An Evaluation of Domestic Violence Shelter Programs and Research Best Practices

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An Evaluation of Domestic Violence Shelter Programs and Research Best Practices

by

Katherine Brown

A thesis submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Master of Arts
Sociology
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An Evaluation of Domestic Violence Shelter Programs and Research Best Practices

Katherine Brown, M.A.
Western Michigan University, 2018

Domestic violence is a prevalent social problem occurring all over the world. The numerous ways society addresses domestic violence programs varies causing further complications. This study aims to better understand some of the domestic violence research best practices, programs, and policies available through a national study examining innovative residential shelter programs. A content analysis of interviews, tour photos, shelter pamphlets/websites, and training materials suggested four themes. The main finding, however, suggested trauma-informed care should be implemented within safe housing for survivors of domestic violence.
ACKNOWLEDGMENTS

I would like to recognize Dr. Angie Moe for her guidance throughout this process. Her wealth of knowledge and enthusiasm was a tremendous support, and I am truly grateful for our many shared conversations. Her critical feedback greatly improved the quality of this work and provided a platform for self-growth as a scholar. I would also like to thank Dr. Jessica Edel for this research opportunity. Without which, this study would not have been completed. I would additionally like to acknowledge Dr. Whitney DeCamp for his feedback and support.

Finally, I would like to dedicate this work to Kevin Nester. He was a great friend and strong support system who always encouraged me to strive for more in life as well as academia. Rest easy, Kevin.

Katherine Brown
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INTRODUCTION

Domestic violence\(^1\) is a universal problem with the capacity to affect anyone and everyone. In the United States alone, approximately 20 people per minute experience physical abuse by a significant other, equivocating to more than ten million individuals in the duration of one year (National Center for Injury Prevention and Control 2010). Of course physical violence is only one aspect of a range of activities involved with intimate partner victimization, the rates of which are undoubtedly much higher and go largely unreported. For example, in 2011, intimate partner rape occurred in 9.4 percent of women in the U.S, and of 66.2 percent of women who have been stalked, reported being stalked by a current or former intimate partner (NCADV 2015). With such a large number of people being affected, it is important for research to continue examining the nature of and best responses to this social problem.

This study focused on programs that provide services to those affected by domestic violence. Specifically, this thesis stems from an evaluation of domestic violence shelter programs and best practices in Southern Michigan. I had the opportunity to collect data for a shelter with the hopes of assisting the facility administrators as they transition into a new building and update their shelter philosophy. This work focused on residential programs with the overall goal of contributing to a fuller understanding of research best practices and policies within domestic violence services.

Six shelters throughout the United States and one state coalition administrator were included in this study – they were analyzed in terms of their respective service delivery

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\(^1\) In this study, I mainly used “domestic violence” to refer to abuse that occurs within a family setting. I do this to emphasize the connection, via consistent labeling between the phenomenon and domestic violence shelters (“domestic violence” is a common label used throughout such victim services). Throughout this study, other terms are used to refer to the phenomenon of domestic violence (e.g., abuse, intimate partner violence, wife abuse/battering), however all refer to the concept of domestic violence.
philosophy, structure/layout, measures of success or program evaluation, cost effectiveness, and other factors. I also continued reviewing existing research and policy initiatives with an eye toward understanding best practices in shelter policy and programming. At the request of the shelter administrators with whom I worked, this included not only residential shelter programs, but for non-residential programs as well.

One of the many reasons providing safe housing and services for survivors of domestic and intimate partner violence is important is due to the adverse long and short term physical and mental health effects occurring from such traumatic victimization (Bott et al. 2012). Women who leave abusive situations may not have a place to go (Shostack 2001). A shelter can be an important place for temporary safe housing as well as the start of much needed healing. Shelters allow survivors the opportunity to get back on their feet and can be an extremely powerful tool for empowerment. Some shelters provide assistance and opportunities for healing in more beneficial and better-received ways than others do. Ultimately, the goal surrounding this research project is to provide the shelter for whom this research was conducted with the means to improve their model as they transition into a new facility.

The shelter I worked with claimed to adhere to an empowerment model with their services, meaning they want women to feel a sense of control and empowerment over their lives after leaving an abusive situation wherein they had very little power (Davis 1988). Unfortunately, it appeared the organization’s board did not recognize or support an empowerment model within the facility, in contrast to the service delivery philosophy of the agency’s relatively new executive director. For example, the women residing at the shelter must adhere to what seems to be an overly strict curfew. Additionally, the shelter itself is very worn down and has inadequate living space (e.g., four people live in a room no larger than twelve feet
by twelve feet.) Obviously, such conditions are problematic in a variety of ways, not the least of which are the types of message such treatment and facility space likely gives to an individual who recently escaped an abusive situation. Such conditions facilitate disempowerment and a lack of control. My research intent was to provide data to demonstrate to the board of this particular agency, and perhaps others, in more advanced models and practices used around the country to support the safety and healing of abused women and their children.

A REVIEW OF THE LITERATURE

Defining Abuse and Domestic Violence

The Office of Violence Against Women within the United States Department of Justice (2016: 1) identifies domestic violence as “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner.” Accordingly, abuse can occur physically, emotionally, sexually, economically, or through psychological actions as well as threats of actions of violence. According to the National Coalition Against Domestic Violence [NCADV] (2015), 2,492 survivors sought help from Michigan domestic violence programs in 2014. Gender is another aspect of domestic violence, which needs to be taken into consideration. The NCADV (2015) recognizes that one in five women and one in seven men experience severe physical violence by an intimate partner during their lifetime. Significantly, women are more likely to experience domestic violence. Between the years 1994 and 2010, approximately four out of every five intimate partner violence victims were women, illustrating further the disparity between male and female domestic violence victims (Catalano 2012).

While all demographics of women remain susceptible to domestic violence, economic, social, and ethnic divergences impact how individuals experience and encounter domestic
violence. Women of low socioeconomic status seem to experience abuse at a greater frequency and with more severity compared to those with higher socioeconomic statuses. In addition to more brutality and a higher frequency of occurrence, poorer women also do not have as great of access to resources and protective services (Williams and Mickelson 2004). Low educational attainment, lack of access to information, and poverty make escaping violence more difficult because these and other structural barriers limit the ability to be financially independent, as well as limit knowledge of available resources (Sokoloff and Dupont 2005). Of course, domestic violence affects all demographics and is not purely a poor person’s problem. An untold number of people experience domestic violence. The exact frequency is difficult to know, however, because shelter research excludes those dealing with domestic violence more privately.

The national definition of domestic violence and the State of Michigan’s both emphasize that a substantial aspect of abusive relationships concerns establishing control over another individual. Adapted from the original power and control wheel developed by Domestic Abuse Intervention Project, the Gender-Inclusive Power and Control Wheel (SAVE: Stop Abusive and Violent Environments 2009), emphasizes various components in which control and power are exerted through domestic violence. These include coercion and threats, intimidation, emotional abuse, isolation, using children against the victim, economic abuse, gender privilege, as well as denying, minimizing, and blaming the victim by making fun of the abuse and claiming the victim is at fault (SAVE 2009). Abuse is not only incredibly widespread, but multifaceted as well.

**Domestic Violence as a Social Problem**

A frequent assumption prior to widespread recognition of domestic violence, was that it was a distinct phenomenon from other forms of violence. It was largely morally tolerable and not perceived as a public problem. As Loseke (1992) aptly argued, prior to domestic violence
being considered socially problematic, few recognized that: “wife abuse is extreme and consequential and intended and done for no ‘good reason’” (p. 44). Labeling a condition or phenomenon as a social problem implies taking a moral stand. Society decides the phenomenon is extreme and intolerable. The responsibility then falls on the public to do something about it. The viability of social problems allegations, however, must rely on convincing the public of the justification of necessary interventions regarding the moral stances being taken (Loseke 1992).

