



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

Chapter 12: Funding and Collaboration: Opportunities and Challenges

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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."

1. Executive Summary

Chapter 12 explores the sources of funding and supplementary services that make it possible for transitional housing (TH) programs to address the needs of survivors of domestic and sexual violence. Section 2 focuses on sources of funding. Section 3 focuses on the relationships with partnering providers and other entities that afford access to the gap-filling resources and services that programs need in order to properly serve survivors - sometimes at the cost of increased complication, and sometimes forcing compromises in program operation.

Aside from OVW grants, grants awarded under the Emergency Solutions Grants (ESG) and Continuum of Care (CoC) programs by the U.S. Department of Housing and Urban Development (HUD) are the most important **other** sources of funding for TH programs. **Forty-two percent (42%)** of all the TH providers we interviewed for this project (all but two of which were OVW grantees) reported receiving ESG Rapid Rehousing (RRH) grants and/or CoC RRH and/or TH grants to operate programs serving survivors of domestic and sexual violence.

CoC TH grants fund what might be called "**traditional**" TH projects (using congregate or clustered units in provider-owned or provider-leased housing, where participants stay until they are ready to move on to other more permanent housing), while **ESG and CoC RRH grants** fund a type of **transition-in-place project**, providing time-limited rental assistance for tenancies in privately owned, participant-leased, scattered-site apartments. Providers told us that some of their HUD grants were used in combination with their OVW grants, while other HUD grants were used to fund separate TH or RRH projects serving survivors.

Given the importance of HUD funding, the majority of the Section 2 ("Sources of Funding") narrative and comments focus on the use of ESG and CoC grants: (a) the rules and processes that govern their use; (b) how those rules and processes are similar to and different from the requirements and constraints governing the use of OVW grants; and (c) how providers address the challenges attendant to operating a program funded with a combination of HUD and OVW grants.

A small portion of the narrative addresses other sources of funding.

The two HUD funding streams -- ESG and CoC grants -- work somewhat differently and have somewhat different rules governing the use of funds.

- ESG grants are administered by the states, counties, and cities that receive annual "formula (block) grants" from HUD. Grants are awarded annually, but can be spent over a two-year period. Requirements and guidelines for awarding and using grant funds are specified in HUD regulations, called the [ESG Interim Rule](#), which also described the regulatory framework for "**Consolidated Plans**," wherein the states, counties, or cities receiving ESG grants explain their priorities and plans for using HUD funds to help address the housing and economic needs of their respective geographies.

Participation in the planning process that guides the development of five-year Consolidated Plans and annual updates is an optional, but important, way of ensuring that the needs of survivors of domestic and sexual violence are addressed in those Plans.

- CoC grants are administered by geographically-defined, HUD-funded consortia called **Continuums of Care**, which bring together a mix of large and small housing and service providers, government entities, housing authorities, members of the business and faith communities, homeless consumers, and other interested parties to oversee planning and implementation of efforts to address homelessness within the specified geography. In turn, Continuums of Care (CoCs) are governed by a representative board, in accordance with the provisions of a governance charter adopted in compliance with HUD regulations, called the [CoC Interim Rule](#), which also define the rules under which CoC funds are awarded and may be used.

Renewal grants are funded one year at a time. New projects may be funded for 1-3 years, depending on whether they are leveraging new grant funds or re-purposing funds from a project that is being ended.

the Participation with the CoC is essentially a requirement of receiving CoC grant funds; the challenges and opportunities posed by these relationships between victim services providers and their CoCs are discussed in Section 3, as they are some of the most important collaborations -- especially in financial terms -- that victim service providers are party to.

Section 2 begins by discussing the similar and distinct participant eligibility rules for OVW and HUD programs. For OVW-funded programs, the rules are simple and straightforward: Participants must be "minors, adults, and their dependents who are homeless, or in need of transitional housing or other housing assistance, as a result of a situation of domestic violence, dating violence, sexual assault, or stalking; and for whom emergency shelter services or other crisis intervention services are unavailable or insufficient."

Eligibility for HUD assistance is more complex, involving different categories of eligibility, different program rules for the CoC versus ESG grant programs, and "**written standards**" (governing eligibility and priority for assistance and the amount, duration, and scope of such assistance) that Continuums of Care administering CoC grants and states/counties/jurisdictions administering ESG grants are required by HUD to develop and implement. Thus, a victim services provider receiving a CoC grant, an ESG grant from the county, and an ESG grant from the City in which it operates would be subject to three separate sets of written standards. The Section 2 narrative explores the various HUD guidelines, and how they overlap with OVW guidelines. The narrative also suggests that **participation in the planning process and periodic review and revision of written standards** may help victim service providers leverage written standards that are cognizant of the unique needs of their clientele.

In accordance with HUD requirements, access to program assistance is increasingly subject to the decisions of a system called **coordinated entry** or **coordinated assessment** that HUD requires CoCs to implement, in order to standardize the process for assessing, triaging/prioritizing, and referring applicants for assistance in their geographic region. Each CoC is expected to develop its own coordinated entry system, using its own standardized assessment process. With the exception of victim services providers, who are offered the option of creating and using their own parallel coordinated entry system, all providers operating **CoC grant-funded projects** must participate in the coordinated entry system implemented by their CoC. Providers implementing ESG-funded projects are likewise expected to participate in the geographically relevant CoC's coordinated entry system. HUD regulations allow victim services providers receiving **ESG grants** to opt out of the CoC's system; they do not have to join up with other victim services providers to operate a parallel system.

Participating in a coordinated entry system means that instead of each TH or RRH project recruiting its own clients or participants, a project can expect to receive referrals from the entity conducting the assessment, determining the priorities, and making the referrals for the geography covered by the CoC. A project can expect to receive referrals of individuals or families who need the housing/services that the project can offer, and who have the highest priority, or the greatest urgency for assistance, among all the individuals and families who have been assessed as having needs that the project can address.

The narrative and provider comments in this Section discuss challenges attendant to participation in a CoC's coordinated system, based on the different ways in which mainstream homeless providers and victim services providers define the terms "priority" and "urgency." As explained in the narrative, the HUD requirement to participate in a coordinated system is intended to ensure that programs focus on housing homeless persons who fit into HUD's highest priority categories: chronically homeless individuals and families and veterans with disabling conditions who have been heavy utilizers of emergency rooms, psych ERs, detox facilities, and/or public safety resources, and who need long-term supported housing. These coordinated systems were not intended to -- and don't necessarily -- assign high priority to survivors who were severely traumatized by their experience of domestic and/or sexual violence, or who are at risk of further abuse or violence. **There is nothing intrinsically "wrong" with HUD's priorities; they are just different from the priorities of the victim services providers that operate OVW-funded TH programs**, which is why it may make sense for providers operating TH

programs targeting specialized services for survivors of domestic and sexual violence to use a parallel coordinated entry system.³

The Section 2 narrative includes discussions about: (a) the relative size and stability of OVW versus HUD grants; (b) the similarities and differences in permissible uses for the funds; (c) the broader purpose underlying the OVW TH grant program (as described in the [OVW's annual solicitation for grant proposals](#)) as compared with the narrower focus of HUD RRH grants (as described in HUD's *Rapid Rehousing Brief* ([HUD, 2014c](#)));⁴ and (d) some of the additional requirements attached to HUD grants, and their ramifications, for example: (i) requiring compliance with HUD's "Housing Quality Standards" and limits on the allowable cost of housing ("Fair Market Rent" or "Reasonable Rent" standards); and (ii) requiring compliance with the aforementioned written standards governing the amount, duration, and scope of housing assistance and services.

Another challenge associated with HUD RRH grants (which provide funding for tenancy start-up and rental assistance in privately owned housing, and can also fund case management and certain other client services) is the requirement that the lease be in the participant's name; in the case of CoC grant-funded programs, the lease must extend for a term of one year, and be renewable, except for "cause." As discussed in the narrative, being named on the lease can pose potential safety problems for a survivor (or heighten her anxiety about being stalked), or could simply be a responsibility that a survivor is not ready to assume, while she is still dealing with trauma and other issues. Even if a survivor is ready to have her name on the lease, getting a landlord to put the lease in her name can be challenging, if, as is often the case, the survivor has poor or no credit, a weak tenancy history or record of evictions (often caused by the perpetrator of abuse), and uncertain prospects for the employment she will need to sustain the tenancy once the rental assistance ends. If the rental assistance isn't guaranteed for the full year, obtaining a full-year lease is that much more of a challenge.

