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

Chapter 4: Taking a Survivor-Centered/Empowerment Approach: Rules Reduction - Voluntary Services - Strategies for Engagement

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This project was supported by Grant No. 2012-TA-AX-K003 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.
# Table of Contents

Chapter 4: Taking a Survivor-Centered/Empowerment Approach

Acknowledgements .................................................................................................................. 1

Note about the Use of Gendered Pronouns and Other Sensitive Terms .................................. 4

1. Executive Summary ........................................................................................................... 6

2. Introduction ........................................................................................................................ 11
   (a) Connected Concepts: Rules Reduction, Voluntary Services, Survivor Empowerment, and a Survivor-Centered Trauma-Informed Approach ......................................................... 11

3. Program Rules and Behavioral Expectations ..................................................................... 13
   (a) Overview - Reducing the Emphasis on Rules ................................................................. 13
   (b) Provider Comments about Program Rules/Guidelines and Behavioral Expectations ...... 18

4. Voluntary Services / Approaches to Supporting Participant Engagement ....................... 27
   (a) Voluntary Services - Overview .................................................................................... 27
      (i) VAWA / OVW Regulatory Framework and Provider Interpretation ........................... 27
      (ii) Voluntary Services and HUD Funding ...................................................................... 30
      (iii) Implementation Guidance ....................................................................................... 32
      (iv) Measuring Fidelity to Survivor-Defined Practice, a "First Cousin" to the Voluntary Services Approach .... 34
      (v) Voluntary Services and Participant Selection .......................................................... 35
      (vi) Why TH Program Participants Might Not Be "Engaged" with Services .................. 36
      (vii) Provider Strategies for Encouraging Participant Engagement .............................. 38
      (viii) The Challenge of Voluntary Services in Supporting Survivors Coping with Addiction, Depression, PTSD, and Other Concomitants of Trauma and Abuse that Can Undermine Capacity for Engagement .................................................. 40
      (b) Provider Comments ................................................................................................ 43
         (i) Comments on the Importance of Trusting Relationships and Non-Judgmental Communication ................. 43
         (ii) Comments about the Importance of Creating a Safe, Supportive, and Inspiring Program Environment ... 49
         (iii) Comments about Using Motivational Interviewing ................................................. 52
         (iv) Comments about Focusing on Deadlines and Natural Consequences .................. 53
         (v) Comments about the Importance of Making Participation Easy, Fun, Useful, and Rewarding ............ 56
         (vi) Comments about the Importance of Meeting Participants Where They Are, and Respecting Their Boundaries and Choices ........................................................... 60
         (vii) Comments about the Importance of Persistent Outreach, Support, and Validation, Especially When a Survivor Seems Stuck ........................................................................ 68
         (viii) Comments about Requiring Periodic Check-Ins and Setting Clear Expectations to Sustain Engagement .. 74
         (ix) Comments about Linking Continued Assistance to the Level of Effort and Demonstrated Progress ...... 78
         (x) Comments Expressing Provider Concerns and Frustrations with Voluntary Services ......................... 83
Acknowledgements

This project would not have been possible without the valuable contributions of the dedicated provider staff who shared their experience and insights, and whose comments inform these chapters, nor would it have been possible without all of the research, advocacy, and creative energy of all of the practitioners whose publications and online resources we learned from and cited.

Special thanks also go to the following people and organizations for their help:

- The Office on Violence Against Women for their funding support, and our project officer, Sharon Elliott, in particular, for her ongoing encouragement and support as this project evolved, and for her dedicated commitment to the life-changing work that the OVW’s transitional housing grants make possible;
- Ronit Barkai (Transition House), Dr. Lisa Goodman (Boston College), and Leslie Payne (Care Lodge) for their contributions as members of the Project Advisory Team, including feedback that informed the development of the interview protocols, and insightful observations shared over the course of the dozen-plus team meetings during which we reviewed and analyzed topical compilations of provider comments;
- Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative) for their extremely helpful reviews and comments on initial drafts of the report chapters;
- Barbara Broman (AIR) for her ongoing supervisory support;
- Charis Yousefian (AIR) for her extensive help with the coding, excerpting, and analysis of interview data; the preparation of summaries from the many meetings with our Project Advisory Team; and her attention to detail in reviewing citations and in compiling and periodically updating the reference lists;
- Kathleen Guarino (AIR / National Center on Family Homelessness) for her initial draft of the chapter on trauma-specific and trauma-informed care, her generously shared expertise, and her help with periodic problem-solving;
- My former colleagues at the National Center on Family Homelessness, in the early days of our affiliation with AIR -- Dr. Carmela DeCandia, Rose Clervil, Corey Beach, and Maureen Hayes -- for their help conceptualizing the interview protocol, and scheduling and conducting some of the early interviews with transitional housing providers; and
- Melissa Scardaville (AIR) for contributing her time to review of the penultimate drafts of the chapters.

Any and all errors and omissions are the fault of the author, Fred Berman.

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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) and the Missouri Coalition of Domestic and Sexual Violence -- 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 comments 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.

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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."
Chapter 4 explores the interconnected concepts of rules reduction; voluntary, survivor-centered services; and empowerment, and looks at how these concepts are implemented by victim services providers operating specialized transitional housing (TH) programs serving survivors of domestic and sexual violence.

Rules reduction, voluntary services, and survivor empowerment are all integral components of a trauma-informed approach, and the chapter narrative and provider comments frequently reference the impacts of trauma and the importance of taking a trauma-informed approach.

Section 2, introduces the chapter, drawing heavily from the Missouri Coalition Against Domestic and Sexual Violence’s (2011) “How the Earth Didn’t Fly Into the Sun,” which frames the case for rules reduction, and which explains that by reducing and/or eliminating inessential program rules, including rules that require participation in services and that sanction non-participation, programs restore some of the power and control that was forcibly taken from survivors by their abusive (ex-)partners.

The elimination of excessive rules and coercive practices not only creates a more trauma-informed program environment, in which survivors have the opportunity to be more in charge of their choices and their lives; it also reflects an understanding that some of the challenging behaviors that rules and sanctions have sought to address were caused by, or served as coping strategies while victims were in their abusive situations.

Thus, as described in Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project (2011), survivors who are seen by some providers as "unmotivated," "non-compliant," "exhausting to be around," "detached," and/or "difficult-to-serve" may be manifesting patterns of behavior or communication that came about or were exacerbated as a result of chronic exposure to trauma and violence -- so that sanctioning or choosing not to serve these survivors because of the challenges they pose is a type of "double jeopardy" that punishes them anew for the violence and abuse they suffered and eventually fled.

Section 3 addresses the use of program rules. After a brief review of the impetus for rules reduction, the narrative provides links to some resources describing strategies for reducing program reliance on rules; and describing a framework for assessing whether program rules and policies addressing behavioral expectations are necessary, effective, respectful, and enforceable, and whether the unintended consequences that might result from enforcement of those rules outweighs the benefits of having them in place.

The narrative notes that as programs have shifted away from the use of the congregate housing model, in favor of scattered-site housing, many of the rules that TH providers put in place to reduce or prevent chaos and conflict in group living situations are no longer necessary, and can be -- and have been -- discarded.

3 As used in this report, the term "specialized TH program" means a traditional transitional housing program or a transition-in-place or rapid rehousing program, which may be funded by OVW, HUD, and/or other source(s); operated by a victim services provider; and targeting assistance to survivors of domestic or sexual violence. Unless preceded by the word "mainstream," the term "TH program" should be assumed to refer to a "specialized TH program."

4 See Chapter 11 ("Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children") for a full discussion of the elements of trauma-informed care.

5 In earlier times, and in programs not governed by the Violence Against Women Act’s (VAWA) requirement for voluntary services, rules requiring participation in program services and activities were widespread. The topic of voluntary participation in services is primarily addressed in Section 4 of this chapter, but mentioned in Section 3 in conjunction with the discussion about efforts to eliminate rules that require participation in services or penalize lack of participation.

6 As discussed in Chapter 3 ("Program Housing Models"), statistics from the program-wide Semi-Annual Reports indicate that congregate living units now constitute significantly less than 10% of all OVW-funded TH program housing.
Of course, programs continue to need a minimal number of rules and guidelines that address behaviors that might endanger the lives or wellbeing of staff or other participants. However, as provider comments at the end of the section indicate, some programs continue to utilize rules and policies to penalize behaviors with less serious consequences, or to exclude or curtail access to assistance (e.g., beyond the OVW’s six-month minimum) by participants who fail to meet behavioral expectations (e.g., sobriety, willingness to seek mental health care, commitment to separate from the abusive (ex-)partner, active engagement in services, etc.).

The Section 3 narrative explains how such rules and policies may put providers at risk of violating the VAWA\(^7\) voluntary services requirement and the program's commitment to the OVW (in its [grant application](#)) to avoid "activities that compromise victim safety," such as "requiring survivors to meet restrictive conditions in order to receive services..." (p. 4). In addition, rules and policies limiting program access or curtailing assistance that have a [disparate impact](#) on survivors with mental health, alcohol use, head injury, or trauma-related disabling conditions (e.g., PTSD) -- any of which may have been caused or exacerbated by exposure to violence and abuse -- may also violate federal/state fair housing or anti-discrimination laws.

The Section 3 narrative concludes with a [recommendation for training and support](#), and perhaps a [collaborative exploration of systemic solutions](#) by the OVW, the U.S. Department of Housing and Urban Development (HUD), and the OVW's other federal partners, to help providers overcome some of their remaining concerns and obstacles to operating a low-barrier program for survivors with challenging trauma-related needs and behaviors. A mix of training, support, and systemic solutions would be especially helpful for programs that lack the in-house resources to address the specialized needs of deeply traumatized survivors, and that cannot leverage the necessary gap-filling resources from conveniently located mainstream providers. It could also help jointly OVW/HUD-funded providers that want to serve survivors with serious barriers and want to maintain a low threshold voluntary services approach, but worry about not being able to achieve the participant housing- and income-related outcomes targeted by HUD and its proxies, within the shortened timeframes for assistance.\(^9\)

The provider comments at the end of Section 3 illustrate the broad range of program approaches to rules.

Section 4 lays out the VAWA-based regulatory framework for voluntary services; the OVW interpretation of voluntary services, as reflected in the provisions of its [annual solicitation for TH grant proposals](#); the HUD interpretation of voluntary services, as reflected in the regulations governing its CoC and ESG programs; and the implementation guidance that OVW-funded programs have received from the National Network to End Domestic Violence (NNEDV), the OVW's national TA provider (e.g., [NNEDV (2013)](#)).

Although there is broad agreement among providers that program success is largely dependent on the foundation of trust and understanding upon which the staff/participant relationship is built, the mix of provider comments indicates the existence of a [variety of perspectives about what "voluntary services" means and what the advocate's proper role is in successfully implementing a voluntary services approach](#).

The Section 4 narrative presents some of the NNEDV guidance addressing lingering provider misconceptions about what staff can do and what they should avoid within a voluntary services framework (e.g., it's okay -- and helpful -- to initiate unsolicited contact with participants; it's okay to ask participants to regularly check-in

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\(^7\) The Violence Against Women Act, which authorizes the OVW's Transitional Housing Assistance Grants Program.

\(^8\) For more information about "disparate impact," see a June 2015 post, entitled "[U.S. Supreme Court Upholds Fair Housing Disparate Impact Principle](#)" on the National Low Income Housing Coalition website.

\(^9\) HUD funds specialized TH programs through its Continuum of Care (CoC) and Emergency Solutions Grants (ESG) grant programs. 42% of the providers we interviewed reported receiving HUD grants to support their TH or rapid rehousing programs. CoC grants are administered by geographically organized consortia called Continuums of Care and ESG grants are administered by states, counties, and cities. As discussed in this and other chapters, HUD grantees are encouraged to shorten the duration of assistance, typically to no more than 6-12 months, despite the 24-month regulatory limit.
with their advocate;\(^{10}\) it's okay for an advocate to share her concerns about the possible impact of a survivor's intended course of action on her safety or wellbeing, as long as the advocate is mindful of the relationship dynamic, and offers her input as an ally, being careful to avoid the appearance of exerting power and control.

While it is may be well within the bounds of the voluntary services model for staff to be proactive and assertive in offering encouragement and assistance with participant goals, and in articulating concerns about actions or situations that may compromise participant safety, there is a fine line between being assertive versus being perceived as coercive, particularly given the staff/participant power differential. It is likely that some of the provider staff "misconceptions" that NNEDV training materials address (e.g., guidance item #6) -- resulting in perhaps excessive restraint in offering support and encouragement to participants -- may reflect staff recognition of the power imbalance, and their decision to err on the side of caution and support for participant autonomy.

The narrative cites the challenge advocates face in finding the "sweet spot" between active support and overreach, which depends on an awareness of where the survivor is in her healing process, sources of stress in her life, and her particular sensitivities and trauma triggers. An effective staff/participant relationship depends on staff learning to read the distinct patterns of that participant, and developing a sense of when to be a cheerleader and when to put goals aside and simply be an ally as the survivor confronts her challenges.

The Section 4 narrative notes the work of Goodman et al. (2016) in advancing the concept of "survivor-defined practice," which is closely related to voluntary services, and describes a metric Goodman et al. developed to help providers assess their fidelity to the underlying principles of survivor-defined practice: focus on the survivor's goals, sensitivity to the survivor's unique needs and coping strategies, and services offered as an ally, rather than from a position of authority.

The narrative continues with an exploration of how providers seeking to adhere to the voluntary services model -- but concerned about resource constraints or limited staff ability to address the needs of specific subpopulations (e.g., survivors with mental health or substance dependence, survivors from a particular cultural or linguistic community, etc.) or their ability to meet funders' expectations vis-à-vis targeted outcomes -- may be tempted to tailor their participant selection process so as to prioritize candidates they believe they can serve well and who will be a "good fit" with the program and its focus on their funders' priorities, and to avoid enrolling survivors they might not be able to serve as well, given resource limitations, and/or who might not be as engaged in program services linked to funder priorities.

Such an approach may disadvantage survivors who are still grappling with profound emotional, psychological, and abuse-related wounds and the debilitating effects of trauma; survivors who face additional social and economic barriers related to their demographic, other disabilities, immigration status, or prior involvement with the criminal justice system; and survivors with different life priorities or ideas about healing.

Depending on the implementation details, such a participant selection process may be at odds with the OVW's caution to TH grant applicants against "procedures and policies that exclude victims from receiving ... assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or age and/or gender of their children" and/or in violation of nondiscrimination or fair housing provisions.

The Section 4 narrative also notes the approach taken by a small number of providers that offer a baseline period of assistance, but condition extension of program assistance -- or the magnitude of further financial assistance -- on the level of survivor "engagement," "effort, or "progress," and suggests the need for OVW clarification as to whether these approaches are consistent or at odds with the required victim-centered, voluntary services approach.

\(^{10}\) However, the narrative suggests the need to clarify "the line" between a "check-in" and case management services.
The Section 4 narrative continues with a look at some of the reasons why a survivor might not be "engaged" and actively participating in program services, for example, because services don't feel relevant and don't appear to address her highest or most urgent priorities; because she was not as involved as she wanted to be in shaping her path forward; because there are difficult tradeoffs to resolve before the survivor can commit to a particular approach or goal; because of changes to her physical, physiological, cognitive, emotional, or mental health that were caused by prolonged or repeated exposure to violence and abuse; because of anger or resentment or fears related to her situation and the alternatives she feels forced to choose between; because she feels a sense of hopelessness; because in her transitional housing, she feels isolated from the family, friends, and institutions she was accustomed to relying on for support and advice; because she is apart from her racial/ethnic/cultural/linguistic/religious community, and feels disconnected, even though the staff and participants may treat her well; because she is anxious about the consequences of decisions she must make; because she doesn't fully trust the program or staff; because she feels overwhelmed; or because she is simply relieved to be out of the abusive situation, and feels exhausted after running on adrenaline for so long.

A victim-centered program would try to explore with the survivor which of these or other reasons underlie her apparent disengagement, and rather than employing sanctions, would work with her to reshape program assistance, as resources allow, to better address her needs, concerns and priorities. As evidenced by providers' comments, however, supporting engagement may be easier to prescribe than to accomplish.

The discussion about barriers to engagement is followed in Section 4 by a summary look at some of the approaches described by the providers interviewed for this project.

**One of the most frequently mentioned challenges in our interviews was working with survivors whose trauma/behavioral health-related need -- e.g., depression, substance dependence, PTSD, and/or traumatic brain injury-related issues -- seem to limit their capacity for engagement and their ability to prepare for a successful transition, once their program assistance ends.** There are no easy answers, but the Section 4 narrative identifies some potentially helpful resources, and many of the provider comments address their approaches to this challenge.

While a number of providers described being able to partner with community-based agencies to make clinical and treatment services available onsite or in a relatively convenient location for interested participants, other providers cited participant difficulties in accessing such services, due to distance and transportation-related concerns, insurance coverage-related issues, lack of community capacity, or inadequate understanding among mental health and addictions treatment professionals of the traumatic effects of domestic and sexual abuse. Addressing this challenge would require changes that are beyond the authority of the OVW; hopefully, however, the OVW can join with its federal partners in the Executive Office of Health and Human Services to explore strategies for broadening access to trauma- and domestic/sexual violence-informed clinical and treatment services.

Section 4 concludes with an extensive collection of provider comments, loosely grouped to reflect common themes in their approach to voluntary services, including:

- a focus on creating trusting staff/client relationships and encouraging non-judgmental communication;
- a focus on creating safe, supportive, and inspiring program environments;
- using motivational interviewing;
- keeping participants focused on deadlines and natural consequences;
- making participation easy, fun, useful, and rewarding;
- meeting participants where they are, and respecting their boundaries and choices;
- providing persistent outreach, support, and validation, especially when a survivor seems "stuck;"
• requiring periodic check-ins and setting clear expectations (which, depending on the framing of those expectations, and the consequences for violating them, may or may not be consistent with the voluntary services approach, and could benefit from OVW clarification); and
• linking the level of financial assistance or the extension of program assistance beyond a baseline period to a survivor's level of engagement, effort, or progress (which may or may not be consistent with the voluntary services approach, and could benefit from OVW clarification).

A final group of comments evidences some providers' concerns and frustrations regarding voluntary services.

Section 5 addresses the concept of empowerment: how researchers and practitioners have defined and conceptualized it; how empowerment is fundamentally linked to a survivor's ability -- and confidence in that ability -- to make effective choices about her priorities and how she will address those priorities; and how victim services providers can support survivor empowerment.

As described in Cattaneo & Goodman (2015, p.4), "From its earliest days, the anti-domestic violence movement has worked towards the empowerment of survivors as a central goal.... If abusers were taking power from survivors, healing entailed restoring it." Empowerment -- albeit defined differently by different policy makers, advocates, and researchers -- has been linked in research to healing and many of the positive outcomes that survivors and their advocates aspire to, including greater safety, improved mental health, and decreased PTSD symptoms, in the aftermath of sexual assault, as well as domestic violence.

To the extent that empowerment plays such an important role in recovery from violence and trauma, increases in empowerment may be a good indication of progress towards such recovery, and victim services providers seeking to assess the impact of program efforts may wish to measure changes in empowerment. The Section 5 narrative cites the work of Cattaneo & Goodman (2015), in framing empowerment as a domain-specific phenomenon, in recognition that a person can be empowered in one or more aspects of their life (e.g., as a parent, in their profession, or as a runner) while not being empowered in other domains (e.g., as a cook, or as the manager of household finances). Building on that work, Goodman, Thomas, & Heimel (2015) developed an easy-to-use metric called "MOVERS" (downloadable from the NRCDV's Domestic Violence Evidence Project website) for measuring "safety-related empowerment," which they suggest, may be a useful predictor of greater survivor safety and wellbeing, which in turn, would be a very positive program outcome.

The Section 5 narrative on survivor empowerment concludes with a brief discussion about how programs afford current participants and program alumni the opportunity to participate in decision making or other roles that affirm the value of their opinions, experience, and perspectives. (Engagement of survivors in staffing/volunteering roles is further discussed in Chapter 5 ("Program Staffing").

Chapter 4 concludes with a selection of provider comments about how their programs take an empowerment approach and support participant empowerment; how they know participants are feeling more empowered; and how they solicit feedback from and/or engage current participants and program alumni in advising the program, as volunteers, and in leadership roles.
2. Introduction

(a) Connected Concepts: Rules Reduction, Voluntary Services, Survivor Empowerment, and a Survivor-Centered Trauma-Informed Approach

In their seminal publication, "How the Earth Didn't Fly into the Sun," the Missouri Coalition Against Domestic and Sexual Violence (MCADSV) framed the interrelationship of rules reduction, voluntary services, empowerment, and a survivor-centered trauma-informed approach. MCADSV (2011) describes how advocates and providers came to recognize that enforcement of shelter rules developed to prevent problematic situations were, too often, causing unintended harm to survivors -- at the extreme, resulting in terminations that rendered those survivors homeless and at risk of further violence, instead of affording them the sanctuary they needed.

In response, the Coalition undertook a process to identify and eliminate non-essential rules, and in particular, rules mandating survivor participation in services. Instead, the Coalition implemented a voluntary services approach that "takes into account each woman's unique circumstances and respects her personal power of decision-making, [and] avoids the ultimate consequence of terminating services for breaking a rule of mandatory attendance or participation at a time when a woman most needs the safety of shelter." (p.8)

MCADSV (2011) observes that "the more an advocate can resist the urge to make a resident fit a certain mold, the better she can assess what the resident wants for herself. And this is the outcome sought by the project’s process of deconstructing shelter rules. . . . Some philosophies use different terminology for similar approaches. For example, the terms 'woman-defined advocacy,' 'survivor-focused advocacy' and 'the empowerment model' give different names to similar philosophies of advocacy that all seek to empower the woman, or survivor, as the expert in her own life." (p.12)

Excessive rules and coercion are typical strategies for disempowering and controlling the victim in an abusive relationship. A residential program that aspires to be a place where traumatized survivors can heal and can exercise control over their own lives needs to provide an entirely different kind of environment. Minimal rules and an emphasis on voluntary services and empowerment are, therefore, integral elements of a trauma-informed approach. Although MCADSV (2011) described that approach with DV shelters in mind, their explanation is equally applicable to transitional housing:

"Women arriving in shelter have likely experienced traumatic stress, often repeatedly. While everyone experiences daily stress, traumatic stress involves someone experiencing overwhelming circumstances that have threatened their physical or mental well-being and left them feeling vulnerable, helpless, afraid and out of control.... The trauma of experiencing domestic or sexual violence is compounded when a survivor has to leave her community, security and physical home. Homelessness can be a traumatizing experience during which women are uncertain and anxious about the future and the present — when and where they will next be able to sleep, eat, bathe and use the bathroom with privacy."

"Trauma can occur from a single incident or it can be chronic and interpersonal, as abuse often is. This prolonged, persistent trauma, or complex trauma, can change the way a survivor’s brain functions to recognize triggers and try to prevent, ward off or escape repeat experiences. Complex trauma can also have other cognitive, physical, emotional and relational effects.

Trauma survivors might have many triggers that are re-traumatizing, or make them feel again that they are in the danger of a past traumatizing event. Some of these triggers cannot be anticipated by shelter staff, such as a specific smell or sound. However, other triggers are more common, such as a lack of control.... When women who have experienced traumatic stress enter shelter, the program’s rules, consequences and strict expectations can trigger a survivor’s trauma responses."
"By reducing or eliminating [program] rules ... advocates can help traumatic-stress survivors by shifting the feeling of power or control back to the survivor. However, transitions and disruptions to schedule or routine are also common triggers for traumatic-stress. Therefore, it is also helpful when advocates offer residents a sense of what to expect as a routine. Some advocates might argue that rules create a routine, but rules can cause more stress than support. Advocates can offer structure without excessive rules, such as by informing residents about the typical schedule, for example when meals and meetings usually happen, without requiring attendance or demanding a certain behavior." (p.12-13)

The effort to eliminate excessive rules and coercive practices is not just an attempt to avoid re-traumatizing survivors; it also reflects an understanding that some of their "difficult behaviors" are manifestations of the chronic or complex trauma that survivors carry with them, so that sanctioning participants who exhibit those behaviors inadvertently punishes them anew for the violence and abuse they have suffered.

Thus, for example, as described in Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project (2011), a survivor with PTSD or complex trauma might communicate or behave in ways that result in her being seen as "high-strung, needy, non-compliant, inappropriate, difficult, or exhausting to be around; ... as detached, not caring, or unmotivated; ... or as overreacting, trying to get attention, or as unreliable, rather than [as] coping." (p.14) These characterizations describe the kinds of clients that are most difficult to serve, and who exhaust the patience of program staff, yet who deserve the same compassion and support as other survivors, who seem more compliant and receptive to assistance:

"When domestic violence, sexual assault and disability organizations were asked who they find the most challenging to serve, they said people who: have multiple complicating factors such as inability to maintain employment, substance abuse, and homelessness; do not want to be helped; have mental health issues; don’t take their medication; do not follow the “treatment plan”; “lie” or change their stories; do not follow the rules; or do not seem motivated to help themselves.

Our responsibility in a trauma-informed organization is to notice our judgments, impatience, disrespect, and maybe our misuse of power and control with someone who is coping with trauma in the best ways she can at this time. With a better understanding of trauma and its impact, we can think more carefully about our individual and organizational responses to victims/survivors with and without disabilities." (p.16) 11

Or as MCADSV (2011) put it,

"The more advocates know about providing trauma-informed services, the better they will be able to understand and accommodate residents’ concerns and be proactive to avoid further crisis." (p.13)

This chapter focuses on rules and behavioral guidelines, voluntary services, strategies to support participant engagement, and empowerment. Chapter 11 ("Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children") focuses on the adverse impacts of trauma on survivors and their children, approaches that support healing from that trauma and its concomitants, and the meaning and importance of taking a trauma-informed approach and becoming a trauma-informed program and organization. However, the topics of trauma and trauma-informed services will also be marbled throughout this chapter, as well.

11 And, as described in greater detail in Chapter 2 ("Survivor Access and Participant Selection"), implementing a voluntary services, trauma-informed approach -- that works to avoid the use of rules and behavior sanctions that are likely to have a disparate impact on persons with disabilities (including PTSD, complex trauma, and other concomitants of domestic and sexual violence) and/or other protected classes -- is more consistent with federal fair housing and anti-discrimination laws, with VAWA requirements, and with the OVW TH grant program’s admonitions against "procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children."
3. Program Rules and Behavioral Expectations

(a) Overview - Reducing the Emphasis on Rules

Concerns about the impact on survivors of rules that program participants perceive as unnecessarily restrictive are described in Melbin, Sullivan & Cain (2003), Lyon, Lane, & Menard (2008), and Baker, Niolon, & Oliphant (2009). MCADSV (2011) provides a brief history of the Missouri Coalition's efforts to explore and implement alternatives to rules in congregate shelters, and suggests organizational change strategies for reducing reliance on rules, replacing more burdensome rules with less onerous rules, and devising and implementing policies and practices that avoid the need for rules by eliminating the problematic situations that the rules would have tried to address.

MCADSV (2011) explains that many such rules were developed to address the kinds of challenges that arise in congregate living, for example, competition for shared resources, like cooking space, TV, computers, children's toys or books; differing approaches to oversight of children; conflicting attitudes about cleanliness and responsibility for routine chores; keeping personal possessions safe; protecting privacy; avoiding onsite intoxication; and maintaining the confidentiality of the location and the identities of the people staying there.

While some of the challenges that arise in congregate housing may also exist for clustered housing programs, other challenges are only relevant in a group living setting. As the percentage of programs using congregate housing shrinks and programs increasingly rely on scattered-site units, the need for such rules has decreased. MCADSV (2011) and three briefs from the Washington State Coalition on "Physical 'Fixes' that Help Programs Minimize Rules" (2008)¹², "Moving from Rules to Rights and Responsibilities" (2008), and "Rethinking Punitive Approaches to Shelter" (2008) provide helpful suggestions about alternatives to restrictive and punitive rules. Approaches discussed include strategies for managing and reconfiguring program spaces to minimize conflict over their use; reframing rules and behavioral guidelines as rights and responsibilities; jettisoning unessential rules that leave participants unnecessarily vulnerable to sanction; replacing rigid enforcement with "dialogue and compassion" and transparent process; focusing on "natural consequences;" and working with participants to find alternative ways to address their needs and constraints that minimize any adverse impact on others.

A substantial portion of the survivor complaints about rules cited by Melbin, Sullivan & Cain (2003), Lyon, Lane & Menard (2008), and Baker, Niolon, & Oliphant (2009) were related to requirements to participate in services, which, if violated, might lead to program terminations that jeopardized the very safety that TH programs are intended to provide. Such concerns had led to inclusion in the Violence Against Women and Department of Justice Reauthorization Act of 2005 (hereinafter, "VAWA Reauthorization Act of 2005") of statutory language prohibiting TH grantees from requiring participation in services as a condition of receiving housing assistance. (Similar legislation was enacted in 2010 extending the voluntary services requirement to domestic violence shelters funded under the Family Violence Prevention Services Act (FVPSA).)

By the time HUD promulgated the ESG Interim Rule (Dec. 2011; governing projects receiving Emergency Solutions Grant funds) and the CoC Interim Rule (July 2012; governing projects receiving Continuum of Care grant funds), the VAWA/FVPSA voluntary services requirements were well established, and so HUD exempted VAWA-covered Rapid Rehousing (RRH) and Transitional Housing (TH) projects (i.e., projects operated by victim services providers or jointly funded with VAWA-authorized grants, such as OVW TH grants) from any mandatory services requirements. (In fact, CoC-funded TH project staff are not regulatorily required meet with participants; although providers must make services available, §578.53(b) of the CoC Interim Rule leaves it up to the provider as to whether to impose a participation-in-services requirement.)

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¹² Specifically cited by the Missouri Coalition as a source of helpful ideas on rules reduction.
A [no longer downloadable] PowerPoint presentation accompanying a 2015 training by Judy Benitez, NNEDV's TH Program Deputy Director (hereinafter NNEDV/Benitez (2015)) clarifies that the requirement for voluntary services does not mean a program cannot impose reasonable rules. However, echoing MCADSV (2011), NNEDV/Benitez (2015) suggests a "less is more" approach to rules; encourages providers to "avoid making rules or policies in response to isolated incidents;" and urges providers to "review policies and rules at least annually" to assess whether they are effective, necessary, and respectful13 and to answer the following questions about each rule:

- "How does it help survivors increase safety?
- How does it help survivors gain economic stability?
- How does it help survivors locate and maintain safe, affordable housing?
- Is the rule enforceable?
- Is it respectful?
- Does it take into account survivors' varying physical abilities?
- Would you refer your best friend to this program?"

NNEDV/Benitez (2015) notes that well-intended rules can have unintended consequences. For example, "requiring attendance at groups or meetings at set days/times suited to the program" can interfere with a survivor's ability to hold a job or participate in other beneficial activities; "maintaining a no-visitor policy" can deprive participants of valuable support from family and friends; and "strict rules around substances" can encourage subterfuge, instead of candor about an addiction that may be linked to the abusive relationship. And, as noted in MCADSV (2011),

"For rules to be effective, they must have consequences if not followed. Often, a providers' only real consequence is to deny or terminate services. This means kicking a woman out of a safe place to live because they broke a rule.... Terminating services can have life and death consequences. A survivor is at risk for injury or death if she no longer has safe shelter." (p.9) 14

The test of such a rule, the authors suggest is, "What would it take to defend that decision as reasonable?"

"Adjusting expectations to make them more reasonable affirms the underlying philosophy of advocacy, the belief that everyone deserves safety and the right to be respected. When safety is viewed as a basic human right, it is not something that must be earned by good behavior, a grateful attitude or any other attribute or action that might be deemed necessary to receive services." (p.9) 15

MCADSV (2011) offered the following example of a program participant with an apparent substance dependency issue (again, the reader can substitute the words "transitional housing" for "shelter"):

"Shelter programs often serve women with addictions. If they don’t, or discharge women who use, then they are not serving a significant portion of the women needing shelter services. Missouri project participants concluded that it was unreasonable to expect individuals with chemical dependency problems to simply discontinue using because they come into shelter. They recognized that creating a rule that requires sobriety will not make residents stop using. 15 Addiction is a complex disease that is not easily

13 NNEDV/Benitez (2015) labels these the "Lydia Walker Test" after a pioneering advocate for reducing shelter rules.
14 Again, although referencing shelters, the recommendations in MCADSV (2011) are equally applicable to TH programs.
15 Elsewhere, MCADSV (2011) observes, "Some rules proposed by shelters already exist as laws. There is no need to state them. For example, illegal drugs and assault are already against the law and programs do not need rules to reiterate that. More importantly, the role of advocates is not to serve as law enforcement officers. An advocate’s primary role is to provide safety, support, resources and options for residents, not to look for opportunities to enforce the law." (p.10) For TH program, one might similarly observe that certain prohibitions (possession or use of illegal substances on the premises, storage of weapons, etc.) may already constitute a violation of the lease.
treated in many individuals. As programs reflected on their missions and philosophy that all individuals have a right to safety, they recognized that 'all individuals' included those with substance abuse or dependence problems . . .

If a resident is under the influence of alcohol or an illegal substance but is not aggressive or disruptive, an advocate could ask the resident to stay in her room or space and “sleep it off.” As soon as possible, once the resident is no longer under the influence, the advocate could have a confidential, non-judgmental conversation about substance abuse issues and how the resident’s use of substances affects the safety of everyone in the shelter. For example, many survivors said the smell of alcohol reminds them of their abuser and the abuse they suffered—they said they don’t feel safe when they smell alcohol. Advocates could explain to residents that they want everyone to feel as safe as possible while they are staying at the shelter. Therefore, they ask that residents do not use while in shelter.

However, many women have said that they use alcohol or drugs to try and cope with what has happened to them. The advocate could ask if the resident thinks she needs help with substance abuse issues, and if so, offer to help with that. The advocate could then provide referrals or discuss treatment options available in the community. (It should be noted that advocates in the Missouri project found that [accessing treatment] resources for residents remains a challenge in many communities....)

If a resident is intoxicated or under the influence of illegal substances and her behavior is unsafe for the rest of the shelter community, then the advocate could address that behavior through voluntary admission to detox, which is preferred, or law enforcement intervention, as a last resort. Emergency medical intervention would be used when needed." (pp. 37-38)

Baker et al. (2010) (p.437) cites research by Redlich et al. (2006) and Tsemberis et al. (2004) to assert that, "Using housing as leverage to promote treatment adherence has had mixed results when applied to homeless populations.... Given the experience of domestic violence survivors, whose lives have been marked by the controlling and coercive behaviors by their abusive partners, an emphasis on respect for client autonomy has special significance. Program models that minimize mandatory services and are driven by individual survivors' goals and circumstances may better ensure that they are both accessible to diverse populations of survivors and respectful of the unique needs of survivors for self-determination and choice."

From a strictly pragmatic perspective, MCADSV (2011) observes that, "In many cases, the more control a program has over residents and information about them, the greater the liability. When a program sets specific directions for residents to follow, if harm comes to a resident while following that direction, the program could be held liable. For example, if a shelter requires residents to hand over all of their medications to shelter staff for storage, but then a staff member was unavailable when a resident urgently needed her inhaler or anxiety medication, the program could be held liable for the consequences." (p.10)

Note: One rule that seems to be "acceptable" for OVW TH programs is a requirement that participants meet periodically with their advocate/case manager/services coordinator. Such a "meeting" for "check-in" purposes -- but not to engage in case management or other "services" -- is not viewed as a violation of the voluntary services requirement that governs all OVW grant-funded TH programs. Similarly, in congregate programs, monthly house meetings are not considered "services" and attendance can be required. Interestingly, as noted elsewhere in the narrative, pursuant to VAWA provisions, HUD exempted victim services providers and VAWA grant-funded programs from the usual requirement that participants in ESG- and CoC-funded rapid rehousing meet at least monthly with their case manager, suggesting that such monthly meetings were seen as "services" that could not be required.
Finally, as discussed in Chapter 2 ("Survivor Access and Participant Selection"), rules that screen out or disproportionately disqualify applicants in certain protected classes—race, ethnicity, disability, including persons with behavioral health-related disabilities, like specific mental health diagnoses or alcohol dependency—risk violating federal (and state) non-discrimination and/or fair housing laws, as well as the OVW’s admonition (in the annual solicitation for TH grant proposals) against "procedures or policies that exclude victims ... based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in the sex industry, or the age and/or gender of their children." (pp. 8-9)

Generally speaking, the providers we interviewed about their program’s use of rules described significant efforts to reduce the number and scope of such rules, retaining only those rules that seemed essential to the success of the program and the safety of participants—and enforceable. A number of providers said they got rid of rules that might have been more necessary and enforceable in a congregate setting (e.g., pertaining to overnight guests) where other participants could be impacted, and where compliance could be monitored. In scattered-site units, one participant’s actions don’t affect the safety or wellbeing of other participants; and compliance is nearly impossible to monitor: if compliance can’t be checked, having a rule doesn’t make sense.

Indeed, with apparent pressure from the states/counties/cities and Continuums of Care that oversee HUD grants to shift from congregate TH programs to the Rapid Rehousing model, and with an increasing number of OVW-but-not-HUD-funded programs utilizing a transition-in-place approach, the perceived need for the kinds of rules enforced by congregate TH programs in years past is dwindling.17

Still, as their comments indicate, a few programs continue to utilize rules and policies to sanction "problem" behaviors or as a basis for excluding or curtailing access to assistance (e.g., beyond the six-month minimum) by participants who fail to meet behavioral expectations (e.g., sobriety, readiness to seek mental health care, readiness to separate from their abusive (ex-)partner, active engagement, progress on outcomes, etc.).

In some cases, those rules and exclusionary practices are in place because staff feel that they lack the resources (that more richly endowed agencies can contribute, or that more propitiously located programs can leverage from the community) to adequately cope with or address particular problems (e.g., addiction, untreated mental illness). In other cases, those rules and exclusionary practices are in place for philosophical reasons (e.g., because of a belief that the "best" use of limited resources is to offer assistance to those who will make "good use" of it); pragmatic reasons (e.g., because participants with serious barriers to gainful employment will not be able to afford area rents, which will leave them at risk of losing their placement housing once program assistance ends); or in order to meet a funder’s (e.g., HUD’s) program performance expectations, defined in terms of participant housing/income/employment outcomes.

Given that a survivor’s "lack of motivation," "non-compliance," or other "problematic behaviors" may well be manifestations of the PTSD, complex trauma, traumatic brain injury, or other disabling conditions that survivors suffer from in the aftermath of the physical, sexual, emotional, and psychological violence and abuse

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16 If the program is based in provider-owned or provider-leased housing.