In 1974, Gelles argued that by socially defining family as both nonviolent and nurturing, a “perceptual blackout” was created that effectively condoned violence within “normal” families (Dutton 1992). Significantly, without calling attention to the problem of abuse within the familial setting, U.S. society remained in a position of not having to recognize the issue. This was especially pertinent among families where abuse was taking place, in that no words or labels were even available for naming it. Familial abuse was allowed to perpetuate as families in which it was occurring had little to no recourse for understanding or responding to it.

This slowly began to change in the late 1960s and early 1970s when grassroots women’s groups began responding, locally, to the needs to their neighbors, friends, and relatives who were caught in violent relationships. Many of these earlier activists were feminists who were already aware of gender based violence, due in part from the contributions being made within the realms of sexual assault. Feminists recognized a link between battering and the patriarchal nature of gendered social relations (Schechter 1982). While some of these early activists focused on reforming the criminal justice system to respond immediately and consistently to domestic violence, while concurrently raising social awareness around violence towards women, there was also an urgent need to deliver immediate support and emergency shelter for victims. Through the 1970s, such efforts initiated the development of services for domestic violence survivors across
the nation as well as the world. Indeed, some of the earliest shelter efforts occurred in England through women’s aid societies (Schechter 1982; Berk, Newton, and Berk 1986).

**History of Shelters**

With two main foci, the battered women’s movement sought to reconceptualize the idea of family and accentuate the formation of shelters as establishments for transition. Whereas prior to the movement, the home was acknowledged as a haven with absolute stability, the movement proposed the notion of the home as potentially violent and dangerous (Lasch 1978). Grass roots activists noticed physical abuse occurring among women and children, and consolidated resources with the hopes of generating alternative possibilities for violence. Simultaneously, grass roots attempts to confront gender stratification were done through the creation of shelters (Ferraro and Johnson 1983). Interestingly, the formation of shelters occurred prior to the battered women’s movement as well, but the goal of such efforts was to provide places of refuge for victims of alcohol induced violence (Pahl 1985).

In 1971, Erin Pizzey founded a small shelter by the name of Chiswick Women’s Aid in England. Shelter and safe house programs rapidly spread across Britain and to other countries, illustrating a heightened awareness of the peril and anguish survivors of domestic violence face. With the development of what has been called the Battered Women’s Movement in the U.S., the quick development of emergency housing for battered women and their children marked the 1970s as a time of substantial change and advancement regarding the treatment of battered women (Shostack 2001). The United States alone established at least 300 shelters during this decade, a number that drastically increased in subsequent decades. As of 1996, there were approximately 2,000 domestic violence programs in the country, most of which were operating residential shelter programs (Saathoff and Stoffel 1999).
Such expansion of services did not come without costs however. The Battered Women’s Movement has, at times, had a difficult time sustaining shelters and victim services, which had previously been largely financed through private donations and local philanthropy. As the need for additional shelters and a greater array of victims’ services grew, sustainable sources of funding became a concern. Many U.S. agencies became increasingly reliant on public (government) funding, while elsewhere, such as Canada, faced privatization. For instance, in 1985, the Canadian government attempted the privatization of its shelters, commencing in British Columbia, which threatened the quality and philosophy originally intended within the movement. Indeed, forced privatization often accompanies “the drastic cutback in state services and subsequent shifts to the private sector to meet welfare needs” (Picket 1969:266).

Domestic Violence Shelters Definitions and Conceptualization

Since the establishment of shelters in the 1970s, research has focused more on the impact that shelters have on women’s experiences. From the research and corresponding literature, three themes emerged. The first theme conceptualizes shelters as a place of short-term refuge, the second considers the experience of shelters in ceasing violence, and the third assesses the decision-making process among females (Davis 1988). Davis contends (1988) that alternative housing for women and their children acts as a “short-term refuge.” Women and children are able to remove themselves from the violent situation and obtain assistance with permanent housing, access legal aid, and initiate contact with social services. Such efforts are important for those hoping to divorce an abusive spouse, obtain custody of children, and/or relocate to independent housing. Whether women decide to leave or return to their abusers makes up a huge proportion of the literature in this area, specifically in relation to factors such as fear, perceived lack of options, traumatic bonding, and lack of resources (Eisenberg and Micklow 1977). In
terms of the third theme, how shelters influence the halting of violence, existing research shows little consensus. However, Berk, Newton, and Berk (1986) contend that compared to women seeking assistance from clergy, relatives, or friends, women using shelters are more likely to be a part of significantly more violent relationships. Whether or not relationships end after a shelter stay must be considered within this context – the sheltered woman’s circumstances are likely to be especially dangerous and precarious. Shelter access in its own right, then, is of critical importance.

Though dated, Davis (1988) offers a helpful typology of models for domestic violence shelters that still seems relevant: feminist, social service, custodial, and family welfare. The feminist model recognizes male oppression in the forms of institutionalized sexism as well as imbalances of power among men and women, as being the primary cause of domestic violence. Shelters using a feminist model perceive the shelter’s purpose as a source of protection, an avenue for allowing women to transition to a lifestyle with more autonomy, and providing a safe house structured in women’s advocacy. Feminist shelters promote the ideology of survivor empowerment and strive to create a “safe environment” for such liberation to occur. Referring to “the capacity for self-care and taking charge of one’s own destiny,” (Davis 1988:408) this philosophy of empowerment meshes with the feminist ideology of security and protection in the context of social control and individual rights.

The social service model views the cause of domestic violence as deriving from learned helplessness and internalization of the victim role by the abused individual. Primarily, the social service shelter is utilized as a short-term intervention, a type of safety net as well as a resource center where women and children in crisis can receive goods and services. Using both a victim-centered ideology in addition to a medical approach, the social service ideology emphasizes the
individual as being deficient in some way. Victim-blaming can be common in these settings and seemingly rigid sets of rules are consistently enforced (Davis 1988). However, the ultimate goal is to instigate change within shelter clientele by providing counseling, support, protection, networking, and advocacy within courts and welfare agencies (Davis 1988). An important objective is to encourage victims to advocate for themselves within these settings as well. Within the social service model, it is not uncommon to integrate services meant primarily for the welfare population. As such, this model seems to have become particularly common within current domestic violence shelters. There is a bit of a ‘supply and demand’ component here, wherein many domestic violence victims qualify for traditional social welfare services. As such, the social service model seems to be even more susceptible to bureaucratization as it is become increasingly dependent on government funding (Davis 1988).

Somewhat relatedly, custodial shelters view individual factors as the main cause of domestic violence. As such, they place much of the blame for abuse on survivors, seeing their victimization tied to, for example, mental illness, alcoholism, family disorganization, or individual pathology. Such ideologies are often found within shelters that provide housing specifically for the homeless. Indeed, unlike the social service and feminist models, the custodial approach caters more to the homeless population as opposed to battered women and children, calling for a more universal ideology of addressing human suffering whatever the cause. The population at shelters using the custodial model tends to belong to the lowest socioeconomic groups and are often characterized as destitute and hopeless. Women and children, specifically, are stigmatized as coming from deplorable backgrounds, misusing drugs and alcohol, and as having lived with violent men previously. However, because such individuals are human, this model identifies them as being deserving of at least a bed with limited protection
from criminals on the street. The custodial model’s philosophy is very similar to that used in various institutions that housed “surplus populations” (e.g., workhouses, asylums, houses of refuge), within the eighteenth and nineteenth centuries. Because of the universality of this shelter model, distinctive needs of the people are ignored (Davis 1988).