By contrast, OVW grant funding allows providers to put the lease in the agency's name, and then arrange for the landlord to transfer the tenancy to the participant when she has earned the confidence of the landlord. However, as discussed in [Chapter 3](#) ("Program Housing Models"), the prevalence of provider-leased housing is declining: over a two year period ending June 30, 2014, the number and percentage of OVW-funded provider-leased units steadily decreased from 273 (21.8% of the total OVW-assisted housing stock) to 183 (12.5%). Meanwhile, participant leased units increased from 655 (52.3% of the total OVW-assisted housing stock) to 917 (62.6%). As the number of programs utilizing provider-owned⁵ or provider-leased housing shrinks, the options for survivors who don't want or can't get a lease in their name likewise dwindle.

As described in the narrative, although HUD's RRH model is increasingly replacing HUD TH grants supporting "traditional" congregate and clustered TH programs, the remaining "traditional" TH programs -- mostly now

³ Although several CoC grant-funded providers that we interviewed expressed interest in forming their own coordinated systems, the specifics of the requirement to be part of a CoC system or form a parallel system with other victim service providers were new at the time of our interviews, and none of those providers had yet developed such separate systems.

⁴ The [FY 2016 OVW TH grant solicitation](#) states that, "Successful transitional housing programs provide a wide range of optional services that reflect the unique needs of victims and promote victim choice and autonomy. Transitional housing programs may offer support services, such as counseling, support groups, safety planning, advocacy, child care, employment services, transportation vouchers, and referrals to other agencies. Trained staff work with survivors to help them determine and reach their goals for permanent housing." (p.1)

By contrast, HUD's *Rapid Rehousing Brief* ([HUD, 2014c](#)) informs providers that, "An operating principle is that households should receive "just enough" assistance to successfully exit homelessness and avoid returning to the streets [or] emergency shelter;" (p.1) that "rapid re-housing is not designed to comprehensively address all of a recipient's service needs or their poverty. Instead, rapid re-housing solves the immediate crisis of homelessness, while connecting [participants] with appropriate community resources to address other service needs;" (p.2) and that taking a "crisis-related, lighter-touch (typically six months or less) approach allows financial and staff resources to be directed to as many individuals/households experiencing a housing crisis as possible." (p.5)

⁵ Over that same two-year period, the number and percentage of provider-owned units experienced relatively little change, moving from 325 (25.9% of the total OVW-assisted housing stock) to 364 (24.9%).

funded by the OVW -- provide an important alternative for survivors who need or prefer on-site/nearby access to services and peer support, or who need the higher level of security that those program models can provide.

As discussed at greater length in [Chapter 4](#) ("Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement"), OVW **requires** grant-funded projects to use a voluntary services model, whereas HUD **allows** grant-funded projects operated by victim service providers to use a voluntary services model. Theoretically, then, jointly funded projects should not face contradictory pressures with respect to the VAWA voluntary services requirement.

However, pressure to meet HUD program performance standards (defined in terms of the rate of participant housing placements and/or the rate of placement retention, whether or not such housing is the participant's top priority) combined with pressure to shorten the duration of assistance (typically to no more than a year, and to as close to six months as possible, whether that timeframe is realistic and adequate to address the survivor's needs, and compatible with the survivor's pace and state of mind) may conflict with OVW guidance to take a victim-centered, voluntary services approach that focuses on survivor-defined priorities, and that avoids pushing survivors in directions they aren't interested in or ready to take.

Specifically, the Section 2 narrative observes that a focus on survivor-defined outcomes is an integral part of the voluntary services model, and notes the conflicting pressures that arise when a survivor's highest or most urgent priorities are inconsistent with the priority outcomes that HUD asks each program to track using performance metrics reported on annually and in the provider's annual application for HUD grant renewal.

Although HUD's housing-, income-, and employment-related goals⁶ are all important (and cited in the enabling statute of the OVW TH program), and although they may be longer-term goals of TH program participants, they may not be a survivor's top priority when she enters a program -- and it is the survivor's priorities that should, by definition, guide the efforts of a victim-centered program.

In addition to posing a problem when participant priorities don't align with funder priorities, a shortened program timeframe poses fundamental problems for any program serving an area of the country where affordable housing is in short supply, particularly if participants don't have the income and tenancy credentials to successfully compete for market-priced housing. As discussed in [Chapter 10](#) ("Challenges and Approaches to Obtaining Housing and Financial Stability"), there is a nationwide shortage of affordable housing, a widening gap between the need for and supply of housing subsidies, and a significant and widening gap between what low-skill workers can earn and what they need to sustain a tenancy anywhere in the country. The less time survivors have to transition to a tenancy, the less likely they will be able to make a sustainable transition, particularly if they enter the program with significant housing and income barriers.

Pressure to achieve a high percentage (80%) of "successful" outcomes can influence client selection processes, and discourage enrollment of survivors with significant barriers, who are less likely to achieve sustainable placements within the shorter timeframe. At the same time, such participant selection practices may put a jointly OVW/HUD-funded program at risk for ignoring OVW's warnings (in its [annual solicitation for TH grant proposals](#)) against "procedures or policies that exclude victims from receiving safe shelter, advocacy services, counseling, and other assistance based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition, physical health condition, criminal record, work in

⁶ Indeed, developing a plan to achieve sufficient income to be able to sustain housing is cited by [Davies \(2009\)](#) as an essential element of safety planning, which helps a survivor avoid future dependence on an abusive partner. The potential conflict with the survivor's priorities is largely related to the timing: survivors may have other more urgent needs to address before they can begin thinking about income and employment. Given that many survivors enter their TH program with limited employment histories and/or barriers to employability, developing the kind of income they will need is not a short-term endeavor, but something that will take years.

the sex industry, or the age and/or gender of their children;" and against "requiring survivors to meet restrictive conditions in order to receive services."

Some providers that feel accountable to HUD or to the CoC or state/country/jurisdiction that administers their HUD grant, told us that they do, indeed, target "motivated" survivors who can "make good use of program resources," and in some cases, survivors who are employed or who are likely to obtain employment, in order to meet performance expectations.

These kinds of tensions illustrate the challenges of combining an OVW TH grant with a HUD RRH grant to fund a transition-in-place program, and arise from the fundamentally different conceptions of the OVW TH program and HUD's RRH model, as described in HUD's *Rapid Rehousing Brief* ([HUD, 2014c](#)):

- On the one hand, the OVW program anticipates serving survivors with potentially complex needs above and beyond housing and employment barriers, who, in some cases, have suffered years of physical, sexual, emotional, financial, and psychological abuse leading to their flight from violence and current homelessness. By contrast, the HUD program assumes that "the majority of families and individuals [who will be served by the RRH program] become homeless due to a financial crisis or other crisis that leads to the loss of housing. Addressing homelessness for these households primarily entails addressing their housing barriers to help them return to permanent housing." (p.1)
- On the one hand, the OVW approach emphasizes building a trusting, supportive relationship that will be central to the program's ability to offer the necessary assistance; walking alongside survivors; and staying engaged for up to the full two years allowed by statute. By contrast, the "operating principle [of the HUD RRH program] is that households should receive 'just enough' assistance to successfully exit homelessness and avoid returning to the streets ... and emergency shelters." (p.1)
- On the one hand, the [OVW's annual solicitation for TH grant proposals](#) states that its TH grants program "focuses on a holistic, victim-centered approach to providing transitional housing services that move survivors into permanent housing" and that:

"Successful transitional housing programs provide a wide range of optional services that reflect the unique needs of victims and promote victim choice and autonomy. Transitional housing programs may offer support services, such as counseling, support groups, safety planning, advocacy, child care, employment services, transportation vouchers, and referrals to other agencies. Trained staff work with survivors to help them determine and reach their goals for permanent housing." (p.1)

By contrast, HUD's *Rapid Rehousing Brief* states that:

"The focus of services in rapid re-housing is primarily oriented toward helping families resolve their immediate crises, find and secure housing, and connect to services if/when appropriate. Case managers should monitor and provide ancillary services in the short run to promote obtaining and maintaining housing. . . . This crisis-related, lighter-touch (typically six months or less) approach allows financial and staff resources to be directed to as many individuals / households experiencing a housing crisis as possible." (p.5)

Section 2 closes with a selection of provider comments on funding-related approaches and challenges.

