicarious trauma. Someone from the state coalition, the clinical director, I think, comes to lead monthly workshops on self-care, vicarious trauma, and burnout to keep up awareness. We also do fun days when staff do something not work-related together.

(#06) If we had the time and money for an additional training, I would suggest self-care, because if we're not healthy, we can't serve the clients well.

(#07) We're a small, close-knit staff. And we try real hard to take care of each other, and be alert to challenging situations. We bring in a professional so our staff can talk to them, have a very generous leave policy of four weeks of paid vacation in a year, so you can get away. I know that once you cross that line, it is real hard to bring yourself back from burnout and heal and be able to move on from that.

It makes a huge difference when you have new staff that, from day one, you've helped them set professional boundaries and helped them understand how to work within those boundaries. Helped them understand that our job is not to save our clients, not to rescue them. It is to provide them with options so they can make good choices; to support them, but not to live their lives for them.

(#08) With our transitional housing clients, we've gotten to the point where we don't do a lot of home visits for safety reasons. If we're concerned about safety, we can do case management by phone. Or the case manager can meet them at the public library or somewhere for a cup of coffee. It depends on the community, and where they can safely meet. It might still require the case manager to travel, but not to the client's home. We're like any other community. We've got areas of crime and as a general policy, we try not to do home visits, either with follow-up from shelter clients or with transitional housing. Because in the early years of this program, we did do home visits and a case manager walked into a couple of apartments where the offender had moved in, and there's the victim, there's the boyfriend, and it was just a bit uncomfortable.

(#09) I think the agency does a good job of talking about and helping us process the things that are going on. When something bad happens to a survivor, we process that as a staff, which I think is very important to self-care in dealing with those things. Our agency is a remarkable group of people. We have staff retreats that focus on taking care of ourselves, yoga and things that really help us walk away from our work.

(#10) OVW offers a lot of webinars on self-care. Staff will take the time during the day, and everybody goes to the conference room and watches them together and talks about them. That's part of the training. If there are any trainings around the city, we try to send staff.

There's a local private foundation that targets assistance to programs serving vulnerable populations; they make available a center, at no charge, where we do retreats. We try to do a staff retreat once every quarter, if not more often. The foundation also offer a series on staff self-care to which we can send a staff person for free. We also have a staff member who specializes in self-care who is going to do a training on self-care for our staff. We make sure that our case managers have self-care plans, because the work is really difficult, and the pay isn't the greatest. We really try to value that work as much as possible.

(#11) I think supervision is key to minimizing burn out. We have our weekly supervisions; I meet with the transitional living advocate to talk about caseload, to talk about house dynamics, to talk about pretty much everything she's got going. We also are a proponent of using your benefit time - making sure you take a vacation to avoid burnout. As a program director, I have a manager support line as well as we have a backup support system, so if for some reason things are getting really spicy on site and the responding staff member needs help from another staff member, there is somebody to call 24/7.

(#12) We have fun to avoid burnout. Our agency has a pretty generous vacation leave schedule. We have great supervisors that check in with staff on a regular basis. We've really tried to create a culture of caring for one another. I operate with the philosophy that the most important thing is taking care of yourself and your family. If I've got a sick child at home, or I'm missing my 5-year-old's dance recital because my boss is forcing me to work, I'm probably not giving 100% -- and my clients will probably sense that I don't want to be there. So, our staff knows that they come first; we really try to do all we can to encourage a good work/life balance.

Our supervisors are really good at noticing when people are starting to isolate and pull away and show some of those signs of burnout and vicarious trauma, and they sit staff down to talk about it. Although as a small non-profit, we don't have a formal EAP program, we do offer to pay for counseling and therapy for staff, and give people extra days off if that's what they need. We also offer a flexible schedule. Our work can't always be done from 8am to 4:30pm, and evening or weekend hours sometimes encroach on people's personal life. So we allow staff to make up for that at other times; some people would prefer to come in at 10am, and others would rather be doing paperwork at 7am. Just to allow that flexibility to meet personal needs.

(#13) We emphasize to staff that you have to take care of yourself. Our agency has implemented a morale committee that plans parties and luncheons just so we can get together and have some fun. We also have an employee assistance program which funds a therapist who can provide up to six free sessions with individual staff, and then help that staff member decide whether they need a referral for further assistance.

(#14) We try to have an open communication zone, where if somebody needs some time or help to process something, or needs to vent, they can go to their supervisor or one of their peers; just making an open and honest space for that conversation so we're not feeling like we're stuffing everything inside. Our regional DV network has a sub-committee that focuses on the experience, concerns, and professional development of staff from communities of color. I identify as African-American, and participating with that committee is almost a form of self-care; it gives me a space to speak freely about what it is for me, as a professional and a person of color, what I have faced or areas I see that aren't being addressed, and I like that about my job. I feel there is space for me to grow, that my time and role are valued and that if there's an opportunity for me to educate myself and expand my career for later in life, they want me to take it. I really appreciate that here.

(#15) (Not a current OVW grantee) I know it sounds corny to say that we're a family but that's exactly what we are. Most of the core staff has been here for years. If I get sick, I know my manager will visit me in the hospital; it's just that simple. I know what's going on in the lives of the majority of my staff members, the younger ones who are in college as well as the older ones who have children. We work very closely together and it helps. We try and celebrate birthdays. We try to remember that there are other events in your life beyond work. We support each other as human beings, not just as staff that fill a role. We care about each other -- with healthy boundaries: it's not like everyone knows the ins and outs of all our lives. We try to use humor. And we eat a lot of chocolate.

We work very closely together as a team. We have a clinical supervisor, and when there's a situation that's got everybody's nerves on edge, she leads us in talking it through. We attended a circle training offered through a local university -- it's an old model for processing difficult issues which is getting more and more attention. We sit in circle and make decisions together, resolve issues, and just support each other.

(#16) (Not a current OVW grantee) We have a really awesome policy of paid time off. We don't have holidays here because we're open 365 days a year, but our staff can earn hours off every month. Our front line staff are on call once a month as a primary person, and then once a month as a secondary person. And, the incentive for being on call is that they earn a day off every month they do that. We really encourage staff to use their PTO, when they feel burnout or overwhelmed, to make sure that they're getting that mental rest they need. We have a staff healing room - a place where staff can go at any point during their day and meditate, listen to calming music, sit in a quiet space away from the shelter, their phone, or email. We've had book groups to read [Trauma Stewardship](#), so our organization is very aware of vicarious trauma and its effects, and in supervision, we talk about it one-on-one with our staff to make sure that we can help prevent it before it takes its toll.

(#17) Our leadership and the Board have always been very supportive of making sure that the advocates have enough time off, and that they are able to leave their job when they go home, so they can be mentally healthy as well. And I think that's just a really important part of a successful agency.