Lastly, family welfare models perceive the breakdown of family relations, along with individual pathologies, as causing domestic violence. These shelters are premised on offering sanctuary and being used as a safe house for community reform (Davis 1988). The family welfare approach comes from a more liberal perspective that regards shelters as having a healing component. As such, adherents to this model see shelters more as “healing centers” with the potential to transform individual, family, and community life through promoting “partnership, cooperation, and mutual commitment rather than dominance, violence, and submission” (Canadian Task Force on Violence Against Women 1986). In addition to the liberal model, a more conservative version also exists with the goal of perpetuating traditional female roles in the home. According to Marchack (1984), this specific subtype encourages men as the unchallenged authority figure within families, with women playing traditional roles as mothers and wives, and a much more conservative sexual code. Such a philosophy may also mesh well within religious affiliated shelter/service agencies. Reunification of families is the ultimate goal of this model. Rather than escaping a violent and destructive family situations, more emphasis is placed on acceptance and adjusting one’s expectations.

RESEARCH QUESTIONS

In accordance to my work with a domestic violence shelter in Southern Michigan, and informed by the above literature on the history, evolution, and model typology of domestic violence shelters, the following served as research questions for this study:
1. What domestic violence shelter services are considered most effective today in the U.S.?
2. What common philosophical and structural characteristics occur in such facilities?

METHODS

As I examined best practices for residential and non-residential domestic violence facilities, I interviewed executive directors or other administrative leaders from six shelters across the country as well as one state coalition. These were selected through recommendations from the executive director of the shelter this research was conducted on behalf of, identifying shelters through reviewing materials on current shelters, and suggestions offered by shelters once I started the research process. As Janesick (1998) describes, an interview is a “meeting of two persons to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular topic.” The interviews followed a more structured approach using purely open-ended questions. Although I used a question sheet to ensure that all of the necessary questions were asked, I asked further questions when the conversation permitted and were relevant to the study. In this regard, aspects of semi-structured or in-depth interviews were integrated as well. Esterberg (2002) discusses semi-structured interviews as having the objective to allow greater exploration of a topic in a more open fashion. This style of interview gives the interviewee the opportunity to convey their own ideas and opinions. In coordination with the executive director of the shelter with whom I worked, the objective was to contact administrators from shelters with newer and different philosophic service-delivery models (e.g., shelters catering to victims of same-sex partner violence). A wide range of questions were asked touching on the history of each model and how it was decided upon, as well as sources of funding, cost of running the model, and the various programs and policies in place within the shelter (see Appendix A). These interviews were
conducted in person between March and September 2017. I transcribed the audio-recording of each interview within one week and stored each of the transcripts in a password protected laptop computer. (The HSIRB of Western Michigan University exempted this study from formal review – see Appendix B.)

I also toured the facilities whenever possible and reviewed each of the shelter’s existing domestic violence program literature (online and print, as available). Funding for such travel was provided by Western Michigan University’s Graduate Student Research Grant and the Department of Sociology’s Kercher Endowment. In preparation for this project, vigorous and thorough noting of outcomes for each shelter occurred by reading literature and familiarizing myself with each shelter’s model philosophy listed online. Along with outcomes, strengths and weaknesses of each model were considered as well as the implementation of research-identified best practices. The preparatory work helped me to familiarize myself with the shelter environment, allowing me to be more knowledgeable during my tours and interviews. I was able to collect more detailed notes because of this.

Within the context of this study, I referred to content analysis as a way to describe how I analyzed the data. Content analysis is a methodology aimed at examining communication through its form and substance. The objective was to identify elements of patterns and underlying ideas and meaning within the data (Yang and Miller 2008). One such pattern I expected to observe, for instance, was how facilities transitioned from older to more updated models. Themes were identified through the process of coding as suggested by Babbie (1999). Babbie discusses the process of empirical coding, guided by each researcher’s individual coding system, which allows for observations of the data to be made and conclusions to be drawn. As I went about this analysis, I read through my interview transcripts, field notes and other materials
generated from the shelter tours, as well as any other information obtained about each shelter’s services. As I went through them, I looked for similarities and differences and developed codes. I also highlighted and typed up outlines of what I found interesting, unique, and/or distinct about each shelter’s service delivery model.

Table 1 below lays out each shelter I visited, the name of the interviewee or interviewees from the respective shelter, the size of each shelter, and the data collected and analyzed at each location.

Table 1: Summary of Shelter Labels, Interviewees, and Research

<table>
<thead>
<tr>
<th>Shelter Number/ID:</th>
<th>Shelter Size:</th>
<th>Interviewee(s):</th>
<th>Source of Research:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter 1</td>
<td>43 units/apartments</td>
<td>Karen</td>
<td>Interview, web resources, presentation (training), article on shelter research</td>
</tr>
<tr>
<td>Shelter 2</td>
<td>23 beds</td>
<td>Tamara</td>
<td>Interview, walk-through tour with photos, website information</td>
</tr>
<tr>
<td>Shelter 3a</td>
<td>100 beds</td>
<td>Leslie</td>
<td>Interview, walk-through tour with photos, website information</td>
</tr>
<tr>
<td>Shelter 3b</td>
<td>NA</td>
<td>Lauren</td>
<td>Interview, published book on low-barrier shelters</td>
</tr>
<tr>
<td>Shelter 4</td>
<td>15 beds</td>
<td>Sharon and Brian</td>
<td>Interview, pamphlets, website information, administration walk-through</td>
</tr>
<tr>
<td>Shelter 5</td>
<td>18 beds</td>
<td>Amanda</td>
<td>Interview, walk-through tour (no photos), website information</td>
</tr>
<tr>
<td>Shelter 6</td>
<td>25 beds</td>
<td>Stacey</td>
<td>Interview, walk-through (no photos), website information</td>
</tr>
<tr>
<td>Shelter 7</td>
<td>40 beds</td>
<td>Jasmine</td>
<td>Interview, walk-through (no photos), focus group, website information</td>
</tr>
</tbody>
</table>

The table depicts a wide range of data used and analyzed across the sample. Additionally, it is important to note that there is a Shelter 3a as well as a Shelter 3b. Shelter 3a refers to one shelter I visited that was part of an ongoing effort, along with several other shelters in that state, to

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2 To maintain confidentiality, pseudonyms were used for the interviewees.
reduce the amount of rules within each facility. Shelter 3b represents the corresponding statewide effort - a member of the coalition provided insight on this.

The shelters studied in my research varied in size. Shelter 1 has separate one-bedroom apartment-style units for each family that enters their safe housing with forty-three units total in the building. Shelter 2 has twenty-three beds at their facility. However, during the interview, Karen noted that they can serve up to thirty-six people at a given time with the use of couches and pull-out chairs, Shelter 3a was the largest safe housing facility examined for this research with 100 beds. With fifteen beds, Shelter 4 was the smallest shelter included in this study. Shelter 5 has eighteen beds. Shelter 6 has four suites total and can serve up to twenty-five people. Lastly, Shelter 7 is a forty bed shelter.

FINDINGS

Four overarching themes were identified through this research: trauma-informed services, client autonomy, community engagement, and health and safety. All four of these themes are closely interconnected and my ordering of them is purposeful. For example, my findings indicate that trauma-informed services is an over-arching concept that needs to be implemented in numerous ways. Client autonomy, community engagement, and health and safety are all important elements of a trauma-informed service delivery model, however they also stand out as emergent themes in their own right. Trauma-informed care is, therefore, an idea that is present within each theme discussed throughout the research. Taken together, these themes illustrate a bridge between philosophy and practice within domestic violence shelters.