Section 3 focuses on the opportunities and challenges attendant to partnerships and collaborations. The narrative begins by noting that no program has the resources to provide every service that survivors need. By requiring applicants for TH grants to enter into a funded memorandum of understanding (MOU) with at least one provider, the OVW has made linkages with mainstream providers an integral part of the TH program. And by basing more than 20% of an applicant's score on its description of the MOU collaboration and how it will benefit survivors, the OVW affirms the importance of the contribution that an MOU partnership can make.

The narrative and subsequent provider comments describe the broad range of collaborations and partnerships that OVW TH providers have put in place to meet needs that the TH program, by itself, would be unable to

address, and to enhance the cultural and linguistic competence of the overall package of services, enabling programs to reach and more appropriately serve distinct segments of the community.

After a brief overview, the Section 3 narrative discusses the privacy and confidentiality-related ground rules that underlie such partnerships and collaboration. That discussion is followed by providers' comments addressing their privacy- and confidentiality-related concerns and their approaches to addressing the challenges that arise when combining OVW and HUD funding.

The largest portion of the Section 3 narrative explores the nature of the collaboration between OVW TH programs and the mainstream homeless services system, offering a somewhat different perspective from a prior assessment ("Closing the Gap") by [DeCandia, Beach, & Clervil \(2013\)](#), which focused more on the relationship between DV shelters and the mainstream homeless services system. Whereas the prior analysis found little collaboration, the Section 3 discussion cites as strong evidence of collaboration the fact that 42% of the providers interviewed for this project are part of the mainstream system. The narrative further credits the OVW's requirement that every grant-funded project include a funded MOU with a partnering provider with promoting more extensive collaboration with mainstream providers. Furthermore, one of the expectations attached to the receipt of HUD funding is active engagement by the provider in their geographically relevant CoC; by virtue of that requirement, the integration of OVW and HUD funding sources ensures engagement between the victim services and mainstream provider communities. Indeed, many of the providers interviewed for this project cited their active participation in their local Continuum of Care.

The narrative observes that despite these elements of cross-system collaboration, there remain tensions arising from the conflicting philosophies and approaches described by [Baker et al. \(2010\)](#), and manifesting as pressures to define success and measure performance using standard metrics that fit the mainstream system better than the victim services framework; to shorten the duration of assistance; and to shift from the traditional transitional housing model using provider-owned or provider-leased housing, in favor of a transition-in-place model that is more compatible with rapid rehousing. That is, the relationship between the mainstream homeless system and TH providers targeting survivors of domestic and sexual violence isn't accurately described as entirely collaborative or entirely confined to silos, as was suggested by [DeCandia, Beach, & Clervil \(2013\)](#).

The Section 3 narrative next explores the roles and functions of each component of the mainstream system -- outreach, shelter, transitional housing, rapid rehousing, permanent supportive housing, and non-residential supportive services -- and concludes that (a) practically speaking, ***HUD-funded mainstream permanent housing projects -- rapid rehousing and permanent supportive housing not operated by victim services providers -- are largely unavailable to individuals or families running out of time in DV/SA-focused transitional housing programs or in unsustainable transition-in-place tenancies***, because such households will likely be deemed ineligible for such assistance, or will have low priority, as compared to the homeless and chronically homeless individuals and families in shelter or unsheltered situations.

Although survivors timing out of TH programs or unable to sustain transition-in-place tenancies may, on occasion, be able to access available units in mainstream TH and emergency shelter programs, subject to program-specific eligibility and prioritization criteria, competition for slots in these mainstream programs will be fierce, given that the high demand routinely exceeds the number of openings, so such safety net placements will not likely engender significant new collaborations between the mainstream and DV systems.

Looking at the "big picture," the narrative suggests that lack of additional collaboration between survivor-focused TH programs and mainstream homeless providers ***does not reflect poor coordination or poor intentions***. Rather, that lack of additional collaboration is a consequence of various other factors:

- the nationwide shortage of affordable housing and housing subsidies, and the resulting increased cost of tenancies, which combine to add time and expense to the cost of assisting participants in TH and RRH programs, further straining the capacity of ***both*** the mainstream system and the victim services provider-operated system, which are both ***under-resourced*** to meet the needs each system is funded to address;

- HUD's articulation of system priorities and policies that address HUD's goal of maximizing the numbers of households transitioning from homelessness to housing, but that allow **insufficient time** and have a **too-narrow focus** (on housing, rather than on addressing the adverse impacts on the survivor and her family of the physical, psychological, sexual, and financial abuse and violence) to **adequately** serve survivors; and
- mainstream providers' inadequate understanding of the profound impacts of chronic exposure to domestic and sexual violence, and **too-limited adoption of a trauma-informed approach**, so that the mainstream homeless system lacks the capacity to adequately address the needs of survivors.

In fact, rather than having the capacity to offer additional resources to support programs operated by victim services providers, the mainstream system could likely benefit from additional support from DV/SA providers:

- If specialized TH/RRH programs had additional capacity, many homeless survivors of domestic and sexual violence currently in mainstream shelters, TH, RRH, and outreach programs would probably benefit from referral to specialized programs offering trauma-informed housing and services.
- If the staff of victim service providers and/or state coalitions had the capacity, the mainstream system and the survivors it serves would likely benefit from (a) staff trainings to build the capacity of mainstream providers to better serve survivors; and (b) the provision of the specialized services that survivors of domestic and sexual violence may need, and that more generalist staff may not be prepared to offer.

Identifying such opportunities for collaboration is beyond the scope of this project, but is worth further study. (One agency interviewed for this project provided such training, as part of its collaboration with CoC partners.)

The Section 3 narrative cites the very positive vision that HUD has articulated in its *FAQ on Coordinated Entry and Victim Service Providers* ([HUD, 2015d](#)) for how implementation of coordinated entry could lead to broader-based collaborations that would be compatible with victim services providers' emphasis on trauma-informed, survivor-focused, culturally competent services. However, as long as HUD-funded homeless programs don't have the capacity -- given current funding levels, system priorities, and regulatory constraints -- to serve survivors who have been unable to resolve their housing and income needs while in "specialized" TH/RRH programs, a trauma-informed coordinated assessment/coordinated entry (CA/CE) process will likely be unable to find openings in appropriate programs to which these survivors can be referred for assistance.

On the other hand, a more trauma-aware CA/CE system will likely identify more individuals and families than the mainstream system currently knows about, whose homelessness is linked to domestic and sexual violence, and who -- if victim services providers had more resources and system capacity -- could benefit from referral to "specialized" TH/RRH programs.

A brief portion of the Section 3 narrative summarizing the benefits of participation in state coalitions of domestic violence and sexual assault providers, and some of the benefits and challenges attendant to participation in Continuums of Care, as described by the providers we interviewed, is followed by the actual provider comments about their experiences as CoC participants and as members of statewide DV and sexual assault coalitions.

The Section 3 narrative concludes with a more general discussion about the challenges and strategies for collaborating with mainstream providers, drawing, in part, from the rich experiences of several collaborations supported by OVW grant funding, which enabled the Vera Institute of Justice to provide staff support.

Chapter 12 ends with several sets of provider comments addressing partnerships and collaborations generally, and then more specifically, partnerships and collaborations to fill gaps in children's services, education and employment services, health and behavioral health services, housing and housing search services, legal services, and life skills and financial management training.

2. Sources of Funding

(a) Two Primary Sources of TH Program Funding: OVW and HUD Grants

(i) Overview

The two primary sources of funding for transitional housing (TH) programs for survivors of domestic and sexual violence are the Office on Violence Against Women (OVW, an agency within the U.S. Department of Justice) and the U.S. Department of Housing and Urban Development (HUD). While there are a number of TH programs whose entire funding comes from an OVW Transitional Housing grant, our interviews suggest that a majority of programs utilize multiple sources of funding -- possibly including foundation grants, grants from other government sources, and individual and corporate donations. We encountered a handful of programs that also derive revenue from in-house thrift stores, cafes, or other social enterprises.

Approximately 42% of the providers we interviewed⁷ also receive grant funding for transitional housing or rapid rehousing⁸ programs from HUD. In some cases, the OVW and HUD funds are pooled to operate a single program; in some cases they operate separate programs. In a few cases (as noted at the beginning of their comments), these providers were not currently receiving OVW TH grant funding when we did the interview.