17 See the discussions in Chapter 3 ("Program Housing Models") and Chapter 12 ("Funding and Collaboration: Opportunities and Challenges") describing how HUD Continuum of Care-funded programs—including significant numbers of providers operating OVW-funded TH programs—are increasingly shifting away from the traditional congregate model to a program model, known as Rapid Rehousing (RRH), facilitating survivor tenancies in participant-leased apartments supported by time-limited rental assistance and services. Even among OVW TH programs, the use of scattered-site, participant-leased housing is increasing, as providers either seek to avoid the challenge of property ownership or choose to rely on privately-owned rental housing to help them cover a large geography that would not be well-served by a central provider-owned or provider-leased housing location.
they experienced, such rules, policies, and practices that deny or curtail access to housing/services based on inadequate participation in services and lack of demonstrated progress vis-à-vis targeted outcomes may put providers at risk of violating fair housing or anti-discrimination laws, if those provisions have a disparate impact on persons with disabilities; they may also put providers at risk of violating the VAWA voluntary services requirement, and the provider’s commitment (pursuant to provisions on p.17 of the OVW’s annual TH Grant Solicitation) "not to engage in or promote activities that compromise victim safety," such as "requiring survivors to meet restrictive conditions in order to receive services...." (pp. 8-9)

18 As noted in the Introduction section, in the absence of an understanding of trauma, a survivor with PTSD or complex trauma might communicate or behave in ways that result in her being seen as "high-strung, needy, non-compliant, inappropriate, difficult, or exhausting to be around; ... as detached, not caring, or unmotivated; ... [and/or] as overreacting, trying to get attention, or as unreliable, rather than [as] coping." Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project (2011, p.14)

Similarly, as explored in greater detail in Chapter 11 ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children"), many of the behaviors that might violate program rules or expectations or weigh against the decision to enroll or extend the stay of a survivor, are manifestations of the cumulative trauma that survivor has experienced, as illustrated in the following chart, excerpted from Table 3 ("How common trauma reactions may explain some 'difficult' behaviors or reactions within homeless service settings") in Hopper, Bassuk, & Olivet, 2010, p.149:

<table>
<thead>
<tr>
<th>&quot;Difficult&quot; Behaviors or Reactions within Homeless Service Settings</th>
<th>Common Trauma Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has difficulty getting motivated to get job training, pursue education, locate a job, or find housing</td>
<td>Depression and diminished interest in everyday activities</td>
</tr>
<tr>
<td>Perceives others as being abusive, loses touch with current-day reality and feels like the trauma is happening over again</td>
<td>Flashbacks, triggered responses</td>
</tr>
<tr>
<td>Avoids meetings with counselors or other support staff, emotionally shut down when faced with traumatic reminders</td>
<td>Avoidance of traumatic memories or reminders</td>
</tr>
<tr>
<td>Lacks awareness of emotional responses, does not emotionally respond to others</td>
<td>Emotional numbing or restricted range of feelings</td>
</tr>
<tr>
<td>Has difficulty keeping up in educational settings or job training programs</td>
<td>Difficulty concentrating or remembering</td>
</tr>
<tr>
<td>Is triggered by rules and consequences. Has difficulty setting limits with children.</td>
<td>Feeling unsafe, helpless, and out of control</td>
</tr>
<tr>
<td>Seem spacey or &quot;out of it.&quot; Has difficulty remembering whether or not they have done something. Is not responsive to external situations.</td>
<td>Dissociation</td>
</tr>
<tr>
<td>Has difficulty trusting staff members; feels targeted by others. Does not form close relationships in the service setting.</td>
<td>Difficulty trusting and/or feelings of betrayal</td>
</tr>
<tr>
<td>Puts less effort into trying--does not follow through on appointments, does not respond to assistance</td>
<td>Learned helplessness</td>
</tr>
<tr>
<td>Has ongoing substance abuse problems</td>
<td>Use of alcohol or drugs to manage emotional responses</td>
</tr>
</tbody>
</table>

As observed by Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project (2011), "Our responsibility in a trauma-informed organization is to notice our judgments, impatience, disrespect, and maybe our misuse of power and control with someone who is coping with trauma in the best ways she can at this time. With a better understanding of trauma and its impact, we can think more carefully about our individual and organizational responses to victims/survivors with and without disabilities." (p.16)

19 As described in a June 29, 2015 post by the National Low Income Housing Coalition (NLIHC), the Supreme Court’s June 25, 2015 decision in "Texas Department of Housing and Community Affairs v. The Inclusive Communities Project" upheld the Disparate Impact principle. The Court found that "the Fair Housing Act of 1968 bars both intentional discrimination and policies and practices that have a disparate impact, i.e., that do not have a stated intent to discriminate but that have the effect of discriminating against the Fair Housing Act’s protected classes of race, color, national origin, religion, sex, familial status, or disability." The Court cited the Fair Housing Act’s "results-oriented language," stating that, "Antidiscrimination laws must be construed to encompass disparate impact claims when their text refers to the consequences of actions and not just to the mindset of actors, and where that interpretation is consistent with statutory purpose." The NLIHC post explains that "under the disparate impact standard, courts assess discriminatory effect and whether an action perpetuates segregation, whether the discrimination is justified, and whether less discriminatory alternatives exist for the challenged practice."
**Recommendation**: The residual use by well-intentioned providers of rules and practices that exclude or curtail assistance for survivors whose trauma-affected patterns of communication and/or behavior limit their ability to fully "engage" in services suggests the need for renewed training and technical assistance (T.A.) on safely and effectively operating a program without such restrictive policies. Such training and T.A., and perhaps a collaborative effort on the part of OVW, HUD, and its other federal partners to explore systemic solutions would be especially helpful: (a) for programs that lack the in-house resources to address the needs of deeply traumatized survivors, and that can’t leverage the necessary gap-filling resources from mainstream providers; and (b) to help providers address the challenge of operating a program that embraces its role in serving survivors with serious barriers while still meeting HUD expectations vis-à-vis participant housing/income/employment outcomes.

(b) **Provider Comments about Program Rules/Guidelines and Behavioral Expectations**

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

(#01) We ask that they maintain confidentiality of the shelter so that there is protection and safety for all the families. And we definitely encounter some families who say, well, I’m not really worried about that because my abuser is in jail so why can’t I tell other people? And we talk about how we are a community, and there are members of that community who benefit from staying in a confidential location.

Other than that, I'd say the only behavioral guideline is trying to practice non-violence and non-violent communication. We really hold everyone to that expectation. We're not asking you to change overnight and stop raising your voice or stop getting angry ... but we are asking you to try to carry on a calm conversation.

When it comes to violence, we have managed to avoid involuntarily discharge. It hasn't been easy. I definitely have had some staff that felt that we should have asked a person or family to leave. It's not black and white.

(#02) As far as rules, there are not many, but when they get to the point when they want to begin a new relationship (e.g., bringing in a male partner), it means that they no longer need our services, and so we don’t assist them past that point. If they decide that they want to get back with the abuser, we don’t assist past that point either. Funds are for women who need immediate assistance.20

(#03) If someone is doing something that causes safety concerns for themselves, their children, other people in the program, or other people in the community, they may be asked to leave the program.

(#04) Discharge for us – whether its transitional housing or rapid rehousing is always a last resort. We will do anything and everything to avoid having to discharge someone. The only rules we need have to do with safety. In our transitional program, all the participants live independently in their own apartments, which really reduces the risk of conflict because they have their own space.

It's easier to talk about what rules we don’t have. We don’t have rules requiring women or men to participate in case management. So a family could come to our program and choose not to receive case management.

20 **Concern**: As described in Davies (2009), there are many reasons why a survivor might maintain a relationship with their abusive (ex-)partner. In the meantime, such a survivor might benefit from the safe housing and services the TH program provides. As long as the survivor remains in the TH unit and doesn't co-habit that unit with their abusive (ex-)partner (or a new partner), they are not violating the OVW grant terms. Abruptly terminating assistance could place them at risk.
There's no curfew, you don't have to report in to your case manager, you don't have to keep your apartment in a certain order. We used to be like that. Some transitional programs still do apartment inspections, and if your bed isn't made, if your dishes aren't done, you're going to get written up. We don't do any of that. We ask residents not to have illegal drugs or firearms in their apartments. If they want to have alcohol, they can; they're adults. We ask that there not be any criminal behavior, but that is hard to enforce, so it's not really relevant. If we can't enforce a rule, then what is the point of having the rule?

All the women in our rapid rehousing and transitional housing program live independently in their own apartments. So even if we say to them, “You have to use time-out, you can’t physically discipline your kid,” how in the world are we going to enforce that? We can’t, because we’re not there. So we don’t tell women how to discipline their children. The only thing we do, is if we suspect that a child is abused, even if it’s just a tiny suspicion, we report that to the child abuse agency. Other than that, we don’t tell women how to parent.

(#05) Our number one rule is, you can't move in your abusive partner to our program. We don't have any guidelines around, “you can't see your abusive partner.” There are reasons women need to maintain contact with their abuser, but you can't bring them to the property or cohabit with them.

You can't start a new relationship and move him into one of our units. Your sister can stay for the weekend, but she can't be there for three weeks. We want you to be connected with your family and have relationships, friends, but we're not supporting them.

You can’t break confidentiality.

There shouldn’t be 15 pages of rules if it's really about transitioning and independence. If it's one of your three or four truly dangerous safety issues, like having your abuser live with you, then you have to be firm. Otherwise, you need to ask, “Why is this a rule?”, and if I’m having clients constantly break this rule, perhaps there’s a problem with the rule. I'm anti-power and control. It's toxic and painful for clients. You need to have a minimum of rules that are true non-negotiable, and everything else is a conversation.

(#06) We are a domestic violence agency, so no violence is allowed; that’s a non-negotiable. The safety and security of children is non-negotiable. So we’re going to involve law enforcement if someone’s behavior warrants it. We rarely call the police. But if we need to we will because those are the non-negotiables.

Involuntary program termination would be warranted if there was active drug use - use of an illegal substance - on the property. It would be warranted if someone put their hands on someone else in a violent or threatening manner. Both of those would result in immediate, same-day termination.21 The other involuntary termination that we use is a 30-day program termination, typically after a series of lease violations.

We feel badly when someone is asked to leave when they have children because it’s not the kids’ fault that the adult can’t get it together. But that’s a feeling and something we try not to take personally when we have to deal with compliance and the safety and security of everyone in the building. I don’t think there should be different standards for discharging single individuals as compared to women with children.

(#07) Instead of calling them rules we call them expectations. We expect that the client: will meet with the case manager at least once a month; will pay $100 towards the deposit, possibly in installments; will follow

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21 While an instant termination may be warranted if a participant poses an immediate and continuing threat to other participants or staff, one would hope that the nature of the offense and the likely threat to others was assessed before an instant termination was automatically triggered.
the lease; will notify us if they have someone else living in the house. We had one situation where the sister was living in the house to help with day care so we allowed her to stay because it benefited the client.

We have had to terminate a few times. Mostly it had to do with the abuser living in the home. We’ve had a client not tell us she got married to a new person and they were living in the house. When I’ve had to terminate people I always explain to them if they are ready to leave the abuser in the future, this won’t prohibit them from being in the program again. We always talk about the other programs we have available. We’re not shaming them. And we don’t do instant terminations; if a client is terminated, we give them 30 days to either find a new apartment or to work out whatever they need to. And I still meet with them for the three month follow up if they request it. We don't just walk away. They still get some of that support.

If a child was involved in illegal activities, such as selling drugs, and the parent knew about it, that would probably be the only situation where the behavior of a child might result in termination.

(08) There used to be an expectation -- and I think there's still a mindset in some programs -- that people get services based on how engaged they are. It's something we've worked to change. A lot of our programs have gone to the NNEDV voluntary services training, and a training on shelter rules that the Washington State Coalition did a while ago. So there's been a lot of discussion about voluntary services and engagement and motivational interviewing to engage people where they're at, and not basing services on how motivated someone seems, or how quickly they meet their goals. We need to serve all kinds of survivors, and they shouldn't have to do XYZ to get housing. Our community has come a long way to make that happen.

Mostly people want to stay engaged and the scattered-site transitional housing model is set up to be more flexible, so people aren’t asked to leave based on violence, roommate conflict, being disruptive, using drugs. With the change from a congregate to a scattered-site model, people are able to have a lot more autonomy and independence, and we can work with them on the struggles and issues they're having. If they relapse and are using in their scattered-site apartment, that doesn't affect all the other participants as it would have in a congregate program. So the policies can be a lot more supportive and flexible.

We encourage programs to think about framing their rules and expectations as guidelines, living agreements, something more supportive. And if we have guidelines about what we expect from you as a participant, then we should also be clear that as a participant in our program, this is what you can expect from us. The fewer rules, and the less punitive programs are, the more successful they'll be. People coming from poverty, especially if they've been in the system, they're used to people being punitive; it's not a motivating force for engagement or change. Taking a more collaborative approach is more successful with these participants.

It’s sometimes a lot more work to deal with issues when they come up, rather than just referring back to rules and policies and saying, "if you do this one more time, we’ll have to ask you to leave." Discharging people doesn’t solve their issue. Once people lose housing, especially HUD housing or Housing Authority housing, they have nowhere to go. It’s our moral responsibility to make sure people succeed, and to not be a part of their failure, or to their getting another eviction on their record. To try to understand and be supportive when people have complicated lives and challenging behaviors, meet them where they're at. Scattered-site housing is a better model, because people have more flexibility and independence; we don't have to see all their behaviors day in and day out.

If you have to address problematic behavior, engage with the participant, use motivational interviewing: How is this behavior benefiting you? What are the pros and cons? Are you motivated to change this?

22 For more about motivational Interviewing, see the footnote in Subsection (4)(a)(vii) of this chapter.
It’s challenging if someone is destructive to their apartment or not paying rent or major landlord issues, but if there are workable issues, it’s important to just have those conversations and not judge people based on whether they’re using drugs, engaging in other negative behaviors, seeing their abuser, etc. If someone is seeing their abuser, it doesn’t mean they’re not serious. Our participants have complicated lives; the abuser may still be giving the participant money, still helping out with the kids, or still involved in her life for other reasons we don’t know.

(#09) The safety of the participants is paramount. You can’t bring an abuser in. That is the golden rule that cannot be broken because you can’t run a DV transitional housing program or shelter without people being able to feel safe in their unit. They know from the beginning, if they break that rule they’ll be asked to leave. They can never tell anybody outside this agency who resides here; and they can’t use or bring drugs or alcohol on site, because there are children in this building. I’ve found pills on floors, and we cannot take that chance. Those are the three rules you cannot break. Everything else is decided at our weekly community meetings.

In life there are consequences, and everybody needs to understand that that does not go away just because you have been traumatized by an abuser. If you look at all three of our rules, they are all to protect the safety of the people living there. There have to be consequences if you put somebody else’s safety at risk.

(#10) We don’t have a ton of rules; our only expectation is that participants follow the terms of their lease. In terms of rules and regulations, some of that is predicated on the funder, for example HUD expects program participation. Some of our other funders don’t require participation in services and housing can’t be contingent on it, so we are guided by what our funders allow or require. Our rules are essentially: follow your lease. You can’t do illegal things in your home, you can’t destroy the property, and basic things like that.

My advice would be very reality based and practical, and only put in rules that contribute to the client sustaining their housing. The rationale is that domestic violence survivors are coming out of controlling environments, and one of the things we don’t want to do is replicate that controlling environment by mirroring the behavior of the assailant by setting up rules for the sake of having rules, or in any way giving the resident the sense that we are trying to control them. The consequences for any rule violation need to be informed by an understanding of the reason that rule violation occurred.

If they have the assailant move in with them, that’s a violation. Sometimes, the assailant has pushed his way in and they just don’t know how to get rid of him -- and we will work with that; but if they have voluntarily elected to bring the assailant into their program housing, they are essentially saying “I don’t need a domestic violence program.” If that’s the choice that they’ve made, that is a violation that would get them exited.

It’s even okay with us if they have a new partner, as long as they are claiming that income, and adjusting their rental amount. We don’t say, "you can’t date, and you can’t have a new boyfriend." You can do those things, but you have to do it in accordance with the lease.

We have had families evicted because of the behavior of their children, and we just re-house them in another part of the program. We understand that kids act out, and we understand that kids have problems. They’re witnesses to violence and they maybe were abused themselves. We have counselling that can help address those needs, but we don’t exclude people from the program based on the behavior of their children.

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23 As noted in the narrative which precedes these comments, HUD program regulations exempt programs operated by victim services providers (or operated with VAWA-authorized grant funding) from usual HUD requirements mandating at least monthly meetings between case managers and program participants. However, all HUD-funded programs are required to report on standard performance metrics, which track participant housing/income/employment outcomes.
The biggest thing is trying to not make someone feel re-victimized. So, with the transitional program, there’s no curfew. If a participant were to get a third-shift job, they’re free to take it. They are able to have visitors. The only thing that we ask is no male overnight visitors except a brother or immediate family; there are really not any other policies, since you can’t enforce them.

For example, I couldn’t say that their curfew was 11pm if I’m not sitting outside and waiting for them to come home. I know that they actually enjoy the program because of that and I’m also very flexible. I don’t penalize anyone if they can’t make a planned meeting. If they’re ready to be out in the community, they should be able to live as if they were on their own.

Asking someone to leave is a very serious thing. It’s really important not to jump to the conclusion because you could be wrong. Your assumptions can be off-base. There could be reasons that people are doing things that might not make sense to you on the outside but when you sit down and talk to people it might make more sense. We love working in the gray.

You have to ask someone to leave once in a while but we try to minimize that. Reasons for termination would be a physical or sexual assault of another resident; extreme inappropriate boundaries, like refusing to wear clothes. If somebody is overtly racist or homophobic in how they treat another resident, it’s not an automatic termination, but somebody who refuses to stop behaving in a racist or homophobic way we’ll ask to leave.

The most obvious situation has been when there’s been alleged sexual assault, but what we typically have tried to do -- this might sound terrible, but I hope you understand in the spirit -- was to isolate the alleged perpetrator while still providing services. Isolate in the most progressive way that you can, because that family still needs services. But we need to keep everybody safe, so we do our best to meet both needs.

Meeting with the case manager is a requirement of the program, so first off, if they’re not meeting with the case manager, we’re not really able to assist them. But other than that, if there are other issues coming into play that need to be worked on, we just address that in case management. There are very few program requirements. We can’t mandate that they come to support group, but the couple of things that we can require are that you meet with the case manager and you don’t break your lease with the landlord. Those are the two requirements, and violation would be the only reason for dismissing someone from the program.

We have a very low termination rate from our housing program. I think we’ve only asked maybe five clients to leave the program in the last eight years. Sometimes it is beyond their control, such as if Child Protective Services becomes involved and the children are removed from the home for more than 180 days, so that they are no longer a family in the eyes of the housing authority. We also had to terminate a family because the child was violent towards other tenants. They need to follow the County Housing Authority’s Section 8 lease agreement. We have had some that were evicted because they didn’t pay rent, which is very, very sad, and we just couldn’t stop the eviction. We don’t ask very much. There are no rules.

If they miss a rent payment, then they miss a payment and we move forward working on how we can better accommodate them because the grant covers the rent. In essence no one is being asked to leave for nonpayment of rent. It’s not necessarily a penalty but it’s something that we do want residents to be mindful of that once you leave this program this is not how the real world works.
(16) We do have some rules: If they participate in violent and aggressive behavior, bring drugs onto the property, or if their abusers come onto the property, those are things that are non-negotiable. If they have been abusive to anyone else, been aggressive or violent, that would be an automatic dismissal. To stay in our housing they are required to pay rent, based on their income. We understand that sometimes things come up and maybe you can't pay on time or maybe you can’t pay it all.

There's always a little bit of a tug at the heart whenever children are involved. It can be tough, but there are certain rules where it is just cut-and-dry. Like the rule about an offender staying on the property. That’s for the safety of everybody, whether they have children or they don't, they would be terminated. We would want to make sure that the children were going to be safe, whether they stay or whether they go, in any situation.

(17) They have to have a monthly check-in meeting with me. I think that’s the main rule in our program. And then we do have a three-month evaluation meeting. We check their goals and progress, and then — that’s it. If they don’t comply, we give them a few more months, and I reach out to clients by calling and sending mail, and if they don't respond to the phone calls and the mail for several months, then we discharge them.

(18) We’ve only had one situation where we had to have somebody leave the program, when she tried to cash a check for rent instead of giving it to her landlord, and that violated our program rules.

(19) We’re very onboard with the movement towards no rules. We don’t even use the word rules; the major exception is confidentiality. That's not negotiable. They can’t have folks over, or tell anybody where it is. That’s nonnegotiable because it’s a safety issue in a congregate situation like ours. Our rules are completely around safety. So obviously you can’t use violence or aggression towards other clients, or your own children. Those are the things that aren’t negotiable. In transitional we still have curfew, but it’s a safety issue, not a rule that can’t be broken. If they call and say, “Hey, I’m running late,” that’s no problem. If they call and say, “I need an overnight,” that’s no problem. We just want to know that they’re safe, because of the nature of our program. But that's it. We don’t have rules around chores or anything like that anymore, and it seems to generally go well. The only rules we have are all safety-related.

(20) They cannot bring boyfriends or male friends over and if it’s a male, he can’t have females and same sex partners. We want them to focus on themselves and their children and on recovering from the situation they’re in. Our program is clean and sober. If somebody discloses that they’re using, we ask them to get an assessment and follow whatever the treatment plan recommendations are. We don’t screen at the beginning, so if somebody discloses — and we do ask — that they’re schizophrenic or they’re suffering from PTSD and they’re not seeking treatment, that wouldn’t prohibit them from coming in, and it wouldn’t necessarily prohibit them from working the program successfully. It’s when the issue is unaddressed and it’s becoming problematic for the client and/or the community. We’ve had that happen. We had to discharge a woman because she refused to seek any type of treatment and became very disruptive to the community.

We never discharge anybody immediately; what typically happens if somebody is noncompliant is they receive warnings, we put them on probation, and we counsel them the whole time. We issue warnings and go talk to them, we try to work with them to help them resolve the issue. If it continues and we have no choice, we do discharge them but we give them a 30-day discharge and a caseworker works with them to try to get them into other services that might be more appropriate.
(21) Participants have to abide by the terms of the landlord’s lease. If they violate the lease a certain number of times, that would be grounds for termination. Some of our rules the participants come up with themselves; we frequently review our policies and procedures with them. Committing a new violent or sexual crime would be grounds for asking them to leave. Manufacturing, buying, or selling drugs on site; or moving in your boyfriend, ex-partner, or another adult who’s not part of the program are violations of the guidelines.

(22) Fewer rules help participants be more open. They’re grown-up people, and we trust them to make the choices, and we’re just here to provide ideas or experiences. I think people appreciate that and they stay more connected because of it.

(23) We have a real gentle touch approach. We don’t come in and say spices must be in your cabinet like this. We see home visits as them having company, like “thank you for letting us into your home,” and not like a home inspection. [This is a transition-in-place program.] We do have in our paperwork that you will not be involved in any abusive relationships, and that one reason you would be exited without question is if you haven’t kept your address confidential. So if the abuser they’ve fled knows where they live, they need to be exited from the program.24 There have been people who have moved on and dated and had an overnight here and there and I think that’s just what a lot of single women in the world do. We don’t allow anyone that’s not on the lease to live there. We strongly encourage participants to let us know if they’re going to be out of town for a little while, or if a cousin needs to come stay a few days, but we haven’t had much problem with that.

The HUD-funded program doesn’t follow the voluntary services model. That’s certainly not our choice. We have a transitional living program support group; it’s a really powerful group that helps form a sense of community for the women who are rebuilding and going through this process. People in the HUD program and people in the OVW program both really want to come, and the attendance is very high. But if someone in the HUD program chose to never show up to any groups and not participate and not meet with their advocate, they could technically be seen as someone who could be exited from the program for not participating -- so that is one of those HUD rules that is just totally different from our OVW philosophy.25

(24) [Not a current OVW grantee] [This is a shared living program] You’re not supposed to have someone move in with you. You can’t have visitors except outside service providers. No violence against your roommates, verbal or physical. You can’t use drugs or alcohol in the apartment. You can go and have a drink with a friend, no one checks you when you come in. You can’t put your roommates in danger. We had a woman move in her abuser. He came out of jail and she moved him in and didn’t tell us and on the lease to live there. We strongly encourage participants to let us know if they’re going to be out of town for a little while, or if a cousin needs to come stay a few days, but we haven’t had much problem with that.

(25) Everyone has to come to the monthly mandatory house meeting; that’s it. The other requirements are just about following the lease guidelines. One more thing: participants cannot get back together again with

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24 **Concern:** The requirement to keep one’s address in a scattered-site transition-in-place program confidential is unusual, given that participants are encouraged to integrate into the community, maintain employment, etc. While programs often draw the line at continuing rental assistance when an (ex-)partner moves in, terminating a participant whose ex-partner has learned her address seems to be establishing the kind of restrictive condition that would compromise victim safety. Perhaps, as Davies (2009) recommends, the provider could facilitate safety planning for various contingencies.

25 In fact, as noted in the narrative preceding these comments, HUD regulations exempt victim services providers and providers implementing VAWA-authorized grant-funded projects (e.g., OVW TH projects). As also noted, HUD CoC regulations governing Transitional Housing projects allow providers to require participation in services; the regulations themselves do not mandate such participation.
the abuser. Our program is designed to pay the rent for whoever is on the lease, so if it’s you and your three kids, and then sister moves in [or] your boyfriend, that would be considered a lease violation.

(#26) If somebody is extremely mentally ill and doesn’t take medication, is really out of control, we won’t put them in the cottage because it won’t work for anybody. We don’t tell people you can’t drink at the cottage, but if we ended up with somebody there who was drinking all the time and was disruptive to everyone else, or they were breaking the rules of the cottage and having visitors, we would have to address it. But we wouldn’t just say, “No, you can’t come here. You can’t drink here.” We do say no illegal drugs, but we haven’t had that happen there yet. Our thinking is we’ll deal with each individual situation as it comes. But we do our best to screen and find out as much about the person and anticipate any big problems before they happen.

(#27) I was with the program when it started, and in those days, there were so many rules that didn’t make sense to us. We were the first program in our area that I knew of that had the idea of looking at each participant and building a program around them without rules. From that point, the most important rule has been that there's no one-size-fits-all approach; that we look at the individual. We’ve maintained that philosophy over the years because we know that people have different needs and respond to things differently. And sometimes, that's much harder than having rules about how to do things.

(#28) Participants in the transitional housing program have to be substance free.

(#29) As a transitional program dedicated to serving survivors of sex trafficking, including women fleeing their pimps and afraid of being found and punished for running, of course we have rules. You've got to sign in and out; you’ve got to give us your calendar for the week so we know where you are; if you want to go for an overnight, you have to let us know where you’re going; if you’re going to be gone more than that, you need to call us every day to check in; if we suspect drug use, we might drop you, use a drug test on you to see where you’re at; if you come back with a black eye, we may just say we’re not going to let you go. We need to have more of a conversation as to what happened, why it happened, and what safety nets we need to provide.”

(#30) Active physical violence would get someone kicked out of a community. And our mission is also to eliminate racism, so we take racial issues quite seriously and we see them as opportunities for education; to work with somebody on what they may think or not think about someone, but if it gets to an extreme level we would exit somebody for that reason.

(#31) As a program serving women on probation, we are required to have a curfew. We put it to the resident advisory committee and we asked, “OK, if there has to be a curfew, what time do you think is reasonable?” Because they're the ones who developed the guidelines or rules, and they seem to satisfy the criminal justice organizations that we work with, because there has to be a structure in place to satisfy them.

(#32) I’m often asked, "How can we prevent same sex participants from having sex in the shelter?" Personally, I think it’s pretty paternalistic to tell people they can’t have sex or be in relationships. It doesn't come from an empowerment place. And, as someone who’s worked in congregate shelters, I have to say that realistically, these programs have been in denial about what is happening.

When you have a survivor who is in a place of complex trauma, who has experienced poly-victimization, who’s a survivor of childhood sexual abuse, or rape as an adolescent, and they come to TLP from a DV shelter, and
for all the complex reasons that people cultivate the necessary survival skills in the face of oppression and trauma, just trying to hold on emotionally, they might not have boundaries that we believe are conducive to their safety, or that we think of as “healthy.” And even as we recognize being in a place of judgment, their boundaries worries us, and they are in a residence that we’re nominally in charge of, and we want to keep them safe. We struggle over what do in those messy circumstances when we’re concerned that people can’t hold their own boundaries, and yet we want to work the empowerment model, but we’re watching people who have been traumatized since they were very small and don’t know what their boundaries are.

On the one hand, are we replicating the structures of oppression when we tell DV survivors -- whether LGBTQ or cisgender\textsuperscript{26} and straight -- that “you can’t have sex,” even though it’s such a fundamental part of most human being’s lives. When we try to set up those kinds of rules, we end up policing people, which is the antithesis of what we’re about. At the same time, we are far more likely to be serving people with complex trauma histories and with mental health and/or substance abuse histories -- if we’re doing what we’re supposed to do and screening those people into our programs. I’ve had people in shelter and TLP who I am terribly concerned for their children, for the group safety when it’s congregate TLP or clustered apartment, and sometimes that’s about someone’s new partner is actually their pimp/drug dealer/scary-person-in-general, and our alarm bells are going off. What you do is different in every situation, the nuances and details are different in every situation, and the advocates and counselors, everyone, needs to be involved in addressing those situations. Unfortunately, there is no single right answer every single time.

Philosophically, I’m in agreement that telling someone they can’t have a sexual relationship because they’re "not ready" is at odds with our effort to support agency and empowerment. Northwest Network has a great handout on the self-determination versus safety question, and how agency and empowerment have to come first.\textsuperscript{27} But, when I put on my manager hat, I become ambivalent. I agree that from a clinical place, healing is about establishing healthy boundaries, about finding value in your own self, and not only in other people's eyes. But people in pain look for ways to self-soothe, and sex is one way people do that. The value of empowerment is in people making decisions for themselves. Even if people are making decisions we have questions or concerns about, what I have learned as an advocate is that there is always an internal logic to what people are doing -- at least for the vast majority of people we serve. People make decisions based on real needs, and a real calculation of their options in life, and those decisions and calculations are usually grounded in the choices they perceive. We may judge those choices differently, because we think there are more options than they perceive, whether there are or not.

\begin{center}
\textbf{Questions to Consider}
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1. The authorizing statute for the OVW TH grants expressly targets the transitional housing to "minors, adults, and their dependents," and that language, which is echoed in the annual TH grant solicitation, has been understood to prohibit TH program participants from living in grant-assisted housing with their abusive partner or any person other than a dependent. In turn, that prohibition is part of the body of rules in pretty much every program.

In the few interviews that "dating" was discussed, the majority of providers -- but not all -- saw no problem with program participants entering into dating relationships while they are in the program, although programs based in shared housing typically prohibited visits, especially overnight visits, by male friends/boyfriends.

(a) Other than in shared living situations, is there any compelling reason to restrict guests and dating, including overnight guests, as long as the guest is not effectively moving in?

\textsuperscript{26} “Cisgender” refers to people who feel there is a match between their assigned sex and the gender they feel themselves to be. You are cisgender if your birth certificate says you’re male and you identify yourself as male or if your birth certificate says you’re female and you identify as female.

\textsuperscript{27} Two versions of the NW Network handout by Connie Burk offer useful perspective: version #1 and version #2.
(b) Should entering a "serious" relationship (as long as the party is not moving into housing assisted by the program) trigger the end of program assistance? Why or why not?

(c) If a program ends assistance to a participant in a relationship, and that termination leaves the participant homeless and dependent on their new partner for a place to stay, has the program compromised her safety?

(d) Most rules about guests in shared housing pertain to male guests, under the assumption that survivors are female and heterosexual; should there be different rules for guests and partners of male participants or LGBTQ participants?

(e) If a survivor wants to share her program-assisted apartment with a sibling or friend who can provide material assistance (e.g., help with childcare, transportation, interpretation) and support emotional healing, should it be allowed, as long as the friend/sibling is added to the lease and can contribute her share of the rent/utilities? If not, why not?

2. What kinds of rules should go into a lease, and what kinds of rules should go into a supplemental program agreement?
   - Is there a difference when housing is owned or leased by the provider and made available to the participant versus when the participant leases the housing from a private landlord and receives rental assistance from the provider?

3. Given fair housing and anti-discrimination laws that protect persons with disabilities, including persons with an alcohol dependency condition, and given the risks to the safety of a survivor who is terminated from a residential program:
   (a) How should a program operating a shared living facility address (i) moderate, non-disruptive drinking on the premises, (ii) disruptive behavior while drunk on the premises, (iii) storing alcohol on the premises?
   (b) If a survivor suffers from mental illness, PTSD, or traumatic brain injury that was likely caused or exacerbated by her experience of abuse, should aggressive outbursts related to those conditions be cause for sanction and possible termination, if they adversely impact other participants?
   - Is there a reasonable modification of policies and procedures that allows for a trauma-informed accommodation of that disabling condition?
   - Would it be okay at that point to require the survivor who caused that disruption to participate in treatment, as a condition of remaining in the program?

4. When is involuntary termination an appropriate response to a rule violation, and when is a non-punitive response -- a conversation, motivational interviewing, a more intensive intervention, or a warning -- more appropriate? Why?
   - If involuntary termination is the appropriate response, when is it appropriate to implement the termination immediately, and when is it appropriate to provide a transition time to allow the survivor to (work with program staff to) identify alternate housing?

5. Under what circumstances is non-payment of a required share of rent/utilities grounds for sanction and possible termination, and under what circumstances is it "forgivable"?

6. One provider mentioned that if they involuntarily discharge a survivor with children from the program, they have a rule that requires them to automatically contact Child Protective Services to let them know. (a) What are the pros and cons of such a rule? What are the alternatives? (b) If the provider believes that contacting CPS is the right thing to do, is there a way to engage the survivor in the process, so as to facilitate the best possible outcome of a difficult situation?

4. Voluntary Services / Approaches to Supporting Participant Engagement

(a) Voluntary Services - Overview

(i) VAWA / OVW Regulatory Framework and Provider Interpretation
As noted earlier, concerns about the adverse impacts of rules requiring survivor participation in services led to inclusion in the VAWA Reauthorization Act of 2005 of language prohibiting TH grantees from requiring participation in services as a condition of receiving housing assistance. Specifically, subparagraphs (a)(2)(D) and (a)(4)(C) of section 602 of Title VI of Public Law 109-162 added the following statutory language:

- **42 U.S. Code §13975(b)(3)(C),** stating that, "Participation in the support services shall be voluntary. Receipt of the benefits of [TH grant-funded] housing assistance ... shall not be conditioned upon the participation of the youth, adults, or their dependents in any or all of the support services offered them."

- **42 U.S. Code §13975(d)(2)(B),** requiring providers seeking TH grant program funds to assure the OVW, "that any supportive services offered to participants in [an OVW grant-funded TH program] are voluntary and that refusal to receive such services shall not be grounds for termination from the program or eviction from the victim’s housing...."

While strategies for effectively implementing the voluntary services model continue to evolve, the OVW is clear in its annual solicitation for Transitional Housing grant proposals that rules requiring participation in services or sanctioning survivors for non-participation are prohibited:

- It emphasizes that "all support services (e.g., budgeting, counseling, substance abuse treatment) made available to and/or offered to participants of the program must be voluntary. Applicants cannot require participation in services as a condition for participation in and access to transitional housing." (p.8)

- It penalizes applicants describing approaches that "compromise victim safety and recovery" by "requiring survivors to meet restrictive conditions in order to receive services (e.g., the decision to seek a protection order or counseling is a choice that should be reserved to the victim, and should not be a precondition to services, background checks of victims; or clinical evaluations to determine eligibility for services." (p.9)

- It labels as "out-of-scope" any sanctions against survivors for non-participation in services: "Participation by survivors in support services shall be voluntary, and must not be made a condition for receiving transitional housing and/or rental assistance. Survivors should not be ordered to attend therapy or other specific services or be penalized for choosing not to participate in the criminal justice system. All activities specifying mandatory participation in support services will be considered out-of-scope." (p.9)

As compared with Baker, Niolon, & Oliphant (2009), whose survey of TH programs five years earlier found that "86% of programs required women to take part in one or more services offered," the interviews we conducted for this project found only a relatively small number of providers using approaches that appeared to be explicitly at odds with the voluntary services model.29

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28 For example, Melbin, Sullivan, & Cain (2003) cite research by Davis & Srinivasan (1995) suggesting that "mandated services and rules limited [participants'] freedom and may reinforce 'society's message to these women that they are inadequate.'"

29 Although the data from our TH provider interviews were not collected in a way that allows us to quantify our findings, our general impression, reflected in the comments included in this chapter, is that a far smaller percentage of those providers than the 86% cited by Baker, Niolon, & Oliphant (2009) mandated participation in any services. Even if we could accurately estimate that percentage, comparing our estimate with the findings of Baker et al. would be problematic, since the two studies collected data from two different sets of programs: nearly all of the providers we interviewed receive(d) OVW funding -- although not necessarily for all of their survivor-focused TH programs, and would have been subject to the voluntary services requirement. By contrast, Baker et al.’s study sample was less DV-specific: "To be included in the [Baker et al.] sample, THPs had to be either exclusively for survivors of domestic violence or must at least serve survivors among others; and had to allow for a minimum length of stay of 6 months." (p.465) Programs that were non-DV-specific would not have been subject to the VAWA requirement for voluntary services.
The large majority of providers we interviewed -- but not all 30 -- stated their support for the concept of voluntary services, with quite a few pointing to how the model empowered survivors to determine the goals they pursue and to choose the type and amount of services they access. At the same time, other providers expressed frustration about their challenges in serving participants who were not doing what staff thought they needed to do to obtain permanent housing (or, in the case of transition-in-place programs, to get ready to assume full responsibility for the cost of their housing and other expenses).

As illustrated in the mix of comments in this chapter, however, there was a range of interpretations about the appropriate role of providers in implementing the "voluntary services" model, and a range of opinions about appropriate strategies for promoting "engagement" among survivors whose level of participation was a source of concern to providers.

**Recommendation:** A few providers described the use of policies and procedures that might benefit from OVW review and -- if needed -- guidance, to ensure consistency with VAWA voluntary services requirements:

1. **Mandatory "Check-Ins"** - Nearly all of the providers we interviewed described regular "check-in" meetings with participants31 as a routine element of their program, and/or as an "expectation" that could be codified in a written "program agreement" signed by the participant as part of the enrollment paperwork. Unlike many of the providers surveyed by Baker, Niolon, & Oliphant (2009), who mandated participation in specific services,32 the providers we interviewed typically limited participation requirements to these periodic, usually monthly, "check-in" meetings with the case manager or advocate.

Although a few providers expressed uncertainty as to whether such check-in meetings constitute a service, and so, cannot be required, the general sense was that periodic check-ins are not counted as a "service," 33,34 so that requiring check-ins does not violate the voluntary services requirement. However, the nature of "check-ins" can vary from program-to-program, in terms of what providers hope to accomplish, and whether there might be consequences to the survivor if they fail to maintain the required level of contact with staff. **It would be helpful if OVW could clarify the "tipping" point between a "check-in" and a "service," and/or under what conditions, if any, requiring periodic check-ins crosses a line and violates the voluntary services requirement.**

2. **Segmenting Assistance:** A number of providers described their programs as consisting of a baseline period of assistance (e.g., six months), after which the provider might or might not offer extensions of their assistance (by three or six months), based on whether a participant was "engaged" or "utilizing services" or "making an adequate effort" or "making progress." Does this approach violate the voluntary services requirement?

On the one hand, neither the [OVW's annual TH grant proposal solicitation](https://www.ovw.gov/PRA/2014/) nor the [enabling statute](https://www.govinfo.gov/content/pkg/USCODE-2015-title42-part1/title42/part1/chap15/subchapV/sessionlaw/pdf) restrict the applicability of the voluntary services requirement or the prohibition on "restrictive conditions" to some

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30 Comments by such providers explaining their reservations about voluntary services are in the last part of Section 4.

31 Providers described face-to-face meetings, where the program logistics allowed, and meetings via telephone, texting, skype, or email, where more than an occasional face-to-face meeting was impractical because of distance.

32 In Baker, Niolon, & Oliphant’s (2009) study, required services included case management (75%), job/education assistance (41%), money management (36%), life skills classes (31%), and support groups (30%).