(#18) (Not a current OVW grantee) I think the turnover we have is because our advocates are paid between \$15 and \$17 an hour and it's just not enough money for them to have a reasonable life in this city. It's really tough, but we can't increase their wages any higher and that's an institutional problem. In the city and county, it's the going rate, and no agency seems to have the money to pay more. So, we get about two years out of staff members who are good, and then they go back to school to do their Masters and progress with their careers.

(#19) I think about some of the situations that our advocate has found herself in with participants, situations that feel overwhelming, that seem hopeless -- having to walk with somebody through those situations can really take a toll. You have to care deeply about that, and at the same time you have to be able to walk away from it. Supportive supervision is really helpful and important. When our advocate is all amped up about a situation, my job is to keep a cool head and help her take a step back. Our advocate needs to be somebody who cares a lot about finding a way to resolve difficult situations, and her supervisor needs to be somebody who can say, "Ok, wait, this is just a problem that we have to solve." Finding that way to separate yourself from what's going on is really important, and a good way to avoid burnout.

We've tried lots of different supervision models at our agency. We've tried using a shared leadership model; we've spent some time looking at trauma stewardship, Laura van Dernoot Lipsky's stuff [[Trauma Stewardship](#)

[Institute](#)], and thinking about the impact of trauma on the way we do our work and the way we are. I think that the fact that we're always experimenting with trying to get it right means that it's really important.

I think clinical supervision has been really helpful when our agency has been able to provide it. I'm solution focused, so I think that clinical supervision is important, if it's well-structured on an outcome. We do case reviews in our staff meeting, and that accomplishes two purposes: (1) It allows us to look at our services and make sure we're offering the best services with the most likelihood of positive outcomes; and (2) It allows staff to get support from each other. But when you get involved in that kind of a process you have to be careful that it doesn't devolve into victim-blaming, because we start to have expectations of the people we serve. Working in a team can help dispel that if you have a team that trusts each other enough to ask, "Are we talking about our participant or are we talking about us right now?" That can be a really freeing question or it can be a really loaded question, depending on your own perspective on who you're talking about.

A few years ago, we started to see that as a staff, we were burnt. We were getting old and tired of doing this work together over all these years. And we really had to say it out loud and then we had to say, "We're going to commit to look at this." And we made that commitment knowing that one result might be that some of us didn't continue to work here. And that was exactly what happened: we made a really intentional commitment to look at our organization, at our staffing, and at each of us as individuals. A couple people decided, "I'm ready to move on." And that's important, too: recognizing when it's time to move on.

(#20) (Not a current OVW grantee) The therapist on staff is also the clinical supervisor for the case managers. Our deputy director has a Master's Degree both in HR and in social work and so she's the direct supervisor of the direct service staff. We try to limit the caseloads and to create an environment here that is very convivial. We very deliberately hire people who believe in the power of love and the power of healing. I don't think we have a cynic on our staff. I think everyone is here because they really love to do this work. We have a generous leave policy and give them lots of holidays and we even have a health and wellness benefit that will pay for gym memberships and things like that, so people feel like they're cared for and taken care of.

We're trying to create an environment for our clients that suggests love, welcome, healing, and hope, and we have to embody that. If we feel that way about each other and we like coming to work and there's a lot of laughter and a lot of love here, then when the client comes in they're immediately going to feel like this is a place that they'd like to be, as they begin to work on their own journey.

(#21) I meet weekly with all my staff for all these sites. And usually one time a month we have food delivered and that's always a big thing. They love being fed for free; I think we all do. I encourage self-care all the time. We have a church that comes in once a month and they do what's called "soul care." They'll come in for three hours and they bring food, too. They'll do a craft with us and then they'll paint our nails and give us neck massages. I know it sounds super cheesy, but that goes such a long way and I make sure that all staff are present, because it's important that they feel special and that other people show them how special they are for doing this work -- because people are not waiting in line to help people who have been sex trafficked.

(#22) Over 60 people work in this facility and they're all focused on keeping survivors safe and holding batterers accountable, so just being able to work in an environment where everybody gets it, everybody understands the language; you don't have to explain it, you don't have to justify it. Because this is a longer-term program, it's not just a shelter program -- they get to see survivors really becoming better; they get to see them getting their life back; they get to see them when they come back; they've had their apartment for several months and they're looking better, they're dressing better. That just makes the changes tangible. They're not just seeing the woman coming in with the black eyes and the broken bones and depressed with no self-esteem. We're actually seeing survivors getting empowered, getting their voices back, and really being successful, and everybody celebrates that and so that's what helps keep people from burning out.

(#23) I do progress notes weekly, so I document my communications or my concerns, and I discuss them with my supervisor. If I can't figure it out, she definitely gives me the direction that I need, or "let's call the client," and we've done that, where it's been the three of us with the client. But if there is an issue with the client that I feel I can't address on my own, I bring it to my supervisor, usually immediately.

We all have a sense of burnout, and we all go through things. I feel more impacted by the shelter than I do by the transitional clients, because when we're seeing a constant turnaround in the shelter. We have staff meetings often where we talk about our issues and problems we're having, and our supervisor's great at addressing the issues and basically reassuring us that our job is hard. Our group is a really good group. We're all close, we're friends, so that helps, because it helps us be able to vent a little bit and not feel like we're being judged if we might have a particularly bad exchange with a client.

Questions to Consider

1. What are the contributing factors to secondary traumatic stress (STS) or staff burnout in your program?

To what extent is their STS or burnout a result of the vicarious experience of participants' trauma versus a consequence of the way the program operates and/or the nuts and bolts of supporting survivors in overcoming their obstacles to achieving a "successful" outcome? For example, do any of the following factors (or other factors) contribute to the STS/burnout problem, and if so, how could they be addressed?

- Unmanageable caseload size;
- Heavy documentation and reporting requirements;
- (internal or external) expectations about participant outcomes that may be unrealistic, given the circumstances and barriers facing participants and the timeframe for delivering services;
- Difficulty connecting with participants;
- Challenges navigating the benefits bureaucracy;
- Difficult housing or job market conditions;
- Frustrations about inadequate resources or barriers to accessing those resources (internally and in the larger community).

2. Do different advocates/case managers need different types, levels, and frequency of supervision, or are there certain standards for supervision that every program should follow? What kinds of resources are available to support staff in programs which aren't funded to provide regular supervision?

3. What are the pros and cons of contracting out for clinical supervision, rather than adding supervisory responsibilities to the other responsibilities of a program or agency administrator?

4. How can programs that lack the resources to provide regularly scheduled reflective and/or clinical supervision fill the gap so that they can more adequately support staff? How often should such supervision be scheduled?

5. How should a supervisor handle a situation in which a staff member who appears to be suffering from STS or burnout indicates their desire to "keep working"?