Theme One: Trauma Informed Services

It was clear during my interviews, visits, and review of materials that each member of the staff within the shelters, whether an administrative worker or a therapist, were expected to
comprehend the lasting effects of violence experienced by those served. Indeed, it has long been recognized that a majority of clients in human service systems are survivors of trauma (Browne and Finkelhor 1986), and certainly domestic violence victims have experienced trauma. Within my study, there was a very explicit emphasis on trauma-informed care and why it is necessary. The main premise of trauma-informed services is to not set out or attempt to treat the symptoms related to victimization, but rather “provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors” (Harris and Fallot 2001:5). An important aspect of this approach involves listening to, including the input of, and updating shelter models based on the feedback provided by survivors (Elliot et al. 2005).

Trauma informed services can be implemented in a variety of ways, ranging from allowing space for residents to meditate to taking into consideration how survivors of domestic violence might react to various scenarios. Stated differently, according to training materials from Shelter 1, “being trauma informed is about creating a culture that understands the physical, mental, and emotional impacts of trauma.” Tamara, from Shelter 2, suggested that their services are trauma-informed in similar ways to how other shelters define the concept. She stated “It’s more of a philosophy that staff has to recognize and be willing to participate in ‘how can what WE do serve your needs?’” Such an approach was discussed in greater detail with Leslie, from Shelter 3a, in which she described the physical layout of her facility:

So this is now the entrance to the shelter. As we have designed all of our spaces, we try to have an eye for accessibility and also trauma-informed spaces, so just thinking about what it’s like to be a survivor who is home one minute, and the next thing they are coming into shelter. We try to think about how traumatizing and scary that would be. Our old place had a stairway and all sorts of people, and it was loud and chaotic. We wanted to have an entry way where people could just walk in and not have that, so we could ease people into that. Also, to have little spaces around like this (and I’ll show you more). It’s community living, and it’s really hard. We’re a one hundred bed shelter, so space for alone time is important to have. (Refer to Image 1a and 1b).
By having a welcome/entrance area in addition to a separate area for intake, clients do not have to face a lot of people or activity when first entering the shelter, thus creating a more positive, client-centric, and trauma informed space. A separate intake room was also noted at Shelters 2 and 3. Significantly, a playroom was attached to both of these intake rooms as well. During the respective interviews with Tamara and Leslie, both noted that the reason for such space was to prevent children from having to hear about the direct or indirect trauma experienced
by members of their family prior to entering shelter. By including an additional playroom off the intake room, the children can be monitored by their mothers without the added stress of worrying about what their children are doing and/or hearing. Moreover, the presence of a playroom off a private area illustrates that the shelter is considering how to best serve the survivors entering shelter. It is believed that these extra spaces also allow for an easier transition into the shelter and help to build trust with the staff. As such, these layouts align with a trauma-informed care approach:

Human service agencies need to work with the women they serve to modify staff approaches, programs, procedures, and the physical setting to create a place perceived as safe and welcoming for survivors. A welcoming environment includes sufficient space for comfort and privacy (Elliot et al. 2005:467). Moreover, it is believed that greater and timelier healing can occur because of such efforts. As trust builds between residents and staff, a greater sense of comfort develops in how the women feel within the shelters, which may have varying positive ramifications. “When one understands the abuse of power inherent in all victimization, it becomes clear that the power differential between the person seeking help and the person offering it will be threatening” (Elliot et al. 2005:468). For example, more survivors may want to participate in different therapies offered within the shelter, but even if they do not, within a trauma-informed space, the autonomous living conditions contribute to self-care because the women are the ones making the decision if they want to attend therapy for themselves.

As previously discussed, physical spaces are important to consider through a trauma-informed lens (Elliot et al. 2005). Therefore, acknowledging that women entering shelter may want to bring companion animals with them is also important, especially because pets are often “hidden” victims of domestic violence (Flynn, 2000:102). It is estimated that one out of every
five battered women do not seek shelter right away out of concern for their companion animals (Ascione 1998). Indeed, previous studies that included interviews with shelter residents indicated that women would have left their abusers sooner had they not had to worry about the welfare of their pets (Flynn 2000). So not only does using a trauma-informed approach to on-site pet shelters benefit the women in that they will seek out shelter more rapidly, but more lives may be saved by doing so.

Shelter 3a took this into consideration when including a pet-friendly meditation room in their facility (Image 2). As one of the only shelters in the country with an on-site animal shelter for the pets, Shelter 3a took it upon themselves to not only look at what trauma-informed care means for humans, but other sentient beings as well. Moreover, survivors are encouraged to bring their pets in from the outside pet shelter to relax with them.

Flynn (2000) also discussed how women found it soothing and reassuring to talk with their companion animals following an assault. If survivors find a comfortable presence from their emotional attachment(s) during an abusive situation, it makes sense that these same sentient
beings would be comforting in a time of transition. Such human-animal bonds indicate the importance of having on-site shelters and areas for animal therapy. Of course, Shelter 3 also recognizes that not all of their residents will desire contact with animals and so pet-free meditation rooms are also available.

Another element of trauma-informed services involves offering nonresidential support groups, therapies, and other services for survivors of domestic violence (MCADSV 2015). Leslie discussed the importance of having spaces for non-residential individuals participating in therapy and group within the shelter setting:

This is another multipurpose room. Some people use it for small groups, but it’s also for nonresidential therapy. Some people want to have a meditation/quiet room for them as well, so when you think about someone having a really heavy, intense therapy session, and I’m done, but I’m not quite ready to get in my car and go home with everything I’m dealing with, we just wanted to have a space where they could come. And that’s one of our practices of trauma-informed care. We actually have a trauma-informed care committee, a wellness committee, a diversity connections committee that looks at cultural competence, and a performance and quality improvement committee, so we can ALWAYS be looking at ways to improve. So many of the improvements we’ve had done have been impacted by the direct service staff and survivors.

Therefore, being trauma-informed in this instance means meeting the needs for those who are receiving nonresidential services as well.

Previous research has indicated that trauma among children is very distinct to that of adults. Tamara, from Shelter 2, addressed this during her interview, “We offer private counseling. We don’t have a counselor on staff, so we do contract with a trauma-trained counselor for children and they come here weekly for our group, and then once a month, they come for the support groups.” At Shelter 4, children were paid a lot of attention to in terms of healing within the shelter atmosphere. Shelter 2’s representative, Leslie, expressed some similar sentiments during
her interview. However, Shelter 4 seemed to go above and beyond, given their limited resources, to cater to children’s needs within the shelter setting. Sharon from Shelter 4 said:

Our focus is very strong on rapid rehousing…What we’re looking to do in shelter though is to make sure, with our child advocate, that we have a response for families and kids. Using specific childhood advocacy programming and specific parenting programming helps navigate some of that ‘My child’s been exposed to violence. They’re behaviors have changed.’ Sometimes helping the kids doesn’t even have to do with violence - providing referrals to programs that maybe have nothing to do with violence, such as tutoring. Especially if the family is relocating, we can help provide contacts to those families to allow for them to move to Georgia and set them up with a great tutor, or therapist, or whatever…She [the child advocate] does a lot of voluntary participation crisis counseling with the children and families. We try to keep it trauma-informed, but that’s with our limited resources and serving twenty-three different counties in a 30 bed/30 day shelter…which is why rapid rehousing is the best way to serve and help the community in [state] with all of the statewide reorganization.

What the experience of Shelter 4, and others, suggests is that even without a lot of resources, it is still possible to be trauma-informed. Throughout my research, it became increasingly evident that a trauma-informed philosophy of care was quickly emerging as a best practice within domestic violence shelter agencies throughout the country. As training materials for Shelter 1 put it: “advocates are expected to offer ‘trauma-informed’ support by considering the unique situation of each survivor, and use critical thinking and an individual approach to offer meaningful services”. As will be discussed in further detail, a critical aspect of such a service philosophy is respecting client autonomy.