33 Adding to the confusion are provisions (noted earlier and detailed in Section 3) in the HUD CoC and ESG Interim Rules exempting VAWA-covered programs from the usual HUD requirement for at-least-monthly meetings between a case manager and participants receiving Rapid Rehousing rental assistance. (See CoC Interim Rule: 24 CFR §578.37(a)(1)(ii)(F) ESG Interim Rule: 24 CFR §576.401(e)(2).) If such meetings weren’t a "service," why would the exemption be needed?

34 Two [no longer downloadable] trainings by NNEDV staff illustrate the need for clarification. The PowerPoint used by Ashley Slye in a January 2015 training (slide #11) indicated that "You CAN require participants to check-in with you." The very similar PowerPoint used by Judy Benitez in a July 2015 training did NOT include that statement. Some programs that expressed frustrations with voluntary services would likely have been more comfortable with that model if they believed that it allowed for periodic check-ins to be required; some programs that described their support for and use of the voluntary services model DO require such check-ins.
baseline period of assistance. In fact, 42 USC §13975(d)(2)(B) states that "refusal to receive such services shall not be grounds for termination from the program or eviction from the victim’s housing." Also, given that the levels of "engagement," "effort," and "progress" may be adversely impacted by, for example, depression, PTSD, or complex trauma, such a policy might be problematic, due to its disparate impact on persons with disabilities.

On the other hand, the statute and OVW's annual TH grant proposal solicitation offer no guidance as to the appropriate duration of program assistance beyond the six-month minimum, and providers may be interpreting language in that solicitation requiring grant-funded programs to "offer housing services and/or supportive services for an anticipated minimum length of stay of six months..." as allowing them to make further assistance beyond that six month minimum conditional on participant "engagement," "effort," or "progress." It would be helpful if OVW could clarify whether making such further assistance contingent on such factors crosses a line and violates the voluntary services requirement.

(3) Basing the Amount of Financial Assistance on the Level of "Engagement": A significant number of providers adjust the level of financial assistance over the course of a survivor’s participation in the program. Often, the changes in the amount of assistance are based on a predictable formula, that gradually increases the survivor’s responsibility for covering their housing-related costs. In other cases, the amount of assistance is adjusted as the survivor’s circumstances improve, or when they experience a crisis that prevents them from sustaining their prior contributions to housing-related costs.

A very few providers indicated that after a baseline period of assistance, they might adjust the level of financial assistance based on whether a participant was "engaged" or "utilizing services" or "making an adequate effort" or "making progress." Clearly, the amount of financial assistance can determine whether a survivor is able to afford to stay in her program housing; decreasing that assistance too much could effectively end a survivor’s ability to participate in the program. On the one hand, such a decrease in financial assistance could be interpreted as violating the spirit of voluntary services; on the other hand, neither the statute nor OVW guidelines specify a basis for establishing the amount of financial assistance, and programs take different approaches. It would be helpful if OVW could clarify whether making further assistance past a baseline period contingent on "effort," "engagement," or "progress" violates the voluntary services requirement.

(ii) Voluntary Services and HUD Funding

As noted elsewhere, many OVW-funded providers also receive HUD Continuum of Care (CoC) grant funding or Emergency Solutions Grant (ESG) funding to support their TH programs. In our survey, 42% of providers utilized ESG or CoC "Rapid Rehousing" grants and/or CoC "Transitional Housing" (TH) grants in combination with OVW funding for a combined transitional housing/transition-in-place project, or to operate separate transitional projects. Although each HUD funding source is subject to somewhat different regulatory constraints, all projects operated by victim services providers and projects utilizing VAWA-authorzied grant funds (e.g., OVW TH grants) are exempted from any HUD provisions that might require participant in services:

(a) The requirement for at-least monthly meetings between program participants and their case manager and the exemption for victim services providers and programs funded with VAWA-authorzied grants (e.g., OVW TH grants) are spelled out in subparagraph §578.37(a)(1)(ii)(F) of the CoC Interim Rule:

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35 42 CFR §13975 (b)(3)(C) states that "Participation in the support services shall be voluntary. Receipt of the benefits of the housing assistance ... shall not be conditioned upon the participation of the youth, adults, or their dependents in any or all of the support services offered them." 42 CFR §13975 (d)(2)(B) requires that the application for grant funding should "provide assurances that any supportive services offered to participants in programs developed under subsection (b)(3) of this section are voluntary and that refusal to receive such services shall not be grounds for termination from the program or eviction from the victim’s housing...."
"These [Rapid Rehousing] projects ... require the program participant to meet with a case manager not less than once per month to assist the program participant in ensuring long-term housing stability. The project is exempt from this requirement if the Violence Against Women Act of 1994 (42 U.S.C. 13925 et seq.) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.) prohibits the recipient carrying out the project from making its housing conditional on the participant’s acceptance of services."

A similar requirement and exemption are described in the ESG Interim Rule\(^{36}\) for ESG-funded Rapid Rehousing programs in subparagraphs §576.401(e)(1)(i) and §576.401(e)(2), respectively.

(b) HUD distinguishes "rapid rehousing" (RRH) projects (in which the participant holds a lease in their name, and the provider furnishes rental assistance and services) from more traditional "transitional housing" (TH) projects (typically sited in provider-owned or provider-leased housing\(^{37}\)) in which the participant holds a "lease or occupancy agreement for a term of at least one month that ends in 24 months and cannot be extended." HUD CoC TH grant-funded projects are **not** subject to the HUD RRH requirement for at-least monthly meetings between the participant and case manager. Instead, §578.75(h) of the CoC Interim Rule *allows* TH providers to require participation in (non-disability-related) supportive services -- an option that victim services providers would presumably not choose:

\[\text{§578.75(h) "Recipients and subrecipients may require the program participants to take part in supportive services that are not disability-related services provided through the project as a condition of continued participation in the program. Examples of disability-related services include, but are not limited to, mental health services, outpatient health services, and provision of medication, which are provided to a person with a disability to address a condition caused by the disability. Notwithstanding this provision, if the purpose of the project is to provide substance abuse treatment services, recipients and subrecipients may require program participants to take part in such services as a condition of continued participation in the program."}\\

In fact, the most recent HUD Notice of Funding Availability (NOFA = annual competition for CoC grant funds)\(^{38}\) actually **awarded extra points for embracing a voluntary services model**, indicating that a TH project seeking funding, "can receive up to 10 points for how the project demonstrates that it is low-barrier, prioritizes rapid placement and stabilization in permanent housing **and does not have service participation requirements** or preconditions to entry (such as sobriety or a minimum income threshold)." (p. 10)

The NOFA also awards extra points (p. 45) to a Continuum of Care in which 75% of the permanent and transitional housing projects utilize a Housing First approach, which it defines as "an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and **does not have service participation requirements** or preconditions such as sobriety or a minimum income threshold. Projects using a housing first approach often have supportive services; however, participation in these services is based on the needs and desires of the program participant." (p. 19)

On paper, then, HUD funding need not compromise a provider’s commitment to the voluntary services model. However, as discussed in Chapter 12 ("Funding and Collaboration: Opportunities and Challenges") and other chapters, a number of providers interviewed for this project cited challenges reconciling HUD expectations

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\(^{36}\) See page 75986 of the Federal Register 76(233) for Monday, December 5, 2011, under "Rules and Regulations"

\(^{37}\) Some HUD-funded TH projects involve provider-leased housing in which a participant can, pending landlord approval, take over the lease after they complete the program; these, too, might be labeled by OVW-funded providers as transition-in-place programs, but for HUD purposes, they are not Rapid Rehousing, because the participant did not hold the indefinitely renewable lease with the property owner while HUD-funded housing assistance was being provided.

\(^{38}\) See [HUD’s Notice of Funding Availability for the 2015 Continuum of Care Program Competition (2015)](http://www.huduser.gov/portal/datasets/hudnotice.html)
vis-à-vis standardized performance metrics (measuring participant housing/income/employment outcomes); pressures from their CoC or ESG funder to shorten participant lengths of stay; and the survivor-driven pace of "progress" in a program where staff efforts and services are guided by survivor-defined priorities and needs.

(iii) **Implementation Guidance**

Affirming a belief that many of the providers we interviewed share, an NNEDV fact sheet on [The Basics of the Voluntary Services Approach](https://www.nndsv.org/) (part of the NNEDV Transitional Housing Toolkit) asserts that **participant-staff relationships are "the foundation [of efforts] to assist survivors in reaching their goals"** and reminds providers of the philosophical and legal underpinnings of the approach: "that participation in services should be voluntary and not a condition of housing or receiving other services ... based on the belief that survivors should have the freedom to make their own decisions about their lives." Other key points include:

- "The voluntary services approach promotes the building of relationships between staff and survivors in transitional housing, working as allies and not as 'providers.'"
- "Input from survivors is actively solicited and incorporated when designing services and policies" in order to ensure that housing and services "are driven by the needs, wants, and individual goals of survivors...."
- "Value is placed in meeting survivors where they currently are in their lives," and in ensuring that they have "choices and options," including "creative and less-traditional services" as well as "more traditional approaches, depending on the needs and wants of the individual survivor."
- Housing and services should be "respectful and welcoming," creating a "nonjudgmental, safe space ... for survivors to talk about their experiences, fears, beliefs, and goals."
- "Services are consistently made available to encourage participation and ensure assistance is as relevant and accessible as possible. Staff are encouraged to make suggestions and express concerns or encouragement as appropriate, but to never require participation."

A [Virginia Department of Social Services / Office of Family Violence training](https://www.dss.virginia.gov/family-violence/training) on the voluntary services model, which addresses many of the points in the aforementioned [NNEDV "Basics"](https://www.nndsv.org/) document, frames some of the attributes of the model using different words, but in the same spirit:

- Personal autonomy of survivors
- Empowerment-based rather than compliance-driven programming
- Staff in the role of allies / partners with survivors, rather than in a provider/client (hierarchical) role
- Services, such as support groups and individual counseling, are offered consistently, and repeatedly, in an effort to encourage client participation, adapting services to ensure their relevance.

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39 **There was near-universal agreement among providers we interviewed that the quality of the participant / provider relationship is critical to the level of participant engagement and the benefit that survivors derive from the program.**

We heard from providers that congregate and clustered-site programs and scattered-site programs in which participants live in close proximity to a central meeting/service location have an advantage over programs in which participants live too far apart to sustain regular face-to-face meetings with staff, because in-person meetings -- including all-important impromptu, unstructured, and informal conversations -- are more conducive to building trusting relationships than emailing, texting, telephoning, or other electronic communication.

To avoid that barrier, some providers that operate both a congregate shelter and a scattered-site TH program organize the two programs so there is at least a partial overlap in staff, with the expectation that staff who have established a trusting relationship with a survivor, while she was in shelter, will be able to offer more effective support and encouragement for engagement once that survivor is in her TH apartment, as a compared to a different staff person with whom the participant has never bonded. (See comments in [Chapter 5 "Program Staffing"](https://www.nndsv.org/))
Two [no longer downloadable] slide presentations used in conjunction with NNEDV trainings on Voluntary Services offered pointers on the day-to-day aspects of building and strengthening the staff-client relationship:

- "Be available;"
- "Actively offer support services;"
- "Talk to survivors and [engage in] relationship-building" -- which can "take time;"
- Schedule "check-in meetings [to] discuss any needs they have and how you can help;"
- "Solicit survivor feedback" using "surveys and survivor focus groups" to inform efforts to "create and offer relevant support services;"
- Create and "offer fun/interesting/useful opportunities for the survivor and their family" (e.g., movie tickets, "plays, summer camps, etc."). as well as "informal opportunities to get-together (cookouts, outings to the public pool, holiday events, etc.);"
- Give group activities names and descriptions that will attract participants; and
- "Use natural consequences" -- like "losing custody of children, dui arrest, driving without insurance, expire tags, utilities being cut off, car being repossessed, [and] incarceration / probation" -- as an opportunity to discuss coping/survival skills."

The presentations advised providers to be mindful of "potential barriers [to participant engagement related to the] power differential [between staff and participant], office hours, [different] cultural values, organizational philosophy, location/transportation, childcare, [differences in] survivors' needs versus program needs."

Addressing what it calls a "common misconception" about the inability to require participants to maintain regular contact with the program, the PowerPoint for the January 2015 training (slide #11) notes that "safety planning is a requirement under [the OVW transitional housing] grant," and that "you CAN require participants to check-in with you."

The two slide presentations outlined other "common misconceptions" about the voluntary services approach" that might result in staff taking an unduly passive posture:

- "I can never ask a program participant to do anything;"
- "I can never initiate unsolicited contact [and instead] have to wait for [participants] to come to me;"
- "I can't intervene, even if I have a concern about [the participant's] safety or emotional wellbeing;"
- "I can't institute any rules, even for safety;"
- "participants will sit around and do nothing;"
- "If I don't require services, I'll never know if the program is working;" and
- "I can never ask anyone to leave the program, except for illegal behavior or if their time is up."

While it is well within the bounds of the voluntary services model for staff to be proactive and assertive in offering encouragement and assistance with participant goals, and in articulating concerns about actions or situations that may compromise participant safety, it is important that staff not use their position to assert authority -- and avoid acting in a way that might in any way suggest to a participant that their statements of encouragement or concern carry the weight of authority -- particularly given the aforementioned staff/participant power differential. Judging by some of the comments by providers we interviewed, the "misconceptions" that NNEDV training materials addressed may reflect staff recognition of the power imbalance, and their effort to err on the side of participant autonomy.

Perhaps, finding that "sweet spot" between active support and overreach depends on the link between the program's definition of success and the survivor's, and the trust and understanding that undergird the staff/participant relationship. All things being equal, if both the program and the participant define success in
terms of progress towards the participants' self-defined goals, and if the program's supportive services have been embraced by the participant as a resource that can help her achieve those goals, she is more likely to be voluntarily engaged with those services, and understand the spirit in which staff encouragement is offered.

But in the aftermath of an abusive relationship, all things are not necessarily "equal" -- among the many possible concomitants of trauma, PTSD and depression can be powerful and exhausting disruptors of progress and focus40, as can be the day-to-day exigencies of establishing new routines for the children, re-assembling lost documents, fixing credit problems, addressing pending legal matters, and just putting the pieces of a life back together again. An effective staff/participant relationship depends on staff knowing when to be a cheerleader and when to put goals aside and simply be an ally as the survivor confronts her many challenges.

(iv) **Measuring Fidelity to Survivor-Defined Practice, a "First Cousin" to the Voluntary Services Approach**

Building on the foundation of the voluntary services model; the empirical understanding that "survivors' situations, and thus the goals they want to pursue and the support they need, vary enormously -- by virtue of each survivor's culture, class, sexual orientation, immigration status, degree of social connectedness, family situation, and many other factors;" and echoing concerns by other scholars41 that domestic violence services are becoming more standardized and menu-driven, so that survivors are often offered a set of options for assistance based primarily on the availability of services or the mission of the organization, rather than on the survivor's unique circumstances and hopes for the future; Goodman et al., 2016 call for greater adherence to a "survivor-defined approach" to services and support.

As described by Goodman et al. (2016), survivor-defined practice is an approach to delivering support that is: "(a) shaped by the [survivors'] goals for themselves, (b) offered in the spirit of partnership [i.e., without expectations and non-hierarchical, and] (c) sensitive to the unique needs, contexts, and ways of coping of individual survivors and their families." (p.165) Echoing Melbin, Jordan, & Smyth's (2014) emphasis on how survivors define "success," Goodman et al. (2016) explain that, "At the very heart of survivor-defined practice is the work of eliciting a survivor's own priorities and then supporting her efforts to reach them." (p.167)

Goodman et al., 2016 proposed and statistically tested for reliability and validity a Survivor-Defined Practice Scale (SDPS) to help programs use direct participant feedback to assess whether their approach to services adequately emphasizes client choice, partnership between staff and participant, sensitivity to each survivor's unique needs, the context in which services are provided, and each survivor's coping strategies. The SDPS measures each of the following elements on a Likert Scale:

- I feel respected by staff in this program.
- Staff help me to shape goals that work for me.
- Staff here support my decisions.
- Staff here do not expect me to be perfect.
- Staff here support me even when things are not going well.
- Staff here make sure that services are right for what I need.
- Staff here offer choices.
- Staff here believe that decisions about my life are mine to make.
- Staff here respect the way I deal with things, whether or not they agree with it.

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40 In their comprehensive survey of the literature on the process, predictors, and impediments to leaving an abusive relationship, Anderson & Saunders (2003) cite studies reporting temporarily higher levels of PTSD and depression in survivors who have recently left the abusive partner as compared to victims living in an abusive relationship.

(v) **Voluntary Services and Participant Selection**

As discussed elsewhere, HUD defines more specific performance metrics (based on participant housing placement/retention rates and income/employment) than OVW.\(^{42}\) In addition to being accountable for meeting nationally defined program performance metrics, HUD-funded providers are often accountable for meeting the expectations of the Continuum of Care or state/county/jurisdiction administering their HUD grant that program outcomes will be achieved within a shorter timeframe — approaching six months, and typically no more than a year — so that more homeless households can be served/housed with the same funding.

As discussed in Chapter 2 ("Survivor Access and Participant Selection"), one way providers may try to increase their chances of meeting those expectations is to selectively enroll participants who have compatible goals — and the capacity and resources to achieve those goals — and who don't face obstacles that will prevent or unduly delay attainment of such "successes."

The idea that providers might tailor participant selection to meet the goals of the program, instead of tailoring program services to meet the needs of eligible survivors is not new. When Baker, Niolon, and Oliphant (2009) did their survey, they found that, "About 80% of programs screened women for their ability to work toward economic self-sufficiency (e.g., finding employment or going back to school for specific training) [and] almost 50% assessed whether women were motivated...." (p.470) They posited that,

"[That] criterion may have to do with directors' desires to ensure that **program goals** [but not necessarily survivor goals] are met. Many of the directors mentioned that they believe if women are not willing or able to work or go back to school, they are more likely to have housing problems later and may be forced to return to an abusive relationship. As a result, many directors noted that they began screening women for their willingness to work toward self-sufficiency as a way to informally weed out those who would not make it. Given the short supply of affordable housing, directors were comfortable giving housing to those whom they felt were more likely to be able to remain on their own and secure permanent housing after their stay in temporary housing." (p.475)

While the provider interviews conducted for this project appear to indicate that such limiting selection criteria are significantly less prevalent today than when Baker et al. did their study, a number of comments (see especially Chapter 2) described selection processes that prioritize participants who demonstrate, while they are in shelter, that they are "motivated" or "appropriate" or "ready" for the work they will need to do in a TH program to produce the outcomes that HUD and other funders with similar definitions of "success" look for. While an emphasis on "readiness" to focus on income and housing search is likely to yield candidates whose top priority is independent housing and who will be able to succeed in the **difficult housing and job markets** that characterize many parts of the country, as discussed in Chapter 2, it is likely to relegate to a lower priority survivors still grappling with trauma and the other concomitants of chronic physical, sexual, emotional, psychological, and financial abuse; survivors who may have other, more personally urgent priorities: and survivors who may not be physically or emotionally prepared to focus on income and housing:

- It relies on the kind of subjective assessments and/or considerations of disability-related factors that may -- explicitly, or by virtue of their disparate impact -- violate non-discrimination and/or fair housing laws;
- It disadvantages survivors with profound emotional, psychological, and trauma-related wounds that may delay or hinder their ability to move forward in addressing their housing, income, or legal needs;

\(^{42}\) Several providers we interviewed said that other funders have embraced the HUD metrics and now also assess their performance in terms of those same metrics.
• It disadvantages classes of survivors who face additional social and economic barriers because of race, ethnicity, religion, sexual orientation, gender identity, immigration status, and/or disability status; and

• It disadvantages subpopulations of survivors whose culturally-informed goals and ideas about healing, recovery, community, and "success" are different from that of mainstream funders and providers.

**Recommendation**: As suggested in Chapter 2, additional training and guidance may be needed to help providers: (a) to better understand the sometimes similar impacts of complex trauma, traumatic brain injury, and depression -- which can manifest as "lack of motivation," "hopelessness," "lack of focus," "non-compliance," "poor follow-through," or "difficulty trusting others," and which can undermine a survivor's ability to take positive steps; (b) to implement strategies for better supporting affected survivors; and (c) to replace any exclusionary participant selection practices with a more trauma-informed, inclusive approach.

As also noted in Chapter 2, addressing conflicting pressures to, on the one hand, effectively serve survivors with complex needs and priorities, despite difficult housing and job markets, while, on the other hand, achieving the high rates of "successful" survivor housing/income outcomes within shortened timeframes that funders, such as HUD, have targeted is clearly a larger issue than can be unilaterally resolved by the OVW, and will require a collaborative solution, involving the OVW's federal funding partners:

• To clarify what constitutes "effective" services; to help TH providers better distinguish between survivors their programs cannot safely serve versus survivors who can and should be served, even if there are doubts about their ability to make a targeted level of progress within the allotted time; and to reform funding mechanisms so as to eliminate the financial risk attendant to serving survivors with serious barriers or competing priorities, who -- even with effective services -- might not achieve their targeted outcomes within the allotted time;

• To help providers develop better strategies for supporting survivors with barriers that might ordinarily limit their ability to "succeed" in difficult housing and employment environments; and

• To expand the options and resources available to TH providers' for effectively partnering with mainstream providers that can offer trauma-informed gap-filling services.

**(vi) Why TH Program Participants Might Not Be "Engaged" with Services**

Providers interviewed for this project shared a range of interpretations of the voluntary-participation-in-services principle, a range of ideas about the type and intensity of effort that should be invested in cultivating participant interest and engagement, a range of strategies for encouraging and nurturing that engagement, and a range of approaches for responding to participants who seemed to be disengaged or whose low level of engagement -- or lack of participation -- in program-sponsored activities or services raises provider concerns.

Generally speaking, programs utilizing congregate or clustered housing (in which staff are onsite on a regular and frequent basis, and encounter participants both informally and during regularly scheduled meeting times, described offering more in-house services, creating more opportunities for group activities, and setting higher expectations for participant engagement in those activities and services than programs utilizing scattered-site housing. The difference was especially significant when compared to programs utilizing housing scattered across great distances in largely rural service areas, given the more challenging logistics of in-person meetings.

As described by the providers we interviewed and the literature we reviewed, there are many possible reasons why a participant in a TH program -- whether congregate, clustered, or scattered-site -- might not be fully engaged in services:

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43 See discussion in Chapter 11 ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children").
• The services being offered might not feel relevant to the survivor, or the survivor might have more immediate priorities, for example, addressing the needs of her children, reconnecting with family and friends from whom she became estranged while she was being abused, and from whom she remained estranged while she was incommunicado in shelter, etc. Given that women who flee an abusive relationship often leave little more than the clothes on their back, it is not surprising, for example, that a study by Postmus et al. (2009) found that above all else, survivors value tangible assistance -- housing assistance, financial assistance, food, etc.

Survivor-defined advocacy recognizes the ability of a program participant to identify her needs and priorities, and seeks to affirm her sense of agency, which her abusive partner may have sought to undermine. Goodman et al., 2016 cites studies by Cattaneo (2010), Kulkarni et al. (2012), Zweig & Burt (2007), and Cattaneo & Goodman (2010) showing that, "When survivors report greater control over the help-seeking process, they are more satisfied with systems ranging from the police and justice system to residential and community-based DV programs, expressing or evidencing a greater likelihood of using those options in the future." (p.166).

• The survivor might be anxious and uncertain about her next steps -- weighing the kinds of difficult tradeoffs discussed by Thomas, Goodman, & Putnins (2015) and Davies (2009) -- the risks to herself, her family, and her friends from further violence (if she stays or leaves); the benefits of being part of the family and community she may become alienated from if she leaves the relationship, or if, for safety-related reasons, she relocates to a new location and/or terminates contact with people who are part of the social circle she shares with her abusive (ex-)partner; the benefits to her and her children, and the accompanying risks, of being in the relationship with their father -- in short, all of the things she has to gain and lose by returning to the relationship versus permanently ending it;

• The survivor, having left her abusive (ex-)partner, and moved on from the shelter environment, might simply be exhausted and relieved, and appreciating the sanctuary of her own apartment;

• The survivor’s PTSD, trauma, traumatic brain injury or depression might be limiting her energy and capacity to engage;

44 Cattaneo & Goodman (2015) cites concerns that "the web of systems that have been developed to address IPV have unintentionally led to a menu-based or service-defined approach in which a survivor is offered a set of options for assistance based primarily on the availability of services or the mission of the organization, rather than on the survivor’s unique circumstances and hopes for the future." (p.20) That is, survivors are expected to be able to have their needs addressed within the context of a relatively standardized program model, rather than having programs individualize their responses to each survivor.

45 The concept of tradeoffs is a core component of the "Five Domains of Wellbeing" that underlies the "Full Frame Approach" to supporting survivors. As Smyth (2008) observes, "people do what they do and choose what they do for a reason: Their framing of what is possible, probable, desirable and worth the effort and trade-offs (for themselves or for others) is heavily informed by past experiences, personal and cultural history, and current context." (p.6)

46 See the National Center on Domestic Violence, Trauma, and Mental Health’s Tips for Supporting Survivors with Reduced Energy, discussed later in this section.

47 See the earlier notes from Hopper, Bassuk, & Olivet (2010) and Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project (2011) about the possible impacts of trauma on survivors' program participation.
The survivor might be frustrated with "the system," which made her be the one who had to leave home, and who now has to jump through hoops to try to find a new place to live;

The survivor might feel isolated -- perhaps missing her abusive (ex-)partner; perhaps uncomfortable reconnecting with friends and family -- or shunned by friends or family who are angry at her for leaving the relationship (and perhaps taking her children); perhaps because she is in a community where she knows nobody; perhaps because she is bereft of her racial/ethnic/cultural/linguistic/religious community; perhaps because she is afraid to disclose her whereabouts;

The survivor might not trust the case manager/advocate; might be wary of being pressured to make decisions that she won't be comfortable with; might be worried about being reported to the Citizenship and Immigration Services by a vindictive (ex-)partner; might be worried about being "reported" to Child Protective Services or otherwise facing a loss of child custody;

The survivor might be feeling hopeless, given the seemingly impossible odds of getting housing and gainful employment within the limited time the program can provide assistance; or might be feeling overwhelmed by the daunting logistics of putting all the pieces in place -- re-assembling all the important documents, dealing with the legal processes, figuring out school and childcare, seeking public benefits, piecing together transportation, addressing credit issues, gearing up emotionally for job interviews, and having to run around looking at apartments that she probably can't afford; and/or

The survivor might have lost her sense of urgency, now that she is in her own apartment, because scattered-site housing feels more like "housing" than like a "program," even though she may be at risk of losing her apartment without the income she needs to sustain the rent.

In other words, there are any number of reasons why a participant might not be fully engaged in services -- even if the services she is being offered are exactly the services she may appear to need and want.

The goal of the voluntary services model is to work with that: to be a partner with the survivor, offering insights into the landscape and experience-informed suggestions about what the survivor might go through, helping her think through the possible ramifications of her various choices and, supporting her as she makes decisions about the directions she wants to take and the pace at which she wants to move.

**Provider Strategies for Encouraging Participant Engagement**

Perhaps the greatest disparity in approaches to voluntary services that we heard in our interviews pertained to the amount and tone of "reaching out" that is appropriate: Some staff described doing frequent outreach to participants, proactively encouraging them and sharing resources that might support their individually identified goals vis-à-vis healing, housing, etc. By contrast, other staff expressed the opinion that they could not -- or should not -- encourage participants to take steps that participants did not appear to be interested in taking, even if those steps would help participants reach the goals that they had defined for themselves. Instead, they suggested, their job was to offer participants the information, and let the participant decide whether and how to follow up.

A significant number of providers emphasized the importance of participants' "first impressions" in building trusting, safe, supportive relationships with staff, as a prerequisite for sustained participant engagement in program services. In some agencies, the relationship between TH program staff and participants begins while participants are in the agency's DV shelter; in some cases, the advocate that worked with them in shelter continues to work with them in the TH program, building on their existing relationship. In other cases, TH program staff attends occasional meetings with shelter residents, fulfills a specialized role with shelter residents (e.g., supporting housing search), or gets to know shelter residents some other way.
Several providers mentioned efforts to encourage a sense of community among participants -- organizing festive gatherings, meals, movie nights, etc. -- as a strategy for supporting engagement and creating opportunities for peer support. Logistically, such efforts are easier in programs that utilize congregate or clustered housing, or scattered-site housing in which the units are close enough to a central meeting area, so participants can either get there themselves or be easily transported by program staff.

Different providers mentioned different approaches to engage participants that staff believed were "stuck," and not doing what staff believed they "needed" to do in order to be ready for the transition to a more independent living situation when program assistance ends:

- Offering persistent encouragement, support, and validation, and trying to identify the barriers standing in the way of participants achieving their targeted goals.
- Motivational interviewing.
- Incentivizing participation with tangible rewards, ranging from food, to door prizes, to access to an in-house thrift shop, to housing subsidies.
- Stepping back, to respect the boundaries of participants who don't appear to be interested in services.
- Focusing on deadlines and clarifying the consequences of not being prepared when their housing assistance ends; and cautioning participants about how quickly time will pass, and urging them to take the necessary steps before it becomes too late to put the pieces in place for a successful transition.

48 As discussed elsewhere, there are many reasons why survivors may decide to return to their abusive (ex-)partner or may not seek independent housing (See for example, Thomas, Goodman, & Putnins (2015) and Davies (2008), which emphasizes the importance of safety planning and advocacy with survivors who, for whatever reasons, decide not to leave the relationship with the person who has abused them.

49 Emphasizing the importance of validation, Sullivan (2012, rev. 2016) notes that, "Self-efficacy is influenced not just by prior experiences of success, but by encouragement from others (Bandura, 1977; Bandura & Cervone, 1983; Hyde et al., 2008)." (p.14)

50 Motivational Interviewing (MI) is:

- "A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion." Miller & Rollnick (2012), as quoted in Rollnick (2012).
- "A counseling approach which helps people change harmful behavior such as alcohol or drug abuse by exploring and resolving the ambivalence most people feel when they seek to make major changes in their lives. Emphasis is on respecting [an] individual’s right to make their own decisions as they are ready to do so, which [is] compatible with the empowerment approach favored by victims’ advocates." Edmund & Bland (2011) (p.309)
- "A conversational approach designed to help people with the following: (a) Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs); (b) Express in their own words their desire for change (i.e., "change-talk"); (c) Examine their ambivalence about the change; (d) Plan for and begin the process of change; (e) Elicit and strengthen change-talk; (f) Enhance their confidence in taking action and noticing that even small, incremental changes are important; (g) Strengthen their commitment to change." Center for Evidence-Based Practices at Case Western Reserve University (2011)

For more about MI, see, for example, (a) an excellent summary of MI principles and approaches on the University of Massachusetts website; (b) Chapter 3 (Motivational Interviewing as a Counseling Style) in CSAT/SAMHSA (1999), (c) a 2012 video presentation by Professor Stephen Rollnick on "The Changing Face of MI", (d) Markland et al.’s (2005) paper on Motivational Interviewing and Self-Determination Theory, and (e) Resnicow & McMaster’s (2012) paper on moving from why to how: "from building motivation to more action-oriented counseling, within a [client] centered framework."
• Setting clear "expectations."  
• Linking the extensions of housing assistance -- or the amount of housing assistance -- to the participants' level of engagement and/or demonstrated effort or progress in achieving targeted outcomes.  

(viii) **The Challenge of Voluntary Services in Supporting Survivors Coping with Addiction, Depression, PTSD, and Other Concomitants of Trauma and Abuse that Can Undermine Capacity for Engagement**

Given the prevalence of PTSD, depression, and complex trauma-related issues among survivors of chronic abuse and violence, it is no surprise that interview conversations about strategies for supporting participants who seem "stuck" surfaced concerns about serving survivors with behavioral health issues -- mental health problems and/or substance dependencies, or symptoms that resemble mental health problems, arising from PTSD, complex trauma, or traumatic brain injury -- that seem to limit the ability of survivors to make progress.

As discussed in Chapter 2 ("Survivor Access and Participant Selection"), some providers embrace the challenge of serving survivors with such complex needs, while other providers utilize selection processes that tend to screen out survivors who manifest these kinds of issues -- potentially contravening the spirit, if not the letter, of fair housing and/or non-discrimination laws, as well as requirements of their OVW grant funding -- because they feel they lack the capacity to appropriately serve them and to protect their safety and the safety of other participants, and/or because they believe that their limited resources can be "more effectively" used to serve survivors with fewer/different barriers, who appear to be more likely to achieve targeted outcomes.

Chapter 11 ("Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children") and the "Disabilities" section of Chapter 7 ("Subpopulations and Cultural/Linguistic Competence") include discussions about current thinking on effective strategies for serving survivors with so-called behavioral health issues, as well as provider comments describing their approaches and the challenges they encounter.

The National Center on Domestic Violence, Trauma, and Mental Health publishes a series of Tip Sheets on Creating Trauma-Informed Services, three of which pertain to working with participants who seem unable to fully engage:

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51 Compatibility of this approach with voluntary services probably depends on the way these "expectations" are framed, and on the consequences of violating them; that is, if these "expectations" are essentially treated as "requirements," and if violation leads to reduction or loss of services or assistance, this approach is more likely to be seen as inconsistent with voluntary services. It may be helpful for the OVW to clarify whether and how this approach might be used.

52 See earlier note about possible problems this approach entails vis-à-vis the VAWA voluntary services requirement, the OVW's provisions discouraging "restrictive conditions," and fair housing requirements.

53 For example, see Anderson and Saunders (2003), Courtois (2010), and Warshaw, Sullivan, & Rivera (2013)

54 Providers operating congregate or clustered programs raised concerns about the adverse impact on other participants of being around a participant with erratic behaviors or substance abuse issues; providers operating scattered-site programs raised concerns about the challenges of connecting with off-site survivors, who may live in apartments that are too far for the kind of regular face-to-face contact that helps building trusting relationships, and who are depressed, who isolate, or who, in the absence of close-at-hand support, turn to alcohol or drugs for comfort from their pain.

55 The American Public Health Services Association defines behavioral health as "including both mental health and substance use, [and] encompass[ing] a continuum of prevention, intervention, treatment, and recovery support services. A blogpost in Psychology Today (Premack-Sandler, 2009) posits that the term "behavioral health" may feel less stigmatizing than "mental health" and that a "behavioral health condition" may sound more temporary and treatable than "mental illness" or "addiction." On the other hand, "the frame of behavioral health places the onus on the individual to change, rather than examining and working to change external, environmental factors that influence an individual's well-being, such as poverty, discrimination, or abuse."
• **Tips for Enhancing Emotional Safety** frames steps and approaches that providers can take to "reassure and comfort survivors, but also to activate and engage the thinking processes that can lead to greater safety and control. This may mean offering a caring and calming presence, helping with tasks that are overwhelming, working to identify achievable goals, offering frequent breaks, and tailoring program expectations to the individual survivor."

• **Tips for Supporting Survivors with Reduced Energy** explains that

> "Dealing with domestic violence often takes every bit of energy that a woman can muster to remain vigilant and keep herself and her children safe. Survivors may seem very sad, lack energy, or feel hopeless. For a survivor who is also experiencing depression or another mental health condition, the increased demands that are posed by having to manage internal distress may mean that she has very little energy for DV counseling and advocacy. This lack of energy may also reflect the impact that mental illness, [trauma,] head trauma, depression, and stress have on the brain’s capacity to focus, sustain energy, and maintain attention. . . . In addition, sometimes the medicines that are prescribed to help with mental health symptoms can make a person feel “slowed down” and lacking in energy.

> It is important not to mistake this loss of energy or optimism as disinterest or “laziness.” It can be very discouraging for a person trying as hard as she can to get through the day to be told that she is not doing enough. Instead of saying, ‘You aren’t meeting your goals. What’s wrong?’ "

The Tip Sheet addresses how staff might explore with the survivor how her sleeping patterns are affecting her energy, and whether the program could support her in getting better quality sleep; afford the survivor an opportunity to talk about the sadness or hopelessness she feels; and explore possible accommodations that would make it easier for the survivor to participate in the program, for example by creating a more schedule and more flexible expectations, and by simply acknowledging the survivor's low energy and affirming the program's willingness to adapt to it.

• **Tips for Making Connections with Survivors Experiencing Psychiatric Disabilities** acknowledges how challenging it can be for provider staff who provide information and support with their usual survivor-centered focus, but who get feedback that suggests that the participant is distracted, or disinterested, or unappreciative, or mistrustful. "

> "It can be easy to get distracted from your purpose by the fact that a survivor does not return your smile or acknowledge your offer of connection. We may become judgmental, frustrated, blame the survivor, distance ourselves, or become critical. Staying on track means continuing to use the skills, caring, and commitment that you offer to any survivor, regardless of the symptoms or struggles that a survivor is experiencing."

The Tip Sheet offers strategies for how staff can stay on track in the absence of customary feedback; notes the importance of being affirming and consistent and transparent in their messaging, and creating opportunities for participants to ask for clarification or otherwise express themselves; and offers suggestions for staff in getting help when they need it.

While many of their comments reflect providers' very positive experiences with the voluntary services model, other comments reveal challenges and frustrations in serving survivors with mental health-related issues that seem to compromise participants' ability to achieve their individually defined objectives (or the program's or funders targeted objectives) within the allotted time. Some of these comments reflect the provider's belief that had they been able to require treatment or services, they could have facilitated a better outcome.

Specifically, a number of comments describe staff frustrations as they watched the program clock tick down, while participants -- whose focus or abilities seemed compromised by depression, trauma, or substance use -- failed to take important steps (e.g., addressing income, employment, credit problems, legal problems, and
housing), so that when financial assistance or their stay in the TH program ended, they had not made the necessary progress to secure stable housing. The shorter the allowed length of stay, the less time for the kind of “natural healing” that might have mitigated the impact of the trauma and its concomitants, and the greater the likelihood that program assistance would end before participants were ready for a "positive" transition.

While a number of providers have been able to partner with community-based agencies that can make clinical services available onsite or in a relatively convenient location for participants who are interested in seeking such assistance, other providers' comments\(^{56}\) cited difficulties in accessing treatment services, either because of distance and transportation-related concerns, insurance coverage-related concerns, the lack of community capacity, or inadequate understanding among mental health and addictions treatment professionals of the traumatic impacts of domestic and sexual violence.

**Recommendation:** There appears to be a continuing need for support and guidance on using the voluntary services model to effectively support survivors whose trauma/behavioral health-related issues – depression, substance dependence, PTSD, depleted energy, etc. -- threaten to jeopardize their ability to prepare for a successful transition at the end of their program stay, particularly in programs subject to sharper length-of-stay constraints (e.g., scattered-site programs jointly funded with HUD RRH grants).

One OVW grantee described an interesting approach to voluntary services, utilized by providers with other sources of funding, to offer survivors a level of accountability that the survivors requested in order to support their participation in substance abuse or mental health treatment. The challenge of integrating the kind of voluntary accountability described in their comment is making sure that participation is truly voluntary, and not coerced or reluctantly agreed to by survivors willing to consent to any conditions, because they feel they have no other decent alternative to homelessness or to returning an abusive situation. In order to remain consistent with the voluntary services requirement, the participant's continued access to transitional housing or housing assistance could never be made contingent on their continued adherence to the standard they asked to be held accountable to, and any such voluntary accountability could continue only as long as the participant wanted it to.