Few, if any, programs have enough funding to provide all of the services their participants need, and so, nearly every program we interviewed told us that they leverage services from other sources. Programs that are part of well-resourced larger agencies are typically able to leverage the services of some of the in-house staff funded by other grants and fundraised moneys. But not even the most well-endowed agencies have the capacity to offer every type of assistance a survivor might need; therefore, programs also told us that they leverage services from community partners⁹ and/or from individual providers who contract with them or generously donate their time. These arrangements are discussed in the section on partnerships and collaborations.

Because HUD funding is so important to so many of the providers we interviewed, a significant portion of this chapter is devoted to discussions about the similarities and differences in OVW and HUD funding, and the benefits and challenges in utilizing HUD funding to provide TH for survivors of domestic and sexual violence.

(ii) OVW versus HUD Funding: Similarities and Differences in Population Served and Eligibility

(A) Eligibility for OVW-Funded Transitional Housing

Per to the provisions of [42 USC §13975\(a\)](#), OVW TH grants "provide assistance to minors, adults, and their dependents (1) who are homeless, or in need of transitional housing or other housing assistance, as a result of a situation of domestic violence, dating violence, sexual assault, or stalking; and (2) for whom emergency shelter services or other crisis intervention services are unavailable or insufficient."

As discussed at greater length in [Chapter 2](#) ("Survivor Access and Participant Selection") and [Chapter 8](#) ("OVW Constituencies"), the majority of participants in OVW-funded TH programs are survivors of intimate

⁷ With three exceptions, we drew our interviewees from a list of OVW grantees and the providers they referred us to.

⁸ As will be discussed later in this section, many of the programs that the OVW would categorize as "transition-in-place" transitional housing are funded, at least in part, by HUD Rapid Rehousing grants. As will also be discussed later in this section, HUD considers Rapid Rehousing to be a type of permanent housing, rather than transitional housing.

⁹ OVW now requires TH grant applicants to enter into a funded Memorandum of Understanding (MOU) with at least one provider, and bases over 20% of an applicant's grant score on the MOU collaboration and how it will benefit survivors.

partner violence¹⁰, in part, because DV shelters are such a major sources of candidates for enrollment in OVW-funded TH programs. The majority of DV shelters receive Family Violence Prevention and Services Act (FVPSA) grant funding,¹¹ which allows them to serve survivors of intimate partner violence (i.e., domestic and dating violence) or family violence, but **not** sexual violence perpetrated by an acquaintance or stranger.¹²

By contrast, OVW-funded TH programs are authorized to serve survivors of domestic violence, sexual assault (by any perpetrator), dating violence, and stalking, but **not** other types of family violence.¹³

The overlapping constituencies -- i.e., the types of survivors who can be served in FVPSA-funded shelters **and** OVW TH programs -- are DV survivors and survivors of sexual assault by family members.

(B) Eligibility for HUD-Funded TH and RRH Assistance

Eligibility for HUD Continuum of Care (CoC)-funded **Transitional Housing** or **Rapid Rehousing** assistance or for Emergency Solutions Grant (ESG)-funded **Rapid Rehousing** assistance is largely governed by **HUD's four-part homelessness definition (HUD, 2011a)** -- concisely summarized in a **documentation-of-eligibility requirements** guide (HUD, 2012) -- and the regulatory framework that determines which **categories of homeless persons can access the different types of HUD-funded projects (HUD, 2012a)**¹⁴

"Category 1" ("Literally Homeless") - persons living in shelter, transitional housing for homeless persons, or a motel unit paid for by charitable/public entity; in a place not meant for human habitation (e.g., the street, vehicle, abandoned building, etc.); and persons who were literally homeless, until they entered institutional care (e.g., jail, treatment facility, etc.), where they have resided for the past 90 days or less.

HUD Eligibility: ESG Shelter, ESG RRH, CoC TH, CoC RRH

"Category 2" ("Imminent Risk of Homelessness") - persons whose primary nighttime residence will be lost within 14 days, who have no identified subsequent residence, and who lack the resources or support networks needed to obtain other permanent housing

HUD Eligibility: ESG Shelter, CoC TH

"Category 3" ("Homeless Under Other Statutes") - unaccompanied youth/young adults (under age 25) or families with children/youth who: (a) are defined as homeless under other federal statutes, but who do not qualify as "homeless" under categories 1, 3, or 4 of the HUD definition; (b) meet specified criteria for housing instability, and (c) face one or more of the enumerated barriers to housing and income stability. **NOTE: Continuums of Care need special permission from HUD to serve "Category 3" homeless persons.**

HUD Eligibility: ESG Shelter, CoC TH (**with special permission from HUD, as noted above**)

¹⁰ The five [VAWAMEI semi-annual reports](#) covering 7/1/2012 - 12/31/2014 indicate that DV and dating violence survivors constituted 85.6% and 8.4%, respectively, of the households served by OVW-funded TH programs. Approximately 9% of TH program participants were sexually assaulted by someone other than an intimate partner (e.g., family member, acquaintance, or stranger). The total exceeds 100% because some survivors were victimized by multiple perpetrators.

¹¹ "FVPSA formula grants are awarded to over 200 Tribes and every State and Territory, which sub-grant funds to more than 1,600 community-based domestic violence shelters." (p.8) [FYPSA report to Congress 2009-2010](#).

¹² Per the footnote on p. 1 of [Navigating the Family Violence Prevention Services Program: A Guide for State and Territorial Administrators](#), "Congress uses [the term] 'family violence' in its legislation that authorized FVPSA. Family violence and domestic violence are used interchangeably within the FVPSA program announcements. It is important to know that the emphasis of the FVPSA program is on family violence, domestic violence, and dating violence as they occur in the context of intimate partner relationships."

¹³ See, for example, subparagraph (a)(1) of 42 U.S.C.A. § 13975, the [statutory authorization of the OVW Transitional Housing grant program](#) or the "Overview" on page 6 of the [2015 OVW Transitional Housing Program Grant Solicitation](#).

¹⁴ This chart pre-dates the promulgation of the CoC Interim Rule in 2011, and so, lists the "Supportive Housing Program" (SHP) and the "Shelter Plus Care" (SPC) program, which were folded into the new "Continuum of Care" (CoC) program. Not listed in the chart is the CoC program's "Rapid Rehousing" (RRH) component, added by §578.37(a)(1)(ii) of the [CoC Interim Rule](#), which serves categories 1 and 4 homeless persons, whether or not they have a disabling condition.

"Category 4" ("Fleeing/Attempting to Flee Domestic/Sexual Violence") - persons fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; who have no other residence; and who lack the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing."

HUD Eligibility: ESG Shelter, ESG RRH (**only if survivor also meets category 1 criteria**), CoC TH, CoC RRH

In addition to eligibility guidelines based on the HUD Homeless Definition, eligibility and priority for TH and RRH assistance is also determined by "**written standards**" that HUD requires states, counties, and cities administering ESG grants and Continuums of Care administering CoC grants to:

ESG-Related Written Standards: Per §576.400(e)(3) of the [ESG Interim Rule](#), "At a minimum, these written standards [that states, counties, and jurisdictions administering ESG grants must develop] must include:

(vi) Policies and procedures for determining and prioritizing which eligible families and individuals will receive ... rapid re-housing assistance;

(vii) Standards for determining what percentage or amount of rent and utilities costs each program participant must pay while receiving ... rapid re-housing assistance;

(viii) Standards for determining how long a particular program participant will be provided with rental assistance and whether and how the amount of that assistance will be adjusted over time; and

(ix) Standards for determining the type, amount, and duration of housing stabilization and/or relocation services to provide to a program participant, including the limits, if any, on the ... rapid re-housing assistance that each program participant may receive, such as the maximum amount of assistance, maximum number of months the program participant receive assistance; or the maximum number of times the program participant may receive assistance."

CoC-Related Written Standards: Per §578.7(a)(9) of the [CoC Interim Rule](#), "At a minimum, the written standards [that CoC's must develop] must include:

(i) Policies and procedures for evaluating individuals' and families' eligibility for [CoC-funded] assistance;

(ii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

(iii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance; [and]

(iv) Standards for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance."

Per §578.37(a)(1)(ii)(B) of the [CoC Interim Rule](#), Rapid Rehousing projects "may set a maximum amount or percentage of rental assistance that a program participant may receive, a maximum number of months that a program participant may receive rental assistance, and/or a maximum number of times that a program participant may receive rental assistance." Although this provision of the [CoC Interim Rule](#) allows these parameters to be defined as project-specific written standards, a CoC could establish such a standard for all RRH projects funded using CoC administered grant funds.