**Theme Two: Autonomy, Low Barrier Rules, and Voluntary Services**

As previously noted, the basis of trauma-informed care is how “trauma-informed services recognize the impact of violence and victimization on development and coping strategies” (Elliot et al. 2005: 465). While several principles of trauma-informed care have been widely agreed upon, some of these principles are emphasized more than others regarding the implementation of services within domestic violence shelters. This is evident with the second theme, which
involves respect for autonomy through low-barrier rules and voluntary participation in services. Such practices align with an empowerment philosophy which melds well with a trauma-informed service model (Elliot et al. 2005).

An interview with a representative from Shelter 3b provided insight on a statewide effort in Missouri to streamline and reduce the number of rules within the domestic violence shelter system. Lauren (Shelter 3b) described the first state-wide meeting on this effort:

Everybody did bring their handbooks, their policies, their procedures, and really started examining where certain rules kind of came from. What would happen if you got rid of those? For some there are some things you’re always going to have. For example, no smoking in the building, but that’s everywhere anymore. But what does that look like even as it’s written? Does it explain that there are smoking areas available? So it’s also do you have a structure? It’s not like you have no structure or guidance on things, but it’s really how can you…what do you really have to have right there in writing? And what can you do to build a relationship with that person in shelter in letting them know what they can expect while they’re here...so [Person X from the Y program], one of the things she had come up with in how she wanted her approach to be was to take - maybe it’s not the rules necessarily, but they still have for me the perfect set up which is individual cottages kind of set up. So not even your own room, but you have your own cottage. It’s a resort down by the lake. Her thinking was, this isn’t really about what we should expect from people that are coming here to live. This is about what people coming to here should expect from us.

Several components are important to note from this passage. The main one regards rules. Some rules will always have to be present because of housing laws, such as the smoking example. However, there are also places for freedom, which each shelter may need to figure out individually. Another item to note is that communal living is much more likely to have a greater number of rules than individual living. So for Lauren, an idyllic shelter is not only one in which you have your own room, but rather a cottage, apartment, or some other structure that mimics individual housing. More flexibility is possible with non-communal living.

Of course such a structure is not available in all shelters. For those with communal living, respecting autonomy comes down to finding a balance between how many rules are absolutely
necessary within a communal living environment. As an example, many shelters have rules around the use of a laundry room, particularly sign-up sheets for when it is acceptable to use the facilities. This is seen in many social service model shelters. During my interview with Shelter 2’s executive director, Tamara commented:

Although there are standardized things for safety that we have to do, we’re working more towards the elimination of a lot. We have some rules that aren’t around safety. We’re working on being definitely more client-centric and trying to individually tailor things....For example, [the laundry room] wasn’t open 24/7, but it is now. We said ‘Why are we only having laundry hours? It’s not like you’re in a house anymore, so now we’re open 24 hours. They don’t have to sign up. We haven’t had any issues with people ya know, moving things and everything like that, and if we do, we’ll have to have a time slot to sign up for laundry, but that hasn’t happened yet. (Refer to Image 3).

Eliminating the rules and sign-up sheets surrounding laundry room use at Shelter 2 has been unproblematic. Shelters 1 and 3 have not had a problem with flexible laundry room use either. Image 3 shows the orderliness that has been the norm within Shelter 2 since this change. The tidiness of the laundry room illustrates that survivors in shelter are able to take care of the facility and their own personal items in a communal setting without any kind of cleaning or chores system in place.
Image 3: Laundry Room

The concept of ‘rules’ should be seriously considered because in many cases, they get overcompensated for within the shelter environment. Many shelters use rules as a way to aid a problem for a one-time occurrence, so rather than working with the individuals at hand, rules are a way to maintain authority amidst the shelter. After leaving a situation where an individual is controlled in every aspect of his or her life, entering a place of shelter can have detrimental effects if control is perpetuated within that environment. Lauren provided an extreme example of a one-time incident.

There was a program, and I was reading through their rules at one time. They were real specific in that you cannot eat Cheetos in your room. Well and I had to find out, and THAT is a SPECIFIC rule…. and it was only Cheetos. So I’m talking with the program, and this consistently happens too, and it is because this one time incident happens, so we create a rule. Cheetos dust makes a mess, and some child had Cheetos and painted the walls with Cheetos dust and that kind of thing. But instead of just kind of working with that situation, the rule got created, so no one can eat Cheetos in their room. That’s an extreme one, but you can kind of look through, and you can pick those things out.
A shelter banning Cheetos, specifically, from residents’ rooms is a clear example of how rules are escalated within the domestic violence shelter vicinity. Although this is an extreme example, it illustrates how easily relatively insignificant rules can accumulate.

A related matter concerns chores. According to a trauma-informed service delivery model, residents should not have to ‘pay their keep’ for safe housing. However, many shelters require residents to do chores. As an alternative, Shelter 3a uses a reward based program. No one is forced to do chores, but can instead volunteer for ‘money’ that can be used at the shelter store. Image 5 (below) shows the kitchen from Shelter 3a. Note this is a very large shelter with 100 beds. The staff realizes that the areas of the facility are bound to become messy, especially when half of the shelter’s population is typically comprised of children. However, during the tour and based on this image, the shelter is clearly able to handle cleaning tasks through its reward based system.

![Image 4: Kitchen Cleaned Using Reward-Based System](image-url)
All of the shelters in my research have guidelines in place which represent their low-barrier, voluntary service model(s). Shelter 6 has done away with curfews. Written materials from Shelter 1 indicate that it “uses a voluntary services model to align with their core belief that safe housing is a human right, and thus should be free of mandates. This means that survivors are not required to participate in any program or service in order to qualify for or sustain housing with [Shelter One]”. Also important here is that there not be any sort of penalties attached to those who chose not to participate. According to Tamara at Shelter 2, “we provide a meal on Tuesday night for group, so even if you’re not attending, you’re invited to come to that just to have a meal”. Additionally, Shelter 3a’s executive director stated:

All of the programs are voluntary, so people get to pick and choose what they want. If they want to do therapy, that’s great. If they don’t want to do therapy, that’s fine. We still check in throughout their stay, but it’s up to the residents to choose what they want.

It is important to note that instituting a low-barrier, voluntary service approach to shelter is a constant work in-progress. Shelter 7, for instance, is taking a positive step forward in abiding by the best practices indicated in existing research. During her interview, Jasmine commented:

So there were a lot of rules. There was no autonomy. Medication, tampons, everything was locked up. I mean every time someone needed a tampon, every time someone needed toilet paper, I mean EVERYTHING had to go through staff. It took up so much time. We have eliminated all of that now…I don’t like having residents come to staff for basic needs. I want them to come for advocacy, counseling, support, conversation, so I think most of the time my shelter advocates spend is getting a tampon or roll of toilet paper, or stuff like that, and I don’t think people should have to ask for those...because those are basic needs. People shouldn’t have to ask for basic needs.

This quote emphasizes that shelter space should be used more productively by encouraging staff/client relations, rather than doling out personal items, which is in line with a philosophy of empowering domestic violence survivors.

**Theme Three: Health and Safety**

Most of the shelters I visited and conducted interviews at address health and safety
within their facility. What makes this topic germane in terms of the analysis at hand is how it is
so closely intertwined with trauma-informed care. This is because health and safety refers to
physical as well as psychological health, which can be bolstered through providing unconditional
support and emotional safety (Wilson, Fauci, and Goodman 2015: 589). Such practices indicate
respect for individuals in a holistic way, respecting the dignity of the residents through malleable
care options. As Leslie from Shelter 3 stated:

Examples of things we’ve had in the health clinic is we’ve had a couple of women who
have come in and been diagnosed with cancer, and their abuser had prevented them from
getting treatment. Once they disclosed they had cancer to the health care professional, we
were able to get them back into treatment. It was one of those situations that when you
think about power and control dynamics, you don’t think about it to that extent.