- What if her departure, even for a few weeks, would overburden other staff, disrupt continuity of services to participants, and jeopardize participant progress in matters that don't lend themselves to intervention by other staff?

6. The reflective supervision model presumes complete transparency on the part of both parties. What if a staff person fails to disclose a "mistake" -- something they did (or didn't do) with a participant that they are embarrassed or uncomfortable about -- that has resulted in a setback or a problematic participant outcome?

- How might the problem be "discovered" by the supervisor?
- What might their goal be in speaking with the staff member, once the situation is revealed?
- What approach might they take in their next conversation with the staff member?

11. Roles for Volunteers

(a) Overview

Quite a few of the providers interviewed -- especially providers operating scattered-site programs that do not have a regularly used central meeting place for participants -- indicated that although a hotline or shelter that they operate may utilize volunteers, their TH program does not.

Providers most likely to utilize volunteers were full-service domestic violence and sexual assault providers that also operate non-residential service programs that serve TH program participants, and agencies that operate congregate or clustered housing programs, or programs in which scattered-site participants are close enough to regularly access services or attend activities at a central meeting place.

Recognizing the diverse range of backgrounds, skills, and knowledge that volunteers might bring to bear, the Missouri Coalition's [Standards for Domestic Violence Programs](#) (p.33) suggests a broad range of direct and indirect services for which volunteers could be utilized -- some of which might or might not be applicable to a TH program, depending on how it is set up -- including, but not limited to: (a) program facility coverage, crisis intervention, case management, court advocacy (or accompaniment), hospital/medical advocacy (or accompaniment), support group facilitation for adults and/or children, professional therapy, intake or assessment of service needs, and development or implementation of service plans; (b) transportation or accompaniment; (c) recreational activities for adults and/or children; (d) educational, job readiness, job training and/or other assistance or services related to obtaining employment; (e) agency/program administrative duties, fundraising/development activities, event organizing, public speaking, and facilities maintenance, improvement, and upkeep.

Of the TH programs that reported utilizing volunteers, some leverage pro bono services by local professionals (e.g., attorneys, therapist/counselors), who provide the kind of services that the agency cannot afford to fund out of its budget, and cannot leverage from other providers. Other programs utilize MSW student interns to offer routine assistance to TH program participants. Some programs engage corporate or community volunteers in periodic "days of service" to maintain program facilities or in more one-on-one type activities, like assisting with mock interviewing or resume development. Some programs have community volunteers that fill administrative roles; provide haircuts, manicures or pedicures, or massages; teach yoga for participants (or staff); contribute food or baked goods for meetings or presents for the holidays; or help with childcare during adult group meetings.

Several providers spoke about the importance of integrating volunteers from segments of the community that are not adequately represented on the paid workforce in order to increase the overall diversity and cultural and linguistic competence of the program. In some cases, these volunteers may serve as interpreters, if they speak a language spoken by one or more participants, but not by staff. On the other hand, advocates for cultural and linguistic competence might argue that lack of proper compensation devalues their importance to the program, and might prevent the program from accessing professional caliber interpreters who might do a better job.

Providers hold very different opinions about the roles that volunteers can fill. Some providers recalling the "early days" when domestic violence programs were all staffed by volunteers, believe that -- with the right training -- volunteers can provide essential participant services. One person we spoke to suggested that if volunteers can staff a crisis line that handles calls from potentially suicidal callers, they should be able to handle some of the more routine advocacy/case management work, with proper training and supervision.

However, other providers, expressed concerns about the consequences of volunteer turnover or lapses in confidentiality, and so, reluctance to commit resources to such training, or to put volunteers in position that involve direct work with participants.

Still other providers believe that even with training, volunteers are not qualified to work with survivors in the program, and that it would be a disservice to those participants if volunteers delivered services instead of fully qualified and trained staff members.

Even if they do not provide services directly for TH participants, utilizing volunteers was seen as a good way of engaging the community in supporting and publicizing the work of the agency, and building its base of funding and "political" support.

(b) Provider Comments on the Use of Volunteers

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) Volunteers are crucial for us, especially with decreased funding. I think volunteers could do anything that we do. They answer the hotline, crisis intake, crisis intervention. We've had some MSW interns do case management and be part of the residential team. Back in the 70s and 80s, everyone was a volunteer. I think they're crucial and we'd be lying to ourselves to believe they can't do it just as well as we can. Like anyone, they need supervision, but if they're compassionate and willing, they can do a lot.

(#02) We see what participants are interested in and we try to find volunteers that can meet those needs. For example, the people in our current program wanted art and we found volunteers to come in to teach painting. We also use AmeriCorps and Jesuit volunteers. For example, right now, we have an Americorps (through a job center here) who helps people with resumes, skill building, mock interviews, getting clothing for interviews, and things like that. Volunteers do not act as case managers or advocates in this program, although they do in other of our programs. This program uses volunteers to supplement services. I would avoid placing them as the case manager or in a position that needs consistency.

(#03) We have all sorts of people from the community helping us. An attorney providing legal services; licensed counselors who are volunteers as well as some that do it on the sliding scale; volunteers who do the translations; an individual who comes in twice a week to does the life skills training and job readiness. But in areas where you want to have that consistency, like case management, you wouldn't want to have volunteers, because they come and go, and are not as reliable.

(#04) We don't have any laypeople that volunteer with our transitional housing because it's hard to find a layperson that is qualified to work with victims of domestic violence, and who can keep those professional boundaries that you need when you're working with victims.

(#05) Our experience with volunteers in the transitional program has been minimal. We have had good experiences with volunteers in other programs, but haven't figured out how they can fit into this program, especially around confidentiality and that's a big priority. And I feel that a volunteer wouldn't do justice to the type of services we try to provide. Participants deserve someone who knows what's up, what the options are, what services are available. If we're going to put time into training a volunteer to provide the type of service our staff does, we want to know that they'll be here a long time, and we have not seen that with volunteers.

(#06) I don't know that there's anything I would limit volunteers to do. I started out with this agency as a student intern. As a volunteer, I went to court, I led groups, did crisis calls. It was a great experience in learning what was going on. I wouldn't put a volunteer in a case management role by themselves. But, I think

it would be okay to have them sit in and assist in certain roles -- if only just for liability purposes of making sure that the agency knows what type of interactions are taking place with our clients. Even with crisis calls, all volunteers have to handle the crisis calls with another employee. They can't make a decision on their own.

(#07) We have a therapist who is a volunteer. She comes to talk to the women once a month, so depending on what's happened in the program, I'll tell her I want you to cover this. If I felt that child discipline was an issue, then I would ask the therapist to talk about it and give alternatives, etc. Last time, for example, I saw a lot of transitions going on, people having new boyfriends. They didn't know how to deal with it, how to introduce them to the kids, when is the right time, etc., so I asked our therapist to talk about transitions. We also have volunteers who do different things; today, we have volunteers coming to give massages.