(C) Similarities and Differences in Eligibility for Assistance

- On the one hand, HUD's definition of "Category 4" homelessness is a bit broader¹⁵ than the target population defined by [42 USC §13975](#), the statute authorizing the OVW TH grant program. On the other hand, there are two ways in which the HUD framework narrows access to program assistance:
 - As noted above, "Category 4" survivors who do not also meet the criteria for "Category 1" homelessness are not eligible for ESG-funded RRH assistance. That is, only survivors who are in shelter or another TH program or on the street (or who transitioned from one of those settings to residential treatment or incarceration within the past 90 days) can be served in an ESG RRH program. Persons still living with their abusive partner or who fled to a friend or family member's house are not "Category 1" homeless.
 - As described in *Rapid Rehousing: ESG vs. CoC Guide* ([HUD, 2013a](#)), in order for RRH housing assistance and/or services to extend beyond the one-year anniversary of program enrollment, RRH participants must be reassessed for eligibility within one year of their initial determination. §576.401(b) of the [ESG Interim Rule](#) establishes an income test for continued ESG RRH eligibility at the one-year anniversary; survivors whose incomes exceed 30% of the median family income for the area¹⁶ are no longer eligible for ESG RRH assistance. (HUD does not require an income determination as part of the initial assessment for ESG or CoC RRH eligibility, nor does HUD require an income determination as part of the CoC RRH anniversary assessment.)
- Section 602 of the [VAWA Reauthorization Act of 2013](#) (p.56) **eliminated the word "fleeing" from the statutory language establishing the target population for OVW-funded TH programs** (i.e., persons homeless as a result of fleeing domestic violence, dating violence, sexual assault, or stalking).

HUD's definition of "Category 4" homelessness (see [HUD, 2012](#)) pre-dates the VAWA Reauthorization Act of 2013, and refers to individuals or families that are "fleeing" or "attempting

¹⁵ In addition to including survivors of domestic violence, dating violence, sexual assault, and stalking, HUD's "Category 4" includes persons fleeing or attempting to flee "other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence."

¹⁶ The requirement for income eligibility at the anniversary reassessment is intended to ensure that extended assistance is limited to participants whose extremely low income makes it more difficult to become self-sufficient in housing. One provider that we interviewed saw the requirement as penalizing survivors who make an effort to increase their income.

to flee"¹⁷ domestic violence, sexual assault, etc. Although the language governing documentation of eligibility appears to offer some flexibility, a few providers interviewed for this project described unsuccessful attempts to enroll survivors in HUD-funded TH or RRH programs because the survivor was not seen as "fleeing or attempting to flee" because (a) the survivor was still living with the abusive partner; or (b) it was several months since the survivor had fled an abusive situation to a series of temporary situations; or (c) the survivor had timed out of a DV shelter and was staying with a friend or family member.

Apart from this distinction, eligibility under the OVW guidelines and the Category 4 definition largely overlap, and should pose no barrier to accessing CoC RRH assistance.

- The requirement for "**written standards**" allows CoCs administering CoC grants and states, counties, and jurisdictions administering ESG grants to narrow eligibility for assistance, or to establish priorities for assistance that have the effect of limiting access by survivors who would otherwise be eligible for TH or RRH assistance. For example, in its *Rapid Rehousing: ESG vs. CoC Guide* (HUD, 2013a), HUD notes that a CoC **could** prescribe an income requirement, if it wanted to:

*"As part of its **written standards**, a Continuum of Care may establish an income requirement for continued eligibility in order to align ... its RRH assistance with ESG assistance provided within the CoC's geographic area. In addition, an ESG recipient may, in developing its written standards, set a more restrictive income eligibility standard. That is, the HUD eligibility standard defines the upper bound of eligibility, which the CoC and/or the ESG recipient may narrow further as part of its effort to target limited resources."* (p.4)

Similarly, a CoC could prioritize serving "Category 1" homeless survivors over survivors who only meet the "Category 4" criteria, but who are not "literally homeless."

- The required implementation by CoCs of a coordinated entry/coordinated assessment system and the required utilization of that system by ESG- and CoC-grant-funded projects could, depending on the standardized assessment instrument and process, result in a lowered priority for serving survivors of domestic and sexual violence. As noted elsewhere, the [ESG Interim Rule](#) (24 CFR 576.400(d)) and the [CoC Interim Rule](#) (24 CFR 578.23(c)(9)) both allow victim services providers to be exempt from the requirement to participate in the CoC's coordinated entry system. While the ESG Interim Rule provision simply allows providers not to use the CoC system, the CoC Interim Rule provision requires that victim service providers not using the CoC's system instead use a coordinated entry system

¹⁷ HUD offers no regulatory definition of "fleeing or attempting to flee." The regulations governing documentation of eligibility ([subparagraph \(b\)\(5\) of 24 CFR Part 583.301](#) on pp. 76018-19 of the 12/5/2011 Federal Register) state that,

*"Acceptable evidence includes an **oral statement** by the individual or head of household seeking assistance that they are fleeing that situation, that no subsequent residence has been identified, and that they lack the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other housing. If the individual or family is receiving shelter or services provided by a victim service provider..., the oral statement must be **documented** by either a certification by the individual or head of household; or a certification by the intake worker. Otherwise, the oral statement that the individual or head of household seeking assistance has not identified a subsequent residence and lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain housing, must be **documented** by a certification by the individual or head of household that the oral statement is true and complete, and, where the safety of the individual or family would not be jeopardized, the domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening condition must be **verified** by a written observation by the intake worker; or a written referral by a housing or service provider, social worker, health-care provider, law enforcement agency, legal assistance provider, pastoral counselor, or any another organization from whom the individual or head of household has sought assistance for domestic violence, dating violence, sexual assault, or stalking. The written referral or observation need only include the **minimum amount of information necessary** to document that the individual or family is fleeing, or attempting to flee domestic violence, dating violence, sexual assault, and stalking."*

maintained by local victim service providers that meets HUD's minimum requirements. Such an alternate system may not exist in all locations, which would presumably mean that CoC-funded victim services providers had to participate in the CoC system.

- On August 5, 2016, the **U.S. Department of Justice, U.S. Department of Health and Human Services, and HUD released a jointly signed letter** ([HUD/HHS/DOJ, 2016](#)) clarifying that OVW-, HUD-, and FVPSA-funded mainstream emergency and DV shelters, OVW- and HUD-funded TH programs, and HUD-funded RRH programs, may all provide emergency housing assistance to undocumented immigrants. As summarized by an accompanying **news release on the HUD website** ([HUD, 2016c](#))

"Today, the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Justice (DOJ) issued a joint letter reminding recipients of federal funds how the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 applies to their programs.

Through PRWORA, Congress restricted immigrant access to certain federal public benefits but also recognized exceptions to protect life or safety. Congress authorized the Attorney General to identify programs, services, and assistance that meet specific criteria for which immigrants remained eligible regardless of immigration status.

The purpose of this letter is to remind housing and service providers that they must not turn away immigrants experiencing homelessness or victims of domestic violence or human trafficking, on the basis of their immigration status, from certain housing and services necessary for life or safety – such as street outreach, emergency shelter, and short-term housing assistance including transitional housing and rapid re-housing funded through the Emergency Solutions Grants (ESG) and Continuum of Care (CoC) Programs.

The letter from the Attorney General and the Secretaries of HHS and HUD, dated August 5, 2016, is not a new policy. It reiterates existing laws and policies and applies those policies to programs that were not in effect when the original Attorney General Order was signed in 2001."

(iii) OVW versus HUD-Funding: Grant Size and Stability

OVW Transitional Housing grants are typically three-year grants. With the maximum grant award being increased to \$350,000 beginning with the FY 2014 awards, providers now typically receive three-year grants of between \$300,000 and \$350,000 (mostly at the higher end). Grants may or may not be renewed for a follow-up three-year period, subject to a competitive application process.

The amount of HUD's total ESG award to any state, county, or jurisdiction is based on a complicated formula. In turn, the amount of ESG funding that that state, county, or jurisdiction awards to a particular project is left to the discretion of that state, county, or jurisdiction, which can also decide from year to year whether to increase, decrease, or terminate project funding, based on the availability of funds and competing demands. Thus, grants vary greatly in size across the country. ESG funding may be expended over a 1-2 year period.