Shelter 2’s representative, Tamara, discussed how they have private entrances, not only
for nurses entering the facility to conduct SANE (Sexual Assault Nurse Examiner) exams and
interviews, but for the maintenance room as well (See image 5).
Image 5: Maintenance Room with Private Entrance

As Tamara described:

The reason I’m showing you this is so that you can see we don’t have to have all the maintenance workers come through the front. They can come right through here and then go out that side door, and fire marshals can come through this way and have a key to that. Such efforts maintain a sense of not only physical safety, but emotional safety as well. The interviewees noted how important it was to maintain privacy in all aspects of the shelters, from advocacy, to medical care, to the involvement of outsiders/community members. However, only Shelter 2 went so far as to comment on their efforts at keeping their maintenance room separate from the shelter, which they believed provided a more comfortable environment for the residents.
Relatedly, it is important to ensure residents feel safe in all aspects of their shelter stay. Shelter 2 also has two garage stalls available, so if women seeking shelter need to hide their vehicle for safety purposes, they are able to do so (See image 6). As Tamara stated,

If somebody would need to hide their car in here, they can do that, and we have remotes so they can come in and out, and we can do that with both [garage stalls]…we haven’t really had the need for two cars to be hidden, so the second one we use more as a storage unit.

Image 6: Garage Entrance

Additionally, Tamara touched on the topic of weekly safety checks. She expressed the checks as having several functions. They serve as a way for the shelter to help residents achieve personal goals for self-care and taking care of their family, which may simply mean supporting a survivor’s goal to create a safer environment. This comes with the added benefit of helping residents avoid involvement of Child Protective Services.

We do a safety check weekly. If we were given the release for CPS and we know from conversations with the clients and CPS workers, if we saw something concerning during the check, we would try to be like ‘OH! Safe Sleep! Here’s that brochure! We need to
make sure, because part of your plan was safe sleep, so here is some more information, and here’s what that would look like, so we’re just providing you with that information.’ So we help the residents stick with their goals when it’s really just about health, safety, and hygiene when we do those checks.

The above quote emphasizes the importance of relational collaboration as a critical aspect in trauma-informed care. Saakvitne and colleagues (1996) explain relational collaboration as a type of therapeutic relationship wherein consistent interaction allows for greater information and encouragement to be provided. Through connecting with survivors prior to safety checks, interacting with them during such checks, and continually providing information to help them in such a way that meets their individual goals, the belief is that shelter residents might have a more proactive and positive outlook on their situations. Such is a goal of a trauma-informed approach that fosters mental well-being.

Safety checks are also a way to ensure a shelter remains an emotionally supportive environment for everyone residing there. For example, substance use within the shelter setting can have varying effects depending on a survivor’s past coping strategies. Substance abuse often coincides with domestic violence. Therefore, several shelters discussed how substance use is not allowed on the premises because it is believed to be a trigger for others (Kaysen et al. 2006). However, individuals may go out for a drink as long as they do not return highly intoxicated or belligerent. Shelter 2’s representative commented on this, saying “It’s a safety issue. But if somebody goes out to have a drink, and we’re not controlling if people do that, it’s in here that there is no drinking or drugs, and that’s mainly a safety issue.” She continued to say that there is a room available for people if they return at night after drinking. The stated purpose for these rooms is to avoid one roommate waking up another. As part of being trauma-informed, substance use and abuse is recognized, but instead of writing up an individual or kicking him or her out of shelter, a conversation will ensue.
Another way of being sensitive and holistic to individual needs involves alternative modes of therapy and expression. An example of this is within Shelter 3a, which Leslie described:

This is the sand therapy tray room, which is really cool. The kids can lay out the scenes in the tray of things that happened at home and what not. It's been found to be really beneficial….This room [across from sand therapy] is for more therapy. Again, just being able to use the different ways for residents to cope. We do a lot of trauma training. For survivors, among adults, they can build resiliency, but let’s start with when they’re young to help break the cycle of violence.

Image 7: Sand Tray Therapy Room

In sand-tray therapy sessions, children are able to act out whatever they want through placing the figurines pictured in the back shelves on the sand tray. Leslie stated she noticed a definitive difference in the sand tray designs between children when first entering shelter versus when they leave. While she did not share much detail about these differences, she believed they signaled at least some amount of processing and healing on the part of the child residents.
Additionally, Leslie showed me the various play areas within the grounds of Shelter 3a, all of which supported the shelter’s efforts at being accommodating, flexible, and attuned to the needs of various clients (See images 8a-c).

Image 8a: Playground 1

Image 8b: Playground 2
These images represent the efforts put into trauma-informed childcare, much of which consist of playground and play therapy. These areas also allow for children to socialize with other children, which may be beneficial seeing as they went through similar experiences.

Shelter 3a also attends to the recreational and physical mobility needs of its adult residents. Image 8 represents an effort at encouraging physical fitness. Aside from the obvious physical benefits of exercise, it is believed that such activities may also help residents express their feelings in more healthy ways than say, using alcohol or elicit substances. Moreover, the shelter staff have also found the work out area to be a helpful place for processing their own job stress and secondary trauma.
Finally, community engagement was seen as an important aspect of contemporary domestic violence shelters that operate from a trauma-informed philosophy. It is believed that shelter residents as well as staff fare better with strong ties to the community (Elliot et. al 2005). The perception I got from the interviews was that shelters who publicize their location and are open about their efforts receive the most community support. It is believed that such exposure motivates the surrounding community to take part in the effort to end domestic violence. People within the area seem to care about the shelters and want to help, and by receiving these benefits, survivors are able to make further connections.

Tamara, from Shelter 2, discussed several occasions where community engagement occurs at their shelter. During my tour, she showed me a space indicating “This is our ‘friend
store’ (view Image 10). It is free and volunteers come in and take care of it, so they take care of this for us, but anybody can access this – like outreach clients or shelter clients”.

Image 10a: Friend Store

Additionally, Shelter 2 does a lot by way of community outreach. Images 11a and 11b provide further insight into such activities.
Each dove in image 11a represents an individual who donated $1,500 dollars or more. This image is particularly interesting, because below the doves are bags and boxes of community donations going to those within the shelter. At the time of my visit, these contained women’s and children’s clothing, books, and various household supplies.
Image 11b: Larger Community Donations

Image 11b provides an example of a space that Shelter 2 included as a result of their recent capital campaign. Because community members are not allowed within the shelter for privacy reasons, a brick memorial was created near it so that donors and others can see the level of community support behind the organization. Each shelter in this study had its own range of community partnerships, however Shelter 2 stood out with numerous such examples. For instance, Tamara discussed how:

On Thursdays, we have a volunteer that just comes in and sees what we have and we just fill a couple things, and she makes a meal, so everyone is invited to that, and then on Wednesdays, we have a church that provides food, so everybody is invited to that.

When I asked Tamara about the rationale behind keeping the location of Shelter 2 public, given that historically shelters choose to have a private location, she explained:

Domestic violence has been so quiet for so long and so hidden that we don’t want people to be afraid, and it needs a community to be involved to help stop it. So we’ve found people are keeping their eye open and call if something funky is going on, or if a car is driving by. The neighbors do the same thing, so we’ve found perpetrators are less likely to be lurking as much because people in the community know what this is and they know we’re going to call. They know police are driving by, and if people on the street see
somebody that looks weird, they call us. So we think that’s worked to our advantage, and you know the community has been pretty proud and supportive of the program. It’s been a really nice thing.

Stacey, from Shelter 6, also discussed the importance of community partnerships. The shelter has childcare provided through community volunteers throughout the week, meaning volunteers come in from the community to help watch children while parents are at work or in therapy. Amanda, from Shelter 5, explained that her facility also utilizes an array of volunteers for their childcare program. Every Tuesday and Thursday, for instance, about four volunteers come in to watch the children while the parents are at work. During this time, they also provide a group for children in which therapeutic components are addressed through art and music.