(#08) We get help from volunteers during the holidays: delivering gifts, delivering Thanksgiving baskets, holiday baskets, and things like that. They're not necessarily in contact with participants on a daily basis, but we use them a lot around the holidays because, as you can imagine, it'll get very crazy around here. They're all background searched and they'll help deliver gifts to our families. If the families come for Christmas to get gifts, the volunteers are there to show them what's available, help them with gift wrap, and all of that.

(#09) Our volunteers and the case manager will work with people on filling out employment applications.

(#10) Connected to our transitional housing program, we have a group of absolutely amazing volunteers. One is an interior designer; when a participant moves into transitional housing, she gathers a group of volunteers, and using household furnishings donated by the team, they basically set up the entire apartment.

(#11) We have lots of volunteers. This year we're hosting six interns, ranging from undergraduate interns to MSW interns. And the MSW interns are giving us about 20 hours a week so that's additional onsite staff time. They co-facilitate support groups, provide individual support, hotline support, run onsite workshops for both shelter and transitional living residents. One intern will be dedicating most of her time to the transitional living program, providing a weekend bridge so transitional living clients have an anchor seven days a week.

In addition we have teams of volunteers that do "days of caring" that support the physical structure. We have one corporate sponsor that does annual projects from painting to grounds work to dumpster filling.

We also have a male volunteer that is like my right arm. He is a retired gentleman who helps with most of the maintenance repairs. And that really is a help because those are the small things that build over time and wear on individuals' psyches. If it takes a long time to replace a light bulb or unclog a toilet, people start feeling like we don't really care; it seems small, but it does make a difference.

(#12) We couldn't do the work without volunteers - it can be someone coming in wanting to teach how to create a budget, how to dress for an interview, or strategies to save money. We also have a couple of attorneys who do some pro bono work for clients.

(#13) (Not a current OVW grantee) Our volunteers right now are all from an organization that recruits and trains volunteers to provide childcare when we have workshops and groups in the office in the evenings. We've also had volunteers run a group or lead workshops on specific topics, maybe one session long, maybe six weeks....

(#14) It is a priority for our agency to recruit a diverse group of volunteer and board members. In smaller communities, volunteers may be the face of the agency for the client, especially for client interaction. For example, the program from my home town had only one staff person, and almost everybody that interacted with clients was a volunteer. At the same time, sometimes confidentiality and safety issues can come up within smaller communities... and in immigrant communities. So the question is how can we connect with this community and provide culturally relevant services and support, and recruit good staff and volunteers, without compromising our client's confidentiality or putting them in danger.

We now have an acupuncture program -- a professional volunteer who comes out once a week and does an acupuncture group, where he treats PTSD. It is open to our clients, staff and volunteers who are experiencing PTSD, secondary trauma, signs of stress. It's been a huge success, and it came about because one of our housing advocates had a contact in the community who was interested in volunteering, and she did the meetings and preparation to make this project happen. We have a community garden for a similar reason.

And that collaboration piece -- when staff and volunteers feel like empowered members of the team -- seems to facilitate more collaboration with clients. That is, our ability to be collaborative and work together as a staff carries over into our ability to be collaborative and share power with the residents and the clients we serve.

(#15) We have volunteers who go to municipal court and provide information and resources to victims who are appearing there as part of a criminal case.

(#16) We have a very active base of volunteers, donors, and supporters, including a community task force that is pretty involved. We have a really good community support system, which took years to develop. One of the biggest challenges facing this agency is that we don't have in-house legal services. Even just to be able to answer questions from the women that are sometimes beyond our ability. Sometimes we need an attorney to go back into the courts and challenge a denial of a protection order. At times, we can arrange pro bono representation, but not as often as we'd like. Not with the needs as great as they are.

(#17) A lot of times, our volunteers are survivors and that's usually how they first come to us. They may not have directly accessed our services themselves, but they want to give back in some way. We have several different volunteer opportunities. A staff member who supervises each particular volunteer opportunity does one-on-one interviews with the person who wants to do that kind of volunteering. All volunteers have to go through domestic violence training with our staff. They do a lot of observation and shadowing before actually volunteering on their own. Our 24/7 crisis hotline is one of our larger volunteer opportunities. Volunteers also provide childcare while the moms are in parenting class. And we always need data entry volunteers.

(#18) We have volunteer community groups who do things for our transitional housing residents. There's a church that makes a monthly dinner and drops it off when we have a community dinner. We have somebody doing a nutrition class right now, so different kinds of classes or presentations. Our transitional housing residents are aware that they have access to our 24-hour hotline, and that's staffed at night and on the weekends by volunteers, and we have volunteers who provide childcare. Occasionally we've used the services of a board member who is a therapist; he's always available to us if there's something that we just can't figure out. The staff who've taken him up on that consistently report that it's really helpful.

(#19) (Not a current OVW grantee) We work with law firms who can provide pro bono assistance.

(#20) We have volunteer therapists that actually come to our site and out of the kindness of their hearts, do one-on-one therapy, and they're all women who have either been "in the life" or they're just really invested because they've loved someone deeply who has been in that lifestyle, so they have experience with it.

(#21) We have volunteers who donate haircuts, massages, and yoga or some other relaxing things. We wouldn't even exist if it weren't for volunteers. Between running our houses and the coffee shops where we train and employ participants, there's not a lot of staff for all the things we do. Last year, a local company was looking for a program to send a large group of volunteers to paint or do whatever. They made our house look brand spanking new.

Questions to Consider

1. Do the kinds of roles that volunteers fill depend on the configuration of program housing?
 - For example, does volunteer involvement look different in a scattered-site program versus a congregate program or clustered housing program that provides services (e.g., advocacy/case management, group activities, childcare, festive gatherings, access to visiting staff from partnering agencies, etc.) out of a central location?
 - Can volunteers conduct home visits? What (other) roles can volunteers play in a scattered-site program in which participants don't regularly come to a central location?
2. Are there differences in the kinds of roles that supervised college- or graduate school-level interns can be asked to fill, as compared with other volunteers?
3. What kinds of roles that volunteers fill require a 3-month commitment, a 6-month commitment, a 12-month commitment?
 - What is the minimum commitment that a volunteer must be willing to make in order to justify the level of training and oversight that the agency will provide?
4. How does your program distinguish between the services for which staff get paid and the services for which volunteers contribute their time?
 - When volunteers are used to provide an essential service, should they be paid?
 - When volunteers are used to diversify the "face" of the program, are they serving a role for which they should be paid?
5. Not all professional volunteers -- therapists, lawyers, etc. -- may be willing or feel like they have the time to participate in the DV 101 training that would otherwise provide them with the same grounding in trauma and same basic understanding of domestic and sexual violence as other staff and volunteers.
 - How firmly should an agency hold to a requirement that all volunteers participate in the same training, regardless of the skills and talents that certain professionals may have to offer?