HUD CoC grants are awarded annually, and likewise vary greatly in size; some provide substantially more funding per year than OVW grants, and make it possible for the recipient agency to provide transitional housing or transition-in-place housing assistance to many more clients than they would be able to using only OVW funds. CoC grants are awarded pursuant to an application to HUD via the Continuum of Care, which is responsible for prioritizing all of the projects seeking funding.

Over the years, HUD has increasingly emphasized permanent housing projects -- that is, permanent supportive housing (especially for chronically homeless individuals and families) and rapid rehousing projects providing short- or medium-term rental assistance, with services, to help individuals and families transition from homelessness to housing. Many of the HUD CoC "Transitional Housing" grant-funded projects date back to the 1990s, and have been consistently renewed. Very few **new** transitional housing grants have been awarded in

the past 10-15 years. In years that Congress has funded the Continuum of Care program¹⁸ at a level that was adequate to renew ongoing projects as well as fund new ones, HUD has generally supported CoC requests to sustain existing, well-performing projects. During less well-funded budget cycles, HUD has not always funded a CoC's¹⁹ lower priority projects. In those lean budget years, the projects at greatest risk of partial or total loss of HUD funding have been "transitional housing" and "supportive services only" projects. Thus, in the 2015²⁰ award year, a number of TH grant projects, including projects dedicated to serving DV survivors did not receive renewal funding, eliminating them from the annual HUD grant cycle.

(iv) OVW versus HUD Grants: Allowed Uses

The following bullets examine similarities and differences in the allowed uses of OVW versus HUD grant funds:
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- ***Apartment leasing (provider holds the lease):*** OVW and HUD TH grants allow. As described below, units leased with HUD grant funds must meet certain standards for quality and pricing.
- ***Rental Assistance (participants hold their own leases):*** OVW and HUD RRH grants allow. (Technically, HUD TH grants can also be used for rental assistance, but most, if not all, TH grants involving rental assistance will probably have been converted²² to RRH grants by now.) As described below, units supported with HUD rental assistance funds must meet certain standards for quality and pricing.
- ***Utility Costs:*** OVW and ESG RRH grants allow. (HUD TH grants can also cover the cost of utilities in properties owned/leased by the provider.)
- ***Up-Front Costs for Moving into Housing:*** Rental application fees: HUD TH grants and CoC/ESG RRH allow. Moving costs: HUD TH and CoC/ESG RRH grants allow. Last month's Rent and Security Deposit: HUD CoC/ESG RRH allow. Utility Deposit: HUD CoC/ESG RRH allow. Rent/Utility Arrearages (up to six months): HUD ESG RRH allows. The [2016 OVW TH grant proposal solicitation](#) identifies "payment of bills/utilities in arrears" as an "unallowable activity" (p.10). The OVW solicitation is silent on the other upfront costs, but providers reported using OVW funds for these tenancy start-up costs.

¹⁸ The Supportive Housing Program, which awarded grants eventually totaling more than \$1 billion/year for transitional housing (TH), permanent supportive housing (PSH), and supportive services only (SSO) projects was the precursor to the Continuum of Care program, which came into existence pursuant to passage of the HEARTH Act in early 2009 and the issuance in July 2012 of interim regulations, known as the [CoC Interim Rule](#). CoC program grants total about \$1.5 billion.

¹⁹ Continuum of Care (CoC) is the name of the HUD-funded grant program, as well as the name for the geographically defined collaboration of public and private stakeholders that come together to address homelessness within that geography (which can be a state, city, county or some mix thereof). CoCs must have a formal board and decision-making process -- based on data-driven review of funded projects and assessment of outstanding needs -- that determines which projects will be submitted for full or partial renewal funding, and which projects will be allowed to end.

²⁰ See for example, *FY 2015 CoC Program Competition Recap* ([HUD, 2016](#)) and the *July 2016 Message "Addressing the Needs of Persons Fleeing Domestic Violence"* ([HUD, 2016a](#)) from HUD Deputy Assistant Secretary for Special Needs Ann Marie Oliva.

²¹ This is an incomplete discussion of allowed use of funds, intended to illustrate the similarities and differences between the different funding sources. HUD regulations governing the use of grant funds -- the [CoC Interim Rule](#) and the [ESG Interim Rule](#) -- are extensive, and should be consulted for more complete information. The [2016 OVW solicitation for TH grant proposals](#) provides less specific information about eligible and ineligible costs; information about "unallowable activities" and "limited use of funds" for legal services and purchase/lease of vehicles appears on p.5 of that solicitation.

²² In the grant competitions that took place shortly after the HEARTH Act became law, a number of TH grants that utilized a rental assistance model were converted to Rapid Rehousing grants. After that "adjustment period" ended, the process of shifting from a TH model to an RRH model has involved "reallocation of funds," whereby an existing TH project would be terminated, and the funds re-purposed by the Continuum of Care as a RRH project.

- **Case Management and Other Supportive Services:** OVW and HUD TH and RRH grants all allow the use of grant funds for services, whether provided by staff or purchased from another provider.

Generally speaking, the OVW is less prescriptive about the allowable uses of TH grant funds. All budgeted items (e.g., funds for leasing housing and/or providing rental assistance, funds for essential personnel, funds for travel, funds for necessary supplies and equipment, etc.) must be explained and justified as they relate to the proposed project activities. Except in the case of state and local government project partners whose role in the project is accomplished as part of their ordinary work responsibilities, all project MOU partners must be compensated in the budget.

Exhibit 5 (pp. 10-12) of *Rapid Rehousing: ESG vs. CoC Guide* ([HUD, 2013a](#)) provides a convenient comparison of the wide range of supportive services available under CoC-RRH grants versus the somewhat narrower range of services reimbursable under ESG-RRH grants. (Note that CoC-TH grants can cover exactly the same supportive services as CoC-RRH grants.²³) Types of supportive services covered by both ESG and CoC grants include case management, housing search and related services; credit repair, and legal services, including services related to orders of protection and other civil remedies for victims of domestic and sexual violence. CoC grants can also be used to pay for child care by licensed providers; a range of education-related services; a range of employment-related assistance and services; food and meals for program participants; life skills training; outpatient health, mental health, dental health, and substance abuse treatment services; counseling; and transportation-related assistance.

- **Cash or In-Kind Match Requirement:** OVW TH grants do not have a cash or in-kind match requirement. HUD ESG-RRH grants have a dollar-for-dollar cash or in-kind match requirement.²⁴ However, that match requirement is an aggregate requirement, that is, it applies on an overall basis to all of the projects funded by a state, county or jurisdiction. Each state, county, or jurisdiction may determine whether and how much specific projects must contribute to meeting the match requirement. Every CoC TH and RRH grant-funded project must meet a cash or in-kind match requirement. CoC RRH grants must provide a cash or in-kind match totaling 25% of their grant amount. CoC TH grants must provide a cash or in-kind match totaling 25% of their total grant amount, not including any portion of that grant used to lease property. See the *HUD FAQ on the CoC match requirement* ([HUD, 2014a](#)) for more information and an example.

(v) HUD Rapid Rehousing Grants: Benefits and Challenges for Providers and Participants

As noted above, over the past 10-15 years, HUD has increasingly prioritized permanent housing -- including RRH projects (in which participants lease scattered-site apartments and receive time-limited rental assistance and services to support their transition from homeless to housing) -- over "traditional" TH projects (in which participants have time-limited stays in provider-owned or provider leased housing -- typically congregate or clustered apartments -- until they are able to find their own permanent housing). This has resulted in the award of many new rapid rehousing projects providing time-limited rental assistance and services to help move tens of thousands of households, including survivors, from homelessness to housing ... as well as the loss of thousands of units of traditional transitional housing, including a number of projects serving survivors.

[Chapter 3](#) ("Program Housing Models") explores the relative advantages and challenges of the traditional TH program model versus the RRH/transition-in-place model; provides some historical perspective; and asserts the need for both kinds of programs to address the varying needs of survivors across the country.

²³ See §578.73(c)(9) of the [CoC Interim Rule](#) for a **detailed** list of the types of supportive services that can be covered.

²⁴ Per §576.201(a)(2) of the [ESG Interim Rule](#), the cash match requirement for states administering ESG grants is statutorily reduced by \$100,000.