Amanda went on to explain that Shelter 5 also has an entire unit of clothing and household items on site, all coming from donations. Along with these items, cleaning supplies and hygiene products are also readily available due to donations. Similarly, Shelter 3a also relies on community support to run a shelter ‘store’. Run purely by volunteers, this ‘store’ contains clothing, along with personal and household items for shelter residents. Shelters 2 and 3a have community groups that come in to help with lawn care and landscaping, and just like Shelters 5 and 6, most of the childcare, tutoring, and art therapy is run by community members. Something that makes Shelter 3a unique, however is that it has paired up with businesses from the community to provide an animal shelter on site. The care and socialization of dogs through the on-site pet shelter is primarily done by community partners. Shelter 2 was going to do something similar, however as Tamara explained, “they were going to do a pet boarding area…but we have found community partners to do that”. This is yet another example of the importance of community partnerships within shelters operating through a trauma-informed lens.
CHALLENGES

Interviewees from this research expressed challenges they faced when transitioning from the old model to the newer, more trauma-informed model. Lauren from Shelter 3a explained that one major problem was with the staff’s unwillingness or inability to change the way they perceived how the shelter should run believing it functioned better with rules. Lauren stated “unfortunately we did have to let some staff go and some people quit. They just could not get behind the changes we were making. Ultimately when we hire people now, we make sure they have the right personality to fit our shelter model.” She continued to explain that the right personality consisted of someone who was willing to work as a team member and work towards empowering the clients.

Another issue raised by Jasmine from Shelter 7 was with the staff falling into the old habit of implementing rules whenever a problem arose. She said:

The staff is so used to having rules for every little thing that when something comes up, which is a frequent occurrence, instead of trying to think ‘how can we solve this [problem] while maintaining an autonomous atmosphere,’ they immediately want to make up a rule.

For instance, at Shelter 7, teenage boys were found watching pornography in the computer lab. In response, the staff locked the computer lab door and required residents to sign up for a particular time slot. Afterwards, Jasmine held discussions with the staff to brainstorm ways the residents could maintain more power. Several conversations among the staff lent themselves to the final decision of implementing an open-door policy for the computer lab, which was a technique recommended by Shelter 3b. To help mitigate challenges when transitioning between models, holding conversations with the staff about where each rule derived from was found to be
helpful. The staff was able to reach solutions that were more empowering for the residents by doing this.

**DISCUSSION**

Although my sample size is small and cannot be generalized in a traditional manner, the data are suggestive of some new and innovative models for domestic violence safe housing that may certainly be helpful to others looking to update their practices. Of foremost relevance, the data indicates that trauma-informed care is a relevant and beneficial service philosophy for survivors of domestic violence. Although empowerment is one aspect of this framework, much more is involved with a trauma-informed care approach. The social implications of changing terminology, such as switching the words “empowerment” with “trauma-informed care,” may have radical implications. Socially, the word “feminism” still receives backlash (Houvouras and Carter 2009). The term “empowerment” is often associated with feminism. Therefore, the phrase “trauma-informed care,” though not synonymous with “empowerment,” may receive a more positive social response, and among other things, contribute to a greater presence of community engagement within shelters. Much of the literature regarding domestic violence shelters is dated. This study helps fill this void by providing some insights as to the direction of contemporary domestic violence shelters, including changes being made within them. Based on my findings, updating the language surrounding shelter best practices is necessary. Traumatization was heavily emphasized among the shelters included in this study. Therefore, referring to contemporary best practices through a trauma-informed lens is appropriate. Although trauma-informed shelters most closely match the feminist model as Davis’ (1988) typology described, trauma-informed models take the ideas associated with the feminist model to the next level.
There is also a very specific structure dictating what a trauma-informed approach is, which has been discussed throughout my findings.

Indeed, becoming more trauma-informed is amongst best practices for today’s domestic violence shelters in part because of the efficacy of how these shelters operate and run. Theme one examined the implementation of trauma-informed care approaches while themes two through four showed different ways trauma-informed care was addressed specifically within the shelter setting. Each theme illustrates a different kind of effectiveness that occurs within shelters, leading to the common goal of providing a trauma-informed environment and trauma-informed services.

The numerous committees formed to help maintain and improve trauma-informed services, seen in Shelter 3a (a shelter proud to identify as trauma-informed), exemplify one kind of effectiveness. Shelter 3a discussed having a trauma-informed care committee, a wellness committee, a diversity connections committee, and a performance and quality improvement committee. The number of committees may seem tedious, but each one was in charge of a specific aspect or function of shelter, creating the opportunity for survivors to be present and involved in the process as well as allowing the committees to focus on distinct aspects of shelter services. Therefore, trauma-informed care may also be about a collaborative process of determining how to offer the best programs.

A different kind of effectiveness is noted in how trauma-informed care focuses on emotionally safe spaces for survivors as well as low barrier rules in regard to chores and shelter upkeep. The second theme discussed the importance of autonomy within a shelter setting. One aspect of autonomy is allowing the residents to decide when and if they want to contribute to chores. The findings from this research indicate that requiring chores is often unnecessary,
particularly in light of communal spaces within the facilities that were respected and maintained by the residents. This suggests that the availability or opportunity to help out, and more importantly to make a decision to help out, is important for shelters wanting to operate in an empowering manner.

Indeed, my findings highlight several positive characteristics of contemporary shelter practices. Autonomy within the shelter environment is a necessity while domestic violence survivors transition between an abusive relationship and their new life away from an abuser. Autonomy may be achieved several ways. One way, as previously discussed, is through not requiring chores. Another way is allowing survivors to decide for themselves when and if resources are needed psychologically, emotionally, spiritually, etc. The shelters from this study offered several forms of therapy and encouraged peer-to-peer support. However, participation in programming remained voluntary. Trauma-informed care requires an atmosphere that focuses on and respects survivors need for acceptance, respect, and safety – with no strings attached.

Another important characteristic of contemporary trauma-informed shelters is the recognition of companion animals. Previous studies have noted the positive contribution of companion animals within shelter settings (Flynn 2000; Ascione 1998). Shelter 3a conceptualized this in terms of the importance of safety for all sentient beings involved in abusive situations. Companion animals are often subject to the manipulation and control tactics of domestic violence and so it is important that safe spaces be offered for them as well. As prior research has indicated (Ascione 1998), survivors are more likely to seek help earlier if their companion animal(s) are able to join them in shelter. The presence of an on-site (or nearby) animal shelter contributes to a trauma-informed framework in that survivors may feel a
heightened sense of security and less stress while in the shelter if their companion animal(s) are accessible.

The third theme addressed health and safety in depth. The purpose of maintaining a sense of physical safety within the shelters is to provide a feeling of mental and emotional security for those residing there. The shelters in this study found different ways of accomplishing this, such as Shelter 2 which had private entrances for the maintenance room and the Sexual Assault Nurse Examiner station as well as garages for survivors to hide their cars in if needed. Additionally, Shelter 3a had its own health clinic for the women on-site.

Another way to examine effectiveness within shelters is through community support. Engaging volunteers and other means of community support are effective in allowing shelters to provide greater resources for their residents, such as in Shelters 2 and 3a which provided childcare through community volunteers. Shelter 3a also used volunteers for tutoring and art therapy. Community involvement is also important in heralding public support around domestic violence. It helps make it known that domestic violence occurs everywhere and impacts all demographics (Williams and Mickelson 2004).