"A couple of our programs have been very innovative, and using other funding sources, have set up programming that is a little more communal in nature and is specifically for women who have either mental health or substance abuse issues. They have different houses for each of those, and one of the things they do, because they don’t use our dollars for it, is they establish some requirements. For some of the women who have mental health issues, they have check-in dates to make sure that if a woman is suicidal or if there are issues with meds, they’re staying on top of things. And on the substance abuse end of it, they have urine checks. Some of the women are out on probation, or to get their children back they’ve got to prove that they’re no longer using.

One of the issues that some programs have raised with us -- that our model – where we don’t allow those kinds of check-ins – doesn’t adequately serve some populations who may need or even want that for their own purposes. We recognize that it’s a valuable resource and that there are women asking for that, but we feel that we can’t fund it all anyway, so for simplicity as much as anything, we’ve stayed true to our voluntary services model. With those programs, we’re lucky that they’re both big enough and have the capacity to fundraise other dollars; and so for them, we think it’s wonderful that they’re doing that programming, but we don’t financially support it. They find other funds."

\(^{56}\) See especially Chapter 7 ("Subpopulations and Cultural / Linguistic Competence") and Chapter 11 ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children").
"If we had enough resources to fund those kinds of programs, we’d probably segregate the money so that there’s basic transitional housing that follows the pure voluntary services model, and then specialized transitional housing that is voluntary, where a woman has said, 'I have a substance abuse issue' or, 'I’m dealing with mental health, and I really want to be with other woman who have the same kind of issue and I need that support.' Just like nobody makes you join Weight Watchers; you join Weight Watchers because having a group of people to connect with that way, and having the structure of being weighed and accountable that way is what’s going to be helpful to you.57

The same way, a woman might say, 'I want to have urine checks' or 'I want you to check on me because I hate these meds and I might not want to take them.' We’d segregate the funding, and we’d be careful to monitor it, because I think it could go awry real quickly. I look at how much of a struggle it has been and still is with workers whose inclination is, 'I know better than she what's good for her.' And I think it would be so difficult to know what somebody genuinely wants and is voluntarily agreeing to versus it being required of them to get housing."

Questions to Consider

1. How does the program distinguish between “supporting the survivor’s engagement” versus "supporting the survivor?"
2. Where is the "right" balance between actively assisting and advocating for a survivor and supporting the efforts of the survivor in being their own advocate and in taking whatever steps they need to take?
3. Could a focus on supporting participant engagement over-emphasize the importance of survivors taking the initiative to "engage" with program staff and services, and under-emphasize (a) the importance of consistent staff efforts to reach out, support, encourage, and make themselves available and useful to the survivor; and (b) the obligation of a victim/survivor-centered program to offer services that are relevant to the survivor’s needs and priorities?

(b) Provider Comments

(i) Comments on the Importance of Trusting Relationships and Non-Judgmental Communication

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

(#01) This is a relational program. It’s 100% about the relationships that staff develop with the participants.

(#02) I think developing rapport with the clients is really important, and our adult and children’s counselors and program coordinator, are really great at connecting with clients and just continuing to remind them about their availability. They are consistently checking in so that if participants want to take advantage of the services, it’s always available and they’re always visible.

57 The Weight Watchers model is certainly not the only type of program that is built upon voluntarily consented-to accountability. There are Twelve-Step programs that address a broad range of addiction and dependency issues. The Oxford House Model for self-run recovery homes is for people in substance abuse recovery who want peer support and accountability to help them stay sober. The Recovery Association Project (RAP) sponsors several such houses in Oregon specifically for survivors in recovery. People with money hire coaches to support them and hold them accountable for exercising, eating properly, completing tasks that need to get done, etc.
(03) I think the most important thing we can do is work on developing our rapport or relationship with the families, so they'll be comfortable coming and talking to us about what they're struggling with, what's going on in their lives, and that's what helps us to be able to identify their needs and what we can best do for them.

(04) Openness and constant communication are the most important things. Their knowing that there is an open door and someone available to them when they're ready has been critical to the success of the program. We don't struggle with lack of participant engagement as much as we struggle with finding time to accommodate everyone and address their needs, because there are only two of us providing services.

(05) The initial phase working with clients is critical. That's the time to create a good impression and show them that we're ready, willing, and able to help if they need us. We talk about difficult things, we listen carefully, and we give feedback. We discuss the decisions they might want to make. And we leave it at that. Great things happen during that period, the period of crisis, and that helps us to get good results later on in the program. If we are successful, the clients are motivated to participate, and we help them maintain that motivation by speaking often with them, by discussing and reviewing their goals, by looking at the kinds of changes they might need to make down the road. The constant contact, the constant feedback, the constant work on motivation and empowerment goes a long way.

I've learned that there's no second opportunity for a first impression. That was the moment, the critical moment, the moment to capture the client's trust and, also, the moment for us to do an effective intervention, and build a foundation for ongoing participation. We invest greatly in those moments and we try to use them to our advantage, as providers, and to the participant's advantage, more importantly.

(06) We do a lot with engagement, especially on the front end. Since participants come from our shelter, and since the case manager they had in the shelter is going to follow them into the transitional program, there's already a relationship. And we build on that and focus on the expectations for the next phase.

(07) Sometime it's just the little things. Yesterday, I met with someone and we didn't just talk about rent or about how she budgeted her money. She mentioned that, "I love poetry," and just wanted to talk about that, so I listened to her and at the end of the meeting she said, "I want to see you again; can I bring some of my poetry to read to you," and I said I would love that. So she feels like a woman instead of just a client. I try not to use the word client. I use their name or "participant" or "tenant" or "survivor" because that's what would I like to be called. Once we can connect at that level, we can work together and be productive.

(08) I strongly believe it's the relationship with the social worker. They have to really believe that they're not being judged whenever they ask for assistance. That's crucial to success in a program where participation in services is voluntary. It's building a trusting, non-judgmental relationship with the clients.

(09) Recognizing how important it was to build relationships, when I first came to work here, I sat down with every client and asked them four or five questions about how the program had helped them and their children and what they would change, if they could, to make the program better. And we really implemented some of those things that they said, and our demonstrated responsiveness made a difference.
The relationship they establish with their advocate is integral to how much they take advantage of the services provided. And the ability of staff to do what the participants need -- to go with them to doctors’ appointments and courts and just be there, even if staff don’t really need to do anything, but just to be there. They trust staff to bring the resources they’ll need. We don’t force anyone to do anything; we offer what we think will be helpful, and they tend to be more open to that because of the relationship established.

It doesn’t do anyone a favor to pretend like everything is perfect, but at the same time, the choices people make are their choices, so we just talk with them about it. We don’t tell them that they’re doing the right or wrong thing; it’s just up to the client. People have decisions to make, and hopefully there’s open enough dialogue that they don’t feel judged in our program, and that’s a high priority -- that we’re culturally competent and not judgmental. The women we work with have for too long been told that they’re not good enough, not doing things right ... that they’re bad; so our hope is that the program environment is supportive enough to allow them to feel comfortable acknowledging shortcomings or seeking guidance when they’re in trouble versus keeping things to themselves and living in fear of punishment.

I think it’s critical that we build a trusting, safe relationship with our clients, so they can share with us whatever from their past they want to address in order to heal from it. But also, as they’re going through the program, as things happen in their family, we’d like them to be able to trust us, so they can talk about it; we’d like them to view us as a resource, as a source of understanding and empathy and comfort. All of those things are really important.

We've had a few clients who came in and seemed like maybe they weren't completely trusting us, and we just worked really hard to shift that, and talked with them about trust being sometimes broken in the domestic violence relationship, and it makes it difficult to build trust after that with others. Or sometimes victims have had really negative experience with other helping professionals or systems, and we talk about how we understand that as well, and then just look for ways that we can build up that trust.

Rebuilding trust is a process. The more time they spend with us, and the more they see that we are offering support and help, that we’re not requiring unreasonable things from them, and that we can be trusted with their stories and their information, the more they begin to look at us as helpful and useful and supportive. For the most part, it works.

Our organization is all in one building. My transitional program office is in the same building that the shelter is in. 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 the enemy or 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 domestic violence victim will be defensive, and it’s our ongoing contact that 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. Even though we’re not requiring them to participate in services, they want to participate because they have experienced that feeling of support and encouragement.

(Not a current OVW grantee) The relationship is foundational to participant engagement. Without it, you can’t really get very far at all. Although 75% of our clients have experienced severe violence, virtually
everyone comes in broken in one way or another. They feel belittled; they feel abused; they feel discouraged; they feel depressed; their health has suffered; they’re scared; they’ve been told that they’re worthless. And so it’s through the relationship that we communicate that this is a place where you can start over and they start believing in themselves.

That doesn’t happen quickly; it happens incrementally. It happens through the smallest little things, but it’s all relational and that first relationship generally is the case manager and then it deepens into other people. They get to know the credit counselor; they get to know the employment counselor. The children get to know the childcare staff and want to go to the nursery because they all love the woman who runs it, and that’s a relationship, and that can translates up to the parents.

So as they begin to trust us and realize that this is a place where they’re cared for, they’re known, they’re trusted, they can share what’s going on with them. And then, they can start thinking about, "what do I really want to do with my life if I had the opportunity to make some bold changes?" Generally, they’re not thinking that when they come in. Some are, but a person will come in and we’ll ask them, "What are your goals for while you’re here?" Some people, all they can put down is, "A safe place for me and my kids." That’s the farthest out they can see, because of what they’ve been through. They’re not thinking, "I want to triple my income" or "I want to become a Registered Nurse" or "I want to open my own business." That might not be there in the beginning and it won’t happen until they feel safe, and the safety comes through the relationship.

(#15) All our services are voluntary. They always have been and always will be. It’s really about the relationship we develop with somebody and paying close attention to where they’re at and what they need. It may be that we are just checking in with them on a weekly basis because they need to rest emotionally. They may be treading water and just need that break. Or it may be something very active based on where they are at with their goals. Our experience is that our physical presence and capacity to reach them where they’re at, and not having the expectation that they’ll come to us, creates an opportunity to accomplish what’s needed.

They recognize that we’re not going to tell them what to do, we’re not going to tell them what their best options are; we’re here to support them. We approach our work with the perspective that people will engage if you reach out to them in a space that is equitable and about defining their needs. If we are present, and make the effort to connect, it happens. We don’t have to artificially create it. And then once they tell us what they need, we’ll go from there.

We have one full time transitional housing coordinator, who is based at our shelter, and she is constantly working with the women in shelter to see if they are eligible for transitional housing and where things are at with the status of our units and any other transitional housing in our community. Typically, that coordinator already has a relationship with any participants that enter our transitional housing program, because she’s been helping them explore their housing options while they were in shelter. And that ongoing connection is important to supporting transitional participants' willingness to engage in services.

One thing we’ve learned over time from the women we serve in the shelter is that if there are resources that we can bring to them that makes a huge difference in whether and how they reach out and connect with those resources. For example, we bring community health staff to the shelter on a weekly basis, and we bring Goodwill staff for job training. So by the time someone gets into our transitional housing program, they know the coordinator, they’ve met staff from those community resources already, and if they haven’t already used them, they know them as safe resources because they have seen and heard from other participants who are using them. If you give somebody a phone number, but they don’t see or hear the person they'll be talking to, they’re much less likely to follow through. It has everything to do with how trauma affects people and how they take care of themselves. Trust is something that’s communicated by word-of-mouth; the women support
each other in learning who they can talk to, who they can work with, who they can trust, and why. So, for us, that shelter is really a proactive environment, preparing the women to succeed in our transitional housing.

(#16) People who’ve experienced domestic violence may have a lot of reasons to distrust people. So making that connection, being non-threatening, making sure we’re not reproducing a relationship with the same kind of power imbalance that the abuser had -- are important. And demonstrating that we will be there for the participant, no matter what: that we will respond when there’s an emergency; that we aren’t only available Monday through Friday nine to five. When you are available in that capacity, people want your help.

Relationship-building is about being reliable so you can build trust and have an ongoing, working, emotionally-supportive relationship, but still maintain necessary boundaries. It’s about not walking into the room with a service plan that "we need you to complete and sign," but with a sincere greeting and a “how can I help?” It’s about making yourself available to support your client the night her abuser shows up at the door, and the police have come, when she needs to talk with her advocate -- not next week, when your next appointment is scheduled. As an agency, it’s about flexible scheduling, so if our advocate is at the hospital until 10pm with a client, she can come in late the next day or take the day off. When you have that kind of flexibility with your staff, and clients have that kind of flexibility with their case manager, great things can happen.

(#17) Of all the things that culturally and institutionally we try to convey to survivors, the most important is that when we say voluntary, we really mean voluntary: “How can we help you?” “What does support look like to you?” We’re schooled in the Paulo Freire way of thinking, which says that you can only take people as far as they’re willing to go. It’s the opposite of what Freire would call the "banking style" of education, which approaches people with an attitude and energy that says “I know what’s best for you,” or "You need to know what I know” or "if they only knew what we had to offer, how useful it is, they would take advantage of it, so we'll really push them to try." Those are setups that don’t move people. We just don’t do that.

When people are with us, we genuinely listen; that doesn’t mean we don’t challenge people, but the way we do it doesn’t come from a place of judgment, it comes from a place of love – love for their wellbeing, love for them as humans. A heavy hand is just not where we’re going, because we know you can only get people so far. We take the teacher/learner, learner/teacher approach, which is that every time we interact with people, we’re also learning from them about their experiences and their life; we don’t pretend to know it all.

The magical thing that happens when you are a resource for people, and they see that, is that they seek you out. We most certainly have had people in our transitional housing that are more private, but they know where we are and they’ll find us when they need us. People can come here anytime they want when we’re here. They don’t need an appointment. People hang out here. It’s very open. You don’t have to have a heavy

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58 In his seminal book, Pedagogy of the Oppressed, Paolo Freire, a Brazilian 20th century educator, proposed abandonment of the traditional pedagogy (the "banking" approach to education in which knowledge is deposited in students by teachers) in favor of a more mutual, interactive, and egalitarian model of education based on lived experience and dialogue in which teacher and learner share a mutual respect and trust, and a willingness to question what they each know, in order to achieve new knowledge and understanding. According to Freire, such dialogue would help participants develop a critical understanding of their place in the world, help them see the world not as a static reality but as a reality in the process of transformation -- and see that they could be actors and change agents in that transformation (praxis). In this way, education would not be a passive process, but instead an interactive process for building awareness, social capital, community, and empowerment. This philosophy of education and transformation has much in common with the survivor-centered approach, the tenet of voluntary services, the empowerment model, the Full Frame approach, etc. For more information, see, for example, the description of Paolo Freire’s Theory of Education in the New Foundations website and Concepts Used by Paulo Freire on the Freire Institute website.
hand; people will still shift. In fact, we think they shift more without all kinds of rules. We were one of those rules people; OVW pushed people to get beyond that and I’m so happy about that.

The key is having a really solid relationship with the people you’re working with, building up enough trust and time together that you can openly talk about things. I think that some people have denial about what’s going on with their kids and how they’re impacted by what happened. I also think that it’s common when people are removed from battering situations, they flourish in ways they never were able to while they were in those relationships, and they’re much more open to try to figure things out. So, over time, you can start to have those harder conversations with the people you’re working with, as long as they trust you, they don’t feel a judgment from you, and, at the end of the day, they’re the deciders on their own lives and on their children’s lives, to some extent. I’ve worked with women who, when they entered the program, were so beaten down, as if their soul was gone, and then just by having some autonomy and free will, they are like new people.

We all know that people leave, they go back. There are all these dynamics that we see play out that we all know about but, for whatever reason, staff can end up holding it against the people they’re working with. At our agency, we work really hard to not do that. What we say right from the beginning is that “We’re interested in you being happy, thriving, and safe, and whatever that means for you -- going back or staying away -- that’s your choice. We’re always going to be here.” That, in part, is why we get people who do come back after they leave. They’re grown people and I think that when you have these rules, regulations, and ideas of what they could or couldn’t do better, then you’re ultimately saying that they have some fault in what happened to them. If we’re really going to be a non-victim blaming field, then we’d better stop doing that.

(#18) I think that one of the real strengths of our program is our ability to build trusting, nonjudgmental relationships with clients, and the clients reflect that back to us quite often. I think it’s about the message and intentions that are set in those earliest interactions with clients about what it means to be a participant in this program, and about listening to and hearing what the client’s really identifying as their needs at that moment, and making every effort to meet those needs so that client can see the benefit of engaging in a collaborative, working relationship with us from the earliest interactions. I think that really helps to build investment in their commitment to the program. First impressions matter.

One of the reasons we have an embedded trauma-informed clinical program within our direct services is because that level of expertise is really needed. Not for every client; but a lot of clients need somebody who can really understand what they’ve experienced to help them work through it and come out the other side.

(#19) One of the clients that I inherited when I took over the job was kind of leery at first, because she already had this relationship with the previous caseworker. That other caseworker knew everything about her. She knew her story and her struggles, because she was with her from the beginning. I was starting to work with her towards the end of her time in the program. When we did our check-ins, her responses were brief, like “things are good, this is my goal, this is what I’m working on, this is what I’m planning on doing for housing.” I feel like coming in at the end, we were hindered by not having had that fuller relationship, because in a sense, she must have felt like “I’m almost done and my caseworker left.”

But with any of the clients that I’ve been working with the whole time, I haven’t had any real issues in that area, and if I did, I would maybe ask them, “You seem kind of resistant to talking. Can you tell me what’s going on?” With my clients now, they would be honest with me, but I know that won’t always be the case.

(#20) The individual advocate can make a huge difference in whether a woman responds and feels trust with that person or not, and whether she is willing to engage.
Questions to Consider

1. Scattered-site programs often cover geographies that pose logistical challenges to more than occasional in-person meetings between TH program participants and staff. What strategies can staff use to support development of a trusting relationship with participants living too far away for regular visits?

2. If there is no overlap between the staff for a TH program and the staff that got to know a participant while they were an outreach client or while they were in shelter, is there a way to leverage positive relationships with shelter staff or outreach program staff in order to jump start the process of building a trusting relationship between the TH program staff and the participant?

3. If new participants have no history with TH program staff, and haven’t worked with staff from the shelter or outreach program who can vouch for the TH program staff, can the provider leverage the "testimonials" of prior cohorts of participants to attest to the compassion, commitment, and trustworthiness of the TH program staff?

4. What are effective strategies for handling staff turnover, so that trust in program staff is not permanently damaged by inevitable staff departures?

(ii) Comments about the Importance of Creating a Safe, Supportive, and Inspiring Program Environment

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

(#01) One of the things we’ve been really good at is staying connected to our graduates. A lot of them come back as volunteers or donors or just for our regular reunions. They stay connected years and years after they graduate and we hear about them buying a house or a child’s progress. It’s wonderful to hear what they’re doing, and it’s very inspirational and a great motivator for families in the thick of it now.

(#02) I went to some training and we read an article about coaching, and how some domestic violence shelter was doing coaching, and people were thriving, and we thought, what would that look like here? Then, we found somebody to do a short training for us on coaching techniques. We started applying those coaching skills, and we teach those skills to the residents, and we use motivation interviewing, and then we’re great advocates, so we have this mantra: there’s got to be a way, and never give up, and it works.

(#03) As much as we try to provide them with services and connect them to resources in the community, most of their success comes from the individual themselves having the willingness to move forward and to get past the trauma they’ve experienced. I think just being encouraging of that and celebrating the progress that they’ve made is one of the most important things we do to help participants succeed.

(#04) I think what gets her going is her children. She has children so she knows she needs to get better for them. So when I do home visits, we set up goals of what it is she wants to do. To help her out, she requests that I call her every week just to follow up to see how she’s progressing. She really needs someone to talk to, someone she knows is there for her, someone who encourages her to do what she needs to do.

(#05) (Not a current OVW grantee) I’ve been doing housing for almost 20 years. My first exposure to program housing was under HUD. I was from that old school where we used to sit down and meet with the individuals, and they had to agree to comply with all sorts of different guidelines. For example, they needed to agree to get a job within so much time, to go to counseling if they had a mental health diagnosis. When we got that first OVW grant, I didn’t really understand what they meant about not mandating everything; so I went to the
first meeting and they said, “You can’t tell them they have to do anything. They don’t have to meet with you. They don’t have to go to counseling,” and I was like, “OK, how am I going to make this work?”

Those trainings were so beneficial to me; I still run programs funded by HUD, but we don’t mandate anything. And we still meet the performance measures that HUD wants us to meet, like percentage of participants with increased income. Because we have people who are making the choice to acknowledge areas that they want to work on and we’re there for support, for advocacy, for direction. I praise what OVW grants have taught me in that we have a lot better relationships with the individuals we’re working with. They see us more as advocates and people they can trust, talk to, and receive guidance from. But we’re not sitting here trying to tell them what they have to do.

When we sit down with individuals initially, before they come into the program, we talk to them about what the program does, ways that we can be there for them, and what they have a right to expect from us as their advocate. We can’t mandate that participants do anything, but we give them incentives: we have child care available right on site; we have an employment and education coordinator; if you’re curious about job opportunities or you want training so you can earn a livable wage instead of $8/hour, we have connections with colleges and we also have some scholarships that you can apply for to provide you with the training and education free of charge. Those are the incentives we let participants who have those desires know about.

We want to try to create opportunities for them because we know that they were constantly told by their abusive partner that they’re not going to make it on their own, “You can’t provide for yourself and the kids by yourself without me” and “I’m the one that’s going to be able to take care of you.” We want to remove that and provide them with opportunities to dream about: “If I go through this training, I could make $14 or $15 an hour. I actually could maybe do this without him.” It gives them a new lease on life. To the individuals that we know are depressed, we say, “We know you’ve been through a lot, and that it’s sometimes really hard to get that motivation again.” Just to let them know that we’re here for whatever they want for us to be there for.

We ask families to create what we call a “dream sheet” when they first come to us. We tell them, "If you don’t have a dream, we understand that because sometimes those things have been taken away from you." Those dream sheets are just a tool to talk things through. “Here are some of the things you identified. Am I on track? Is this something you’re interested in?” They’re just a guiding tool. “We call it a dream sheet, not a goals sheet; because we aren’t saying that you have to do any of the stuff written down. This is just telling us what you’re interested in, not what you should be doing.” It’s just giving them the freedom to dream again.

The things we do with an individual to create that comfort level -- that nonjudgmental environment where they feel safe -- are key. Knowing that, “no matter what you tell me, it’s not going anywhere.” Obviously, you don’t develop that trust in your first conversation all the time, but being able let them talk about the things they’re comfortable talking with you about, and knowing that maybe next time they’ll be able to share about some of those other things -- the things that make them afraid; can we help them overcome those fears, or are some of those fears okay to have -- and maybe those are fears that will protect them.

(#06) We’ve been trying to use the voluntary services model for as long as we’ve had OVW funding, and our advocate captured the beauty of that model really well one time when she said, “Honestly, people had better participation rates before we switched to voluntary services -- in terms of going to support groups, meeting with their advocate, meeting with the children’s advocate. But then they left our program and some of them fell apart. Now, if they’re struggling, they can fall apart right here, and we can work on it together. They don’t have to hide all that." And that sets somebody up to do a lot better when they leave our program, because they can develop those coping mechanisms or strategies in a safe place. They don't have to be worried that it will get them kicked out.
Different grants come with different guidelines. When we work with people covered under an OVW grant, the services are voluntary, but we encourage them to use them. We do as much as we can in terms of inspiration, like we’ll have graduated clients give an inspirational talk about what they were able to achieve while they were working with us, the degrees and certifications they earned, the debt they paid off, the things they’re proud of – to try to inspire current participants to take advantage of those services. That said, there are people who totally jump in and use everything we offer and people that use very little. Obviously, the people who take advantage of the services end up in a far better place economically, than those who take little advantage of our services.

We try in the first one or two months to get as much information about the person as possible, including what their background is, what’s happened to them, what kind of psychological or emotional issues are going on, what their aptitude is, what their interests are, what the barriers are, and we use that information to try and open up a pathway that might inspire them to move forward. We try and help people move out of that place of brokenness into a sense in which they’re the authors of their future. That requires a lot of information and cooperation, so even though we talk about some mandatory services--where allowed by the funding--we want to work with them so they get excited about the idea of becoming their own bosses.

If somebody were to meet with our credit counselor right away and put 10% of their gross income in a savings account, over a two-year period they could probably become completely debt free and leave with a sizeable nest egg for when they move on. Roughly 10% of our graduates become first-time homeowners within two years of leaving our program, and they’re able to do that partly because they worked with our employment counselor to get a better job, they learned a skill, they got a degree or got certified in something, they tripled or quadrupled their income, they paid off their debts, and they were then able to qualify for homeownership.

But in order to do all that, they have to get started pretty quickly setting and achieving goals. And most people who have been living in poverty and are in crisis mode can’t imagine putting aside 10% of their income into a savings account that is going to be used to pay off some old debt. So where savings is required, it tends to get started a whole lot quicker than if it’s voluntary. A person might eventually choose to do it but they might wait a whole year before they think about paying off debts, so the progress tends to be more successful if some of the participation is mandatory.

If we’re working under a grant that has restrictions, we honor those restrictions. If we’re working with a client that is under a grant that has no such restrictions, and if we sense that this person is capable of doing something, we’ll require them to do certain things; like meeting with an employment counselor within the first 30 days, meeting with a credit counselor within the first 30 days, meeting with their case manager at least once a month. If they don’t know English, they should be attending ESL classes. The important thing is that although we may be requiring this, we’re also providing an enormous amount of support for them to achieve it. We’ll pay for the childcare; we’ll give them transportation; if there’s a fee for enrolling in school or a training program, we’ll pay it. And if they do enroll in school or a training program, their chances of becoming independent are greatly enhanced.

Questions to Consider

1. How can the program help current participants to leverage the experience of prior cohorts of program participants who took advantage of the resources offered by the program to achieve their goals?

2. Above and beyond protecting survivors from violence, what makes a program a "safe place" for survivors to explore their possibilities? How can staff convey a sense of safety?
(iii) Comments about Using Motivational Interviewing

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(#01) It's a continuing challenge to help participants see the benefits of participating in the services, so they can become self-sufficient. Once they see the benefits, they're on board.

We use a lot of motivational interviewing. Participants do a lengthy intake with the case coordinator, talk about the goals they want to achieve, and talk about services that can be provided to help them reach those goals. Should they lose engagement, we sit down and talk with them and remind them of the goals they set when they came into the program. We ask about what has changed, are there different goals they want to achieve, or is there something keeping them from achieving what they said they wanted. Slower starters - the people that have to work through some counseling issues before they are able to go out and apply for work ... those with emotional barriers ... have to be challenged more often on where they’re at in reaching their goals, and those are the participants with whom we most often use motivational interviewing.

We have two thrift stores. If we’re stuck, we use a reward system with the thrift store to incentivize participation. But that hasn’t worked as well as just sitting down and having an honest conversation.

(#02) So many of the women in our program are at the bottom of Maslow’s hierarchy. "How do I keep myself and my kids from being killed?" "How do I house and feed my family?" As they become more stable, the service coordinators are able to guide them in terms of “here’s a program that might work” or “you’re talking about how your kids are acting out, that’s really common, here’s some reasons why they might be acting out, and here are some resources that might be helpful.” You see a lot of the women once they have the housing taken care of, once they've figured out how to pay their rent, how to feed their family ... are much more willing to engage in therapy and talk about the violence they've lived with in their lives.

It's a little bit of motivational interviewing and a little bit of using Stages of Change for figuring out how to engage people: understanding where they’re at and then thinking through the engagement strategy. This person is not ready for an intervention. That person is ready to contemplate making changes in their life.

(#03) We’ve really tried to individualize the support that we offer survivors. We don’t try to make them fit our mold but really just try to shape our services and support around their needs. I think that having that individualized care helps with their success on many levels, whether financially or maintaining independence. It’s really client-based services versus agency based services.

We meet with our clients usually on a monthly basis. If staff are concerned that a client is not doing what they need to do, we have conversations about those concerns and try to offer support around them. We try not to take on a parental role, but instead, work to encourage participants to think about their future and long-term financial issues, about trying to make things sustainable. It’s really just a conversation and then an offer of support, information, and resources. Two of us have been trained in motivational interviewing and in providing trauma-informed care, so we understand a lot of the barriers we see. Both trainings were helpful.

(#04) I’m working with my case managers on their motivational interviewing skills. I really want to use that language with them on change talk, really practical things. Also we try to send them to trauma-informed care trainings so they can get to really look at the context of where our clients are coming from, and maybe understand some of the reasons they might not want to engage.

The good thing about the apartments is that the case managers have their offices right at the entrance, so a
lot of the engagement occurs outside of scheduled appointments, like when a client comes in and they check in with case manager or the case manager sees them in the hallway. “How’s that new job coming along? Have you registered for school yet? How’s that goal we were working on?”

**Questions to Consider**

1. Research by Dr. Daphna Oyserman\(^{59}\) suggests that having a goal is, by itself, not enough to motivate us to do the work we need to do to achieve that goal. The people who are most energized or motivated to do the work to achieve a goal are the people who (a) can envision a real connection between their current self and the future self that has achieved that goal; (b) perceive that the timeframe for action is short enough so they need to take action now, and that action can’t wait until later; (c) see themselves on a path towards the goal and towards the future self who will achieve that goal; and (d) react to obstacles encountered on that path by working harder, rather than seeing them as cues to give up.

For those of us who have taken on "long-distance" projects, these prerequisites for getting started and sustaining momentum will not be surprising. If a due date seems too far away, we have trouble getting started, and procrastinate. Until we get a doctor's warning about incipient problems, our exercise regimens and/or efforts to lose weight are erratic and easily sidetracked. And if -- like victims of abuse who have come to believe the messages about their incompetence that they've heard many times from their abusive (ex-)partner, and perhaps from family members or teachers -- we lack the self-confidence to persevere when we encounter obstacles, we will likely not be able to sustain our efforts.

From a tradeoffs\(^{60}\) perspective, if future possibilities seem too remote and/or unattainable, we won't put the time and energy into achieving them, and instead, will focus our efforts elsewhere.

**Given this understanding of the energy and focus and fortitude it might take for a survivor to undertake and sustain the efforts needed to successfully achieve her employment or education or parenting goals, what kind of support and encouragement should provider staff be prepared to offer?**

**(iv) Comments about Focusing on Deadlines and Natural Consequences**

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59 See especially the research on self-regulation, motivation, future-oriented self-concept, and other aspects of identity, as enumerated in the University of Southern California's biographical webpage for Professor Daphna Oyserman, listing her publications on Identity and Self:


60 See, for example, Thomas, Goodman, & Putnins (2015) and Davies (2009). The concept of tradeoffs is a core component of the "Five Domains of Wellbeing" that underlie the "Full Frame Approach" to supporting program participants. As Smyth (2008) observes, "people do what they do and choose what they do for a reason: Their framing of what is possible, probable, desirable and worth the effort and trade-offs (for themselves or for others) is heavily informed by past experiences, personal and cultural history, and current context." (p.6)
be approved and they’re made aware of that. Since we have so few transitional units compared to the need, we can select people who we think will participate and benefit most from the services.

(#02) We have social workers working with the clients -- providing them with tools, resources, information, and training opportunities -- based on what the client has said about the goals they want to accomplish within the time period. The client could very well say I don't want to do any of those things, but while they are empowered, there’s also an accountability piece, and that accountability piece says, "OK, at the start of the program, we told you how long you would be able to stay in the program. So you have a date certain; what are your plans for being ready for a transition by that date?

The social workers that have relationships with the families are walking alongside them, talking with them, trying to educate them, and give them a realistic picture of what’s going to happen if they don’t do anything between now and when they have to exit the program -- encouraging them to think about how they'll provide for their family once the program is no longer helping them with the rent. Our goal is not to have anybody exit the program back into homelessness. Our goal is for them to be self-sufficient. We try to work with them to help them to make the right decisions so they can become self-sufficient.

A lot of the people who come into the program are grappling with a multiplicity of issues. They might be depressed, they might be suffering from PTSD, they might have a substance use problem. If I’m addicted to drugs on day one, you can’t convince me that I need to do certain things. There’s a lot to address first; there has to be a systematic addressing of issues.

Program participants who haven’t fully engaged won’t be kicked out of the program for non-participation. But there’s a date certain for everybody, and if they don’t take the steps they need to take, they most likely won’t be able to make a successful transition.

(#03) We don’t wait until the last minute to say “your subsidy runs out tomorrow." When we recognize that we have someone who’s not doing what they need to do, we tell them, "you’ll be coming to 12 months sooner than you think, and we’re not going to extend you. We’re not going to discharge you from this program, but unless you make some changes now, when 12 months comes, you’re going to be right back at the drop in center. Do you really want that?” No one wants to go to the drop in center, believe me. So we really try to get people to see the potential consequences and a lot of times it works. Sometimes it doesn’t.

(#04) The 24-month deadline is a really big deal. When a family comes into the program, 24 months feels so far away, and they feel like they have lots of time. And then, time passes and all of sudden, it’s “Oh, you mean I have to be out in six months?” So, the 24-month deadline can contribute to a lack of motivation, or it can be very motivating, depending on how close to the end of their stay they are. Eventually, as they approach that deadline, they realize, “I need to start doing stuff.” And no matter how much we advocates encourage and remind them about their own goals, in the end, it’s the deadline that really motivates them.

(#05) When someone seems to be disengaged, the case manager and the director of residential services meet with the client, and talk about her goals and give her concrete tasks around looking for permanent housing ... because sometimes a client just doesn’t know how to get unstuck. But if they haven’t been actively searching, and they’re at the end of the 24 months, we unfortunately have to let them go. We hate for a client to go back into a shelter, but that has happened. They’re empowered to make their own decisions. We may not agree with their decisions, but if they don’t want to look for housing, there’s nothing we can do about that except reach out to them and give them the information; the decision is theirs.
(06) We try to have direct communication with the client and talk to them about how choices they’re making now are going to impact their options in the future. If you’re not following through on employment leads or going to school, or if you haven’t submitted your housing applications… We try to make it very clear that our transitional program is time-limited; people really will have to leave, whether they have a great option or not. We try to help people understand and plan for the future, and weigh their choices. You hate to think that every choice is that critical, but sometimes, when a couple of choices could change the big-picture outcome, it’s important that clients really put that into perspective. We try to make it clear that we have certain obligations to our funders and to the community at large, so we need people to do their best to adhere to those big-picture requirements. And if they don’t, they may be limiting their own options also.

Occasionally, we’ll have someone who doesn’t want to meet with their case manager. We try to talk to them up front about how that’s going to limit their options. If they’re not meeting with their case manager, they’re not going to get the referrals and the resources their case manager has at her disposal. Right now, for example, some public housing units are becoming available in the city. If you’re not working with your case manager on those applications, you’re going to miss out on affordable housing.

(07) We try to motivate them to understand that if they don’t do some of the things on their list, they’ll end up homeless and we can’t take care of them forever. We run into those situations – we have one now – and it’s troubling. I really don’t know what the outcome’s going to be at this point, but we will not exit anyone into homelessness. We’ll figure something out. Sometimes we can get the family involved, the resident’s mom and dad, and they will pick up the slack on housing cost, so we can move them into permanent housing. We can back them up with our ESG-funded Rapid Rehousing for a while, but once they hit 24 months in transitional housing and we have extended them for an additional six months (up to 30 total months), then either we’re doing something wrong, or they’re not participating in their own recovery, and we have to start over with the basics, help them define what has or has not occurred, so that they’re not yet ready to pay for their own permanent housing. More intensive case management, looking at additional options.

(08) If someone chooses not to engage, we try everything, we try nontraditional ways of engaging, we slip notes under doors and whatever. Our team is constantly talking about the folks who choose not to engage, and how the advocate is still responsible for figuring out what to do. It’s not like she would wash her hands of that family, and say, "Oh well, they don’t engage." We do everything we can, and we try various strategies, but at the end of the day, we would have to say, "We probably can’t extend your stay because we have no idea what you want or need from us, or how we could continue to help." Natural consequences would unfold for a family that we weren’t able to engage. We can be lenient and flexible in situations where we understand what’s going on. But if we haven’t been able to engage, it’s hard for us to know what’s going on.

(09) We develop budgets with our clients at the beginning and again three months later -- basically putting together what their expenses are and what their income is. We show them what their expenses would be if they had to pay the entire rent themselves: "If the assistance ended, could you meet your lease obligations?" Just showing them clearly where they stand financially stresses the importance of finding employment or other income. We might explore with them what their career goals are and how they can meet those goals. We try to connect them with alternate income if they are having challenges looking for work.

(10) The way we present it is “Here are the services we have. Because we use the voluntary service model, we will work with you on the things you want to work on. However, we don’t provide food. We don’t provide
money for all the things you might want or need to take care of yourself and your kids. You need an income -- either mainstream benefits or employment income -- to be able to live on your own.” We ask them to clarify their goals: “Tell me about the housing you want to transition into by the time you leave the program.” If they say, “I would like to move into a leased apartment,” we can tell them how much different sized apartments might cost in our area, and how much money they’d need in order to move. After we help them compare their current income to the income they’ll need to move to the housing of their choice, the person will say “OK, I’d like to work,” or “I’d like to increase my income,” or “I’d like to go back to school.” Later on, the case manager and I can go back to the things we discussed at the beginning, and say, “Given where you are now, and what you are or are not doing, are these goals still realistic?”

Sometimes you need to let them know that “You only have X months remaining in the program; what are you going to do with your kids if you leave the program and haven’t found housing? You cannot stay beyond 24 months in our program.” Maybe that is what they need to hear at that point in time that would make them wake up and say “You know what? I need to go and do something differently.”

(#11) The program is 6 to 24 months. At 12 months, we have a conversation about, "how has it felt since you’ve been here?" At 24 months, it will be too late to help, so what are we doing to make sure you’re in housing by then?" We have that same conversation again at 18 months and 21 months, so they understand our limitations as a program. I don’t think since I’ve been a TH advocate, that we’ve had anyone get to 24 months and just have to leave without a plan.

### Questions to Consider

1. How can staff "help residents understand possible "natural consequences" and remind them about program deadlines" without seeming to threaten them?
2. As described in Subsection (4)(vi), there are many possible reasons why a survivor might not be engaged in services, and might not be taking the steps that the provider believes they need to take. How can a provider gain insight into the reasons that a survivor may not be acting in what the provider believes is a more prudent way, given approaching deadlines?
3. How often should providers have conversations about a participant's goals, the efforts she is making, and the help she may need to achieve those goals?
4. If participants are still weighing the tradeoffs of returning to their abusive relationship versus pursuing independent living, focus on employment and housing search may not (yet) feel like a priority. On the other hand, if efforts to address employment and housing are delayed too long, that path might not be available, given limits on program length of stay. How can a provider support a participant in keeping her options open until she makes a decision, without appearing to push her in one or the other direction?

### Comments about the Importance of Making Participation Easy, Fun, Useful, and Rewarding

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(#01) We have a donation room which is open to clients on Thursdays. Clients like to go through the donation room, but before they can, they meet with the life skills specialist who leads the economic empowerment groups. Having the donation room attached to the group really motivates people to come. They really enjoy the classes -- credit counseling, setting up a budget, learning how to shop, making food go further, and cooking.
Our participants are pretty willing to engage with us. We have a financial workshop that helps them. A wellness workshop. We have the DV group on Wednesdays. They seem eager to be with other people that have been through the same situation. I really haven’t had any issues with the clients participating.

We’re super flexible about when they can meet with us. If they want to meet with us over the phone, that’s okay. We will do everything we can to try to make it as easy as possible for them to engage. When we have our financial education classes, we always provide child care, so that’s not a reason for not participating. We try to remove obstacles. We try to serve refreshments. Sometimes we have door prizes. We try to do things to keep them interested and working with us. But, some still don’t want to. When I talk to survivors, they’ll say that their financial education classes happen when they’re at work, so they can’t participate. We say we’ll work with you one-on-one if you can’t come to our classes.