Although, for example, a **September 2013 HUD posting entitled "What About Transitional Housing?"** ([HUD, 2013](#)) by HUD Deputy Assistant Secretary of Special Needs Ann Oliva identified domestic violence survivors as a population for which "traditional" TH programs are appropriately targeted, her overall message to CoCs was to "consider reallocating funding" from such TH programs to "more promising models" like rapid rehousing and permanent supportive housing. Some of those same themes were present in Deputy Assistant Secretary Oliva's **July 2016 HUD posting, entitled "Addressing the Needs of Persons Fleeing Domestic Violence"** ([HUD, 2016a](#)) written in the aftermath of the 2015 CoC funding cycle which saw a number of DV-focused programs lose their CoC TH grant funding.²⁵

Many of the providers we interviewed who once operated more traditional TH programs described their shift to a RRH model: some made the change enthusiastically, some with apprehensions, and some out of fear that they -- and the CoC -- would lose their funding entirely, if they didn't go along with the shift.²⁶

At the same time that there has been a shift away from traditional TH projects to new RRH projects in the CoC grant program, **there has been a significant infusion of new ESG program funding for new RRH grants** since the HEARTH Act was signed into law in 2009. That is, providers utilizing HUD ESG funding for their transition-in-place projects are leveraging **an entirely new source of funding** (rather than re-purposed funding from the TH projects they had to terminate). These new funds have helped countless survivors jumpstart tenancies in independent housing in the aftermath of their flight from an abusive situation.

With the increased use of RRH grant resource have come some challenges:

(A) Tenancies assisted with RRH funds must be governed by a lease in the participant's name. For CoC-RRH tenancies, the lease must cover a full year.

If a survivor isn't ready to take on the responsibility of a leaseholder or can't find a landlord willing to offer her a lease -- even with the promise of temporary financial assistance -- that survivor cannot become a participant in a RRH rehousing program. As more and more programs (including programs using OVW TH grants to fund housing assistance), rely on scattered-site participant-leased housing, there are fewer and fewer options for survivors who are unable to obtain a lease in their name. In the kinds of tight real estate markets that many of the providers we interviewed described, the HUD RRH model can be a poor fit for survivors with high barriers to housing (and employment), especially as pressures mount for programs to make placements and to complete the transition-in-place process more quickly.²⁷

²⁵ A HUD memo issued in the aftermath of the 2015 funding competition ([HUD, 2016](#)) describes how HUD's strong preference for RRH programs over TH programs played out in terms of funding decisions.

"Funding for permanent supportive housing projects increased by approximately \$165 million to \$1.41 billion. Of this, approximately \$115 million represents 7,500 additional permanent supportive housing units, and the rest is a result of increases needed to keep up with rising housing costs. Funding for rapid re-housing projects doubled to \$197 million. We estimate that this funding will serve approximately 30,000 more households experiencing homelessness than if there had been no increase. Funding for transitional housing projects declined by \$155 million to \$171 million. As a result, CoC Program-funded transitional housing will serve approximately 15,000 fewer households than the previous year."

²⁶ As per an earlier footnote, in the current landscape, "shifting" funding from a TH model to a RRH model involves proposing the termination of the TH project and "reallocating" the funds from that project for use as a new RRH project, (presumably serving the same constituency). The reallocation of funds is proposed as part of the CoC's annual application to HUD for project funding. Typically, unless there are serious problems with the application, HUD approves the request. When a CoC "guesses wrong" and prioritizes a TH project for renewal funding that HUD, in turn, decides not to renew, the CoC forever loses the funding that was allocated to that TH project. If the CoC had "reallocated" that funding from the TH project to a new RRH project, the CoC would have retained the funding. **This gives CoCs a strong incentive to proactively shift funding away from even well-performing TH projects**, to ensure retention of their overall level of HUD funding.

²⁷ See (A) "Pressure to Shorten the Timeframe for Program Assistance" in subsection (vii) on "Other Challenges Posed by HUD Funding."

In contrast, OVW TH grants (using a transition-in-place model) allow a provider to be the leaseholder until the survivor can convince the landlord to transition the lease to her name. The ability (and willingness) of an OVW grant-funded program to take on the role of initial leaseholder for an apartment in which the participant hopes to transition-in-place is also helpful if the participant doesn't want to be named on a lease for safety reasons, or isn't quite emotionally ready for the responsibility of being a leaseholder.

On the one hand, a transition-in-place model provides a survivor with the opportunity to put down roots as soon as she begins her TH program participation. On the other hand, the traditional program model (in which the participant lives in provider-owned or provider leased housing) -- or a version of the OVW transition-in-place model in which the provider acts as the initial leaseholder -- buys the survivor time to repair her credit and housing record and, perhaps, develop a credible income, before she has to make the case to a landlord for offering her a lease.

That extra time, and the opportunity to put her "tenancy credential" in better order can make the difference between a successful and unsuccessful housing search. The OVW transition-in-place model that allows a provider to temporarily hold the lease until the landlord is willing to put it in the participant's name combines the best of both approaches.

Complicating matters for survivors with seriously flawed "tenancy credentials" is the requirement, described in *Rapid Rehousing: ESG vs. CoC Guide* ([HUD, 2013a](#)) (p.8), that tenancies assisted by CoC RRH programs be governed by a lease that extends for a term "**of at least one year that is renewable ... and terminable only for cause.**" Even if a participant is comfortable being named on the lease, and even if a landlord is willing to overlook the participant's blemished housing or credit history and/or limited work history, that landlord may not be willing to offer a one-year lease, knowing that the rent assistance -- her/his assurance of payment -- may decrease over time, and may not last for the full duration of the lease.²⁸

A couple of providers noted that for safety or other reasons, it can sometimes be beneficial to have a shorter-term lease that allows a participant to relocate, for example, if their abusive partner has located them and poses a threat, or if they obtain better employment which would require a time-consuming, expensive, or infeasible commute from the housing where they were holding a one-year lease.

There are no comparable lease-related requirements for OVW grant-assisted tenancies.

²⁸ As discussed in [Chapter 3](#) ("Program Housing Models") and [Chapter 6](#) ("Length of Stay"), the duration of RRH rental assistance can vary from six months to two years, and the level of monthly assistance can vary over time (e.g., some programs offer a consistent level of assistance, others gradually reduce the level of rental assistance over time, etc.)

(B) Compliance with HUD Housing Quality Standards and Fair Market Rent/Reasonable Rent Standards

Tenancies assisted with HUD RRH funds must be in apartments that meet *HUD's Housing Quality Standards (HQS)* ([HUD, 2001](#))²⁹ and must be priced for compliance with *HUD's Fair Market Rent (FMR) guidelines* ([HUD, 2016b](#)) and Rent Reasonableness standard.³⁰

A number of the providers we interviewed indicated that in the increasingly expensive and competitive rental markets that their participants must navigate, HUD's HQS (which are typically more rigorous than the local inspection standards that rental units need to meet) and FMR standards made it that much harder for participants to find transition-in-place housing they could lease. Some of the providers serving more *rural* areas stated that the HQS requirement put much of the housing stock in poor rural areas off limits for use by their HUD RRH-funded program.

Although, of course, OVW-funded providers would presumably recommend against leasing substandard housing or housing that was more expensive than a program participant could expect to afford once their program-funded rental assistance ends, most providers understand that participants may need to make difficult choices and compromises, given their limited options. (Some providers play a more active role than others in helping participants find housing, or in exercising the right to determine whether or not they will "approve" a survivor's apartment selection and provide rental assistance.)

A couple of providers suggested that if HUD funds could help pay for minor repairs/improvements to correct HQS deficiencies, that would expand the supply of affordable housing options in rural areas.

(C) "Written Standards" May Limit Provider Flexibility in Tailoring Rental Assistance to Survivor Needs

Depending on the written standards implemented by the administering state, county, or city, providers utilizing ESG RRH grants may have less flexibility than OVW-funded providers to set the level and duration of housing assistance offered to program participants. Likewise, depending on the written standards implemented by the administering CoC, providers utilizing CoC RRH grants may have less flexibility in tailoring the rental assistance package to meet the needs of a survivor.