The different facets surrounding trauma-informed care comprise similar components. They all emphasize the importance of ensuring shelters create a safe space emotionally and physically, are effective in their objectives and functioning, and provide different therapies for survivors to explore. By doing so, shelters create an atmosphere of respect for the individuals residing there as well as sensitivity for the experiences they have lived through. Existing literature discusses this as an important component of trauma-informed care that can be adopted in several ways (Elliot et al. 2005; Harris and Fallot 2001). For example, respect for survivors and their past experiences is very important and can contribute to self-care. Therefore, one of the
most effective practices a shelter can have is to integrate respect and dignity into their daily operations as well as into their overall philosophical framework.

LIMITATIONS AND FUTURE RESEARCH

One suggestion moving forward from this study is to use a mixed methods approach, or triangulation, to confront some of the existing gaps in the literature. For example, this study is obviously quite small in size. A larger survey or program evaluation across a broader range of shelter models would be beneficial, particularly in terms of comparing and contrasting various shelter practices. Additionally, survivors residing at shelter should be considered. My research examined shelters purely through the eyes of executive directors and leaders. Although valuable data and insights were gained, hearing from survivors firsthand about what they find to be most beneficial would greatly improve future research on best practices within a trauma-informed approach. Furthermore, most of the data from this study focused on residential shelter programs and practices, largely excluding those taking advantage of nonresidential programs. A separate study focusing solely on nonresidential programs would provide further insight.

CONCLUSION

This study arose from a request from a shelter in a neighboring Michigan community whose executive director was looking for more information on current country-wide best practices and policies within domestic violence shelters. Not only will this work be helpful in its direct application to the agency, it is also important academically. People residing in shelters deserve a well informed and intentional set of services. While the findings will benefit a domestic violence shelter in southern Michigan directly, other shelters that may be considering a change or update in service delivery could find this information useful as well.
The discovered emphasis on trauma-informed care is extremely important to note. Agencies utilizing this research will find the examples in each theme helpful in identifying what trauma-informed services may look like. The information can also provide a source of comparison of practices and resources for domestic violence shelter administrations. Academically it is important to perpetuate learning and knowledge, especially within the public realm. Due to lacking current research on domestic violence programs, this study aims to be a useful tool in conceptualizing what trauma-informed means and explain the positive attributes affiliated with this approach. Furthermore, because an insufficient amount of literature on current domestic violence programs exist, this research explored the gap in the literature and aimed to help fill it.

As sociologists, it is important to keep in mind the public nature of our work and to continue to improve conditions for issues arising out of social problems such as domestic violence. In terms of policy, given the ongoing problem of domestic violence in our society, well informed, evidence-based practices are necessary. My research provides some of this, by elaborating on what trauma-informed means and promoting its implementation. In applied sociology, an emphasis is placed on the importance of human services. This research contributes directly to that. We all have a stake in creating, maintaining, and perpetuating a healthy, autonomous, trauma-informed model for survivors of domestic violence.
REFERENCES


Appendix A
Interview Guide

Introduction

a. Purpose of Study (research best practices and policies)
b. Build rapport. How is your day going? What job do you have? How long have you worked here?
c. Okay, are you ready to get started? Great!

Questions

Shelter Demographics

1. How many people can you house at one time? How many served residentially each year?
   a. How does this compare to the need in your area (turn-aways?)
2. How many counties do you serve or what is your geographical service area?
3. What are your annual service statistics and how are they tracked and calculated?
   a. How do you track outcomes and data?
4. How many women/men and/or families stay in your shelter?
5. What does the shelter’s population look like?
   a. What are the main demographics of your shelter? (Race, Age, Women/Men: singles or with Children, etc.).

Shelter Model and Philosophy

6. What does your shelter model look like? (For example, communal, scattered, shared or individual space?)
7. Why/how did you decide on this model?
8. What is your service philosophy?
9. Does your shelter have an age limit for teenage males?
   a. If yes, what does your shelter do to accommodate those families?
10. Are men welcome to stay in your shelter?
    a. How do you communicate to or advertise that your residential services are available for men?
11. Are you able to provide services to men? Transgendered victims? Victims of same-sex abusive relationships?
    a. Are there any barriers or challenges to serving this population within your model?
    b. Are the services tailored to these populations in any way?

Programs

12. Could you share what programs you offer here and explain a little about them?
13. Are there some programs that you have noticed have a bigger impact compared to others?
14. Do residents participate in program evaluations?
a. Do survivors like some programs over others? Which ones?

15. Are you set up to provide services to victims that are dealing with other issues, perhaps substance abuse or mental illness?

16. Are you familiar with the phrase “trauma informed services”? What does that mean to you? Do you believe your services are trauma informed? Is that one of your goals? Can you elaborate?

17. What is the goal of program evaluation for you? Do you measure outcomes and outputs for a funder?

18. Do any of your residential programs have any rules, guidelines, eligibility to access?

19. What, if any, activities and programs are available for the children?

20. If you provide groups on a regular basis (support group, educational, life skills, parenting), how do you motivate residents and non-residents to participate in groups? Are there incentives? If so, what kind?

21. Are all services voluntary?

Budgeting and Funding

22. What is the cost of the implementation of this model? Are you able to share your annual budget and organizational chart?

23. How is your shelter primarily funded?

Logistics

24. How many full-time equivalents do you have? What is the breakdown of full time compared to part time? How do you staff your shelter? Who all is employed? Could you provide job descriptions?

25. What safety precautions are in place for the residents?

26. How do you prepare program participants for life outside of the shelter?

27. What is your average length of stay for residents? If some stays are longer than others, what factors are taken into account to determine length of stays? Is length of stay time limited? If so, why? If not, why? Who makes this decision? Is it based on service philosophy or funding mandates?

28. How does your program handle common communal living struggles? (For example, stealing, children not being supervised by their parent, continuous conflict between residents; drug and alcohol use within the shelter)

29. How does your program handle common communal living struggles? (For example, stealing, children not being supervised by their parent, continuous conflict between residents; drug and alcohol use within the shelter)

30. Do you track nights residents take out of shelter? If so, is there a limitation on this?

   a. Do you ask residents to sign in/out when they leave and return to the building? If not, how do you know who is in or not in the building?

31. Do residents have to return to shelter for the night by a specific time?

   a. If residents work during the nighttime do they have to be spending a certain amount of time at the shelter during daytime to be considering "staying?"
32. Do you have a guideline on children who only reside with the parent at the shelter sometimes?
   a. How do you count bed nights in this situation?
   b. Are children allowed to come visit a parent just for a few hours? If so how do you keep track of this? (Count as bed nights?).
   c. How do you handle daycare of children?
   d. Can other residents watch someone’s child/children? If so, what are the parameters?

33. Is the location of your facility kept public or private? What rationale is behind this?

Conclusion

34. Thank you for participating in my study!
35. Do you have any questions, comments, concerns for me?
36. Would I be able to contact you later if I have follow-up questions after sitting with the data for a bit?

37. (Don’t always need to say this!) When I am finished analyzing the data and writing the report, I will send them your way! Thanks again for all of your help and input!
Appendix B
HSIRB Confirmation

Date: February 15, 2017

To: Angela Moe, Principal Investigator
    Katherine Brown, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: Approval not needed for HSIRB Project Number 17-02-32

This letter will serve as confirmation that your project titled “An Evaluation of Domestic Violence Shelter Program and Research Best Practices” has been reviewed by the Human Subjects Institutional Review Board (HSIRB). Based on that review, the HSIRB has determined that approval is not required for you to conduct this project because you are analyzing a program and you are not collecting personal identifiable (private) information about individual; your scope of work does not meet the Federal definition of human subject.

45 CFR 46.102 (f) Human Subject

(f) Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains

(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.

Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

"About whom" – a human subject research project requires the data received from the living individual to be about the person.

Thank you for your concerns about protecting the rights and welfare of human subjects.

A copy of your protocol and a copy of this letter will be maintained in the HSIRB files.