12. Volunteer Screening, Training, and Support

(a) Overview

Utilizing volunteers to provide any kind of direct services (or to provide other assistance which will regularly require volunteers to be around participants) entails an investment of provider time. Providers that reported utilizing volunteers indicated that prospective volunteers are typically interviewed to screen for some of the same positive attributes (e.g., compassionate, non-judgmental, respect for confidentiality, etc.) and warning

signs (e.g., lack of boundaries, "incomplete healing" from their own experience of domestic or sexual violence -- if such experience has been voluntarily disclosed) that programs consider when they hire new staff.

New volunteers are typically required to complete the same basic 20-40 hour training as newly hired paid staff, and, depending upon their role, may need the same level of detail in their job description as paid staff, and a comparable level of supervision and support, again depending on their roles.

With that kind of organizational investment required, programs have an incentive to focus their recruitment efforts on candidates who can make a credible commitment to their volunteer role.

The Missouri Coalition's [Standards for Domestic Violence Programs](#) (p.33) and [Standards for Sexual Violence Programs](#) (p.38) require that member programs have

"written policies and procedures regarding the recruitment, screening, training, recognition, supervision and/or dismissal of volunteers used to provide direct and indirect services [that] clarify the roles and responsibilities of volunteers..., with specific detail addressing professional boundaries, disclosure, and how, when, where and the frequency with which volunteers will be used."

The standards -- which would apply to shelters, TH programs, and non-residential programs -- require:

- the same kind of written job description as for a paid staff person;
- that volunteers receive training that meets current Coalition standards;
- ongoing supervision of volunteers by program staff; and
- that programs maintain a confidential file with the volunteer's application to volunteer and documentation of any certifications, information from completed background checks and reference checks, a signed confidentiality statement, and a record of all trainings completed.

The Coalition requires that programs conduct periodic evaluation of their volunteer program and of the performance of each volunteer to ensure quality of services.

The Oregon Coalition's [Domestic Violence and Sexual Assault Program Standards \(Self-Assessment Tool\)](#) similarly states that

"Each program should have clear and comprehensive policies and procedures regarding volunteers, [including] written job descriptions; the philosophy, goals, and objectives of the volunteer program; the procedures and criteria for selecting volunteers; criminal background check policies; training standards; working conditions; non-discrimination policy; sexual harassment policy; accountability and reporting requirements for volunteers; confidentiality agreement; performance standards; designation of probation periods, process and time period for evaluation, grounds for disciplinary action and termination; rules of conduct, including accident and safety procedures; harassment policies; and drug free workplace policy." (p.17)

However, the Oregon Coalition leaves it to member providers to define those standards.

(b) Provider Comments on Volunteer Screening, Training, and Support

Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.

(#01) We look for the same strengths and positive attributes in volunteers as we look for in our staff. They don't need the same education or experience as staff, but they need to understand and share our voluntary services philosophy and dedication to the mission.

If someone is working more directly with the participants, they have to go through the interview, background check, 40 hour training (at a minimum), and they are supervised in their contact with people and have the same orientation period as staff.

(#02) Volunteers have to sign a confidentiality agreement and our code of ethics. We spend time training about setting boundaries with the clients, to try to make sure that they set those boundaries at the start. Not showing too much attention to one client. Sometimes, volunteers become partial to a particular client and when you recognize that, you have to address it; or if a client becomes very attached to a volunteer.

(#03) When screening volunteers, we look for someone who's open to learning, who can respect and honor boundaries, who's not so rigid in their thinking that they come in with predetermined ideas and stereotypes, definitely someone who can respect the confidentiality, and also someone who won't treat clients as if they're second-class citizens.

Volunteers are required to participate in an orientation with staff from all parts of the program. I think that some of the same training that's provided to the staff would be great for the volunteers. For volunteers who do not work directly with the participants, we would maybe just have training on a more basic level, maybe some basic DV 101 to understand the population. I think it is important to refresh that volunteer training, rather than just offering training in the beginning and thinking they're good to volunteer forever.

(#04) Part of the reason why we rely more on interns than volunteers is because every person that comes on site needs to go through the certification training, which is 30 hours. We're investing a lot into that person and if we don't get a return on investment it doesn't feel worth it. There are some people that are really excited about volunteering, get involved but then, if things change in their life, they have less time to give and it can be a little disheartening for our staff and for the residents that develop relationships. What's great about utilizing interns attending school for their MSW is that there are clear start and end dates that allow us to make deliberate transitions, so that they're exiting well, that relationships are terminating well.

(#05) We've had two or three volunteers that help us with things sometimes, but we don't really rely on them. We hired a full time Volunteer Coordinator to help build our capacity, partially because within the last year, our service area doubled in size. We're still in the process of figuring out for sure how we're going to use volunteers, and getting them trained properly for direct service, but what we have found is that once we started asking for help, people were pretty willing to help, they just need to know what to do and how to do it. I think the key is having someone dedicated to that role. In the past, it was always someone with other responsibilities - someone wearing three hats as well as serving as the volunteer coordinator, so at the end of the day, the volunteer coordination piece never happens.

(#06) One challenge involving volunteers is that sometimes they think they want to come in and help, but they themselves need the help. We can pretty much screen those volunteers out in our training. They have to go through rigorous training before they can even come into contact with our clients. So, we tell them this is not going to be a good match, or these are other opportunities that we think you would be better for.

Volunteers get the same basic training as staff -- anywhere from hotline training to assessment training to suicide assessment, legal training, history of our agency, listening skills. We talk a lot about boundaries in our training as well. We can find out pretty quick if a volunteer has crossed boundaries because clients don't keep quiet. And I don't say that to be derogatory about clients, but we hear that "a volunteer bought me a purse" or "a volunteer gave me \$10." So we'll talk to the volunteer and say that's a no-no because we adhere to the Social Work Code of Ethics and so we're asking you not to do that again. And if they do it again, we'll politely say, "Hit the road."

(#07) We get so many requests for people to do volunteering that we can't even handle it because we don't have a volunteer coordinator, and we desperately need one.

Questions to Consider

1. What kind of training, supervision, and support are needed to minimize the likelihood of problematic encounters between volunteers and program participants?
 - What kind of training, supervision, and support are needed to minimize the likelihood of early turnover due to role dissatisfaction, burnout, or STS?
2. What are the pros and cons of treating volunteers as members of the extended staff team?
 - What kinds of conversations, meetings, and team activities should volunteers be invited to join?
 - Should all volunteers be included in those activities, or only those volunteers with direct contact with program participants?
 - What kinds of staff activities should volunteers be excluded from?
3. Should college- or graduate school-level interns receive a different kind of support or supervision than other volunteers?
4. To what extent are internships a potential pipeline for prospective staff hires, when vacancies occur?