I think probably the way we get people to work with us most effectively is we provide them with emergency assistance. They know that when a crisis occurs, they can come and ask us for financial help. Probably most of the women who live in our housing have gotten some kind of emergency financial assistance over the course of a year. They know we’re there for them, if they need help. We also provide all those services I described. And that’s another way to keep them engaged, through those services. Almost all of them have stayed in groups; I think that the groups are a way for them to feel a sense of community. For most, it’s not that hard to get them to participate. There are always a few who won’t.

Although we worried they wouldn’t come, we decided to offer all the services and group meetings on a voluntary basis. For a while, people still came. Then, people started dropping, and we realized this was about us, and that we had to figure out a way to engage the residents.

So we did focus groups with the residents, and decided that we would form a residents’ council. We hired someone to work with the residents, teach them the decision matrix, how to make decisions, and how to prioritize. So we had a residents’ council. We gave them jobs serving on the residents’ council, and people were very engaged, and they loved it. We told them, "If you are serving on the residents’ council, you can put it in your resume." So it’s an employment program, and since employment is a focus, it’s on their radar.

I told them that I wanted them to do presentations and facilitate meetings so that they can get the experience. Last night, one of them facilitated the meeting, and she just loved it, was very nervous but loved the experience, and I told her, “Look, now, you can put that on your resume, and when you go to an interview, it’s really going to relieve tension, because you had this practice.” Not all of them come to the meetings; with those that don’t, we’ll check in and say, “You’re not coming to the meetings. What’s going on? Is everything okay with you?” If somebody says, “I just took a job working nights, but I’ll still be meeting the advocate,” we can relax about it.

We have some eligibility requirements that they work on and once they meet those eligibility requirements, they receive a portable housing choice voucher which they can use in another apartment that they move to. Our eligibility requirements are things like from the time they moved in, they were able to either go to school, find a job, increase their income, etc. We also ask them to participate in an intimate partner violence curriculum, which is a 12-week course that talks about what domestic violence is, the effects it has on children, and what to look for in a healthy relationship.

These are not requirements for program participation, only for getting a portable voucher. They are not required as a condition for having transitional housing. We have some women who don’t want that voucher.
when they leave and don’t try to meet the eligibility requirements. They want the stability of the transitional housing. They want support. They feel like they can build their income while they’re here.

(#06) We try to make our services interesting and try to reduce barriers. Our case managers try to be as flexible as possible. So while the moms are in financial counseling, for example, we have child care available. We make food available to the moms who attend the class and their kids. It’s not helpful to have childcare and then, at 7:30pm when your workshop ends, you still have to go home and make dinner. If the client doesn’t get home from work until 6pm, a 9 to 5 appointment won’t work for them. So we meet with the client after she comes home from work; we offer to come to her apartment when her baby is sleeping.

(#07) To maintain participants’ engagement, we have to be able to demonstrate that by engaging in our services, you’ll be in better, stable housing, potentially months faster than you would be if you didn’t engage in case management. I personally believe that engaging in case management is going to get somebody farther than just getting a rental subsidy. But sometimes, articulating that and selling that to people is challenging and so the more that we demonstrate the rewards of participation, the better.

(#08) We have to be very, very creative and use other incentives to get them to do other things -- like you would with somebody with mental health issues or depression or trauma issues that are affecting their ability to function. We offer counseling services, but they don’t want to go to counseling; but in the meantime, they are not able to function well enough to look for a job. What do you do with this client? We have come up with all kinds of things to incentivize them: “Hey, let us work on this goal this month. If you work on that you will get this or that. We will help you get this or do that.”

(#09) We used to hold monthly workshops on topics that participants were interested in, and then once every other month, the Family Life Center would come and do a workshop on financial literacy. A couple of years ago, participants started asking if they could have them more frequently. So we hold them twice a month now and once a month the Family Life Center still does a workshop on financial literacy - on budgeting, credit repair, how to save, how to lower your grocery budget, and things like that.

One of the really exciting things that I’ve seen in the past year or so, is that the residents themselves are providing a lot of the workshops. So they have a topic that they have expertise in, and they take one of those weeks and actually lead the workshop. And we have had really good attendance at those workshops. Participants develop friendships with each other and support each other. They just love them. They learn so much. We feel like that’s been one of the most successful strategies that we have used in getting them connected to the program and to each other. And, it’s empowering. They say, “Before the program, I wouldn’t have done a presentation in front of anyone.” And now they get to know all the other residents and they feel comfortable and free to express what they’d like. Just to teach a class gives them more confidence and independence. And helps create a sense of community among the scattered-site residents.

(#10) The Coordinator meets with them once a week, twice a week or once every other week, whatever the participant wants, at the office, or out in the community, or at their apartment, whichever they prefer. Depending on what went on for them, sometimes we’re looking at their goals and sometimes we’re dealing with a new crisis. So, it can vary. But we’re always re-looking at the goals. Sometimes their goals have changed because of something new that’s popped up, a new direction they want to explore. Maybe instead of finding a job, they’ve decided to go back to school and learn a new trade. We communicate a lot by email. I
have some clients that don’t sleep at night, so they send emails during the night, or they work odd hours, so we schedule things by email and check in that way.

(#11) Participants are strongly encouraged to meet with us regularly, and we call them and bait them with gas cards and food and other things that help make their life easier. Some women will call us like every day and we’ll talk to or see them pretty frequently and with other women, it’s less frequent. It depends on the woman and where she’s at. As women first enter the program, we’re talking to them daily and meeting with them minimum weekly, but as they achieve their goals and gain that independence and becoming comfortable with that independence, they’re not contacting us or seeing us as frequently.

(#12) I've never had a participant refuse a home visit. I always bring something. My mother taught me never to go to someone's home without bringing something. I’m really good about bringing over laundry detergent, or coupons, or information, so I always bring something and it’s seems like our conversations are always uplifting and encouraging. So, most of them look forward to my visits. At least that’s my experience so far.

(#13) Residents receive small vouchers for gas and/or groceries upon the timely payment of their rent on a monthly basis. Otherwise, it’s up to them to be as engaged as they want to be. We periodically have opportunities along the way to offer some small incentive, and when they are available to us, we make them available to our clients. We ask residents to help with some basic chores around the complex. We also encourage them to consider participating in some of our support groups. The reward is the participation. In the complex that we own and operate, our clients see their neighbors participating in our community garden or in a fitness project we created. And I think that has inspired them to join in. Perhaps if they weren’t living close to one another, they wouldn’t see these opportunities, and wouldn't participate.

Our strategy for promoting engagement is just lots of communication and presenting options and opportunities. We’re starting to have a more active mentorship program where we have former transitional housing residents stay connected with us; they have the opportunity to meet current transitional housing residents, and help them see life beyond this program. We talk a lot with our residents about their goals and what they want to get out of our program this week, next month, and three months from now. Our hope is that they will work toward accomplishing those goals, and that we and they will see some successes along the way, and be inspired to continue.

I think we have been very discerning and also extremely lucky in the two staff persons that we’ve put into that role. They are really gifted with client service, client rapport. For the past year and a half, all of our TH residents have all either been enrolled in school or employed, and that’s the first I’ve seen that in this three year period. And from what I understand, would be considered very unusual even over a historical period.

(#14) We encourage staff to look at creative ways for engaging participants -- a monthly dinner, movie night, fun activities for the women and kids, distributing household goods, etc. It isn't terribly appealing to just say, “Do you want counseling?” and a lot of people have a bias against counseling. And if there is a Spanish-speaking constituency, programs should offer those same activities in Spanish. We encourage staff to think outside the box and not get stuck in the traditional, “You set up an appointment at 9:00 and it’s over at 9:50.” We encourage them to think about what the women want and need, what would entice them, what would be interesting, and what would be value added? Everything doesn’t have to be about counseling; if you’re showing up a couple of times a month and getting to meet other women and kids and have your family connect and feel a part of something, it doesn’t have to be a formal counseling session. We encourage programs to be creative that way, to really look at what community means. It doesn’t always have to be the
Questions to Consider

1. What kinds of incentives and rewards are appreciated? Are incentives appreciated even if they are perceived as manipulative, but well-intentioned?
- How can incentives and rewards be offered in a way that preserves the integrity of the program and the dignity of the participants?

2. Is it enough for a program to be survivor-driven and for services to be relevant to addressing survivor needs and priorities -- or does it help to try to inject fun, entertainment, and incentives?

(vi) Comments about the Importance of Meeting Participants Where They Are, and Respecting Their Boundaries and Choices

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

(#01) We have an excellent counseling center, and we try to encourage participants to see a counselor, and that counselor may see and tell the case manager about something that's causing the participant to be less engaged -- something the participant might not have disclosed to the case manager. The counseling center is part of the program, so that kind of conversation isn't breaking confidentiality.61 The center is just downstairs from the shelter, so there's easy access, but we can't make someone go. For some participants, it's tough to start counseling, especially if they believe the stereotype that seeing a counselor means you're crazy. We can't make participants go out and look for a job. We try to show them the benefits of having a job. We offer groups to help with interviewing. But it's all voluntary, so if they would rather be out visiting a family member, or hanging out with a friend, that's their choice. It used to be mandatory to go to group. But I think if groups are made interesting, and if meetings are at a time that clients prefer, they'll come. But you may have to ask staff to work on a Saturday because that's when clients want to have the group.

(#02) All our services are voluntary; we don't mandate any services but we certainly encourage survivors to take advantage of the services we have available because they end up benefitting greatly... but nothing is mandatory. Even in our HUD-funded domestic violence rapid re-housing, we do not mandate services, because it's contrary to our philosophy. A lot of agencies that don't have an association with VAWA or OVW don't understand voluntary services, but we can demonstrate that it works; we have strong outcomes.

I am a believer in the voluntary services. We treat women in our program with great respect and a lot of the women we’ve served are not accustomed to that. We don’t create a case plan and say, “This is your case plan; this is what you’re going to do.” The survivor works with the case manager to create her own case plan, to set her own goals. Because it’s really all about what she wants to do, not what we want her to do.

And we have a lot of success in terms of outcomes. Our domestic violence rapid rehousing program was the number one ranked project out of all 41 Continuum of Care programs. I really believe that in part it’s due to the philosophy behind voluntary services – not forcing people to do things against their will.

61 In the interest of transparency and building a trusting relationship, it would be important for all affiliated providers to be clear about how and with whom information might be shared.
I don't think the importance of voluntary services to clients can be overestimated. Self-determination and sovereignty are essential, and it’s frustrating when providers try to control clients. Any resource guide that's developed, should stress the importance of self-determination in empowering people. I tell staff, it's not about you; it isn't your life. Your job is to be an ally and support system, not to lead the ship. If clients feel pressure and are afraid of punitive action, they won't tell you what's really going on. You're closing the communication channel. Some providers with good intentions screw up for that reason.

There used to be an expectation -- and I think there is still a mindset -- that participants get services based on how engaged they are. It's something we've worked to change. A lot of our staff have gone to NNEDV voluntary services training, and a training on shelter rules that the Washington State Coalition did a while ago. So there's been a lot of discussion about voluntary services and motivational interviewing to engage people where they’re at, not basing services on how motivated someone seems, or how quickly they meet goals. We need to be serving all types of survivors, and they shouldn't have to do X, Y, and Z in order to get housing. I think our community has come a long way to make that happen. Mostly people want to stay engaged and the scattered-site transitional housing model is set up to be more flexible, so people aren’t asked to leave based on roommate conflict, being disruptive, getting high. With the change from a congregate to a scattered-site model, people are able to have a lot more autonomy and independence, and we can work with them on the struggles and issues they’re having. If they relapse and use again, that’s not something that affects a whole household anymore. So the policies are a lot more supportive and flexible.

Our case manager meets with everyone that wants to meet. Almost everybody chooses to engage in services. If not, we try to find out whether there is something else we could offer or do a different way, and for the most part, everybody has taken part in case management. We offer education and support groups, which quite a few participants take advantage of. Our case manager works with people on what we call an Individual Action Plan. It is basically a case plan, but it is driven by them. She starts wherever they are at. Some people just want to rest and that’s okay to have a period where you're just relieved and safe and recovering. We had a participant who wasn't engaging in much case management, and the little time she did engage, the case manager assured her that whenever she was ready, we'd be here, and it was okay to hole up in her room and sleep. Now she is employed and getting ready to move into permanent housing. She talks about how that time was important when she didn't have to do anything; how it was okay to go inside herself and rest, and how other programs hadn't worked for her because of all their requirements.

My observation is that the clients that have lived their whole adult life with very unstable housing or who have experienced chronic homelessness have a harder time with long-term success than the ones who had otherwise stable housing when they left the abusive environment. People who have been stably housed are much more motivated, it seems to me, to get back to the stability they’re used to for their children. Participants who have experienced chronic homelessness or instability view "success" very differently. To them, having two years in a stable spot - even if it’s our transitional housing - is successful. Being able to save any money for the future is success. They don’t aspire to buy a house; it’s never been a realistic option.

Another challenge is that we don't necessarily know all the things going on in our participants' lives. We can only work with what they disclose. Sometimes, for example, knowing about mental health issues would be extremely useful to our helping them put the pieces back together, but we have to respect their decisions about what to tell us, and what not to tell us. We walk a fine line between providing support and services and
following the empowerment model. We can ask a resident how they’re doing or if there’s anything else we can support them with. But they’re not required to tell us everything. We may not find out about all the things they’re dealing with. We may think that they’re dealing with x, y or z, but we can’t make them talk to us about it. We try to be very respectful about what they bring to the table, what they want to share with us, what they want to work on with us, and what they want to keep private.

We have one-on-one meetings, work on building a relationship and helping them feel comfortable and safe with us. There’s tactful ways of bringing things up or asking questions. We really try to be respectful. There are some things that they may not want to share. Our advocate only works with them on the things they want to work on with her, the things they ask her for support or information on.

(#08) Our transitional clients are welcome to attend the group sessions at our shelter and the sessions on financial planning or housing, or budgeting. Sometimes we’ll get two or three clients who are there every time there’s a group that is open. And then there are other clients that once they’re in transition, they’ll do what they need to do to stay eligible, but not a lot of other things. They have that choice and we respect it.

(#09) We may have really great ideas about what the women should do, and it just may not work. We have to start with where they are; what's practical to them; what they're focused on ... and move from there. We can make suggestions and express concerns, but ultimately we need to respect where they're coming from.

(#10) We've asked for advice from our TA provider about what to do when participants don't seem interested in participating in our programming, and they told us that what we may be prioritizing isn’t a priority for them. We just have to be supportive and understand that participants may not be progressing at the pace we feel they could be, and accept the possibility that they may have to go to a shelter again -- even if it's just because they didn't take advantage of the wrap-around services we provided, including literally printing out applications, and offering to help complete and provide the stamps to mail those applications.

(#11) We don’t require anybody to participate in services. The bare bones requirement is that participants are in contact with me once a month. Even if someone falls through the cracks, I'll send them a letter and more often than not, they’ll get in contact. If somebody did not want to participate in services, we wouldn’t encourage them to do it until they were ready. It’s been our experience that they will when they’re ready.

We haven’t had anybody in our program in the last two and a half years that’s refused to participate in services other than if they were planning on leaving, but not telling us. When we say services, we mean us helping them do something they need. I haven’t had any experience of anyone saying no. It hasn’t been our experience, but if someone did enter the program and just wanted the subsidy, we would ask them to check in with the case manager once a month as required in the agreement they sign when they come in and that would be it. We wouldn’t be in their face asking them to do more. That’s been the story for a few people: I hear from them once a month, they’re doing well, and I respect that. And that’s how we’re supposed to do it. Sometimes it’s just about housing and that’s the point of the program.

(#12) I’m one of those reality therapy-type people. I will remind myself and them that while this is your life, and it’s completely your decision, with this decision comes limited options. And with this other decision, maybe not-so-limited options. But that’s probably something I need some additional training in, because it’s a little hard for me. I believe in cause and effect. And I think that all I can do is remind them that they know what’s best for them. And when they’re ready to make a different decision, they will. It’s their life. Their time
in the program is limited, and I’m just here to support what they feel they need to do and work on, regardless of if I think something different. At the end of the day, it’s their choice. What I think may be a simple thing may be huge to them. And so I have to respect where they feel they want to go.

(#13) We don’t ask very much. There are no rules. It’s all voluntary services. There are no leases in their name. We hold no keys to the units. We provide low-key case management if they would like it. We do have to stay in contact with them, as far as “How are things going? Are you achieving your goals?” but they do not have to have active case management. Most of them like case management because they like the support and the resources we can connect them with. We haven’t had anybody refuse it.

Sometimes they just need housing. They’re self-sufficient, they’re doing their own goals, they don’t need anything. We check in, “How are things going?” but all they really needed was that housing stability. That’s okay with us. Sometimes they receive their support from their community. Whatever works for them.

(#14) I think that using a voluntary services model requires a different thought process and a really a different way of looking at things. I think patience is required from everyone. From the clients and from us as advocates. Humility and patience -- you can never have enough of either, I think.

(#15) When you have experienced trauma, you’re not going to come in and all of a sudden be ready to sit down and make a list of goals. It’s just not going to happen. You need some time to deal with the traumatic experience; I think that’s been the case with many of the women. When they’ve worked through those issues, then they come. It’s like okay, I’ve got to do this for me. One lady said I’ve got to do it for my kids, and so I think it’s just a matter of giving them the time they need to work through the trauma.

(#16) Not everybody will take advantage of the services available. When we started the transitional housing program, it was kind of frustrating to see people not take advantage of services, and use up their time on TANF financial assistance. I came to see that it really is a housing first model. If people can have their safety in hand and have a place to live, then after a little while, they’ll start realizing that they want a little more and they can do a little more. And maybe they don’t need as much of the coping mechanisms of substances, maybe it’s not in their best interest. And they’ll start to want something else. Not everybody does that. We’ve occasionally had someone who’s been arrested for crimes and they end up in jail and lose their housing at that point. But it has been interesting to have the perspective of several years doing this.

(#17) We see that a lot, that people are kind of in and out. We talk to them about what’s going on, how they’re doing, do things feel stable, are there things we can do to help, do you know about these resources. If things are good and they don’t need help, I totally respect that; just know I’m here when you’re ready.

I feel like people can be pretty honest with us about what’s going on. Because there’s really no rules that could make our services stop. If they are in a new relationship, if it’s not going very well, we can talk about it. When there were a lot of rules about those kinds of things, people were afraid they would lose their housing if they talked to us, and since they couldn’t talk to us about it, they would drift away. I think now that we can have those really open communications, I think just being really transparent, keeps people engaged. They’re grown up people, and we trust them to make the choices, and we’re just here to provide ideas or experiences. I think people appreciate that and they stay more connected because of it.
At a recent dinner meeting for current participants and program alumni, we did an exercise about dreaming and what you want out of life and what it would take to get that. One of the program graduates in attendance -- someone who had completed the program two or three years ago -- became angry and said, "I don’t think you should be asking us to do this. I deal with flashbacks every day. I have no time to be dreaming about what it is that I want in life. I’m barely managing." When she first came into our program, this woman was a go-getter; she had everything done. She was working as a CNA, she had her kids in school, she found housing quickly, she had furnishings; she was focused. She knew everything she wanted. But maybe she hadn’t adequately dealt with the abuse in her life, and the trauma caught up to her. I don’t know the answer. Different women’s lives unfold differently, and the question about finding the balance between focusing on healing from the trauma and focusing on economic empowerment needs to be explored more.

I think you start where a woman is at, and so some of the women that we work with in transitional housing are very clearly struggling with the effects of the trauma, and it takes ongoing assessment to figure out what their barriers are, what supports they need, and how their needs are going to be met. You can only provide transitional housing for 24 months. There’s only so many places you can get subsidized housing. There are always boundaries and limits, but as much as we can, we try to start with the survivor. It’s got to come from her. Of course that changes over time and it’s about continuing to do those assessments and work with her and help her figure out where she’s at and what she and the children need.

If clients don’t appear to be engaged, we try to talk about ways that we could be helpful to them, if the family needs food and clothing, if there are services we could help them connect to in the community that they might find helpful. There have been clients who weren’t ready for case management; one client simply told us that he was, "too overwhelmed" to participate in case management, so we took advantage of a different funding stream that would allow him to stay in his apartment, where he and his children felt safe already. We don’t want case management or our other services to be a hindrance to the family. We want it to be supportive and helpful to the family.

Some people feel that meeting with a case manager on a regular basis is a burden -- almost like checking in with a probation officer, even though it’s a voluntary service. Meeting with us is one other thing they have to do to maintain their housing. A lot of them have been through the system before. They’re used to being required to regularly check in with state agencies and to jump through other hoops to maintain their benefits. It’s not that the relationship isn’t there or that they don’t know that they could contact us for help, it’s that they want their freedom, I think. Even though we try to be a partner, I think we’re still kind of viewed as "The Man," so to speak -- the provider of their housing that they have to appease, just like they have to pay rent. We’re just another system, regardless of what we try to do to maintain a better relationship.

(Not a current OVW grantee) At first I was very resistant to the voluntary services model. When I started here, it was pretty rigid, we had rules and guidelines, there was always a process, we had all these agreements and contracts with clients, and all these consequences when things went sour. We’ve really come to the other side of that. We got into a place of trauma-informed care, a reduced rules environment, and it really has changed how I think about our interactions with clients. Our clients need housing and a lot of times they can’t do anything else until they have safe and stable housing. So, I guess the longer I’ve been around, the more on-board I am with the voluntary services, and for the most part, the clients are fine: they want the assistance, they want to have somebody in their life that’s supporting them, that’s positive, that can help them financially if they need it. Every once in a while you’ll have a client that doesn’t want to see you for case
management. And we've had to say, okay, they need us for housing; and as long as they're maintaining their unit, it's fine.

(#22) One of the most important things we can do for survivors is to give them back their decision-making, which is something that gets taken away from them when they are in an abusive situation -- until they muster the courage to risk homelessness and leave. So the voluntary services model is really important to us.

(#23) To be honest, I was probably a little resistant to the voluntary services model when they made those changes. It was a challenge for our staff and the participants, when participants weren’t making certain meetings, they weren’t going to our support groups; we had a lot of things required. We don’t require participation in the case management component, but we highly encourage it, and we talk about how it has helped other women that have been in the program, and try to engage in that right away.

But I think the Voluntary Services actually is a good thing. Although we might want to require some case management, I think that women know what they need, and we need to let them guide us, so I think it’s been a good thing. Before, if they weren’t making meetings or were sending out letters or they weren’t in compliance and it just became a whole nightmare, so I do support the Voluntary Service piece. It’s not perfect all the time and I think there are individuals that could benefit from additional services, but again, they’re adults, and we just have to trust that they really do know what they need and want.

I think that the key is trying to build those relationships and when you do build those relationships and do provide that support, my feeling is that they’re more willing to check in with you on a regular basis and I just think that’s a key component to getting people really involved with the case management aspect.

(#24) If people aren’t interested in your service, and really don’t want to participate, we have to be comfortable with that being okay, because if they’re dependent on themselves, isn’t that what they’re supposed to be? We want to empower them to not need us. That’s our job. I don’t get wishy-washy if someone doesn’t want our services. I say we did what we were supposed to do. And then if they fall off, and they don’t do well, that’s when we get back reengaged. Before we exit someone from our case management services, we ask, "Are you ready to not have services? It’s perfectly fine, but are you ready? Are you able to pay your rent, are you able to get to your counseling appointments on your own? Are you able to stay sober?" And if they answer "yes" to a lot of those questions, and it’s a mutual decision, then, "Great we’re proud of you. Let us know if you need us again." And that’s where we want to be anyway. Not to have them dependent on us.

(#25) We never really know whether a person we enroll in our transitional housing program will do well in a voluntary services environment. We want them to participate, but it’s voluntary. So we offer the life skills training, we have case management services, and we do everything we possibly can to help the survivors to set goals and succeed in meeting them. Our staff sits down with them in the beginning and lays out some expectations and they lay out their own expectations and the goals they want to work on.

If they don’t show up to appointments, they don’t come to life skills, certainly staff reaches out to them, and asks, "Is there anything we can help you with? What is it? Is it transportation? Is it childcare?" We have childcare workers, we can help with transportation. And if they don’t participate, they don’t participate. We have a philosophy that safe housing is important for them and if that’s what we can do for them, then that’s what we do. We’d like to do a lot more, but if they choose not to participate, then they choose not to participate. But we strongly encourage them. We try to sit down and talk to her, encourage her, support her, and help her to remember that she is better than her abuser’s demeaning words. We try to get her to agree
to attend one counseling session. But whatever decision she makes, we remind her that, "we’re here to support you and your family no matter what." We know all about the cycle of violence. We know how many times it takes a person to leave. We’ll be there every single time for her.

(#26) If somebody doesn’t seem motivated, can’t really identify particular goals, or invest a lot of energy in following her work plan, there’s usually a reason, and that’s often a symptom of PTSD and they’re working on their mental health. All we can do at that point is support them and try to help them move forward, but as long as folks are following the rules that are set forth that are usually landlord/tenant rules that you would find in a normal lease and doing what they need to do, they’re good to go.

(#27) What you offer, if it’s good and it’s valuable, people will use it. And if they don’t, then they either don’t want or need it, and you take that at face value. If at the end of the two years, a person has done nothing, then they’ve done nothing, and they’ll deal with that, and you continue to offer the services that you would offer through your domestic violence program – support groups, other kinds of services, but you’re not going to control people’s lives. You’re going to assume that they will do what they need to do.

For over a decade, our programs have adhered to two important principles: they won’t control participants through rules, and they will not force services on participants; they will offer a menu of services, but if participants don’t engage in those services -- if they don’t participate in groups or counseling or case management -- they either don’t want or didn't need them. Our goal is to give the survivors who come into this program a safe space and freedom to figure out where they want to go for the rest of their life, and how they’re going to deal with the issues they need to deal with. And if they don’t partake in services but they're safe at the end of two years, and they had that space to think through their options, then we did our job. If, at the end of two years, a participant doesn’t have any place to go and she hasn’t got any additional skillsets that make her marketable or whatever and now she has to move in with her sister, we still met our end of things. She was safe for those two years and she had the space, time, and access to resources if they were helpful to her. And if she deemed they weren’t, that was her choice, her decision. Let her make her own choices and decisions. They may not be decisions that we agree with, but that’s not the point. If in the end, those decisions weren’t good ones, she’ll have to deal with that. These women are in our programs because they’re victims of a crime, so why would we want to take over and control their lives and assume that just because they have been victimized by someone that they’re not smart or stable enough to be able to move on with their lives in a perfectly productive way with a little bit of assistance.

(#28) We try to approach each survivor in a very individualized way which takes their needs and circumstances -- trauma, PTSD, depression, other barriers -- into consideration in sitting down with her and finding out what she wants to do – what kind of a plan she wants to make. We use a voluntary service model: if she wants services, we can connect her; and if she doesn’t want services, then no services; rental assistance never depends upon the level of participant engagement. We try to help her identify what would really be helpful to her, and then there’s a pretty high engagement in those activities. Some folks really don’t want to have very much engagement with us, and then our task is to be very clear about what our program can do and how long we can help: we talk about the rent assistance being time limited and how we try to base that assistance on client circumstances and their plan. And we continue to touch base about that during the time that we’re working with the participant -- or not working with her, as the case may be.

The majority of folks do want services and do want our help getting connected with resources that will help them get on their way. We strive to have some meaningful engagement with survivors so that we are touching base on some kind of regular basis, if the survivors elects. Our home visits are usually a time when they can give us their latest utility bill to be paid, and can tell us what’s been going, what they need, etc.
We’ve found that with this voluntary services model, people talk to us about things because we haven’t been pestering them with questions. We’ve had that experience more than once.

One time that comes to mind is a woman who was thinking about letting her abuser back into her life, who opened up about that with her advocate, about how she needed help with her kids, and how being a single parent was really hard. Another person, after several months of working with her advocate, disclosed that she was smoking pot every day and wanted to get some help with that. By not asking a bunch of questions about whether she was clean and sober, for example, it allowed her to open up. So the voluntary services model pays off in terms of having more meaningful and genuine engagements in most situations. That’s not true with everybody; some folks are evasive with any kind of social service-looking person because they’ve felt preyed upon by social services for a long time, and they’re closed up and don’t want to participate.

I was on a panel one time focusing on the voluntary services model and how important it is for domestic violence survivors, and somebody came up after the session and said, “You know, this kind of approach would just be better for people in general,” and I said, “Yes.” I also heard some detractors talk about how important the carrot and stick approach is, and how we need to hold out that they can get this once they’ve done that, because it creates incentive. I think that kind of thinking really needs to be shaken up; it’s pretty institutionalized to treat people that way, and it’s wrong. We’re glad to see "voluntary services" language in some of the guidance that’s coming out through the National Alliance to End Homelessness on the core components of rapid rehousing, and we hope there will be more of a shift in that direction.

Questions to Consider

1. Different providers interpret voluntary services differently. Some providers rely on participants to take the lead in asking for information or assistance; other providers take a more assertive posture in informing participants about resources and offering assistance. Some providers check-in regularly to see how things are going for the survivor, and provide frequent encouragement; other providers initiate contact much less frequently, seeking to avoid excessive dependence on providers.
   - In the absence of a one-size-fits-all approach, how should providers determine the appropriate level of involvement and initiation of contact?
   - Survivors face new and unexpected challenges and stresses on a regular basis, and their energy level and emotional state are likely to vary from time to time. How can staff know when to increase their level of involvement and when to tone it down?
   - How can staff know whether they are being too assertive, or not assertive enough, in their outreach to participants who are largely private or non-responsive?

2. Different programs have different strengths, take different approaches, emphasize different aspects of healing and transition, and have staff with different areas of specialization. On one hand, voluntary services means that survivors don’t have to participate in programming that doesn’t feel relevant to their needs and priorities. But, for example, if a program is oriented around economic empowerment, and has staff that specialize in related areas (e.g., helping participants find training opportunities, helping them do a job search, etc.), what does that mean for a participant who isn’t interested and ready to work on those issues, given their other priorities and concerns?
   - Is it appropriate for a program to base enrollment decisions on considerations of the compatibility between survivor priorities and the focus and strengths of the program? What if there are no other nearby TH programs?

3. Are different kinds of services and support more relevant to participants living in temporary housing versus participants transitioning-in-place in an apartment and community they hope will become their permanent home?

4. When is it appropriate and when is it inappropriate for staff to share with a participant an opinion or concern about the participant’s proposed course of action?
   - Do participants perceive a lack of candor when staff withhold their opinions or concerns?
• Do participants make assumptions about how staff are feeling, if staff don't reveal their thoughts?
• Does failure to share an opinion or concern harm a trusting relationship?

5. Given the inherent imbalance of power between provider and participant, how can staff share relevant information or an opinion or concern -- assuming the participant expresses an interest in hearing what staff is thinking -- in a way that does not unduly influence the participant's decision making process?

6. One provider described their adherence to the Paulo Freire approach to education, which they described as taking a teacher/learner, learner/teacher approach, so that every time they interact with participants, they're also learning from them about their experiences and their life. They contrasted that approach to what Freire called the "banking style" of education, "which approaches people with an attitude and energy that says 'I know what's best for you,' or 'You need to know what I know' or 'if they only knew what we had to offer, how useful it is, they would take advantage of it, so we'll really push them to try.' Those are setups that don't move people. We just don't do that."

• Given the inevitable power differential between staff and participants, how can providers offer information, suggest resources that may be of interest, and proffer opinions in a way that allows participants to make their own choices, without feeling judgment or pressure to choose the path or the alternative that the provider appears to favor?

(vii) Comments about the Importance of Persistent Outreach, Support, and Validation, Especially When a Survivor Seems Stuck

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

(#01) We try to make sure there's regular contact and communication with the family. Not to say we know everything that they're doing. However, we're very attentive to where they're at while they're with us. We work on developing a case plan with the moms and kids; we even do a case plan with the youngest kids, but we do it with the moms. We ask them, "what are some things you'd like to work on with your child while you're in our program?"

And we revisit that case plan at least quarterly, so that we don't get to, "You're at 10 months and you haven't done X, Y, Z." Instead, we've been having the conversation from the beginning. Developing the case plan with the goals for housing, employment, childcare, personal wellness, emotional wellness, all of that. And throughout their stay, tracking and working with them on various aspects of their case. And we try to use the case plan to highlight what they've achieved.

Sometimes, a survivor sets a goal and then maybe a couple months later, they realize that it wasn't really attainable in the short term, and they decide to change it. We never delete anything on the case plan. We just strike through it so they can see they made that choice. Because a lot of them may not have had that opportunity, in the abusive relationship, to make the choice to change their mind.

(#02) We make every effort we can think of. Mostly it's just reaching out over and over again. Our advocates contact participants, even if they're not responsive, to give them opportunities to connect. It's being very available, very accessible, and providing things that they want, incentives to be in contact, like donations or gift cards if we can. But it's hard.

(#03) We have strong case managers who try to help the survivor figure out what's going on, and why they may not feel as motivated. Is there a medical problem? Does she have PTSD or depression? Does she need to be hooked up to counseling? We ask, "What can we do to help you be successful?" And that's our approach to everything. The case managers in our transitional living program spend a lot of time with the survivors.
They’re in very close contact. They help women get to appointments. They help women get childcare. We’ve had two women in our program nominated for scholarships, and they won. We just try our very best to help women feel like they’re not isolated. A lot of times survivors are isolated. So we try to provide a lot of linkages to community resources. And we found that that’s very helpful.

(#04) The first thing is to ask them why they feel stuck or disconnected. Because it could be that they’re just in such a depressed mode that they can’t find the motivation, they don’t have the drive. If that’s the case, then you need to tap into some resources to assist them with that. We try to see it from the client’s perspective, “You’ve been here for four months, and here’s where we are as compared to where you were when you got first got here. You set some goals and they haven’t been worked on. Why do you feel that is?” If they say that they just haven’t been feeling up to it, ask them if they know why: “Tell me what that looks like, what that feels like for you.” You may have to pull in the counselor to do a further assessment. Maybe if this person is struggling with mental illness, if you can get them on the right treatment that can make all the difference in the world. It’s not a matter of saying, “shape up or ship out.”

(#05) If they’re not moving forward, you have to explore why – are they depressed, is there something else going on? Is there something else we can help with? You can be honest with someone and ask questions in such a way that you’re not being demanding or judgmental. You’re trying to assess the situation.

(#06) When people pull back or refuse our services, our case managers and clinicians are like a puppy dog that never leaves your side; it’ll stay until you reach down and pet it. They’re showing, "I’m going to be here." I supervise a clinician now who has a client that got into housing and just completely pulled back and isn’t following through, so we’re recognizing that she has trust issues. So the clinician is literally stopping by every morning and really putting herself out there, as if to say, “I’m not going to go away. I’m here, and one day you’re going to recognize that I’m not going away and you can turn around and trust me.” I don’t know if that comes from an empowerment place, but for me it’s more of an experience of commitment and consistency that some of our families and individuals have never experienced in their life. We use that approach to let them know, “It’s okay to engage with me. I’m not going to leave you.”

(#07) Participants may be motivated when they come in but three or four months into the program, they can fall off of the wagon. When services became voluntary, we questioned whether people would continue to come to meetings. Staff talked about how important it is for participants to understand that this is temporary housing. It will end. We have learned from experience that when we talk about it, people don’t really remember; they say, “You never said that.” So we started doing more visuals.

We know that people sometimes get depressed when they find themselves in the apartment at the beginning of the program. They don’t know anyone. They have their kids at home. They don’t have enough money. We know people are going to get depressed, so we talk about it before it happens, we normalize it, so that they will be more comfortable asking for help.

We developed goal progress forms that we use every three months with residents, and everything is very structured, so there is this zero to three months, overcoming barriers. That’s the first progress form we use. After three months, we say "this is what’s happened, and this is what you can anticipate in the next three months." We have case management once a week, to help keep them on track. We have a great case manager, who developed a report card-type of document -- a weekly log that addresses housing, employment, childcare, transportation, and the services that they need.

We follow up weekly, make sure that they’re following up with their appointments, making sure that they
have copies of applications that have gone to housing. We want copies of everything that they’ve done for the week and then we follow up with them and with their resources and their landlords—it’s a weekly report that they turn into us the day we meet with them, which gets shared with the executive director.

(08) We try to consistently reiterate the importance of case management. We ask in the interview if they’re willing and ready to commit to a self-sufficiency program and to work towards that goal. That helps to establish their commitment before they enter the program. But we are also on top of them, leaving messages, encouraging them to come in, and letting them know we’re a resource we hope they’ll take advantage of.

(09) We do monthly check-ins. That’s where the advocate just calls, sometimes it’s a message, sometimes it’s a note on the door, sometimes they might drop off a small gift that says “Thinking about you. I would love to hear from you.” If there’s a client who is not utilizing services or engaging with us, we check in just to say, “We haven’t heard from you. We wanted to see how you are doing. Is everything okay? Is there anything I can help you with?” Just to let them know that we care.

(10) Recently, we served a woman who was really struggling with substance abuse—especially alcohol. She worked nights and came in very drunk after work. She wasn’t doing much to secure safe housing and her time was running out. I decided to have a conversation with her because it wasn’t working out with her case manager. When she came to my office, she said she was feeling very lonely, that all the trauma and all the things she went through made her drink, that she really needed a drink after work but she overdid it. So, instead of discussing the alcohol, instead of discussing “You might benefit from a substance abuse program,” I had a long chat about her situation. I never mentioned alcohol in my feedback. She was the one talking about her alcohol problem.

Then I slowly shifted the conversation to talk about why it was important to secure housing and not to go into a homeless shelter because, at that point, she couldn’t stay at a DV shelter and if she went to a homeless shelter, she was at risk of being exited quickly and maybe sent back to the city, and she didn’t want to go there because her abuser was there. At the end of the conversation, she said to me “this was insightful and I’m going to do something to secure a place but things are so expensive.” I said that with the assistance of the THP, we could work on finding a place that was more suitable. She was like "This is great. Sounds like a great plan. I think I can go to a room, maybe, (because she was single) and then go to a studio or a one-bedroom apartment down the road during the time I’ll be with the program and receiving rental subsidies and then I will maybe sign up for the substance abuse program with your agency.” I told her “That’s great. It’s a great program, this is what they do....”

So at the end of the chat, we talked about her issues and where she was coming from. Without being judgmental, without trying to put pressure. That kind of interaction is key, in addition to just being available to speak with them—even if that means staying late after a long workday.

(11) One participant was stuck—it just took the case manager being persistent to get her to meet. And when they finally met, she asked her, “What’s going on?” and the participant said she was depressed. We linked her to mental health services and asked if she would be willing for us to speak with a mental health professional. We maintain relationships with them so we can track client progress and support them. She wanted us to go to a few of her appointments. We went through those steps with her to get her out of that depression. And then we went back to focus on her getting a job. And as she got out of her depression, and went back to school, and she ended up graduating. And it really just took the case manager going off the path of, “You need to find employment,” and meeting the participant where she was at. She was depressed. She needed that
extra support, mental health services to get her to a better place, and then focusing on the job and savings and things like that once she got her mental health under control. We want to be supportive, but we also don’t want them to rely on us. And that can be a tricky balance. And there’s times when things like that happen, where we’re typically only meeting once or twice a month with them. And it’s easy to say, “They’re just not engaged in the program.” And that’s when we up our engagement and meet two to three times a week if necessary. It becomes a lot of work, but that’s what we try to do.

