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

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

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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)<sup>1</sup> and the Missouri Coalition of Domestic and Sexual Violence<sup>2</sup> -- 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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<sup>1</sup> 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."*

<sup>2</sup> 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."*

## Executive Summary

Chapter 4 explores the interconnected concepts of rules reduction; voluntary, survivor-centered services; and empowerment, and looks at how those concepts are implemented by victim services providers operating specialized transitional housing (TH) programs<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup> 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,<sup>6</sup> 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.

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

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<sup>3</sup> 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."

<sup>4</sup> 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

<sup>5</sup> 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.

<sup>6</sup> 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.

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<sup>7</sup> 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**<sup>8</sup> 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.<sup>9</sup>

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 with their advocate;<sup>10</sup> it's okay for an advocate to share her concerns about the possible impact of a survivor's

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<sup>7</sup> The Violence Against Women Act, which authorizes the OVW's Transitional Housing Assistance Grants Program.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> However, the narrative suggests the need to **clarify "the line" between a "check-in" and case management services**.

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 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.

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, & Heimerl \(2015\)](#) developed an easy-to-use metric called "MOVERS" (downloadable from the NRCDDV'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.

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