13. Appendix A: Project Description and Methodology

(a) Project Description: Summary

Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot provides an in-depth look at the challenges and approaches taken by Office on Violence Against Women (OVW)-funded providers to address the needs of survivors who have become homeless as a result of having fled domestic violence, sexual assault, dating violence, and/or stalking.

The information in the twelve chapters of the report and accompanying webinars, broadsides, and podcasts comes from 124 hour-long interviews with providers and an in-depth review of the literature and online resources. Our analysis of provider comments was informed by the insights of a small project advisory committee (Ronit Barkai of Transition House, Dr. Lisa Goodman of Boston College, and Leslie Payne of Care Lodge) and the reviews and comments on the initial drafts of chapters by Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative).

Although the components of a transitional housing (TH) program -- a place to live and staff support for healing, decision making, and taking next steps -- are simple, the complexities attendant to providing effective survivor-centered assistance are many, as illustrated by the following enumeration of topics covered in the report (which, in many cases, only scratches the surface):

- [Chapter #01 - Definition of Success & Performance Measurement](#) - Explores how funders and providers define and measure success and program performance; how participant-defined goals are tracked; how participant feedback is collected; and how the definition and measurement of success affects program decisions. Highlights innovative performance and participant outcome metrics. Discusses approaches to collecting, storing, releasing, and destroying data, and the software used to collect, analyze, and report on program data.
- [Chapter #02 - Survivor Access and Participant Selection](#) - Explores the distinct and overlapping roles of domestic violence (DV) shelters and transitional housing; the pathways that survivors take to get to

transitional housing, and how providers select participants from among "competing" applicants for assistance; why providers might decline to serve certain candidates; who is and isn't served; and the regulatory and legal framework within which those processes occur.

- [Chapter #03](#) - ***Program Housing Models*** - Explores the strengths and challenges of alternate approaches to housing survivors in transitional housing and transition-in-place programs. Examines the pros and cons of time-limited housing vs. transition-in-place housing, congregate vs. clustered vs. scattered site housing, and provider-owned vs. provider-leased vs. participant-leased housing. Discusses how the type of housing can affect participant selection and the services offered.
- [Chapter #04](#) - ***Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement*** - Examines the challenges, strategies, and implications of taking a survivor-centered/voluntary services approach, and how such an approach is integral to operating a trauma-informed program. Explores the potential impacts of funder expectations, choice of housing model, staffing patterns, and diverse participant needs and circumstances. Presents comments illustrating the range of providers' interpretations of and responses to the voluntary services requirement, including their approaches to supporting participant engagement and to addressing apparent lack of engagement. Discusses the concept of empowerment, presents comments illustrating the diverse ways that providers see and support survivor empowerment, and cites an innovative approach to measuring safety-related empowerment.
- [Chapter #05](#) - ***Program Staffing*** - Explores program staffing levels and the kinds of positions providers maintain; the attributes and qualifications that providers look for in the hiring process; and how they assess the value of having a clinician on staff, having child-focused staff, and having survivors on staff. Examines how programs support and supervise staff, and their approaches to staff training. Presents comments illustrating providers' diverse perspectives about utilizing volunteers, and describing how programs that do use volunteers screen, train, and support them.
- [Chapter #06](#) - ***Length of Stay*** - Explores funders' and providers' approaches to limiting or extending the duration of housing assistance and services, and the implication of those approaches.
- [Chapter #07](#) - ***Subpopulations and Cultural/Linguistic Competence*** – Discusses cultural and linguistic competence and how providers understand and work to achieve it in their programs. Presents diverse perspectives from the literature and online resources and from provider interviews about the challenges and approaches in serving specific subpopulations, including African American, Latina, Asian American, Native American/Alaska Native, Immigrant, LGBTQ, older adult, deaf, disabled, and ex-offender survivors. Includes an extensive review of the challenges, approaches, and legal framework (e.g., non-discrimination, reasonable accommodation, fair housing) in serving survivors with disabling conditions that affect their mental health, cognition, and/or behavior, including trauma/PTSD, substance dependence, traumatic brain injury, and/or mental illness. Highlights OVW-funded collaborations to enhance the capacity of victim services providers to serve survivors with disabilities and of disability-focused agencies to serve consumers who are also survivors.
- [Chapter #08](#) - ***OVW Constituencies*** - Focuses on the needs and approaches to meeting the needs of survivors of sexual violence -- including survivors of rape and sexual assault, homeless victims of sexual violence, survivors of Military Sexual Trauma, and survivors of human sexual trafficking. Explores possible reasons why survivors of sexual assault constitute only a small percentage of the participants in OVW TH grant-funded programs, even though provider comments generally indicate an openness to serving such survivors. Includes a conversation with senior staff from the Victim Rights Law Center discussing possible options for expanding system capacity to serve sexual assault survivors.
- [Chapter #09](#) - ***Approach to Services: Providing Basic Support and Assistance*** - Explores different frameworks for providing advocacy /case management support (e.g., voluntary services, survivor

empowerment, Housing First, Full Frame) and how motivational interviewing techniques could be helpful. Discusses survivor safety and how safety is assessed and addressed (e.g., danger and lethality assessment instruments, addressing batterer- and life-generated risks as part of safety planning, safe use of technology). Looks at strategies and practices for supporting community integration, and providing follow-up support to program alumni.

- [Chapter #10](#) - ***Challenges and Approaches to Obtaining Housing and Financial Sustainability*** - Examines the challenges survivors face in obtaining safe, decent, affordable housing and the approaches providers take to help them, and some useful resources. Explores the added challenges posed by poverty, and approaches and resources leveraged by providers to facilitate access to mainstream benefits, education and training, and decent employment. Other areas of focus include childcare and transportation, resources for persons with criminal records, workplace-related safety planning, and approaches and resources for supporting survivors in enhancing key skills, including financial management.
- [Chapter #11](#) - ***Trauma-Specific and Trauma-Informed Services for Survivors and Their Children*** – Discusses the nature, impacts, and manifestations of trauma; approaches to addressing trauma; what it means to be trauma-informed; and the steps providers take -- and can take -- to become more trauma-informed. Reviews the impact of trauma on children and families, especially the trauma of witnessing abuse of a parent; and discusses the challenges posed and approaches taken in addressing the effects of that trauma. Includes brief sections on custody and visitation.
- [Chapter #12](#) - ***Funding and Collaboration: Opportunities and Challenges*** - Examines sources of funding for TH programs, focusing on OVW and HUD grants -- the regulatory requirements, strengths and constraints of each funding source, and the challenges of operating a program with combined OVW/HUD funding. Explores the potential benefits, challenges, and limitations of partnerships and collaborations with mainstream housing/service providers, including confidentiality issues. Presents provider comments citing the benefits of being part of a statewide coalition; discussing the opportunities and challenges of participating in a Continuum of Care; and illustrating the range of gap-filling service agreements and collaborations with mainstream providers. Highlights published reports describing successful collaborations.