(#12) How do we respond if they’re not meeting their goals and not finding the housing by the limit? We just keep going over their goals with them and encouraging them. Try to determine if there are other barriers that they’re encountering, like trauma that they’re not dealing with, or drug and alcohol issues, or mental health issues and try to find them help, if there are.

(#13) I think the first thing that we do is increase our contact with the client, if we see that somebody is floundering, seems a little lost, is not finding a job or not applying for jobs ... We increase our contact with them, because the worst thing you can do is pull back, because that person is going to sink.

We try to identify the barriers. Is it childcare, substance abuse, mental health, or something else keeping this person from taking that next step? That can sometimes feel like pulling teeth ... because some clients have a lot of fear of things being taken away from them, having been penalized or punished by an abuser.

(#14) The most prominent issues we see are low self-esteem, low motivation, depression... which can be an obstacle to gaining housing or employment. A successful search takes self-motivation, and the client has to take some initiative. Some of the ways we might be able to help are: laying down clear instructions; having frequent communication; developing a short-term plan with each of the steps they need to take to accomplish their goal; and then following-up with them -- Did you call the phone numbers I gave you? Did you go in person to see the apartment? Did you follow-up with the landlord? Just guiding them through the process and motivating them and also celebrating when they’ve accomplished each step of the plan.

(#15) Our program targets people who face challenges above and beyond the domestic violence and homelessness that make them eligible for our assistance - things like substance abuse, mental health issues, trauma, employment barriers. When they come to us, they may not feel ready to work on all those things. Our case managers/advocates are constantly talking about that in a trauma-informed care way: "I care about you; how far into the future can you look, given where you’re at right now?" We discuss it in our monthly meetings with them: "Are you able to even talk about these issues right now, or are you in a place where you need more space to heal, without focusing on looking for a job or trying to figure out how to maintain your housing, once our subsidy ends?" "What can I do to help you heal?" But we also talk about how, "the clock is ticking on your rent subsidy; what do you want to do?" It’s a proactive conversation that we’re having with people, so that it’s not like boom, it’s been a year and the rent subsidy is over. Being effective and ethical providers, we talk about how this is coming down the pipeline: "Here’s how we’ve worked with other people; are you in a place to do that? Do you want to table that, and talk about it again in three months?"

If a participant seems stuck, if they don’t seem to be taking steps to address employment, or if there seem to be more barriers than we anticipated, we start looking at community resources – what other resource can we pull in to try to help and support the client?

We understand how our program’s notion of success may be different from what the participant might be looking at -- and this is where you get into the grant world versus the real world, and how they don’t always match up. We’re still going to have the conversation, but part of it is preparing for the possibility that this
person may go back into homelessness, and that makes us sad, but it’s also a reality of our work. Of course, the smaller we can get that percentage, the better, but I think it’s always going to be there. But keeping that in mind, we’re going to be looking at community resources, having proactive conversations about the particular barriers, and trying to figure out how we can validate our participant's experience and get them connected to resources that are going to get them where they need to go.

So if they came into this program with substance abuse and mental health issues, we’ll look at which of those the person wants to work on first, and which comes next; of course it’s never that linear. And if the employment piece doesn’t happen, it doesn’t happen. We can’t force a round peg into a square hole.

(#16) If somebody is in the program is trying their best, but they're depressed, or suffering from PTSD, and they just can’t mobilize? That’s one of our greatest frustrations. The OVW grant program gives us flexibility to help in so many ways–counseling, job training, whatever these participants need–yet it almost feels like most of these participants aren’t even to a place where they can articulate what they need. We try to have ongoing conversations with them. Sometimes they drop off the grid until it’s time to pay the rent.

We’ve had many that were able to find employment, but not to maintain it -- for varying reasons - childcare, transportation. But often just because they’re capabilities; I don’t know if they’re not ready, or if they’ve just not ... I don’t want to say work ethic, per se ... but there is a piece of that, too, that they haven’t had steady employment in their lifetime. So they don’t quite grasp the fact that you can’t just not show up, or call in absent all the time. So that’s something I try to work with everyone about too. You have to care for yourself -- but maintaining that employment is pretty important, since there aren’t a lot of jobs available.

(#017) There’ve been times when a participant has kind of dropped off the map for a couple weeks and that wasn’t like them, and I might leave a note underneath their door, saying, "hi, how are you doing, haven't heard from you in a while, I hope you'll give me a call." Maybe they haven't been answering their phone, but when they’re ready, they usually communicate. They might have been assaulted again or they might have been in a new relationship that didn't go so well. It always ends up being okay and the conversation just means that they’re not necessarily in trouble. They're never in trouble with me.

I don't see those times as a personal thing towards me, or like they're lazy or they're not doing their job. I would think there’s definitely a reason why that’s not happening, so I tend to have a conversation about what’s going on. "Is there something that's preventing you from going to treatment? What can I do to make it easier for you?" I see these conversations as an opportunity to connect their trauma with the way life is going for them, so they're not seeing themselves as worthless or failures. "What you’re experiencing makes a lot of sense. This is a common effect of trauma -- feeling like you're tired and not very motivated. What should we try to do to address it?" So, just validating the reasons why they've been avoiding it, and eventually, if we can talk about that, they end up doing what they need to do. I think I do a good job of providing the space to talk about why things are not getting done without them feeling like they’re getting into trouble.

(#18) From day one you work hard at building a connection with the client, a positive rapport with the client, hopefully some trust, and you get to know the person, find out what’s holding them back, what their fears are. Sometimes it may be “I’m really intimidated by going down to the Housing Authority. My last experience was really terrible.” And they’re still holding onto that. So I can offer, “I’ll go down there with you. I’ll sit with you and make that phone call with you and help you do the application.”

From my experience, when people are stuck it’s often for a reason -- usually fear or a previous negative experience. I try to connect with my client to find out what they need and, if they can’t move forward, what’s
holding them back. Let them know we understand and what can we do together to try to help: “You’re going to have hurdles. You’re going to feel stuck and if we can work together, we can get through this.” I think it’s really focusing on making it a team effort: “We’re working together in your journey. I’m not doing it for you. You’re not doing it by yourself; but I’m here for you.”

So far, that has worked really well. I am currently working with a client who is stuck and has a lot of fear and trust issues with the government and it’s a process and I work, very methodically, and really listen to what she’s saying, observing her body language, knowing when to back off, knowing when to push a little bit more, knowing when to say “I can hold your hand.” Progress is coming later than we might have hoped, but progress is happening. This person is at the end of their program stay, but they are finally ready and empowered and able to verbalize their fears and concerns and they’re a different person than when they came in on day one.

(#19) We work with quite a few women that don’t have any income when they start the program, but our goal is that by the six month mark, they’re enrolled in some type of vocational training or have a part time job. That six month mark is more of a guideline than a requirement. We recognize that it’s not going to work for everybody. If someone is depressed or traumatized from the abusive situation, we just try to work through those and other barriers. It’s all about the relationship and having those conversations. I work one-on-one with all the women in the program, and throughout their stay we’re addressing the mental health needs. But things come up, and the participants really guide us by asking for referrals or resources. If we have concerns related to maintaining housing, we definitely have that conversation with them; I think we do a good job with that and they’re our guiding force. If they’re not completing the goals they set, we ask, “what’s getting in the way?” Maybe those aren’t the goals they want to be working on at this point. And with mental health, we’ll bring in the team players -- everybody that’s providing wraparound services for the family -- and meet on a fairly consistent basis so we have a better idea of what the participant’s goals are, what other case managers are assisting with, going back to square one if the participant has changed their goals and expectations.

(#20) First of all, our program advocate tries to notice any lack of engagement really early. She tries to notice that at six months rather than 18 months. The bottom line that we all understand is that the only thing that is non-negotiable is you have to get yourself some housing by this date. So if you choose not to do other things that would enrich your life, like take care of your trauma or improve your income or those sorts of things, that’s kind of up to you. The main thing is, you’ve got to make a choice to not be homeless by this date. The way she’ll try to work with that - and she’s usually pretty successful ... and remember we have a very small population -- is she’ll just go knock on your door and “What can we do today to make that happen?” and “How can I help you?” And if that means, “here are three houses that I saw advertised today, let’s get in the car right now. We’ll go get a cup of coffee and go look at them...” then that’s what she does. It’s a combination of that, just recognizing it before it’s a crisis. And then doing whatever needs to happen to help that person get housing. It’s doing whatever needs to be done.

Our advocate also finds that she has good success meeting with her transitional housing residents on Saturdays. She’s got her schedule crafted so she’s really the only staff-person at the office on Saturday. She often checks in, “Hey, do you guys need anything before I leave?” and if they need milk, she gets it.

(#21) We use an assertive community treatment approach -- meeting clients where they’re at, encouraging them to participate in services, and making the services so worthwhile to them that they want to participate. Assertive community treatment, whether in our rapid rehousing program or our OVW scattered-site program,
is the best way to work with people with serious mental health issues or problems with alcohol.\footnote{Assertive Community Treatment (ACT) is a heavily researched evidence-based practice (EBP) to improve outcomes for people with severe mental illness who are most at-risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system. ACT involves the use of a multidisciplinary team approach, assertive outreach in the community, and consistent, caring, person-centered relationships with participants. People receiving ACT services tend to utilize fewer intensive, high-cost services such as emergency department visits, psychiatric crisis services, and psychiatric hospitalization. They also experience more independent living and higher rates of treatment retention. For more information, visit the Assertive Community Treatment page of the Center for Evidence Based Practices (the source of information for this summary) or the Assertive Community Treatment page of the SAMHSA "Store." The description of this provider's approach as "Assertive Community Treatment" may have been intended to more generally describe their case management approach, rather than to imply fidelity to the standards of care associated with this EBP.}

Being that our clients have been severely traumatized from domestic violence, a lot of times they do have those issues.

In our state-funded program — and we make sure they know this at the beginning – we require participants to meet face-to-face one time per month. And I explain it in a very open way: “we can sit down, you can let me know what’s going on, you can let me know you don’t want any services, but we have to see each other at least once a month in a mutually-agreed upon time and place,” so that there is that minimum level of program participation. As far as informed consent, by joining the program, they are choosing to meet at least once per month in that way. What we do is voluntary; meeting more often is often needed, but it’s as often as the client desires it. I’ve found that the real key to engagement at the beginning is, stuff that’s often mentioned all the time for case management: keep your word; don’t make promises you can’t keep. Once we provide a service they find useful, it can make a huge difference, and then they’re engaged - it can be as simple as helping them call and advocate to get back into their psychiatrist’s office, if they were dropped because they missed several appointments, or because their abuser show up.

Once we’ve provided real assistance, it becomes a lot easier to have a regular, ongoing relationship with them where I reach out on a regular basis. I don’t expect them to contact me. About biweekly, I contact everyone, at least a text, and I try to have meetings based on their needs and their desires to meet. It really comes down to that relationship and providing services that they need and want, and that they find helpful.

### Questions to Consider

1. When does persistent encouragement by staff, however well-intentioned, cross the line and become harassment?
2. People join programs like Alcoholics Anonymous (AA) and Weight Watchers to add a level of external accountability to a goal that they believe they may not be able to reach on their own. People with money hire coaches who can provide assertive encouragement for exercising, conducting a job search, practicing a musical instrument, finishing a project, etc.

   - Is that kind of persistent "support" within the bounds of voluntary services, as long as it is something a participant has requested and consented to, and has the opportunity to discontinue and withdraw their consent for, without jeopardizing their housing, housing assistance, or services?
   - Can program staff provide that kind of "support," or does it have to come from someone not directly connected with the program, in order to avoid any questions about the voluntary nature of consent to receive such support?

### Comments about Requiring Periodic Check-Ins and Setting Clear Expectations to Sustain Engagement

**Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.**
Note: Some of the comments that follow describe policies and practices that fall into a grey area. For example, when does a required case management "check-in" cross the line and become a mandate to participate in services? When does an "expectation" become a requirement, which, if violated, could result in reduction or termination of assistance, in contradiction to the voluntary services principle?

It is hoped that the inclusion of these comments and the questions they raise will encourage useful dialogue about program- and systems-level strategies that can help programs manage competing pressures to, on the one hand, demonstrate positive outcomes, and on the other hand, support survivors in working at their own pace to meet their individually defined needs.

(#01) One of the things we do to try to create a sense of competence or confidence in our participants is we make the check out to the landlord, but we give it to the client to deliver. What we’re trying to do -- which seems to work pretty well -- is develop a relationship between the client and the landlord, and take us out as the person who’s paying your rent. There’s something very empowering for clients who have either had the abuser pay the rent or who have never paid the rent themselves, to be able to get that check and take it along with their own portion of the rent and feel, “This is my house and I’m responsible for it.”

The other piece of that is that we don’t require that you meet with the service coordinator. You have to come pick up the check once a month, so that’s one opportunity for the client to meet with the service coordinator. The other opportunity is a home visit. We go out into the home and then the client wants to bring us into their home. They want to show us where they’re living. If we have gifts that we can bring, curtains, table cloth, something that’s a housewarming, it helps them to feel good in their surroundings. It’s also an opportunity for us to see kind of how someone’s living. Again, it’s voluntary. But most of them have that good rapport, that good engagement. So, they’re willing to, through the course of the payments, keep them engaged because they want the money. But over that time they see that the service coordinator is a very helpful individual who can help them problem solve some of these things that seem overwhelming when you have such little emotional reserves.

(#02) While we can’t mandate participation in services, there are obvious expectations that we have that we think will be best for them. And we make sure that they’re very aware of the expectations, and how often the case manager will be checking in, and what we need to do, and that we don’t want to just pay for their rent.

(#03) Our OVW transitional program consists of 11 scattered-sites. We fully subsidize rental costs; however, we ask the client, if it’s possible, that she save 30% of her adjusted gross income, so that at the end of the year or the two years, she’s able to be self-sufficient and maintain that apartment or move somewhere else permanently. The rental assistance continues for the duration of program. At six months we ask that they apply for an extension, and then we look at goals and how much they’ve saved, if they’ve addressed barriers, etc., so every six months they can apply for an extension up to two years. Even though services are voluntary, the case manager / advocate will check in with the client and they’re priority is always discussing housing options. Are you seeking housing options? Do you need any other housing or other resources?

Most of our clients in our OVW program are accessing case management services; in fact, we don’t have any client now that doesn’t. I believe that when women are given the opportunity to really be self-sufficient and they’re given choices and they don’t have to worry about rent and they’re able to save money and address barriers, that they’re more apt to do that. Both in our emergency shelter and transitional, all services are voluntary. We just find that it makes life a lot easier for the advocate and it empowers the client.
Our case plans have built-in action steps and timeframes. We request that within their first 30 days, they apply for public housing as a backup plan. And within the first 90 days, they're looking for work, is kind of a guideline that we use. Rebuilding credit and dealing with credit issues would be an ongoing thing. We provide ongoing housing counseling, ongoing money management. So if you’re looking at a nine month stay, the first three months tend to be helping the family out of crisis and getting services that they need lined up. The next three-months is them learning to maintain, because they’re not used to things being functional and going like they’re supposed to, and they have to learn again that this is the way we do things and this is what makes us successful. And the last three months is usually the time we deal with transition plans into permanent housing.

We do three-month leases, so we don’t have to do the paperwork every single month. We have a short, two-page application and a two-page income verification form that we ask folks to fill out for every lease renewal. And that way we get a check-in about where they are and make sure that we’re calculating rent correctly based on current income. We make sure with folks they’re paying their rent, following their lease agreement, and meeting tenancy-related requirements. They’re not required to use any other services. Our case managers handle the application and income verification process, so there’s usually at least that required check-in with the case manager, even if it’s just to turn in paperwork and schedule the lease signing. So they have some amount of contact with the case manager to process the paperwork and then meet with our resident services manager to actually get their rent recalculated and sign their lease.

We operate using the voluntary service model; but we have a monthly mandatory in-home meeting, as long as it’s safe and appropriate. At that time, the case manager/advocate asks about safety (for example, is the participant feeling safe in the apartment? Are the doors still locking? Are the windows locking?) And maintenance issues (for example, is the faucet working? Are the smoke detectors working? What things can we do to help maintain the housing without bothering the landlord? What issues require the landlord?).

In their agreement, participants have to check in with me at least one a month, and then they go on and live their lives, but it’s been more like once, twice, maybe three times a week talking with them and dropping by at their house, and they invite me to come and talk. I've just built a good relationship with them, and we operate from an empowerment philosophy and a feminist philosophy, and there's no judging. I think our training as advocates really provides a good base for them to feel like they can trust us – and to get the good support, not the judgmental support, so I haven’t had a problem with voluntary services. The expectation for at least monthly meetings is written in their welcome packet and their agreement (which was adapted from an NNEDV template) in a way that’s not threatening and they understand that, and they’ve always exceeded the minimum requirements for meeting with me. It reads:

"In order for us to provide the support that suits you as an individual we need to have a sense of how things are going, what is working and what isn’t. For this reason, we ask that you maintain regular contact with your Advocate. Within the first week of entering the program, you will meet with your Advocate to set up a mutually agreed upon schedule for keeping in touch. These should be at least monthly but can be as often as needed. You are also free to change the schedule as your needs change, by contacting your Advocate."

Not meeting with the Advocate is not listed as one of the grounds for possible termination. If somebody didn’t communicate with me, I would communicate with them about the importance of communication, and would ask them what’s going on and why it might not be happening. Sometimes the way I have that conversation
opens up more support. I hate to describe it as a punitive thing, like you’d have to leave if.... We've never had to exit anyone from the program, so I don't know what that would look like.

(#08) We talk with survivors as they're coming in, and they also can make decisions to change the services that they want to be participating in. We ask that we be able to meet with them on some kind of regular schedule, but that schedule is really set by the survivor, not by us. Sometimes when they first come into our clustered program, where the staff are right there in the building, they may want to meet with that staff every other day, then they may change and say once a week is fine or once every two weeks is fine, whatever it is.

I really agree with the voluntary services model. I don't think it's helpful to require, say, weekly case management meetings or a requirement that you attend a support group. Every survivor is different and they have different needs. As I said, we do ask that clients meet with us, but on a schedule that works for them. And I guess I've always been a little unclear about whether that is okay, or whether we're supposed to say they could come for transitional housing and not really meet with us at all, and is that okay?

(#09) There are a lot of rules around not requiring people to do certain things in order to participate in the program, which is great. But the one really important thing is that within the first two months or so, we have to start talking with them about applying for housing because there are long waiting lists. And because there's a shortage in our area of elderly subsidized housing, there are waiting lists to get into those properties. Once you get your name on a list, you might wait a year. So it’s important to get your name in soon enough, so you don’t end up at the end of your two years without any housing options. But other than that, we just explain that, “this is what we can do for you,” and let them tell us what they need help with.

(#10) The OVW-funded program uses a voluntary services model; we call and check in on them but the families we've had in the program are open to meeting. Even though they're in scattered-site apartments, we make sure that we meet with them regularly. It just so happens to work out that when people enroll in the program, they stay in town, where our agency is, probably because of the affordability of housing -- which makes for easier access between program staff and clients.

We have very few requirements. We do meet with the participant every three months, that’s one of the things that are required. If the person is not connected, you really don’t know a whole lot about what’s going on. That’s just a model that we use, client driven. I would say 95, if not 98%, of the time we’re having frequent contact with the clients and we’re really connected to what’s going on with them and the things they need – a lot of case management, a lot of follow-up. I personally try to use any and every opportunity to connect with the clients. It could be we have free movie tickets or “I learned about this assistance program,” or any resource that comes across my desk that I could use to connect with them, I use it and it works. Just focusing on trying to connect with that client and working together on a common goal.

(#11) Once a person is approved to be in the transitional housing program, we work directly with her landlord and we agree on a schedule each month, what our rental assistance is going to be. The participant comes in once a month for recertification and based on her needs and her individual situation, we determine what the assistance will be for that next month. It could be direct rental assistance, utility assistance, relocation assistance, or daycare -- a wide range depending on her individual circumstances.

Our monthly recertification meeting is just a way to connect with the survivor, to know what’s going on with her. Has anything changed? We want the ability to work with her and be a partner in her planning process. It
gives us an opportunity to encourage connection with services. And it’s a touching base point so we can make a transparent decision, so everybody is clear what the reimbursement and the support will be for next month.

We’ve been doing voluntary services for years – we’re very much an empowerment model. I think the keys to doing voluntary services successfully is how you frame your services, and giving survivors what they need -- offering meaningful services. More clients want to get these services than we have capacity for. If they have a positive experience with it and they know you’re doing it in a way that you’re trying to help them, and not check up on them, or take away their power, or take away their freedom, and you give them what they need, you won’t have any issue. If they stop coming, that’s okay; that’s their choice and we respect that. We tell them, "We’re here for you. You can always come back." I think it’s just how you frame your services.

Questions to Consider

1. What is the difference between a periodic "check-in" with staff versus a "case management" service?
   - What topics besides participant safety, which is an integral part of transitional housing, can check-ins address?
   - Can a provider require an in-person "check-in" (e.g., either a home visit, meeting in the community, or a visit by the survivor to the provider’s offices), or, must the check-in take place by phone, text, or email if the survivor prefers?
   - What turns a "check-in" into a case management session?

2. If a program requires participants to accrue savings or to make progress on some of their barriers to housing or employment, and makes continued access to housing assistance contingent upon demonstrating increased savings and/or progress with respect to identified barriers, is that different than requiring participation in services?
   - Does voluntary services apply only to the services offered by the provider or by community-based agencies to whom the provider refers participants?
   - If part of the periodic check-in process entails verification of such progress, does that constitute case management?

3. One provider talked about creating "case plans [with] built-in action steps and timeframes...." Their comments talks about a "request that within their first 30 days, they apply for public housing as a backup plan. And within the first 90 days, they’re looking for work, is kind of a guideline that we use....."
   - Are "built-in action steps and timeframes" and "guidelines" about when participants should be applying for housing or looking for work inherent contradictions to the voluntary services requirement, or can they be implemented within the voluntary services framework?
   - If they can be implemented within the voluntary services framework, how would that occur?
   - Could a participant’s continued access to transitional housing or program services be made dependent on their completing the specified action steps within the specified timeframes, or would those action steps and timeframe have to be entirely advisory, with only "natural consequences" resulting if the participant did not complete them?
   - Presumably, even if a survivor's continued access to transitional housing and services is not contingent on her taking specific actions steps within a specific timeframe, if a survivor feels obligated to agree to the those action steps and the specified timeframe, their participation isn’t truly voluntary. What kind of communication needs to occur between the provider and survivor in order for actions steps and timeframes to be informed by provider experience, without being imposed on the survivor? What are the benefits and drawbacks to that kind of communication? What if the participant has different ideas about their next steps?

(ix) Comments about Linking Continued Assistance to the Level of Effort and Demonstrated Progress

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

Note: As discussed in the preceding narrative, while VAWA and the OVW are clear that the offer of housing or housing assistance may not be made contingent on a survivor's participation in services, and
that refusal to participate in services should not be grounds for termination from the program nor eviction from program housing, there appear to be some grey areas pertaining to policies or practices that make continued access to housing or housing assistance contingent on "engagement" or "demonstrated progress," or that make the level of housing assistance contingent on such engagement or progress.

Some of the comments that follow describe policies and practices that fall into that grey area, and it is hoped that their inclusion in this report will encourage dialogue about program- and systems-level strategies that allow programs to better meet survivors' needs.

All the providers we interviewed are well-intentioned -- they want to help survivors succeed -- but many face more need than they feel they are resourced to address; face strong pressures from the CoCs, states, and jurisdictions that oversee their HUD grants to demonstrate positive housing outcomes with shorter lengths of stay, despite the daunting obstacles -- including increasingly difficult housing and employment markets -- that their participants face; often lack the kind of supplemental capacity -- clinical supervision, counseling, children's advocacy and services, employment counseling, legal support -- and staff diversity that better-funded, full-service providers might bring to bear; and operate in parts of the country where they cannot leverage the kinds of community-based resources that providers in service-rich areas rely upon to fill gaps in in-house capacity.

(01) They can apply to extend their case plan and stay in our transitional program for another month. But there needs to be something that they're working on. The program isn't just a place to lay their head for months on end. Our staff try to make it as easy as we can for participants: if they're working, we can meet during their lunch break, we can meet by phone. But if they're not having conversations with a case manager at all, then they're just here to sleep, and that's not going to help anybody.

(02) We normally start everyone off with a six month contract. If they're progressing towards goals, but have barriers, we have flexibility to increase to 7 or 8 months - whatever we need to do - in order for them to have what they need to pay their own bills and rent if they don't get the subsidized housing from another source. Most are in the program for less than a year.

(03) HUD criteria for extending housing assistance are stricter. In our OVW-funded program we have more flexibility. We base it on how they've been setting and achieving goals, and if special circumstances have arisen. We don't extend someone who's been sitting around. Hopefully we don't get to that point.

(04) Maybe a resident has just gotten the younger kids into daycare and is just working on getting that employment, and another six months would help them feel a little more stable and ready. Maybe a person is working on disability benefits, and they need more time to get that settled. Sometimes it's just really hard finding permanent housing, even if they're looking. The Housing Authority is open – if they know you’re on top of things, you’re looking, you’re really working toward finding an apartment, but just haven’t found a place, they’re open to extending your stay.

(05) Although they have up to 24 months, we don't say that up front; we say that every six months we're going to review where you are, and as long as you keep moving forward there is a limit of 24 months but that does not mean you get 24 months. When they first enter our housing program, two years might seem like a long period of time; but spending too much time at the beginning, concentrating on their victimization, leaves too little time to get them truly ready to be on their own. One of the significant challenges of a DV- or sexual
assault-focused housing program is finding the right balance for each participant. The 24 months could be a blessing and a curse at the same time. It gives the victims a sense of, "I thought through all this stuff and I’m here now, and I can just relax." But in reality, two years is too short a time to relax. They have to keep moving and as a compassionate person, you want to give them that time to relax and instead you need to be pushing.

(#06) If we see a client doing all she can without a lot of urging from our staff, then we will come alongside her and maybe not assess occupancy costs because we know that the money she would normally have been paying to us she can save and use towards her exit to permanent housing.

On the other hand, if staff feel that a client is not doing what she needs to do to find housing, we bring to bear some other motivational tools. We have one client now that is not very motivated. We have not been charging her for the rent. All of the programs and services have been free. We let her know that, in a few months, we’re going to make some changes, more or less mimicking real life, and she’ll have to begin to pay for some of her rent.

Now she knows that there’s a day coming where she can’t just ignore what we’re asking her to do. We put her into the mindset of “Okay, this is temporary, even though two years sounded like a long time, it’s not.” We’ve tried to give her a sense of what she’s going to have to contend with in the next year or so when she’s exited out of the program. Hopefully that will encourage her to participate. We don’t want program assistance to cause our clients to lose sight that they are still living in a real world situation, that they are still responsible for their housing needs, and they can’t just rely on the program to do that.

(#07) We have the option of not paying the rental subsidy if the client doesn’t participate. We explain that if someone is not in contact with us and doesn’t call back, we don’t know if the person is still in the housing unit, so we can’t order a check to pay the rent subsidy. So we tell them, “It is important that we at least talk and communicate. It is important that you let us know how you’re doing and if you’re still in your place.”

(#08) Overall, 12 months has been a good amount of time. If there are some participants who might need extra case management support, we can extend that. We do follow up for at least three months. But most of the time, once they hit that year, they’re pretty well off, and they feel like they can manage on their own. For the people who still struggle by the end of that year, I don’t know that extending assistance would be beneficial. I think that if you extend it another year, they would still probably be at the same spot. I think part of it is just their other struggles - poverty, lack of budget, maybe lack of full engagement in the program, lack of dealing with mental health issues, or other barriers that they haven’t figured out how to overcome.

(#09) Most people stay for a full year unless they transition into our HUD-funded permanent supportive housing program. At six months we ask that they apply for an extension and then we look at their progress towards their goals: how much they’ve saved, if they’ve addressed barriers, etc. So every six months they can apply for an extension up to two years. Participation in services is voluntary, but the advocate will check in with the client to see if she is making use of the services. But their priority is always discussing housing options. Are you seeking other housing options? Do you need other housing resources? Along with other resources they may need.

(#10) The maximum length of stay is two years. After they’ve been here nine months we start preparing them for the second year. At nine months they can apply for the second year. Basically it’s just a sit down to explain to us what they’ve accomplished during this first year, what they hope to accomplish in that second year, and
how they can serve as a mentor to other residents during their second year. We look at their program participation, adherence to policies, whether they've developed a good sense of community, no major drug or alcohol issues. In their second year, we're looking for them to be examples to the new residents, by maintaining consistent group participation, sharing their experience, following community chore policies, and getting consistent apartment checks.

(#11) Everyone starts off the program with a six month stay, and we try to get people in the mindset that they're receiving six months of assistance, because we want participants to work hard to get to a place where they can support themselves financially. If they continue to try hard and do everything in their power to improve their situation and they're still struggling, then we'll do a three-month extension. We tell them, "we'll help you three months longer," and we extend their stay for three-months at a time until both the participant and our agency feel they're in a place where they can support themselves. We haven't had anyone who needed the full 24 months.

(#12) We've been flexible. Some of the things we work on in transitional housing are repairing credit and building savings; and some of that just can't be done in six months. As long as they're working the program and working with us and doing their part, we're happy to extend them or keep them a little bit longer. In general, we just extend it to a year.

(#13) Nine months to a year is our internal guideline, but we wouldn’t discharge somebody at nine months or a year if they were working toward a goal and just needed some extra time. Let’s be honest. You do get those people that do just enough to be in compliance, but won’t do anything else. Those people we probably wouldn’t make an exception for, but someone who was truly working the program and just needed extra time, we would let them stay.

(#14) (Not a current OVW grantee) When someone comes in, we go over the program expectations; I don't think it says expectations, but that's how we treat what they're agreeing to do while they're in the program. I honestly can't think of anybody that quit working with us in our outreach counties recently; I think the advocates are really good about establishing rapport and building that relationship with the clients; they'll call and check-in during the week, they'll reach out to clients outside of their appointments if they need something or they want to update her on a court date or, "my abuser showed up and I'm not exactly sure what to do." She's really good at establishing those relationships. And if they start to miss appointments, if she doesn't hear from them, she reaches out to see what's going on. So, we really haven't had anybody recently that's gone away. I think it's her willingness to go beyond the "well, this person didn't show up so, screw it" approach. She really makes an effort to make sure that they're okay, and she comes from that place of, "I'm concerned about you, I'm checking in." It's not, "You didn't show up this week and that's not consistent with the program guidelines."

We're working towards having more formal 60, 90, and 120-day assessments: "You've been here for 60 days and these are all the wonderful things you've accomplished. And here are some things that we still need to work on." And if somebody's not doing X, Y, and Z, then that's the conversation that you have: "You've been in the program for 60 days, and we really haven't seen any progress towards the goals that you set when you came in. We either need to work together to come up with an agreement on how to keep you here for another 60 days, or maybe it's time for you to move on to another program." They're hard conversations sometimes when people aren't doing what they need to do. But, as long as you're informing clients about
their progress, they're able to rise to the occasion, most of the time. So, we try to make sure that clients are always aware of what their status is and what our expectations are.

(#15) (Not a current OVW grantee) A person might sign an agreement with us to stay here up to a year, and if they don’t do anything in that first year or don’t seem interested in accessing services, why would we want to renew an agreement for the second year, when somebody else is waiting for an opportunity to come in the program and that person actually does want to find a job and to learn a skill? On the flip side, if somebody can’t finish something in two years -- school or training, for example -- then in order to ensure that they complete it, we might give them longer term support. That's another benefit of not depending entirely on government funding; there's nothing magical about the 24 month time limit.

(#16) Participants don’t pay anything. They sign a contract providing a minimum of six months of assistance, and pending an evaluation of their situation, we can extend them for up to two more three-month time periods. The maximum they can stay is one year. We look at where they are with their education or their job management, and what they have been doing to stabilize their economic situation. And if there are any barriers for them to get an apartment leaving our program.

They know we have a time limit when they come into the program. The six and nine month evaluations are not so much an issue of whether a participant still deserves assistance and/or whether we should end their assistance. We use those evaluations to assess whether we are getting them to a point that when they come to the end of the assistance, they will be prepared. Have we done what we need to do to get them to a point where they won’t need the assistance? And if there are still some barriers that that individual is facing, what do we do in the next three months to get them to where they need to be? There are barriers that they don’t have control over and those are typically the ones that keep them in the program through that full year.

(#17) They start off with a year and then when the year is almost up we revisit their housing search. So we can give them extensions for up to six months if they’re actively looking for permanent housing. But they have to prove that they’re actively looking for permanent housing in order to get the extension.

Questions to Consider

1. Is there a difference between (a) making renewal or extension of assistance contingent upon participant engagement or progress, as compared to (b) making housing or housing assistance contingent on participation in services (which would violate program guidelines)?
   - If there is a difference, what are the key distinctions?
   - Can a renewal or extension be conditioned upon a participant’s willingness to work on goals that the agency or funder prioritizes, but that the survivor feels are less urgent than -- or inconsistent with -- her own priorities?
   - If the survivor’s inability to "adequately engage" or to make "adequate progress" is related to the cumulative impact of the trauma she has experienced, and associated depression, PTSD, traumatic brain injury, or simple exhaustion, would it violate the Americans with Disabilities Act to nonetheless hold her to the standards that other participants are expected to meet, in order to earn an extension?

2. Although programs cannot make housing or housing assistance contingent on participation in services, there is an apparent distinction between requiring participation in services and requiring periodic "check-ins" with a case manager or advocate, and such check-ins can apparently be required.
   - What are suitable topics and activities during a check-in?
• What topics or activities or intensity of effort would turn the check-in into a case management session, which a participant cannot be required to participate in?

(x) Comments Expressing Providers' Concerns and Frustrations with Voluntary Services

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

The following comments expressing providers' concerns and frustrations with the voluntary services model have been included in hopes that they will inform training and technical assistance efforts that can: (a) help providers better understand and implement the voluntary services model, and (b) address the kinds of real-life on-the-ground challenges that sparked those provider concerns and frustrations.

As noted earlier, all the providers we interviewed are well-intentioned -- they want to help survivors succeed -- but many face more need than they are resourced to address; face strong pressures from the CoCs, states, and jurisdictions that oversee their HUD grants to demonstrate positive housing outcomes with shorter lengths of stay, despite the daunting obstacles -- including increasingly difficult housing and employment markets -- that their participants face; often lack the kind of supplemental capacity -- clinical supervision, counseling, children's advocacy and services, employment counseling, legal support -- and staff diversity that better-funded, full-service providers might bring to bear; and operate in parts of the country where they cannot leverage the kinds of community-based resources that providers in service-rich areas rely upon to fill gaps in in-house capacity.

(#01) OVW is wonderfully trauma-informed which is terrific, but the voluntary nature of services -- where absolutely nothing is required -- is a guideline that's hard to work with, and I don't think benefits the participants. We can offer financial and therapeutic counseling, etc., but can't require it. That's a problem. I understand that not making requirements is trauma-informed at one level. But, you can't throw people into the deep end of the pool and hope they'll float, without giving them a life preserver. And sometimes giving them economic counseling is a life preserver. The lack of program requirements is not helpful to participants, because they're not getting help they need. Having a few requirements would be a good thing.

(#02) If we were advising a new TH program, we would encourage them to require accountability. This is a problem with all our grants: they're voluntary, you can't require anything of victims, and therefore, you're not preparing them. Saying "you can pay 30% and we'll save it and give it back to you," is different from requiring them to pay 30% and be partially sustainable and accumulate more and more accountability over the two year time period, so that by the end of the two years, they're paying the full rent. Instead, we dump them into mainstream society two years later with no income and they're used to paying 30% of their income for rent, and all of a sudden, they need to pay five times more and it just puts them back in the cycle of poverty. What is the best way to start a DV victim on the path to independence? Allow them to be more accountable for their next steps rather than providing free everything. That doesn't prepare them.

An overall review of program expectations and what they're expecting from us, which we do in our on-site units, is important to engagement. We ask questions like "How do you see six months here helping you get ready for the next step?" "What do you see as your next step?" "Where do you hope to go from here?"

We let them know that in their first year in our program, we'd like to see them pay 10% of income toward rent; 30% in their second year. We provide an overview of expectations to make them more accountable: they need a job, if they don't have a job, they need to be going to school; if they're not going to school, they need an idea of their next step, so it's not an extended emergency shelter stay. That's where we've turned a
corner as an agency, because we see that. Some people in a two year unit come back to emergency shelter because they’re not prepared to handle their lives. Accountability, it’s like you and me, we’re accountable to sustain ourselves. If government and agencies sustain them, we’re not teaching them anything. OVW funding is wonderful and helps a lot of people, but handouts don’t help anyone in the long run.

(#03) Voluntary services is a struggle for us. The clients meet weekly with their individual case managers for resources, even if it’s just a general check in -- "do you need help filling out this form, or can I get you this or that?" And we have regular house meetings and regular outings – like in the summer, our advocates have been getting together and taking the clients out on nature walks and just bonding experiences. But, not everyone wants to participate. We've bent over backwards to make groups and classes interesting for the clients, but not all the clients want to participate; some would rather just do their own thing. So, we try to encourage them, tell them about the benefits of the program and the benefits of just coming to a house meeting. Once a month, we have all the clients together and talk about what’s going on in the building, and not even everyone wants to participate in that. It’s hard to motivate women and families who all have different goals. It’s hard to find common ground for everyone.

(#04) Our program is like a pendulum and there used to be so many rules. Now we can’t require anything because of voluntary services. We use gentle reminders and ask if we can help. I’m not willing to work harder than they are or do the work for them. The point is to empower them to do it, and some of them aren't quite ready. We don’t give up on them, we don’t stop calling, or kick them out. We encourage them.

(#05) I’m not a fan of the voluntary services model, because what it says -- and clients sign contracts that say as much -- is that our clients don’t have to participate in case management services or job search activities or treatment planning. Those services are voluntary. So there’s very little required of participants.

We talk with participants about their situation and where they want to get to. The challenge is that the whole hierarchy of needs is present because we’re serving people who are just trying to make it. They can’t get to self-actualization when they’re just trying to survive and get the basics together. So although I don’t think there needs to be a lot of control or enforcement or mandated activities, I don’t think that saying, "if you can get this apartment, we will help pay your rent and a portion of your utilities" is necessarily the best route to go when it comes to empowering or encouraging independence or self-sufficiency. There’s not a whole lot that’s voluntary in the real world: if you don’t pay your electric bill, your lights will be cut off. We should be teaching participants to survive in the real world, whether they’re a DV victim or not. That’s my personal philosophy: we need to help you learn to survive, in spite of what you’ve been through.

(#06) Implementing voluntary services has really been a challenge. We want to empower our clients, and we want to respect where they’re at. And we also want to respect that they have all these strengths and inner wisdom that has helped them survive, and tap into that to help them move forward. That’s our goal and our vision, but at the same time, they came to us for a reason ... that they need support and help. And if services are voluntary, and they decide they don’t want any of our support, what happens next? Are we really helping them? It’s something for us to look at – what we’re doing – and maybe do things differently.

(#07) If somebody is not willing, then they’re just not ready. And it’s a hard balance but I also don’t believe in enabling that type of behavior. If people are not willing to help themselves, we’re not doing them any service by just sitting by and watching them deteriorate.
Following the voluntary services model is definitely one of the most significant challenges faced by our program. We want all our residents to benefit from the education, life skills, and all the information and services we can connect them with. We want them to be able to take that with them so they stay safe when they leave here. It’s a little disheartening when you see residents leave the program who aren’t going to benefit from all that help, just because they wouldn’t let themselves be exposed to it. For some residents it’s a matter of, “I’ve got my basic needs met, I have a safe place to live. That’s my focus.” Our counselor says they may not be ready for all that help, but it’s hard to get them ready if they’re not exposed to it.

