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

Executive Summary of Chapter 5: Program Staffing

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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)¹ and the Missouri Coalition of Domestic and Sexual Violence² -- and uses feminine pronouns to refer to adult victims/survivors of domestic and sexual violence, and masculine pronouns to refer to the perpetrators of that violence. This report also uses feminine pronouns to refer to the provider staff of transitional housing programs that serve survivors. The use of those pronouns in no way suggests that the only victims are women, that the only perpetrators are men, or that the provider workforce is entirely female. Indeed, the victims and perpetrators of domestic and sexual violence can be male or female or transgender, as can the staff that support their recovery, and the shortcut herein taken is merely used to keep an already long document from becoming less readable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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