Although the report chapters attempt to divide the component aspects of transitional housing into neat categories, the reality is that many of those aspects are inextricably linked to one another: the definition of success, the housing model, and sources of funding play a key role in how services are provided; the housing model, sources of funding, and length of stay constraints can play a role in influencing participant selection; the subpopulations targeted and served and the program's approach to cultural/linguistic competency, the program's understanding and embrace of voluntary services, survivor-defined advocacy, and what it means to take a trauma-informed approach all inform how the program provides basic support and assistance; etc.

(b) Project Description: Overall Approach

This project was originally conceived as a resource guide for "promoting best practices in transitional housing (TH) for survivors of domestic and sexual violence." However, over the course of our conversations with providers, it became clear that while there are certainly commonalities across programs -- for example, the importance of mutual trust and respect between participants and the providers that serve them, and the fundamental principles of survivor-defined advocacy and voluntary services -- there is no one-size-fits-all "best practices" template for providing effective transitional housing for survivors. Instead, there are a multitude of factors which go into determining providers' approaches:

Survivors from different demographics and circumstances may experience domestic and sexual violence differently and may respond differently to different service approaches. Age, class, race, cultural and linguistic background, religious affiliation, gender identity, sexual orientation, military status, disability status, and, of

course, life experience all play a role in defining who a survivor is, how they experienced victimization, and what they might need to support healing and recovery. Each survivor's history of violence and trauma and its impact on their physical, physiological, emotional, and psychological wellbeing is different, and their path to recovery may require different types or intensities of support.

Where a program is located and how it is resourced plays a significant role in shaping a program, the challenges it faces, the opportunities it can take advantage of, the logistics of how housing and services are provided, and the kinds of supplementary resources the program might be able to leverage from other sources. Different parts of the country have different types of housing stock, different housing markets, different levels of supply and demand for affordable housing or housing subsidies, and different standards for securing a tenancy; different regions of the country have different economic climates, different labor markets, and different thresholds for entering the workforce; depending on where they are located, low income survivors could have very different levels of access to emergency financial assistance, health care, mental health care, addiction services, child care, transportation, legal assistance, immigration services, and/or other types of supplemental support.

"Best practices" for a stand-alone TH program in which a part time case manager serves a geographically scattered clientele in a rural, under-resourced region will mean something different than "best practices" for a well-resourced, full-service metropolitan-area provider that affords participants access to different types of transitional housing; that can leverage the support of culturally and linguistically diverse in-house staff and volunteers, that can contribute the services of in-house therapists, child specialists, employment specialists, and other adjunct staff; and that can rely upon nearby providers for additional gap-filling services.

"Best practices" in providing transitional housing for a chronically poor survivor whose education was interrupted, who has never been allowed to work, and who suffers from complex trauma as a result of childhood abuse may well look different from "best practices" in serving a survivor who is better educated, has a credible work history, but who was temporarily impoverished due to her flight from an abusive partner.

"Best practices" in serving a recent immigrant, with limited English proficiency, who lacks legal status, whose only contacts in America are her abusive partner's extended family -- will likely look different from "best practices" in serving a teenage girl who ran away from sexual abuse in her small town home, only to end up pregnant and in an abusive relationship, which she fled when he threatened to hurt her baby -- which, in turn, will look different from "best practices" for serving a middle-aged woman who tolerated her husband's abuse for years, because he supported the family and because she couldn't, and because keeping the family together was what her community and her church expected her to do, and what she would have continued to do until he finally went too far.

While there are commonalities to the approaches taken by the diverse programs awarded OVW TH grant funding, the very nature of the kind of "holistic, victim-centered approach ... that reflect[s] the differences and individual needs of victims and allow victims to choose the course of action that is best for them," called for in the [OVW's annual solicitation for TH grant proposals](#), argues against too many generalizations about one-size-fits-all "best practices."

Recognizing that survivors from a broad spectrum of demographics and circumstances may have different needs and priorities and goals, may have and/or perceive different options for moving forward in their lives, and likewise, may have different definitions of "success," the OVW refrains from asking its TH grantees to render judgments about the quality of specific program outcomes.

In the absence of a consistent measurement of success and a framework for measuring differences in clienteles and program operating environments -- that is, lacking a data-informed basis for assessing whether a particular intervention constitutes a "best" practice -- we chose to take a more descriptive approach for this report. Drawing from providers' own words, the literature, and online resources, we have attempted to frame and provide context for the broad range of challenges and choices that providers face; to describe and offer

context for and examples of the approaches they take in furnishing transitional housing for survivors; and to highlight some of the unresolved issues and difficult questions that providers wrestle with.

(c) Project Methodology: Collection and Analysis of Data from Provider Interviews

(i) Development and Implementation of the Interview Protocol

Drawing from information gleaned from the literature and online resources, and from some of the project and advisory team members' personal experience in working with transitional housing programs and/or providing services to survivors of domestic violence, we developed a list of topics and potential questions that we hoped to cover in our provider interviews.

Because there were so many potential subjects to discuss and only an hour to have those conversations, we divided the topics into separate interview protocols. In addition to basic descriptive information ("universal topics")²⁶ that would be collected in each interview, we defined four distinct sets of topics²⁷ that would be sequentially assigned as interviews were scheduled. Over time, we eliminated certain areas of questioning from the interview protocol if we were not getting new information, and added topics or questions, as we identified gaps in our information. By the time half the interviews had been completed, the four lists of topics/subtopics had been condensed into three lists/interview protocols.

Pursuant to early discussions with the OVW, we agreed that the initial protocol would be "field-tested" by conducting interviews of staff from nine TH providers that the OVW identified and reached out to on our behalf. We also agreed that our interviews would be conversational and driven by the providers we were interviewing. That is, ***although we had lists of topics and questions that we might want to address, we would follow the lead of the provider to make sure we covered any issues or concerns or approaches that***

²⁶ **"Universal" Topics:** Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary versus transition-in-place; congregate versus clustered versus scattered-site; provider-owned versus provider-leased versus participant-leased); target constituency (e.g., survivors of domestic violence, sexual assault, etc.); type/number of direct services staff, use of consultants, involvement of other agency staff; other DV- or non-DV-focused programs operated by agency; how survivors access program and participant selection/prioritization; how staff understand the different roles of DV shelter versus TH; characterization of service area (e.g., metropolitan area, small city, suburban, rural, mixed); program definition of a "successful" outcome and how program promotes success; how program implements voluntary services; maximum, typical, and targeted length of stay; other sources of funding; involvement with local or regional network of DV-focused providers and/or with Continuum of Care; most significant challenges faced by program; perceived differences between TH for other homeless populations and TH for survivors of domestic violence/sexual assault.