I like voluntary service as long as there is enough subsidized housing that people can move into. It’s less stressful for us because the clients tell you what kind of help they want based on what you can offer or refer them to. But one challenge we encounter in the voluntary services model is that it leaves decisions about accessing employment and boosting income up to the client. Maybe a client’s immediate goal is to recover from whatever they’ve gone through. But how long will stay in that situation? A year? 18 months? Two years? That might work for the client if they have a long-term housing subsidy, but not if they have to be able to pay for market rate housing and utilities and all their other household expenses.

And because our program combines an OVW grant with HUD funding, we have to complete performance reports for HUD as well as for the OVW. HUD is not measuring participant safety or wellbeing, even if we are a DV program; HUD only tracks increased income and housing stability. You could have a participant who is not working on increasing their income, because that’s not their priority. Or somebody with mental health issues or depression or trauma issues that affect their ability to function. We can offer counseling services, but they don’t have to go to counseling. And in the meantime, they are not able to function well enough to look for a job. Since this is an OVW-funded program, we go with what the participant wants to do. But when clients don’t focus on increasing their incomes, it hurts our HUD-related program outcomes.

Not that people should be discharged from programs for not participating, but how do we justify using taxpayer dollars to house someone when they refuse to participate in services to help them become self-sufficient? How do I justify paying the rent for somebody who is doing nothing but living in the unit and using? I’ve been in the field long enough to feel that I’m doing someone a disservice if I don’t strongly encourage and find what it takes to have them participate in services. All we are, then, is a flop house.

When the women come in and finally have space to breathe, there’s often a period of time where they’re kind of regrouping and not really able to jump in with both feet, and we know that. What we’re generally doing is supporting them where they’re at, at the moment. If they’re stuck, we work with them to try to identify what’s wrong: "Are you depressed?" "Are you worried about the kids and their situation?" We work with them to try to identify the stressors holding them back, so we can help eliminate those barriers to progress. Everyone’s different; we’re aware that some people are going to jump right in and make progress and some are going to take a little bit longer, but our role is to support them and try to identify what’s holding them back and what they need.

I absolutely believe that participation should be required. I feel like the people that have not been successful in the program have been the people that have not accepted programming and support. They’ve either reconnected with their old abuser or a new abuser. They’re not making progress gaining their independence. They’re not going to school or doing job search. If we don't require them to apply for housing, they’re going to
be in the program for much longer than the two years because it’s a process to get all that done. I would be really concerned about people being able to enter the program, close the door, and kind of say, "no, thanks."

Moving to a volunteer-participation model has been very challenging. We’ll give participants a list of resources that address areas that they identified they need help with in their service plan. Maybe they said they need to get their GED, or they need counseling, or they need parenting classes; we make all those resources available; it’s not about forcing them, but really encouraging them to go. If they don’t follow through on any of it, the voluntary services model doesn’t give us any leverage to get them there.

I’ve seen some other transitional programs that have been successful when they make some of it required; for example, a local HUD-funded transitional housing program requires that clients have a job or attend school. That program has a high success rate; people who do those things do move on to be successful. When we don’t require anything of them, participants end up dropping out of the program or the case manager ends up doing a lot more worrying and a lot more of the work to try to get them involved and to help them be successful. There has to be a balance between a requirement and voluntary services.

When somebody comes into the transitional program, most of the time they’re moving from the shelter. We do a thorough assessment and a service plan: “OK, now that you have housing, let’s work together to create a service plan for the goals that you want to accomplish while you’re here.” And they sit down and say, “I want this, I want that, and I want the other thing.” The case manager will work with them and try to encourage them to follow through on some of the goals they’ve identified, give them community resources, offer life-skill classes. Since program participants are staying in housing authority units, we’ve worked with the housing authority to make resources available at their community center, so they don’t have to come to our center. We've tried different things to engage them. But when we ran those groups, we were lucky to get one or two people to attend. Part of that is because the participants that are trying to follow through on getting jobs or pursuing their education can’t always make it to our classes, so we tried having classes at different times. But then, they were tired and just couldn’t make it. And the ones that weren’t going to school or working, they hadn’t bought into the program, and weren’t spending the time to try to improve themselves. As long as we went to their house and did the case management, they would do that, and little bits and pieces of what was asked, but it was difficult to complete the service plan.

The people that are highly motivated are the ones we have a lot of success with; they take advantage of the program and everything we offer. The others that are not motivated probably have been in the system for a while and don’t see a need to work, because they know how to work the system. We've actually had people say, “I don’t want to work. I can make it with what I’ve got; I’m okay.” If that’s their choice, we can continue to provide case management, if they have any issues or want to work on something. They set their own goals and what they want to accomplish when they’re receiving case management.

Every once in a while, we have a participant that tries to dodge the case manager. After a few no-shows, where the case manager goes to their unit and they aren’t there, or we know they’re home, but they won’t answer the door, we start putting letters under the door saying to give us a call, and if they didn’t, then we would basically discharge them from the program. We’ve had a few families do that, probably less than five in the entire time we’ve been doing this. But, as long as they’re in good standing as tenants, they can keep their apartments. So even if we discharge them from the program, they still have housing. So that’s an incentive to get into our program. But it’s not an incentive to actively engage in the program.

We had an OVW transitional housing grant for our co-located program, but we finally just let that funding go because we found that voluntary services for women with these kinds of secondary issues didn’t work very well. It works really well for women with economic issues, but when we
were working with women who had an addiction to crack, if we didn't establish some type of expectation, it was really difficult. We came up with what we thought was a wonderful idea -- we charged a fee for this housing, but if they did certain things, for example attended counseling, we waived the fee, so they could basically end up living for free. However, OVW determined that this approach wasn’t consistent with voluntary services, and that participants had to be able to live here without requiring anything of them.

We decided that we had to take a little bit of a different approach with that population, adding some accountability, which we've found to be very successful. We’re not punitive by any means,. It’s not about kicking anybody out. Our goal has always been to screen in, and to keep them in, and we feel like the only time we fail is when we give up. We work really hard to figure out what’s going on and what other resources might assist them in staying in housing. It’s been a very successful model.

When people come into emergency shelter, there are no requirements on them for the first three weeks of their stay. If they want to continue on, and be in our shelter-based transitional program, we ask that they at least start talking with us. We know that, for many people, they experience all of this and withdraw, and don’t want to deal with life and go to bed. Putting together a case plan might mean setting goals like for the next three weeks, two days a week, they’re just going to try to get up by noon. Or maybe for a mom with kids, their plan for the next week is, "I’m going to help make sure that the kids get on the bus to go to school." Everybody’s at a different place but we’ve found that setting a goal and meeting it is really big, even if that goal is really small. Many of these ladies love going down to the kitchen and baking and cooking and working with our kitchen manager and that can be their goal: “This week, I’ll help cook dinner on Wednesday night.”

When we say that we ask them to be doing something with us, it doesn’t have to be therapy or treatment, which might be more triggering than they can handle. We give them the freedom to not deal with what they’re not ready to deal with, but we encourage them to find something they are ready to deal with, because there’s always something: “I want to go to yoga” or “On Friday, I'll join the group doing line dancing.”

For many of our participants, they might not be ready for counseling or groups or treatment until their last six months here. Or it might never happen. But we’re continually trying to get them ready to do something at the end of the two years. We routinely look at what’s going on in six month-increments and if they’re ready, might transition someone in our co-located program into the scattered-site program, and provide them with community-based support as they start bridging back into mainstream life.

For some, though, this might be as good as it gets. For some folks whose brains have been chemically altered for 30 years, this might be how life is; for them, we try to find permanent housing where we can continue to provide support, like our permanent supportive housing, where they can live as free as they want, and our focus is on stability.

(#14) (Not a current OVW grantee) We are no longer doing transitional housing. We got an OVW grant a couple of years ago, but we chose not to renew it. I think one of the biggest reasons was we really had trouble identifying people who were willing to make the financial commitment. Some of them maybe found other housing that fit their needs better than ours. We followed a voluntary services model, of course, but we expected them to contribute part of the rent and utilities, depending on the payment schedule we had set up. And I think some of them chose housing that maybe didn’t require them to do that, or they weren’t able to do that. Not necessarily formal programs. I think what some of them chose was more along the lines of living with family -- even if it was overcrowded, because they had those informal supports and they didn’t have to make financial contributions.

Several of our transitional housing folks moved their partner in with them, and it was almost like that had been their plan from the beginning. In some ways they got what they needed, because they got housing and assistance paying for that housing, and they were able to maintain the relationship. But that's not the point of
the transitional housing. The only rule we had was that your abuser could not live with you. That happened too often, and was part of the reason we didn’t pursue that grant again.

We had a lot of trouble with folks as soon as we started paying the financial assistance saying that they didn’t want any of our support services, like, "I’m getting the financial assistance; leave me alone." And that made it challenging to even stay in touch with them. We wanted to be sensitive to the fact that this was their home, and we didn’t want to barge in on them. But oftentimes we’d have kids tell us, “Dad’s living with us again.” How do you address that without getting the kids in trouble, without putting her in more danger because now she is at risk of losing the housing because he’s back with her? There were just a lot of challenges.

We had trouble finding people who were interested in our program if it didn't provide full financial assistance, or they would drop out as soon as their portion became due. At first, we'd pay all of the deposits and utilities and then the full rent for maybe three months, with the goal that they have stable housing, and be able to get on their feet. Even if they were already employed, they could be saving some of that money so they’d have a little cushion. We’d talk to them about cash flow and budgeting. And then maybe at the end of three months we’d pay 75% and they’d have to pay 25%. Towards the end of the project, we changed to us paying 100% the first two months, then the third month we’d paid 90%, they’d pay 10%, then the next month 80/20.

Either way, when it came time for them to contribute a portion, they weren’t prepared or willing to pay it. We did have some folks who were able to pay just the bare minimum and stay in the program, but a lot of them were unable or unwilling to handle their share when any part of the cost became their responsibility.

We did have some really positive experiences, including women who participated at every level of their financial responsibility. But for some, I think it was just more comfortable to not pay any bills. For some, it was the typical homeless issues -- the inability to think beyond today, because they've been in crisis all the time. For some it was the domestic violence and that pattern of repeated abuse that kept them from feeling like they could move forward. And for some it was just feeling like "I don’t want to have to pay my bills."

It feels contrary to what we believe in, but it does feel like there should be some kind of accountability on the part of the client to fully participate in the program. And that doesn’t mean jumping through a bunch of hoops or attending support groups or not having contact with your abuser; nothing like that. But meeting with us once a month or something like that, I think, could have made a difference for some of these folks.

We encouraged it. We made ourselves available. We often had appointments set up and we’d show up and they weren’t there or they wouldn’t answer the door. But because we couldn’t make them do it, it made it difficult. It’s hard for me to say that just because I philosophically don’t believe we should make them do anything. So I’m really on the fence about that whole piece.

I’d say that almost everyone who was in our transitional housing program is still in contact with our agency, still accessing our services. One of our former transitional participants just called yesterday about a landlord reference; when she was in the program her landlord wrote us a letter about what a great tenant she was. I think the relationships were there, but once the money was involved, it made things weird.

If I had it my way, I don’t know that I would offer any financial assistance. We could still be their DV or sexual violence advocate. I’d rather just do the advocacy and support than to be the one writing the check.

Would I still do voluntary services? There are different interpretations of voluntary services -- like, “in six months, we’ll reassess and see how you’re doing, and maybe you’ll qualify for another six months” -- that, to me, still imply that you have to do something to deserve the assistance. And if I’m the participant, that’s really the same as not knowing what my housing is going to look like in a few months, so I may be so stressed out the whole time that I am not able to function. I totally get why people cannot move forward when they have all this trauma in their lives. To impose any requirements seems unfair, especially when most of the people
we’re talking about are victims of someone else’s actions. But if the voluntary services model could stay mostly intact but include things like home visits -- I think that accountability piece is important.

I also feel that the client paying for part of their expenses is really important. I think it’s very empowering. For someone who’s not paying anything it’s harder to realize what they’re going to lose if they don’t pay it because they haven’t made that investment themselves. So I would almost make that more of a requirement than some of the services piece -- even if it’s just $5. I know that would be a very controversial thing as well and I know for some people they really can’t do $5. But as far as the financial assistance being separated from the services, I think that would be a very good solution to the concerns that we have had in our program.

The services would be available one way or another, if somebody wanted them. The housing assistance might be contingent on them paying some portion of the housing cost: rent, utilities, a percentage of their income, or some other measurable contribution. But the services would not be contingent on the housing, and vice versa. Even the people we had to terminate from the program, because they had their abuser move in with them, we told them that we could continue to be a support, and that this had no impact on them accessing our services -- but that’s not realistic. If you just kicked me out, I don’t want to come back to you for help. If I let my husband back in and he beats me, I don’t really want you to know that.

That’s where having a separate entity to do the financial assistance would be important – it can’t be the same organization providing the services and administering the financial assistance.

Questions to Consider

1. A participant might not want to meet with the program advocate or attend a workshop or participate in counseling or other activities for any number of possible reasons. For each of the following possible reasons, what might be the response of an advocate who takes a victim-centered approach and believes in voluntary services?
   - The participant doesn’t see value in the activity, or don’t think participation will make a difference in their lives.
   - The timing or location of the activity does not work for them, or the logistics are too difficult.
   - The activity feel disconnected from their day-to-day realities.
   - The participant is exhausted or depressed or suffering from PTSD or overwhelmed.
   - The participant feels like she already has enough issues to deal with.
   - The participant doesn’t feel like she can be successful in this activity.
   - The participant has other priorities, for example, she would prefer to spend time with her children.
   - The participant doesn’t feel comfortable with the staff or with the messaging about the activity.
   - The participant doesn’t feel comfortable associating with one or more of the other participants.
   - The participant is concerned about loss of her privacy.
   - The participant anticipates being rebuked and cited for her inadequacies, just like her abusive partner did.
   - The participant is self-soothing with drugs or alcohol.

2. Thomas, Goodman, & Putnins (2015) and Davies (2009) emphasize the importance of tradeoffs in understanding the choices survivors make, in terms of returning to an abusive relationship versus pursuing separation and independent housing. That same concept of tradeoffs also applies to the choices participants make in a TH program; as described by Smyth (2008), "People do what they do and choose what they do for a reason: Their framing of what is possible, probable, desirable and worth the effort and trade-offs (for themselves or for others) is heavily informed by past experiences, personal and cultural history, and current context." (p.6)
   - How can an understanding of these kinds of tradeoffs inform a provider’s approach to voluntary services, and their response to what appears to be a participant’s lack of engagement?
   - How might an understanding of the tradeoffs that participants are weighing inform a provider’s decision about the type of assistance to offer and the way in which that assistance should be offered?
3. As cited in the preceding narrative, the NNEDV fact sheet on The Basics of the Voluntary Services Approach asserts that staff/participant relationships are “the foundation [of efforts] to assist survivors in reaching their goals.” What steps can a program take -- starting from the time that a survivor is referred for consideration as a candidate for enrollment -- to encourage and enable the development of the kind of relationship that will support participant engagement, as well as candid communication about why the program might not be working for the survivor, and how it could work better?

4. If a program isn't working well for a participant, and she doesn't feel comfortable expressing concerns to the case manager or advocate, is there another person she can confide in, who can help address any barriers to participation? Would identifying such a person during the intake process or the early phase of program participation -- for example, shelter staff that the survivor developed a trusting relationship with, a trusted friend, etc. -- make it safer for a participant to articulate their needs and concerns, so that the program could offer more appropriate assistance?

5. Can the provision of material assistance above and beyond rental assistance encourage participant engagement in program services? Can arranging social activities that bring participants and staff together and/or that provide participants with access to freebies (e.g., donated items, meals, discounts for children's activities, etc.) help ease participants into greater engagement in program services?

5. Survivor Empowerment

(a) Overview of Empowerment

This chapter began with quotes from the Missouri Coalition's groundbreaking publication, How the Earth Didn't Fly Into the Sun, describing how abusive relationships use violence and coercion to disempower the victim, and explaining how, by eliminating disempowering rules and embracing a voluntary services approach, programs that seek to support healing can afford participants the opportunity to "take back or regain the power to make their own decisions and to determine the direction of their own lives."

"In the empowerment model, a survivor of domestic violence is the expert in her life. This philosophy also might be referred to as woman-defined or survivor-defined advocacy. Anyone seeking to help her must encourage and respect the choices she makes. Advocates should consciously reinforce the expectation that a woman who has been battered can—and will—take charge of her own life...."

The empowerment model and the elimination of coercive rules “... contrasts with the control abusers impose over victims’ lives by telling them what to do and how and when to do it. . . . An advocate’s role is to help [the survivor] critically assess her chosen course of action, understand the likely consequences of each action and provide options and resources so she can advocate for herself, thereby taking control of her life and making it safer for herself and her children." (p.48)

This section of the chapter focuses on empowerment -- what it is, how it might be measured, and how the providers we interviewed see their role in supporting the empowerment of the survivors they serve.

As described in Cattaneo & Goodman (2015), "From its earliest days, the anti-domestic violence movement has worked towards the empowerment of survivors as a central goal.... If abusers were taking power from survivors, healing entailed restoring it." (p.4) Empowerment -- albeit defined differently by different policy makers, advocates, and researchers -- has been linked in research to healing and many of the positive

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63 Although most of this narrative focuses on domestic violence, as Missouri Coalition (2014) describes, a perpetrator of sexual violence asserts power and control through sexual harassment, sexual abuse, incest, rape, molestation, and other acts of non-consensual sexual contact. As in the case of DV survivors, empowerment is an integral part of the healing process for survivors of rape and sexual violence.
outcomes that survivors and their advocates aspire to, including greater safety, improved mental health, and decreased PTSD symptoms. (p.5)

Citing Masterson & Owen (2006), Cattaneo & Goodman (2015) state that,

"Both the individual and social conceptualizations of empowerment are necessary, and in fact are inextricably linked: 'Helping individuals to feel more personally powerful will have a limited effect without social change to allow that power to be exercised. Likewise, social change will not be empowering if individuals perceive themselves as unable to make use of those changes (p.26).’ (pp.11-12)"

Integrating these two components, Cattaneo & Goodman (2015) define empowerment as "a meaningful shift in the experience of power attained through interaction in the social world," (p.12) and they note that that "shift in the experience of power" takes time, citing Kasturirangan's (2008) observation that,

"Programs designed to address domestic violence do not, in and of themselves, empower women. Rather, women may turn to programs as a resource at various stages of the empowerment process." (pp.1473-74)

As an example of how the process might work when the survivor's priority is safety, Cattaneo & Goodman (2015) explain that

"A survivor might take steps toward increasing her safety, take notice of the effects of those steps, and perhaps realize that she needs to gather more resources to be successful. She might attempt to gather such resources, observe her progress towards her goals again, and then revise her plans further. Empowerment, in this scenario, is a process involving multiple steps and an evolving sense of what is needed and what is possible, depending on the impact of one’s actions." (p.9)

"Service providers might facilitate (or hinder) any part of the process, from helping a person or group to define personally meaningful goals, to contributing to knowledge and supporting self-efficacy, to identifying and helping with access to community resources, to helping evaluate the impact of actions and consequent need to re-tool goals or actions." (p.17)

This survivor-focused framing of empowerment, which affirms the survivor's strength, agency, and judgment:

- Builds on the work of Peled et al. (2000), which argued against the characterization of "battered women who stay" as "incompetent, weak, and lacking coping skills," and instead proposed a "constructivist model" in which a woman is making a conscious and conditional choice, balancing consideration of her wellbeing, the prospect of further violence, and the resources available to mitigate that violence -- in other words, weighing the tradeoffs associated with each of her options;

- Validates the work of Anderson & Saunders, 2003, which explained the decision to leave an abusive partner as a complex, evolving, and cumulative process -- possibly including one or more temporary separations involving a stay at a shelter or with a friend or relative, and characterized by courage, determination, and persistence -- rather than as the poorly-thought-out last-minute stay/leave decision that it was sometimes characterized as;

- Affirms the work of Davies (2008), who argued for an approach that she called "victim-defined advocacy" that respects the decision of the survivor, whether she has chosen to stay in or return to a relationship in which she has experienced abuse; to leave the relationship, but remain in contact with her abusive ex-partner; or to permanently end the relationship and break off all ties with the abusive ex-partner; and

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64 As illustrated in Sokoloff & Dupont's (2005) review of the literature on the intersection of race, class, gender, sexual orientation, and domestic violence, a perpetrator’s abusive assertion of power and control happens (or is allowed to happen) within the larger societal context, as well as within the individual relationship.
• Underlies the analysis of Thomas, Goodman, & Putnins (2015), exploring the often difficult tradeoffs (e.g., loss of any positives from the relationship, loss of housing and financial stability, possible risk of reprisal targeting friends/family, possible isolation or alienation from friends and/or family, loss of control over parenting, etc.) that victims/survivors weigh as they consider their leave/stay options.

Sullivan (2006) proposes the following meanings of "empowerment practice," "empowerment counseling," and "empowerment advocacy" --

• Empowerment practice is working with a survivor "in ways that increase her power in personal, interpersonal and political arenas." It involves a "helping relationship that is participant driven, [in which] the staff member shares power with the participant, and is a facilitator, not a director, of services, [working] with the survivor to facilitate her access to knowledge, skills, supports and resources. . . . Essential elements of empowerment practice [are] (a) shared power; (b) respect for survivor’s strengths and resources; (c) services are survivor-driven; (d) services are flexible and individualized; (e) problems are not located within the survivor\(^65\); [and] (f) services are action-oriented and proactive. . . . Empowerment practice means discussing the pros and cons of all options with survivors, but, ultimately, respecting their desires and decisions, regardless of whether we agree with them."

For example, although funders and staff may hold beliefs to the contrary, survivors must be respected in their determinations that pursuing a Protection from Abuse Order will heighten their risk from violence, or that returning to the abusive relationship will result in less harm and adversity for themselves and their children than permanently leaving. "If we do not honestly and truly believe that domestic abuse can happen to anyone, that survivors are not to blame for their abuse, and that survivors have many strengths and capabilities [and the competency to make decisions in their best interests], we cannot engage in empowerment practice." (pp. 27-31)

• "Empowerment counseling" involves guiding, supporting and anchoring women, while simultaneously ensuring that each woman is in control of her decisions and choices throughout the process. . . . Experiencing domestic violence frequently results in a loss of trust, as well as a loss of one’s sense of control. Empowerment counseling involves using active listening skills to help women regain that sense of power and control over their lives. . . . [Empowerment counseling] help[s] women discover their own 'bottom line.' For some women, what was different this time is that he abused the children, or he sexually assaulted her for the first time. Or he destroyed something precious to her. Whatever it was, it crossed an invisible line. . . . [It's not that] she thought the prior abusive behavior was acceptable or that she deserved it. . . . We send the message that her experience is very particularized, that we need to delve into her psyche, her past, and her life expectations to understand why she was abused\(^65\). . . . When we engage [in] group support, however, the message becomes quite different. We send the message that the survivor's experience is a shared experience, one she can understand better by hearing from other women who have had similar experiences." (pp. 33-36)

\(^65\) As described by Sullivan (2006), "Battered women's lack of empowerment is NOT due to low self-esteem or masochistic tendencies. It is due primarily to interpersonal and social conditions. Therefore, a major component of empowerment includes modifying structural conditions to redistribute power and resources more fairly." (p.28)

\(^66\) Sullivan (2006) contrasts this with "our knowledge that at least one in five women will be abused in a relationship in her lifetime, and that more than one in ten will be seriously battered." (p.33)
"Empowerment advocacy involves working actively with survivors to help them gain access to resources and opportunities that will improve their lives." Sullivan notes that "advocacy efforts are generally classified as either individual-based -- working with or on behalf of individuals to ensure access to resources and opportunities -- or systems-based, which involves improving institutional responses, [for example,] target[ing] the criminal justice, health care, welfare, child protective service and other systems." Concerned that the provider community has "diluted the term 'advocacy' to include just about any direct service we engage in," Sullivan cites Knitzer's (1976) "six principles common to all forms of advocacy: (a) Advocacy assumes that people have, or ought to have, certain basic rights. (b) Advocacy assumes that rights are enforceable by statutory, administrative or judicial procedures. (c) Advocacy efforts are focused on institutional failures that produce or aggravate individual problems. (d) Advocacy is inherently political. (e) Advocacy is most effective when it is focused on specific issues. (f) Advocacy is different from the provision of direct services." Citing Herbert and Mould (1992), she reframes the sixth principle as, “Advocacy is not primarily concerned with providing a service, but rather with assuring the availability and relevance of the service that is provided.” Sullivan notes that "Empowerment advocacy, like all forms of empowerment practice, is based on the premise that the survivor is in control of what gets worked on with the advocate." (pp. 37-38)

The victim/survivor-centered approach is central to the OVW TH Grant Assistance Program; for example the annual TH grant proposal solicitation calls for programs that take "a holistic, victim-centered approach [in which] programs provide a wide range of flexible and optional services that reflect the differences and individual needs of victims, and allow victims to choose the course of action that is best for them." The victim/survivor-centered approach is integral to the voluntary services principle; thus, the NNEDV fact sheet on The Basics of the Voluntary Services Approach recommends that programs actively solicit and incorporate input from survivors in order to ensure that housing and services "are driven by [their] needs, wants, and individual goals...."

Kasturirangan's (2008) explains the importance of ensuring that both the goals and the strategies for achieving those goals are consistent with survivor’s priorities and values.

"For women who experience domestic violence, goals and actions within an empowerment process should be shaped by their own values. Values are rooted in individual personality and culture. In the current domestic violence movement, the goals and actions that are designed to empower women are shaped by the dominant discourse on domestic violence. In some cases, these goals and actions may not match the values of the women they try to serve. Programs that support empowerment processes must be shaped by an understanding of differences in and barriers to resource access for women who experience violence. The current domestic violence movement views gender violence as the main culprit in women’s limited resources.

However, for many women, gender violence may be only one of several oppressive mechanisms that limit access to resources. Women experiencing oppression based on race, class, sexual orientation, ability, or other forms of oppression may not decide to address gender violence as the first goal in their empowerment process. Those who do identify ending gender violence as a goal may choose strategies for ending violence that reflect their own values rather than the values espoused by the movement." The focus of program staff should be on supporting women’s choices to utilize resources and approaches that are right for them, given cultural, community, and sociopolitical considerations, their personal circumstances, and the "limitations to resource access placed on them by society." (p.1472)

Melbin, Jordan & Smyth (2014) builds on this analysis by documenting the importance of understanding and supporting each survivor’s individualized definitions of success, based on who she is as a whole person, and not only on her "problems" and experiences as a traumatized survivor.
"Many survivors live at the intersection of poverty and multiple forms of violence and often struggle with illness, addiction, mental health challenges ... so not all their challenges are [necessarily] caused by domestic violence; and their experience of safety [may be] strongly influenced by other factors such as historical trauma and oppression, community context and culture, as well as personal identity and preferences." (p.10)

(b) Measuring Empowerment

Cattaneo and Goodman (2015) observe that although empowerment is an iterative process it is also an outcome: "At any point in this process, it would be possible to ask ... how empowered is the survivor at that time?" (p.9) Indeed, because, as described earlier on in this discussion, empowerment has a demonstrated association with improved survivor wellbeing, including greater access to resources, greater mental health, less PTSD, and less repeat abuse, "empowerment may be a key mechanism for the achievement of outcomes any organization working with IPV survivors would target: mental health, satisfaction with services, and safety." (p.6)

Although providers cannot directly measure future safety, if greater empowerment contributes to a greater likelihood of future safety, "then the construct of empowerment has the potential to be useful as a measure of the immediate impact of domestic violence services, as well as [predictive of] the longer-term impact." (p.6) A measure of empowerment may thus be a useful measure of what Sullivan (1998) calls a "proximal change" -- "Proximal changes are those more immediate and/or incremental outcomes one would expect [or hope] to see that will eventually lead to the [more difficult-to-measure] desired long-term outcomes." (p.18)

Cattaneo & Goodman (2015) note that empowerment is domain specific:

"People may be empowered in some parts of their lives but not in others. Within the context of IPV, this point is intuitive: being empowered with respect to one’s abusive partner is different from being empowered with respect to one’s parenting or one’s work life, though they may influence each other." (p.9)

And because that empowerment is shaped by each survivor's needs and values, it will look different for different survivors. For example,

"A survivor may want to find ways to ensure her own safety within the relationship; [or] to leave the relationship and find a new place to live; [or] to gain financial independence so as to increase her range of options; [or] to get mental health treatment for her children who have witnessed violence; or to reduce her isolation.... The process of empowerment involves thinking through possibilities and selecting the best option[s] based on the unique circumstances each survivor faces at any given time. It also often involves revisiting goals and subgoals, as context and other components of the process shift." (p.13)

Goodman, Thomas, & Heimel, 2015 describes an easy-to-use metric called "MOVERS" for measuring survivor empowerment as it relates to safety, which is available for download from the Domestic Violence Evidence Project website. The authors frame "safety-related empowerment" as "the extent to which a survivor has the internal tools to work towards safety, knows how to access available support, and believes that moving towards safety does not create equally challenging problems." (p. 5)

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67 The collaborative development and validation of the MOVERS metric, involving providers, researchers, and survivors, is described at Goodman et al. (2014).

68 As described in Chapter 1 ("Definition of Success and Performance Measurement, the Evaluation Tools webpage of the Domestic Violence Evidence Project website (an initiative of the National Resource Center on Domestic Violence) contains information about evaluation and performance measurement and links to relevant metrics and evaluation tools.
MOVERS consists of three "sub-scales" measuring (a) the survivor's confidence in those *inner tools*, (b) their *expectation of support* from formal and informal sources, and (c) their sense of the *tradeoffs involved in pursuing safety*. Each question is answered by a number from 1 to 5, where 1 = Never true; 2 = Sometimes true; 3 = Half the time true; 4 = Mostly True; 5 = Always true

- **Internal Tools Subscale**: assesses the extent to which a survivor has developed a set of safety-related goals and is confident in their ability to accomplish them.
  - I can cope with whatever challenges come at me as I work to keep safe.
  - I know what to do in response to threats to my safety.
  - I know what my next steps are on the path to keeping safe.
  - When something doesn’t work to keep safe, I can try something else.
  - When I think about keeping safe, I have a clear sense of my goals for the next few years.
  - I feel confident in the decisions I make to keep safe.

- **Trade-offs Subscale**: assesses the survivor’s sense that action toward the goal of safety will cause new problems in other domains (e.g., loss of housing and financial stability, possible risk of reprisal targeting friends/family, possible isolation or alienation from friends and/or family, loss of control over parenting).
  - I have to give up too much to keep safe.
  - Working to keep safe creates (or will create) new problems for me.
  - Working to keep safe creates (or will create) new problems for people I care about.

- **Expectations of Support Subscale**: assesses the survivor’s perception that the support needed to move towards safety is available and accessible.
  - I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbors, people in my faith community, etc.).
  - I feel comfortable asking for help to keep safe.
  - I have a good idea of the kinds of support for safety I can get from community programs and services.
  - Community programs and services provide support I need to keep safe.

(c) **Engaging Survivors in Program Decision-Making and Other Roles**

Correia & Melbin 2005 observe that, "While not offered in every transitional housing program, leadership programs for participants are an innovative way to increase participant involvement, in both the organization and larger community." (p.13) Some of the providers interviewed for this project employ survivors in different capacities at their organizations, ranging from executive director to support staff. Many of the providers we spoke with include survivors on their board of directors. (We didn't ask the question very often, so the topic doesn't appear often in the provider comments.) Some providers invite program alumni to stay connected and attend occasional group gatherings. A few providers mentioned much more active alumni involvement. One provider that operates a micro-lending program engaged alumni that had successfully paid back one or more such loans as "trustees" of the micro-lending fund. A few providers utilize residents' councils which help plan or run some of their programming. One provider framed involvement on that council as a resume-building opportunity, and supported participants in developing meeting leadership and presentation skills.

(d) **Provider Comments**

(i) **Comments Describing How Programs Takes an Empowerment Approach**

*Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.*
(#01) We always consider what the survivor wants. We give them the resources, discuss the options, and they decide what they want to do. We may not agree but we stand by them unless it’s hurting themselves or someone else. Then we give them other options. Pretty much everything we do is empowerment and client-centered. We want them to succeed at what they want to succeed at.

We begin with a 30-day action plan followed by a 90-day plan. The 30-day goals are basic: "What do you need from the program?" "What are your barriers to housing?" After 30 days, we ask them, "Which of the identified barriers would you like to address?" We try to meet with them monthly – weekly at the beginning. I'll talk about what they want to discuss but also what are their goals. Sometimes they just want to talk about sobriety, about how to get through today. I'm okay with that.

If a client proposes goals that will take more than the 18 months they have in the program, I'm honest with them. "I'm excited you want to be a nurse, but you may not finish that goal while you're in the program. But what steps can we take towards it while you're here?"

Because of the shortage of housing, I encourage them to fill out housing applications. Even if they say they'll be living somewhere else, I encourage them to just fill it out. It won't hurt anything. We've had people who've gotten into a state university, and luckily they had filled out an application for affordable housing which was closer than where they originally thought they wanted to live.

People think 18 months is a long time and then it's suddenly gone, and they feel like they haven't done anything. That's why we have the action plan. If you'll be out of the program in 12 months and you haven't begun to pay off your electric bill, you need to know that you won't be able to get utilities in your name until you pay it off. The three-month plan lists what they need to do and how much time they have left.

(#02) We have social workers working with the clients, based on what the clients have said about the goals they want to accomplish within the time period. A client could very well say I don't want to do any of those things, but while they are empowered, there’s also an accountability piece: "At the start of the program, we informed you about the amount of time you could be in the program, so keep in mind that you have a date certain for exiting; what are your plans to be ready to transition by that date?" If someone seems less than fully engaged, then the social workers and staff on the ground that have relationships with that participant are walking alongside them, talking with them, trying to give them a realistic picture of what's going to happen if they don’t do anything between now and when they have to exit the program... encouraging them to think about how they’ll be able to provide for their family once the program is no longer helping them with the rent. Our goal is not to exit anybody back into homelessness. Our goal is for them to be self-sufficient. We're trying to work with them to help them to make the right decisions so they can become self-sufficient.

(#03) The survivor works with the case manager to create her own case plan, to set her own goals. Because it’s really all about what she wants to do, not what we want her to do. And we have a lot of success in terms of our outcomes. Strong outcomes help make our domestic violence rapid rehousing program the #1 ranked project out of all of the Continuum of Care's programs. And I really believe in part it’s due to the voluntary services philosophy – not forcing people to do things against their will. It’s her choice and she’s freely made it.

When I interview people for a job here, I ask this question, “Let’s say you were working with a woman for a couple of months. She’s doing really well, she’s got a job, her kids are adjusted. And then one day she says ‘I’m going back to my abuser.’ How do you respond?" And there’s only one right answer and that’s “We respect your choice.” But surprisingly most people don’t get that. Most people say, “Well, you know, I would really talk to her about safety and maybe get her to remember what brought her to shelter.” That’s wrong.
(04) We’re not here to tell you which life choices you should make. We can be an ally and advocate for you, but we’re not here to design your goals. For us, it’s about what have you, the client, said you want to accomplish? How did that evolve while you were in the program? At the end of your stay, did you accomplish it, and how do you feel? What I consider success might be different than what you consider success. Self-determination and sovereignty are essential to empowerment; it’s frustrating when providers try to control clients. I tell staff, it’s not about us; it isn’t our life. Our job is to be an ally and support system, not to lead.

(05) The client centered approach really allows people to be where they are and decide where they want to go. Ultimately, it’s not my life, and if they make a poor choice, it’s not really going to affect me. Embrace where they are and you’ll be met with a lot less resistance and they’ll be a lot more honest.

There are times that I tell clients that I don’t agree with their thinking; I have a good enough rapport with them to do that. But they still tell me things because we have that trusting relationship. I had a client confess to me that the abuser was living in the house. We had built a good rapport. I highly encourage training in motivational interviewing or other client centered strategies to get rid of that resistance and help them move forward.

We don’t want to be one more person that controls the client. It’s about empowering the client. I would advise any new program implementing a survivor-centered approach to allow the client to set the expectations for their participation in the program; it holds them more accountable. I use the goal sheet format created with the help of NNEDV to record the goals that the client set, the time frame they specify, the steps they say they need to take, and any barriers they anticipate that they might face. I usually do that on a monthly basis. When they reach a goal I’m their biggest cheerleader. It’s important to keep reiterating the positives. Often times, victims of domestic violence and sexual assault don’t hear positive feedback.

(06) Some participants I meet with every week or even twice a week. We discuss what they want and what their long-term and short-term goals are, and how to prioritize. Ethical communication is a huge part of working with participants who propose personal goals that we believe over- or under-estimate what they can accomplish in their program stay. We discuss realistic barriers. We never tell participants what they can or can’t accomplish. If we think there are a lot of barriers, we have an ethical conversation about what might be done to address those barriers. We don’t let our feelings about their ability to accomplish goals affect how we serve them.

(07) When we discuss goals, we ask them, "What do you hope to accomplish while you're here?" We don't say, “OK, we need to set goals around finding housing, daycare, and employment.” If you need to take a breather for the next week or two, then that’s the goal we’ll help you work towards. If it’s not about finding housing and employment, maybe it still helps them get where they need to be. Clients often tell us, “Look I’m going back. I’m not going to be here long.” And our response should be, “OK; we’re not here to judge. If that is what you’re going to do, how can we help you stay safe?” Just listening to them and going from there.

If the case manager believes that a participant has proposed goals that are more than they can accomplish within the specified timeframe, and would set them up to be disappointed, they work it through with the participant. For example, if a participant currently working at a fast food restaurant has set a goal of purchasing a home, the case manager does a budget spreadsheet showing what they’re taking in and what their expenses are. And they talk through how the participant plans to do x, y and z, so that she has a visual tool for understanding the path, the available resources, and how the program can help. Not that it can’t
happen and that the person can’t own her own home, just that it's a big goal. "Let’s map it out. If you can’t get that home, maybe you can get this one."

(#08) Our agency has long had the philosophy that our clients had the right to make whatever decision they wanted to. We may not agree with the decision, but we certainly respect and agree that they have the right to autonomy. When we got the OVW grant, their empowerment focus fit right in with that philosophy about the client’s right to make her own decisions, and our role in supporting those decisions. We don’t have to financially support some of the consequences of her decisions, but....

Sometimes it’s hard to reconcile that empowerment philosophy with the fact that we have to terminate assistance to a participant who starts living again with the boyfriend who abused her. We might think that that’s a poor choice, but we can’t judge her. That’s not our call to make. But there are always consequences to our decisions. And she has the right to make a decision that has negative consequences.

If a participant proposes goals that seem unrealistic, we’ll have a frank conversation. We’re just not going to pat her on the back and say, “That’s wonderful. You just go right ahead and just do whatever you can.” We’ll have a frank conversation and let her know what services or resources are available to her. And if she wants a job as a social worker or nurse or doctor, then these are the steps she'll have to take. Likewise, if a participant is proposing goals that seem to underestimate her abilities, we'll explore with her why she chose those goals, and whether there are some underlying issues preventing her from acknowledging her capabilities. But again, that’s our judgment about underestimating or overestimating. If you have a solid working relationship with your clients and you respect them and they know what your program can and cannot do, then depending on that working relationship, maybe you can push them a little bit or draw them in a little bit.

(#09) Following an empowerment / survivor-centered approach is the way we always want to be. Balancing being client-centered and helping our clients to be empowered to make their own choices, and doing what we can to keep them safe. The number one thing we say to survivors is that our program’s goal is not to have you leave your partner -- because we know that that can be a stigma that stops people from reaching out for help. We’ve actually heard that: “If I talk to you, I know you’re just going to tell me I need to leave him.” It's their choice. We just want to help them get to where they can make more balanced choices that come from a place not of trauma and fear, but of empowerment, and to help them get to a place of feeling stable and safe.

If someone propose goals that staff worry will set them up for disappointment, we talk to them using a strengths-based perspective: "What strengths do you have, what strengths do you need to develop, what smaller goals do you need to achieve to get to that bigger goal?" We help them break it down into steps. Maybe they only get to step one in our program, but they’re on their way to the goal they set. And if they propose goals that seem to sell themselves short, we leverage our relationship to help them see their small successes, so they can maybe create bigger goals. We typically see that when there are self-esteem issues, if they've never experienced success, where their survivor instinct leads them to think in terms of next-day goals, rather than longer term goals. If we can get them comfortable in their relationship with us and feeling more stable in their housing, whether it’s transitional or permanent, they can start expanding a little bit more.

(#10) Our entire department uses the empowerment approach; we provide survivor-led services. We don’t force participants to do anything; they don’t have to sign a contract to enter our program, let us come to their apartments once a week, or meet goals that we define. We let them set their own goals, go at their own pace; we just provide support to them. We do require that they check in once in a while, because we have to know that they’re still in their apartments -- but we don’t require a lot of what other programs require.
We want them to realize that they know their lives and themselves best, they know what’s best for them. While staff can explain what’s available to them, or how we can help them, it’s really up to them to make those choices. We don’t make choices for them. To be in the program, they have to keep in contact with us, but that’s on their terms -- whether they want to meet at a coffee shop, at the office, in their apartment, or by phone, it’s really just to keep in contact for the program guidelines. It’s really them calling the shots. The voluntary service model is very important to us, we don’t mandate any services except the bare minimum.

We have a goal worksheet that we use with them. Usually once they’re in housing and they’ve been settled for a little bit, we work on that next piece of the puzzle, whatever that might be for them. We have to be realistic about what they want for themselves. Sometimes just maintaining their housing is enough of a goal for them. For others it might be attaining their CNA license, for someone else it might be finding a job. It could also be making sure they don’t fall behind on utilities. For each person it’s going to be something a little different and sometimes coming out of the transitional housing program, their only goal is to have that safe housing for two years and then they’ll move on to the next thing and we have to respect that.

If someone doesn’t know what’s involved in attaining a goal they may have articulated, we work with them to help them understand. I recall one time working with someone who was going back to school and she wanted to become a psychiatrist, so we talked about what that meant, what kind of schooling would be required, and how that related to the two year program she was in. Then we focused on her potential goal for the two year period, which was to get into nursing school once she had her prerequisites at the community college. Then possibly work as a clinical nurse in mental health later on. If someone doesn’t know what’s involved and what’s attainable, it helps to help them set realistic goals, so they’re not mad at themselves later on when their goal wasn’t attained.

If someone proposes goals that we believe underestimate what they can accomplish, we start by honoring what they’ve said. Sometimes, for example, just having that housing for two years is all they’re looking for and then they’ll move on to the next thing, whether or not we think they’ve achieved the self-sufficiency they were capable of. Beyond that, letting them know that we think they’re capable of a lot and hoping they do what they can. We’re there to respect what they want for themselves; it’s not up to us to impose our personal beliefs of what they’re capable of onto them. We’re here to help them with what they want help with.

(#11) If a client is not focusing enough attention on housing search or related activities, the case manager and director of residential services meet with her and talk about goals. They give her concrete goals, because sometimes clients just don’t know how to navigate the process of finding housing; we try to help and prepare them. But if they aren’t actively searching, and they’re at the end of the 24 months, it’s unfortunate, but we just have to let them go. We hate for a client to go back into a shelter, but that has happened when they just wouldn’t do it. Our clients are empowered to make their own decisions. We may not agree with them, but they are their decisions. If they don’t want to look for housing, there’s nothing we can do except give them the information; that’s all we’ll do - reach out and give them the information, but the decisions are theirs.

If a client is holding out for housing that they are unlikely to be able to attain or to sustain, we try to explain that it may not be a realistic goal, and that there are potential consequences of putting all their eggs in that basket -- but again it’s their decision. We would repeat that “we don’t want to see you become homeless," because we don’t want to see anyone set themselves up for failure. "If you take something you can’t afford, you will end up being evicted." But they’re the person who has to make the decision.

(#12) If a participant has goals that I believe will be difficult to achieve, I try as gently and strategically as possible to look at the situation in the long term ... to do it in a way that does not make them feel like it’s a silly or unobtainable goal. For instance, I have a client who feels like when her divorce is final, she’s going to
take her children and live in another state, which I don’t think the judge will allow. So I ask, “Well, what if the judge says this or that?” “Can we do some Plan A, Plan B, and Plan C planning, just in the event that something out of your control makes this goal unobtainable?” I just try to encourage them to think of other ways, rather than saying, “This is not something that you’re going to be able to do.”

Sometimes participants propose goals that seem to underestimate what they can accomplish. I think it’s important to give a survivor a lot of praise for the small tasks and accomplishments, which is maybe different than what they’ve experienced in an abusive household. I think positive reinforcement works for people in general ... and can greatly encourage someone to believe that they can do a whole lot more than they gave themselves credit for. So we point out the things they’ve accomplished, remind them of the courage it took to leave their abusive situation, and mirror back to them every strength they've displayed.

(#13) If someone says, "I want to be a medical assistant," and we believe they have greater potential, we might suggest, "have you ever thought about going into a nursing program?" You only know what you know and what you’ve come into contact with; if you’ve only been exposed to one side of life, it’s understandable why you may be aiming for something that we -- persons with education and opportunity -- see as less than you could achieve. We provide residents with information about options and pathways that they may not know about. We start by meeting them where they are and then provide resources for them to consider.

(#14) Empowering the women is part of our mission. We use a survivor-centered approach because every survivor’s needs are different. One survivor’s focus might be on housing. Another survivor might need help with her credit. We want to make sure we’re not trying to put them in our box of what we feel every survivor needs. We try to provide resources and help survivors empower themselves. We don’t want to do everything for them. Moving forward should be a joint effort. We don’t want to cripple them by doing everything for them. We want them to eventually take on the role of sole provider, so they don’t need us anymore.

One of the good things about scattered-site, about not having a program location, is that we don’t have as much hands on. Everything’s voluntary so we generally meet with the ladies once a month and we work on what they want to work on. I feel like staff in some programs can become like parent figures, making sure participants do this or that at this or that time, and they have to show staff that they’re doing this or that. That’s not our approach; we are supportive and we try to empower. We’ll show you, we’ll help you do it if you need it the first couple of times, but we want you to take it on as your own task. We do things with you, not for you.

If a participant is stuck, we help them any way we can. We don't do a lot of "pushing" because we want them to take the lead on their own. If there’s something they’ve identified as a goal, then I’ll mention that goal during our monthly meeting and ask, “Where are you on this?” We don’t make them define a deadline and accomplish this goal by that date. We assist them any way we can, but they make all the decisions.

(#15) (Not a current OVW grantee) In many ways, the empowerment model is the basis of our agency's work. That’s why we call our line staff "resident support coordinators" rather than "case managers," because their work is about supporting participants, not doing for participants or managing or changing their lives. Our message to participants is that "we hope you can do it on your own, and we will help you with information and help you find the power to do it." Our agency uses a "circle process" to facilitate non-hierarchical organizational problem solving and to provide support for staff facing difficult challenges. In the same way that the circle process flattens the agency, our staff try to avoid "managing cases" and coming across as telling participants what to do.
We’ve been challenged by communities of color about our use of the word "empowerment," so we have given it a lot of thought. Empowerment isn't a formula: if you do A, B and C, then you are empowered. A lot of participants are already empowered when they get to us. Leaving their abusive relationship was an empowered act. Making some of the difficult choices they’ve had to make in order to survive was empowered decision making.

While survivors are in our shelter or transitional living program, supporting their empowerment means being respectful and supporting them in making their own choices and setting their own goals. It can sometimes be very difficult to be empowering when one of your funders has rigid definitions and timeframes for measuring success. But we try and as much as possible not come down on participants and say, "you have to do this or that by this or that date." Instead, we hope that they will come to good decisions on their own, with our support, but not because we held them accountable for our meeting our funder’s performance metrics.

(#) (Not a current OVW grantee) I think once a survivor realizes that there is somebody on her side, and somebody willing to help her, that she isn’t alone, that’s probably the greatest source of empowerment. The victim that I was just speaking to was in terribly abusive environment, and by the time she left here, you could just see her kind of relax a little bit, knowing that she wasn’t going to have to go through all of this by herself. That she was going to have somebody to help her through this. Sometimes I don’t even have to do anything when I go to court. I just have to sit there, and they’re fine with that. They’re like “I’m so glad somebody was just here.”

(#) We follow guidelines outlined in the Women Defined Advocacy approach, so we try to empower the women and, for whatever reason, if they’re not comfortable being in treatment and if they’re in the shelter and as long as they are not causing harm to anybody else in the shelter we will work with them. If they’re using and there’s another client in there who has issues with substance abuse, if they’re causing harm to or putting someone in danger, that would be inappropriate.

Our case management staff works with participants to help them complete all kinds of applications for different housing programs. We don’t do it for them. We don’t tell them what to do, because that’s the same as their abuser telling them what to do. We just give them options and try to work with them.

(#) We have some survivors on our staff, and we have a former survivors’ voices group that partners with us in different ways. When we talk about the empowerment model we mean employees being nonjudgmental, understanding, trying to walk in other people’s shoes; trying to help every staff person understand their own trauma and their own trauma history. We don’t ask staff to disclose whether they are survivors. I know there are probably more survivors on our staff than report. It’s more about having an environment that is survivor-driven and empowerment-based. We create a culture where we respect every survivor, whether she walks in the door with a million dollars or one dollar in her checking account.

We have our client-centered values and our empowerment model culture on a big sign at our front door, so every staff person, every visitor, and every survivor who walks in the door sees our guiding principles; we make it very visible. We talk about it at staff meetings in terms of how we’re incorporating those principles and integrating them into all the services we provide. We do lots of art projects with the survivors, and we have their artwork displayed throughout the facility. It’s just something you have to work at, something you have to talk about. You have to name those guiding principles and then you have to really talk about them with the staff: "How are we really implementing this? How are we consciously making sure that this is a survivor driven environment? How do we make sure that we’re hearing survivors’ voices? Are we having focus
groups? Are we involving them in planning? Are we involving them in service delivery? Are we constantly giving them opportunities for feedback?"

We’re certainly going to have professional staff, especially in our trauma recovery services; those are going to be clinicians. I have also been very intentional about bringing on staff that come from local communities of color, and have given them a lot of training so that they’re advancing, as well. 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, so we try to have a very flat organization in the sense that we build teams, instead of a hierarchical organizational structure, so that staff can make decisions about their own programs.

(#19) We reject the whole idea of an outside person coming in for client assessments. That kind of judging persona is not what we ever want to convey. We try really hard to not do that. Every time we do a focus group or surveys with them, that’s been the overwhelming response. In fact, the last time we did a focus group -- part of a [Praxis] Safety and Accountability Audit -- one thing that stood out was that people really felt we were one of the only agencies in which they felt more liberated and empowered than oppressed and judged.

(#20) Survivors enter our program and their own apartment after being micromanaged at the shelter. The transition is overwhelming for some people, especially younger people that may have moved directly from their parents’ house to live with their abuser, and have never run their own household. I do a lot of checking in. A month or two of meeting weekly and setting short-term goals is usually how we start, and then they’re starting to gain their independence. A lot of them were never able to be independent when they were with their abuser. Their abuser dictated everything they did: where they went, when they could go, whom they could talk to.

A 20-year-old client called me the other day and said, “Can you talk to me? I’m really missing my abuser, but I don’t want to call him.” And I was like, “Absolutely. Let’s focus on you and your goals and what you’ve achieved so far.” They’re going to have down days, days they miss their abuser. I’m pretty much available to them 24/7. They have my cell number, so if I’m not in the office, and something’s going on, they can call me when they need it.

As they figure out their daily life, figure out how to cope with being on their own, I ask about meeting less frequently, maybe twice a month. Some of them say yes, some of them say, “No, I still want to do the weekly thing.” It’s dependent on what they need, but we address whatever issues they have. If it’s something I can’t help with, I’ll refer them to one of the counselors here. Some emotional issues might not have manifested until they were sitting in their apartment alone. “I’m here for you,” I remind them, “Not to judge you, not to tell you what to do, just to help you work through what you need help with.” A lot of times the women beat themselves up over and over again: “I should’ve left,” or, “I should’ve done this.” Let’s not focus on the past. Let’s work on you doing what you have to do now. You made the call, you took the right step for you, you got out and got help.

**Questions to Consider**

1. When working with participants, how do staff communicate support for participants' choices, even if they have concerns about the outcome of those choices?
   - Under what circumstances, should staff withhold their opinions from participants?
   - If staff withhold their opinions from participants and simply communicate unqualified support, will participants "see through" that affirmation, and feel patronized?
### Chapter 4: Taking a Survivor-Centered / Empowerment Approach:
Rules Reduction - Voluntary Services - Strategies for Engagement - Page 103

- What are good ways for simultaneously expressing support for a participant’s right to make her own choices; expressing confidence in the participant’s ability to make choices that are right for her; and providing honest feedback about staff concerns about a particular choice?
- If staff believe they have information or perspective that a participant lacks, how can that information or perspective be communicated in a way that doesn’t re-create the power dynamic in the abusive relationship, in which the abusive partner knew more and knew better than the victim? In other words, how can staff be a resource to a participant, without seeming to question the participant’s ability to make good decisions?

#### 2. If staff believe that a participant’s goals are overly optimistic, and a setup for disappointment, given the circumstances, community conditions, and timeframe, how can staff communicate that information in an empowering way?

- Given that setbacks can undermine a participant’s sense of agency, self-confidence, and empowerment, what is the role of staff: (a) in framing the challenges that a participant might expect to face in pursuing their goals, and (b) in putting the possible outcomes into a meaningful context?

#### 3. If staff believe that a participant has much more potential than they have given themselves credit for in defining their goals, how, if at all, should that opinion be expressed?

#### Comments on How Staff Know a Participant is Feeling More Empowered / Measuring Empowerment

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

-(#01) The clients set their own goals. Whether they want to go back to school, find a job, or get a vehicle running. Sometimes their goals change because their thinking changes over time; whatever is best for the client. It’s about empowerment. If they decide a year into the program that they want to get an education, I help them apply to college. I do it with them so they can feel independent and can learn from the experience. As long as at end of the two years they have safe affordable housing and they’re more empowered and more financially independent, then we’ve assisted them in reaching their goals no matter what they may be.

-(#02) “If a mother doesn’t have a high school diploma and says she’ll work towards getting a GED, and over the period of time she’s in the program she completes a GED program, that’s one of our goals. Ultimately, the mother or the head of the family needs to be able to be self-sufficient. The job development component is key, that’s one of our goals. We’ve talked about permanent housing and healthy relationships, but getting that GED and developing the skills they need to get a job, those are important goals, as well. If I gain the knowledge or certification or licensure to get a job and support my family, that’s empowerment.

-(#03) Becoming empowered looks different for everyone. Often, clients will tell us they did something on their own, contacted an agency on their own. Or they were able to set boundaries with children or a family member. Clients self-report; they say that it felt good, that they feel validated.

-(#04) One of the things I see that tells me a person is becoming empowered is that they start taking initiative. They move from, “Will you call and see if...” to saying, “I called. And I have an appointment for ....” They do what needs to be done. You know they’re empowered when they start making decisions without that nudge or without being asked, “Where are you on your goals? Tell me what you got accomplished today.” They just take the initiative. You can also just see it in their whole demeanor when they feel empowered.
(05) What we want to do is to empower the individuals we’re working with. And in order to do that, we want them to be knowledgeable about the resources and strategies. And the more they participate in services, the better able they are to identify strategies.

(06) A participant is empowered when they no longer feel that they’re in crisis -- they need less support, they’re getting on their own two feet, they’re able to do things themselves, they’re not in financial crisis and they have the money to pay their utility bills and their portion of the rent. Empowerment for different people takes different forms. Some people are very empowered and still want to see me once a week and talk to me and share the good things that have happened.

(07) I think you can definitely see a difference in someone who has experienced a loss of empowerment: they’re not confident, unable to make ordinary decisions -- even small decisions, for example, they need help going to the grocery store, because they’re not sure what to pick out. Our role is to help them understand that they are able to make those decisions themselves, and boost their self-esteem. To actually measure empowerment is hard, because it’s specific to each person: you have to be able to compare where they are now to where they were or might have been at another point. To me, the final stage of empowerment is that they don’t need us anymore.

(08) To me a lot of different things indicate empowerment. I wish I could take a picture of the ladies when they first come in and when they leave because their overall appearance is different. The way they come in very timid, looking down or nervous or anxious or upset. And usually when they leave, they not only know more about their resources or their rights, but they are more verbal about what they want or what decisions they’re trying to make. For me, when a woman who has been here for a week decides to get a restraining order, that woman is already more empowered than she was a week ago. Or when a woman that decides to cut her hair or wear jeans because she wasn’t allowed to before. One woman got her first debit card when she was connected with services. She was receiving child support and another type of income, and we recommended that she open her own savings and checking accounts. And she did. For her, just having two cards in her wallet was very empowering.

(09) We monitor their goals closely. At some point, they might say "I got it. I did this for me. I completed this and now we can check it off." The goals are designed by them, how they see their success -- we simply support them and we monitor and track their goals with them. At the end they tell us, "I’m satisfied. This is what I wanted to do. Now I can move on. Let’s talk about what I can do next." That's empowerment.

(10) When they are empowered, they handle situations differently. They are able to address challenges that come up more directly, without being passive aggressive. We served a lady who never wanted to talk to anybody about things they might have done that bothered her. For example, there were kids playing and making noise by her door. She knew she didn’t want the kids playing by her door, but she didn’t want to talk to the moms about it. I encouraged her to go to their moms and talk to them because it’s all part of becoming empowered. "When you have your permanent housing, nobody’s going to talk to your neighbors for you. You’re going to have to know how to do that yourself." It sounds like such a small thing, but being able to go to your neighbor and say, "hey, your kids are making too much noise by my door; can you please ask them to stop?" is becoming empowered. When they can go out and look for housing on their own and not necessarily need me to be with them, they’re empowered. When they can contact the Food Stamp agency on their own and explain that they haven’t gotten their Food Stamps, and they don’t need me to make the call for them,
they’re becoming empowered. Instead of asking me to call their caseworker, they’re doing it themselves. That’s all a part of becoming empowered.

(#11) Becoming empowered means that as our assistance decreases, they are able to maintain their rent and utilities and other financial commitments, without looking for assistance from other community organizations. They’re in a safe place. Their abuser is out of the picture, or if he’s not out of the picture, they’re maintaining a healthier relationship because of the children. Empowered means a survivor is more knowledgeable about healthy relationships, maintaining financial independence, and maybe completing other goals they want to work on.

(#12) Empowerment is a process. For a person whose boundaries have been severely violated, becoming empowered often involves learning to set boundaries -- so taking better care of themselves. Having taken our parenting class, participants will hopefully experience fewer behavior issues with their children, and will feel more competent and positive about their parenting. As they become more empowered, they will be better prepared to make healthy decisions -- not necessarily based on what we deem to be healthy, but based on what feels good to them, and doesn’t put them in situations they want to avoid. As they start dating and other relationships, they will keep in mind what they learned about domestic violence and the red flags. So, there are changes in behavior, changes in self-esteem, a shift in perspective. Many of the women come here feeling isolated. Some haven’t learned life skills because they haven’t had the right to manage their own households, and have lived in a very punitive system. As those women become empowered, they will hopefully experience a lift in their depression, feel like successful members of the community where they work or volunteer, and feel connected and having friends again.

(#13) I’d say empowerment is self-awareness, ability to communicate needs, feeling less helpless, trusting themselves. Trusting that they know what they need, and that they have the tools and the capacity to get those needs met.

(#14) When somebody is empowered, they have a voice, they stop coming to see the counselor, they have their car. You see it in the way they move, the way they walk, their level of confidence; you see it everywhere.

We served a 16-year-old girl who fled a forced marriage that included sex abuse and physical violence. One day, she came out of her apartment and she had on an absurd outfit that was not appropriate for her age. I asked her where she got those clothes, and she told me, “I picked them out of a bag.” How can you help somebody feel better about themselves when they’re digging in garbage bags for clothing? We stopped accepting all clothes donations. Instead we take $100 and bring our women to a really good thrift store and go shopping with them. We spend a whole day with them. We have a lot of fun. We get to know them. We go to lunch. You can get a lot of clothes for $100 at a thrift store.

One of the women -- this is how battered women’s experiences inform our program -- dressed very overtly sexy when she came here. I figured that maybe she liked the look. We got into the thrift store and I said, “What do you like?” She said, “I have no idea what I like. He told me how to dress. He told me how to wear my hair.” So I said, “Not anymore. You pick what you want.” She got to say, “I hate wearing these tight sweaters and having my breasts exposed.” That’s empowerment. The word we use more here is “autonomous.” You become your own person with your own voice -- you don’t have to come to this office, you don’t have to come to therapy. When they tell you what they want and what they don’t want to do, that’s how you know someone is empowered.
One person that’s in our program experienced years of abuse and was very against doing anything; she recently applied for a divorce, which is a huge step. She was crippled with fear, overwhelming anxiety with the thought of going to court and a couple of times I thought she was physically going to be sick but I was with her, I reassured her that she was safe and that “You’re okay.”

She’s gained her power. She speaks up. She says “I disagree. I agree. I want to do this. I don’t want to do that.” Before, she would just go along and stuff her feelings down. She’s found her voice and I hear it now and I see her looking alive and actually talking about the future and what she wants her life to be like.

Other examples are people who come into our program having very little self-esteem. I see them having a huge turnaround, and able to look back and say “I feel stronger. I’m a different person.” We do a lot of self-esteem work. We offer a self-esteem group. The decisions they make are different. The counseling sessions sound different. Those are the ways we can tell that a person is more empowered. Them telling us that they’re more empowered is really the final say-so on where they are and where they’ve come from. I’ve heard it over and over again, “I can’t believe I’m at this place now. I never thought I’d feel this good. I never thought I’d sleep peacefully through the night. I never thought I’d be past feeling so overwhelmed.”

I worked with a woman who never worked a day in her life; she had a lifelong history of trauma and abuse, and she has a job now. It was a long process and she had many fears and anxiety, including a fear of people; she was always looking over her shoulder. Now she works in an environment where she serves the public. Our follow-up work continues, long after the two years of participation in the transitional program. She’s an older person and it’s rewarding to see that she’s gained that autonomy and taking control of her life and realizing that she deserves to have these things in life. She never really believed that before. You hear people say it but she’s never believed that she deserved the basic peacefulness and happiness of an abuse-free life.

Our definition of success evolves over time, as we get to know our participants better, as they share their hopes, their dreams, what they want to do, their motivations, all of that. HUD’s definition of success -- “Do they have a home?” -- is easier to measure. But internally, as a program, we’re looking to know whether we’re meeting their need for some happiness. Some of these folks haven’t had any; it’s been a rough ride since they were born. So, were we able to assist them in seeing something a little bit different? That’s why we try to incorporate entertainment or trips, where they can experience some of the enjoyable things in life.

HUD’s definition of success as permanent housing doesn’t address the question of safety. We recognized that some folks coming to the end of their time in transitional housing were wondering “what do we do?” There’s a barrier – whatever they’re numbing with alcohol or drugs, they’re not able to let that go. That’s just their reality; most of them don’t want to drink, but they need to. That’s when we decided to create the permanent supportive housing -- their own space, where they can have visitors, who can spend the night, because we wanted them to be able to live as they would anywhere else, and we’d be there for them if they need us.

I happened to recognize one of the men who was coming to visit one of the participants as her abuser. I guess we thought that, “we’re giving them this place and they’re not ever going to want to see them anymore,” but that wasn’t really the situation. We didn’t quite know what to do, so we decided to just watch and see what happened -- and this amazing thing happened. They still have relationships with these men that were abusive to them but they know that they control their apartment and they know there’s somebody always here, so if they were to yell or have a problem, somebody would be there immediately. This change in the power balance has allowed them to continue these relationships that they really do want. They just want to be safe and so most of the ladies over there have continued to have a relationship with the same men who abused them -- but on their terms. We have been able to incorporate an element of safety just by the fact that they’re supported.
Note: Arguably the women feel empowered and able to manage the behavior of their partners.

(#17) We’re looking at integrating a new tool developed by a project led by Dr. Lisa Goodman at Boston College. The MOVERS tool attempts to measure empowerment as it relates to making safety-related decisions. We like the model, but we have not yet integrated it into our service delivery. We participated in a couple of research studies that she spearheaded and we’ve been really impressed with the products that have come out of that work.

(#18) We had a client who was in a new relationship. They’re allowed to date, they’re adults. She called me saying that they just got into a fight. She called the police on him. She told me, “I took what I learned and I was able to recognize that he wasn’t healthy for me and so I wasn’t going to deal with it anymore, and I cut the relationship off before it got worse.” In the past she might have said, "maybe he’s having a bad day." She took control; she was empowered. A year and a half after coming into the shelter beaten down, she was able to apply the knowledge she had learned to keep herself safe.

Empowerment is them taking control, knowing what they want, and acting on it -- with relationships, but also in other parts of their lives. Like, “I’m going to school. People have told me my whole life I’m not going to finish school. But I’m going back and doing it. I don’t care.” That’s taking control and strengthening yourself to be what you see as successful.

Questions to Consider

1. How do staff reflect back to participants that they see signs of increased empowerment? What would make that kind of observation affirming, and what might make it feel gratuitous or condescending?

2. How can staff periodically check in with participants about their individual goals and any progress they’ve made towards achieving those goals, without putting undue pressure on participants?

3. As described in the narrative which preceded these provider comments, empowerment is domain specific (i.e., is specific to particular aspects of life, like safety, parenting, cooking) and manifests differently in different people.

   • In what areas of their lives do participants already feel empowered? What does it feel like to feel empowered? In what areas of their lives do they want to feel empowered? What will it look and feel like to be empowered in those domains? For example, a participant might feel empowered as a parent, but not as an advocate for her child at school, and not when it comes to setting clear boundaries in relationships.

   • Assuming that empowerment in one or more life domains is a shared goal of the program and participant, how can program staff and participants talk about and help the participant envision what it will look and feel like when participants are empowered in those areas of their lives?

4. Different providers have different understandings of empowerment. Some may understand it as reducing reliance on other people, government programs, and social services. Others may understand it as a person's ability and confidence in her ability to make informed choices about how best to meet her needs.

   • How do these distinct perceptions of empowerment relate to OVW’s program framework?
(iii) **Comments on How Programs Engage Survivors in Shaping/Advising the Program and as Volunteers**⁶⁹

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

(#01) One thing we've been really good at is staying connected to our former clients. We invite them back after they've gone through our program and feel ready to participate in our 65-hour volunteer training. Some volunteer to provide direct service. Others feel like they're not ready for direct service and help us in other ways, for example, doing outreach and engagement in their communities. A few have become staff.

At the transitional shelter, we started a mentoring program. After a family has completed their stay in the transitional housing program, we provide six months of follow up services and then we also provide a six month support group program that we call Women and Children's Circle. After they complete both of those, and after they've had some time away from the program, if they still want to become a mentor, they're eligible to be trained. Once they're trained, we try to match them with a current resident that speaks the same language. There are six modules they can go through with that current resident. The first topic is getting to know you, sharing your story with one another. Other modules are about navigating your next intimate relationship; navigating your stay at the transitional program; how the transitional program was helpful for the mentor; how the mentor made use of it; and how they handled their fears about leaving the program.

We've had some great successes with people who stayed in touch and got a lot out of the experience.

(#02) Participants in our support group and life skills group are free to share experiences or ask for help from their peers if they need it. I encourage that. They develop relationships with neighbors. Sometimes I’ll bring or invite former residents into group and have them share stories and experiences. That’s as far as we go with peer support. We don’t have a formal mentoring program but some ladies have partnered up for support.

(#03) Our board of directors includes survivors of domestic violence and a formerly homeless person.

(#04) We have a resident council that is inconsistent at best. But the opportunity for folks to be on resident council is always available and encouragement toward participating is always there.

One member of our board of directors reaches out to our clients every six months and does individual interviews and focus groups to get their feedback about staff, about the building, about the program, about anything they want to give feedback on. We use the same list of questions, so we have created a baseline and can look at trends. We want to ensure that we’re solving the right problems, that we’re offering the right programs. And, if our clients -- for whatever reason -- don’t feel they can reach out to staff, they may be more willing to reach out to a board member. It’s been really beneficial for our program to get a pulse on what’s going on and whether we as a team are being responsive, or not, and learning from that. We’ve gotten some really wonderful feedback about how clients perceive our programming, some really great criticism, and some suggestions about what might be more helpful. We really rely on that feedback and have absolutely made changes in the program and in some policies based on that feedback.

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⁶⁹ See also the section on "The Pros and Cons of Hiring Staff who Are Survivors of Domestic/Sexual Violence" in Chapter 5 ("Program Staffing").
(05) I think it would be good to have a DV survivor on the board of directors. There are none currently. One board member is the father of someone who maybe is not completely out of it. That was part of his interest in serving. And we are part of coalitions which have included victims.

As far as providing opportunities for participants to suggest program changes or to express concerns about how things are done, we have the grievance policy to address issues they may have. I go over it step by step with them. We also do an exit interview; it’s just a few questions about what they liked and didn’t like. The last client who exited urged us to notify clients about what their utility bills have been each month. Now I bring the utility bill when I meet with them so they have more knowledge when they exit the program.

(06) We have very limited capacity for allowing current or former program participants to serve in an advisory role. We do vet some of our policies and procedures with participant groups to make sure we’re not missing stuff, but 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?

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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. [Such] 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 "programmatic 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)
(#07) We have a volunteer program for people who've used our services, because they often have no work experience and need to build references; if they volunteer with us, we can provide an employment reference.

(#08) It is part of our bylaws that we must always have at least one survivor on our board. Right now, there are two. How could you be a provider of domestic violence or sexual assault services and not be open to survivors coming back? Until you have walked in those shoes, you never know for sure because you haven't been there. Having those individuals there as part of the planning and providing services is invaluable.

(#09) 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.

We have a formal grievance policy which allows participants to express their concern in a phone call, a face-to-face meeting, or a letter. So there's that avenue but there's a more informal opportunity to just talk to the advocate. We take their feedback seriously. We've changed things as a result of women's feedback. I don't mean just complaints or grievances but what's going well. We use an approach called Appreciative Inquiry in which we ask about what's going well, so we can try to do more of that. And we pay attention to their grievances, and try to be responsive to those, too.

(#10) When they get ready to leave the program, we have an evaluation of the program – not of their accomplishments but of our services. I don’t know if it’s a good or a bad thing but I send them out, there’s a return envelope, and we’ve never gotten any back. So, I can look at it as they are satisfied with everything, or I can say “they just want to get on with their lives.” Usually our case manager does their last case management with them and she asks for feedback – “Is there anything we could have done differently or that you would like to see?” So far, there hasn’t been critical feedback. They’re given the opportunity. They don’t even have to give it to us; if they’re doing the survey, it goes to the deputy director. They don’t have to be afraid that we’re going to withhold services. There are a lot of former clients that check in several years down the line and will call and say how wonderful things are going, but we haven’t gotten any feedback, good or bad. The only thing we can think of is they are done and they just move on.

(#11) We have co-op meetings quarterly for the residents who live there. In those meetings most of the time we try to bring someone in from the community or one of the clients themselves to speak to the other peers about the agenda and different things that are going on in the complex. Lately, what we've been trying to do is have one of the ladies step up and run the meeting, which brings a different feel to the meeting, because it’s a peer who is leading at the meeting, one of the clients. And we have former tenants of supported housing come and speak about what they went through and what they had to do in order to be successful. It's empowering for them, and for the current residents, hearing that from someone who's actually gone through it and succeeded, as compared with one of the staff standing up in front of them and giving them a pep talk.

(#12) There’s a few different ways current participants can provide feedback – probably most feedback is through informal conversations with the advocates. We also conduct more formal surveys every month – how our services are helpful, how they could be better. I find that we get better feedback from those informal conversations -- “why don’t you guys do this or that” -- than from the formal surveys. In case people feel they aren't being heard, either through the informal process or the formal surveys, we also allow for grievances, and we make sure that clients know how they can share a grievance. We will actually take verbal grievances.
We don’t make people write them out, or submit them in a fancy format. So, we try to do whatever we can to limit barriers when people have input. But we do get most feedback through the informal conversations.

(#13) We have an exit survey and we ask about the services they used, how we can improve, what they needed but didn’t get -- and we take their responses to heart. People are very honest on those surveys because they’re leaving and have nothing to lose, so they tell it like it is. It’s been a great resource to help improve our program.

(#14) Our Healing Hearts Bank is a unique way in which graduates of our program get to come back to help current participants. Survivors who successfully participate in our IDA program can go on to work with the Healing Hearts Bank, which allows them to make small micro loans to other survivors in our program. A small micro loan would be like I’m trying to fix my credit. There’s only one $250 debt left: can I get a micro loan from the Healing Heart Bank for $200? Instead of borrowing money from a commercial lender and having the creditor coming after me, I can pay it back with small payments over time. The survivors who work with the Healing Hearts Bank are the bankers that make the decisions regarding which loans to give out.

(#15) We do quarterly surveys with our residents. We try every few years to do tours with survivors, with former clients, with community members. We’ve held focus groups with different populations we felt like we were not serving that well: some of the recent subpopulations that we’ve tried to figure out how to serve better include African-Americans, men, and members of the LGTBQIA community.

We strongly believe that if you seek feedback from your clients, former clients, and the community, it’s really important that you actually use that feedback and respond quickly. So as soon as we get the information, we try to look for what we can immediately implement because it builds faith and trust that we’re not just going through the motions of asking for feedback, we’re interested in putting that feedback to work to improve our services. In turn, when folks see that their insights and feedback are being taken seriously, taken to heart, and put to work, we’re more able to access their participation and feedback.

(#16) We have a Transitional Housing Advisory Council. Women who have completed our program are asked to come back and participate as a stipended ($25) council member. About a third of the women accept our invitation. We survey the women and ask them questions about their experience in that program: Did it meet your needs? How could it have better met your needs? We get some really interesting answers.

(#17) We do client surveys before they begin receiving services, then one a couple months out, and maybe one a couple months later, just to show the difference in what they’re reporting. So there’s one before services, one sometime in the middle, and one when they exit the program, to give feedback. If someone has a concern while they’re in the program, and for some reason they aren’t comfortable speaking with me about it, they have access to my supervisor; we also have a grievance procedure, so they know there are other people above me that they can communicate with. And we have an appeal form; we haven’t really turned away anyone, but they could file an appeal and a grievance if there was something they weren't happy with.

(#18) (Not a current OVW grantee) We don’t ask participants to complete any survey when they exit the program. We’re available, our doors are open all the time for people to give feedback about what’s working and what’s not working for them. And there is a grievance process. If they don’t agree with something, they let us know. If we're not able to resolve it, then the client meets with the director. If the client is still not
satisfied, then the client writes a letter to the board of directors, and then they handle that situation, and the board will advise the director.

(#19) We offer survivors the chance to complete a survey while they are still active participants in the program. When we get those surveys back, they are presented to the quality assurance committee to see where possibly something fell through the cracks, whether it was in the emergency room, with the advocate, the prosecutor, the police department, or wherever, so that we can continue to do this work better and sometimes different. And then that group responds back to the survivors. I think I previously mentioned how we involved Native American participants in helping to make our program more culturally appropriate.

(#20) 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.

(#21) The women we house participate in a committee that advises us on their needs and what they want, and of course it changes, but that’s why we keep the committees going. Because we don’t want to get stuck; what worked for one person may not work for someone else.

We do a lot of peer support-type programming, which seems to work well. All of the staff -- house managers and family justice specialists / case managers -- are in recovery from substance abuse, so they can speak from experience. I have to say it absolutely makes a difference to the women. Each house has a house manager who’s been through our program or another program. We had a professional in that role, but it didn’t work.

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.

(#22) One of my goals this year is to get feedback from my transitional folks -- before, during, and after their stay. It's been on top of my list. We do get feedback, but could do better. I was thinking of a focus group.

(#23) When they leave the program after two years, they fill out an evaluation questionnaire about their apartment; about their case manager; what they loved about the program; what they feel could be improved.

(#24) We ask for consumer feedback periodically. If we’re working long-term with somebody, we wouldn’t wait until 18 months later; certainly, we try to seek that during services as part of the conversation -- "Are we treating you with respect?" "Is there more we can do to help?" "How is this feeling for you?" We offer the feedback form on some kind of a regular basis during the time somebody is in services.
Questions to Consider

1. At what point(s) during a participant’s relationship with the program does the program solicit feedback from the participant about the perceived strengths and shortcomings of the program, about the quality of the participant’s experience in the program, and about how the program could be more helpful?
   - What are the different mechanisms that participants can use to provide feedback?
   - Is it important to be able to deliver feedback anonymously? Why?
   - What are the advantages and disadvantages of waiting until the exit interview to solicit feedback?
   - If the reasons for waiting until the exit interview is to make it "safer" for the participant to provide candid feedback, what can the program do to make it feel safer to offer feedback while the participant is still in the program?
   - What are the advantages and disadvantages of soliciting feedback in writing versus verbally?
   - If feedback is solicited verbally, who should be in the conversation (e.g., staff the survivor knows, a board member, senior staff, or someone else)?
   - If the program solicits feedback periodically during a participant’s stay in the TH program,
     - What steps are taken to ensure that the participant feels safe being candid?
     - How does the program indicate to the participant that their feedback was helpful?
     - How important is it to make timely changes in response to that feedback?
   - Sometimes, a program could be more helpful or positive for a particular participant, if staff did things differently. How does a program make it safe to provide that kind of specific (and identifiable) feedback to staff while the survivor is in the program, so that changes can be made to make the program more helpful to that survivor?

2. How does the program distinguish between grievances and other kinds of participant feedback?

3. What are the advantages and disadvantages of a program advisory committee made up of current participants? What are the advantages and disadvantages of including former participants?

4. If current or former participants have program advisory roles or a volunteer roles assisting current residents:
   - How does the program work to clarify and maintain what it defines as “appropriate” boundaries (e.g., among current participants/former participants, between staff and current/former participants) to protect current/former participants from unintended violations of their confidentiality or from vicarious trauma?
   - How do current/former participants benefit from holding those advisory or volunteer roles?
   - How do other current participants benefit from their peers holding such roles?

6. 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
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 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.

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71 "Universal" Topics: Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary vs. transition-in-place; congregate vs. clustered vs. scattered-site; provider-owned vs. provider-leased vs. 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 vs. 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.

72 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 vs. 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).
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 participation 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 areas 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 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

73 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.

74 Several codes were consolidated as the coding process evolved.
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.

7. References


Chapter 4: Taking a Survivor-Centered / Empowerment Approach: Rules Reduction - Voluntary Services - Strategies for Engagement - Page 124