²⁷ **Group 1 Topics:** staffing details (roles, training, support, etc.); use of volunteers (roles, reasons for/against using, training and support); program philosophy and underlying approach (e.g., trauma-informed, empowerment, survivor-centered, etc.); consumer involvement (Board membership, advisory roles, options for current participants).

Group 2 Topics: assistance obtaining housing (challenges faced, strategies used, partnerships, etc.); employment assistance (challenges faced, strategies pursued, partnerships, etc.); approach to working with participants with significant barriers (e.g., economic, mental health, substance abuse issues, etc.); child- and family-focused services (what triggers needs assessment, needs assessed, how needs are addressed and by whom, interface with schools); follow-up services (type offered, challenges faced, insights into utilization patterns).

Group 3 Topics: challenges, advantages, and reasons for choosing type of program housing and approach to offering financial assistance with housing-related costs; distinctive subpopulations served (population-specific challenges and approach, challenges/approaches pertaining to serving a mixed clientele, etc.); meaning and dimensions of cultural competence; approach to ADA compliance in serving persons with disabilities; collaborations (strategies, challenges).

Group 4 Topics: program rules and the consequences of violating them; performance measurement (formal versus informal approach, specific measures, whether/how participant progress is measured and used to gauge program performance, impact on program design) ; approach to data collection (software used, data collected above and beyond funder requirements, compliance with HUD comparable data base requirement); funding opportunities and constraints (challenges/strategies for government and non-government funding); challenges and benefits of collaboration with local/regional HUD-funded planning entities (Continuum of Care, Consolidated Plan).

they wanted to highlight. Rather than asking a uniform series of questions, we would use our protocols as guides, rather than as interview scripts. To realize this objective, our team worked together to make sure we had the same general understandings of the protocol and the purpose of the interviews. The nine initial interviews were all conducted by pairs of team members, to facilitate full-team participation in our review of those interviews and in any revisions to the protocol based on that review.

Our team followed up the OVW's initial outreach to the nine providers with emails elaborating on the project (and attaching the OVW's initial letter), and providing supplemental information emphasizing the voluntary nature of participation and how **provider responses would be kept confidential.**

Each interview began with an introduction of the project; an explanation of how we intended to create a resource document that would describe the what, how, and why of providers' efforts **in their own words**; a request to record the conversation; and an assurance that **once the project was over, recordings and transcripts would be deleted, so that all that would be left would be anonymous comments.** We followed this same procedure throughout the project, eventually reaching out to almost 250 providers and securing the participation²⁸ of over 50%. Early on, we modified the process, per the request of some of the providers, and began sending a tentative list of topic areas along with the email confirming the date and time of each interview. The email emphasized, however, that the provider should feel free to steer the conversation as they saw fit, to make sure we covered any issues, concerns, or approaches that they wanted to highlight.

Starting with the first "field test" interviews in June 2014 and ending in February 2015, the project team completed interviews with 122 TH providers and one legal services provider that partnered with a TH provider (the Victim Rights Law Center, which asked to be specifically identified), and conducted a joint interview with two providers of LGBTQ domestic violence-related services (identified by Project Advisory Team members, in response to our request for help identifying experts who could help fill that information gap). The project director conducted 62% of the interviews and read the transcripts of all the other interviews.

Of the 122 providers, 92% (112 providers) were current recipients of OVW TH grants; another eight providers had recently lost their OVW grants and, at the time of their interview, were either operating a TH program with other funds, or had ceased TH operations. (Some of these providers subsequently received OVW TH grants.) Only two of the 122 TH providers interviewed had never received OVW TH grants (and were HUD- or state-funded). Fifty-one (42%) of the TH providers we interviewed were current recipients of one or more HUD Continuum of Care Transitional Housing (TH) or Rapid Rehousing (RRH) grants and/or a HUD Emergency Solutions Grant (ESG) RRH grant.

(ii) Processing of Interview Data

All interviews were submitted to a transcription service and the transcript was reviewed for accuracy (and corrected, as needed) by the project director. Transcripts of the interviews were entered into NVivo, a qualitative data analysis software, and then sentences or paragraphs that pertained to each of 27-30 project-defined topic areas²⁹ were coded as being related to that topic area. The project director performed the large majority of coding, and reviewed (and, as needed, modified) all of the coding decisions by the project associate, thereby ensuring coding consistency.

The selected provider comments pertaining to each topic area constituted a voluminous amount of data, and had to be boiled down, so that they could be shared with our Project Advisory Team members, and eventually incorporated into the report. Interview comments were edited for clarity and brevity, with an absolute emphasis on retaining the voice and essential message of provider comments. The interviewer's voice was

²⁸ We actually secured the participation of 130 providers; however, six interviews were not included in the analysis because the interviewee was not adequately familiar with the TH program, or the program was too new to have any experience, or the provider no longer operated the TH program and no longer had staff who could answer our questions.

²⁹ Several codes were consolidated as the coding process evolved.

removed. Names of people, places, and programs were removed and replaced with generic references to ensure confidentiality and anonymity, as had been promised to providers at the outset of each interview, and in our outreach correspondence. The project director did the overwhelming majority of all such editing, and reviewed (and, as needed, modified) all edits proposed by the project associate.

These compilations of provider comments (still averaging 20-30 pages, after editing) were shared with members of our Project Advisory Team and reviewed and discussed in a series of thirteen 90-minute meetings over the course of several months. Insights from those conversations, as well as information and perspectives from the literature and online sources were integrated into narratives that supplement the extensive presentation of provider comments in each of the twelve chapters.

Although this is a qualitative study and not quantitative research, we have included the large majority of the provider comments pertaining to each of the covered topics to provide the reader with not only a **sense of the range of challenges, approaches, and philosophies**, but also with a **sense of the frequency with which they were mentioned or reflected in provider comments**. Some of the comments will seem very similar to one another, some will differ by nuance, and some will be dramatically different.

This report does not include the very important perspective of victims/survivors. Collecting the feedback of survivors served by OVW TH grant-funded programs was deemed by the OVW to be outside the scope of the Technical Assistance grant that generously funded this project. Although our "**Snapshot of Transitional Housing for Survivors Of Domestic and Sexual Violence**" is missing that perspective, we hope it is nonetheless useful to the dedicated providers, researchers, and government officials who are committed to supporting and strengthening these and other efforts to address the scourge of domestic and sexual violence.

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