Although HUD's ESG and CoC program regulations allow for up to 24 months of RRH rental assistance, many RRH grant-funded projects are not able to offer the full 24 months of assistance to participants. In some cases, the limitation may be budgetary (e.g., if their grant doesn't provide adequate funding to extend rental assistance, or because they are nearing the end of the grant term with no guarantee of renewal). In other cases, their flexibility is limited by "written standards" adopted by the entity administering their CoC or ESG grant that **limit or prescribe the amount, duration, and scope of rental assistance and services** that a grant-funded provider can offer to participants:

²⁹ [Housing Quality Standards \(HQS\)](#), which must be verified by onsite inspection, are "performance and acceptability criteria" addressing: (A) Sanitary facilities; (B) Food preparation facilities and refuse disposal; (C) Space and security; (D) Thermal environment; (E) Illumination and electricity; (F) Structure and materials; (G) Interior air quality; (H) Water supply; (I) Lead-based paint; (J) Access; (K) Site and neighborhood; (L) Sanitary condition; and (M) Smoke detectors. The HQS are typically more stringent than the local housing code, and particularly in rural areas and highly competitive urban housing markets, can make it challenging to find compliant units. HQS are codified at [24 CFR 982.401](#).

³⁰ The amount of HUD housing assistance must not exceed the [Fair Market Rent \(FMR\)](#) annually calculated by HUD for apartments with different numbers of bedrooms, for each city or county in the country. The FMR includes the cost of rent plus heat and utilities; if heat or other utility bills are paid separately by the tenant, a standard amount (e.g., the average monthly electric bill) is deducted from the FMR to determine the limit on HUD monthly assistance.

Recognizing that in some higher cost rental markets, the actual cost of housing may exceed the FMR, §578.51(g) of the [CoC Interim Rule](#) ("**Rent Reasonableness**") allows program participants to lease units whose rent (including covered utilities) exceeds the FMR, provided that (a) the amount of HUD-funded rental assistance does not exceed the FMR, and (b) the total cost of the unit is "reasonable" compared to similar units in the area (esp. units with the same owner).

Note: In typical HUD-assisted permanent housing, participants are routinely expected to pay 30% of their net income, as calculated using a standard formula, towards their housing and utility costs. For HUD CoC Transitional Housing, 30%-of-net-income is the maximum amount that a participant can be asked to pay for housing owned or leased by the provider.³¹ **Rapid Rehousing (RRH) is exempted from any of the standard regulations prescribing the amount or percentage or the maximum participant payment towards rent/utilities. Instead, that decision is left to the entity developing the written standards and/or to the provider operating the RRH program.**

- §576.400(e)(3) of the [ESG Interim Rule](#) requires the state, county, or jurisdiction administering the ESG grant to adopt written standards that, **at a minimum**:
 - Determine the percentage or amount of rent and utilities costs each program participant must pay while receiving homelessness prevention or rapid re-housing assistance;
 - Determine how long a particular program participant will be provided with rental assistance and whether and how the amount of that assistance will be adjusted over time; and
 - Determine the type, amount, and duration of housing stabilization services, including any limits, such as the maximum amount of assistance, maximum number of months or maximum number of times a program participant may receive assistance.
- §578.7(a)(9)(iv) of the [CoC Interim Rule](#) **requires the CoC to adopt a written standard** "for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance."
- §578.37(a)(1)(ii)(B) of the [CoC Interim Rule](#) **allows the provider** operating an RRH project to "set a maximum amount or percentage of rental assistance that a program participant may receive, a maximum number of months that a program participant may receive rental assistance, and/or a maximum number of times that a program participant may receive rental assistance."

However, to the extent that the CoC Interim Rule specifies that it is only enumerating the minimum scope of the written standards the CoC must adopt, the CoC is free to develop others, as well. Rather than leaving it entirely to individual providers to "set a maximum amount or percentage of rental assistance that a program participant may receive, a maximum number of months that a program participant may receive rental assistance, and/or a maximum number of times that a program participant may receive rental assistance," the CoC could establish such standards applying to all CoC-funded RRH projects operating in the CoC.

By comparison, OVW-funded providers have considerable leeway in determining how to allocate rental assistance to program participants, and whether and/or how much to ask participants to contribute to their housing and utilities.

On the one hand, written standards ensure a **consistent and equitable approach** with all participants; on the other hand, the flexibility inherent in the OVW model allows providers to **tailor the assistance to the specific needs of each participant**.

(vi) Voluntary Services in the Context of HUD-Funded TH and RRH Projects

As summarized below, victim services providers operating HUD-funded TH or RRH grant-funded programs are regulatorily exempted from any requirements that would prevent them from adhering to a voluntary services approach. However, interview comments suggest that accountability to HUD for housing and income-related

³¹ See §578.77 of the [CoC Interim Rule](#)

participant outcomes (notwithstanding their participants' different priorities and sometimes substantial barriers, and notwithstanding difficulties posed by difficult local job or housing markets) may result in operational decisions that "get around" challenges that might be posed by voluntary services: (a) using participant selection processes that prioritize survivors with compatible housing and employment goals, and fewer barriers to achieving those goals within a shortened timeframe; and (b) using more assertive case management approaches -- including, in some cases, linking interim housing assistance to "effort" and "progress" on housing and employment goals -- to keep participants "on track" to achieve those goals.

- **Transitional Housing:** §578.53(b)(1) of the [CoC Interim Rule](#) states that "For a transitional housing project, supportive services must be made available to residents throughout the duration of their residence in the project." However, there is no provision requiring a participant to engage with those services. More generally, §578.75(h) of the [CoC Interim Rule](#) states that, "Recipients and subrecipients *may* require the program participants to take part in supportive services that are not disability-related services provided through the project as a condition of continued participation in the program," **but there is no HUD requirement for such participation.**
- **Rapid Rehousing:** In ordinary Rapid Rehousing projects, participants and providers must meet at least monthly. However, in projects operated by victim services providers or otherwise covered by VAWA³², the monthly meeting requirement is waived. Thus, §578.37(a)(1)(ii)(F) of the [CoC Interim Rule](#) exempts CoC-funded RRH projects from the requirement to have program participants meet with a case manager not less than once per month "if the Violence Against Women Act of 1994 (42 U.S.C. §13925 et seq.) or the Family Violence Prevention and Services Act (42 U.S.C. §10401 et seq.) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services." And §576.401(e)(2) of the [ESG Interim Rule](#) provides that same exemption for participants assisted by ESG RRH projects.

(vii) Other Challenges Posed by HUD Grant Funding

(A) Pressure to shorten the duration of program assistance ("Length of Stay")

Perhaps the most significant source of tension around the use of HUD RRH and TH funds that providers described was from pressure to shorten the duration of program stay, so as to increase the number of households that can be served with the same level of funding in the same amount of time.

Although, like the enabling statute for the OVW TH grant program, HUD regulations allow CoC TH and both CoC and ESG RRH assistance to extend for up to 24 months,³³ providers we interviewed reported pressure to serve program participants within much shorter timeframes, almost always within a year, and in many cases within six months. As described in [Chapter 6](#) ("Length of Stay"), efforts to shorten the duration of assistance target both the housing search process and the amount of time that participants receive other assistance -- prior to housing placement in "traditional" TH programs and during the post-placement "housing stability case management" period in an RRH "transition-in-place" program.

- **Housing Search:** Although HUD's *Rapid Rehousing Brief* ([HUD, 2014c](#)) suggests that "efficient programs can typically re-house households in a couple weeks and in most cases in less than 30 days," nearly all the providers we interviewed who discussed their housing search experience described much more challenging and protracted efforts. Certainly, any survivor that required permanently

³² Thus, for example, if an organization like a YWCA, which is technically not a victim services provider, sponsors an OVW-funded transitional housing project, it is covered by the exemption, because it is an OVW TH grant-funded project.

³³ See for **OVW TH:** the OVW 2015 TH grant solicitation (p.8) and 42 USC §13975(c) allowing a grant recipient to waive the 24-month maximum for up to six additional months for a client who, despite a "good-faith effort," has failed to acquire permanent housing. See for **HUD TH:** §578.37(a)(2) and §578.79 of the [CoC Interim Rule](#); for **CoC RRH:** §578.37(a)(1)(ii) of the [CoC Interim Rule](#); and for **ESG RRH:** §576.106(a)(2) of the [ESG Interim Rule](#).

subsidized housing would be at risk of eviction and homelessness if their program couldn't accommodate the long waiting period for a Housing Choice voucher or a subsidized unit.

The duration and outcome of a housing search typically depends on (a) the availability and competitiveness of housing in the price range that the survivor can afford in the housing market(s) where she is looking; (b) the "credentials" of the survivor (e.g., her housing history; the existence of any rent/utility arrearages or other problems with her credit; her immigration status; any history of criminal convictions; and, of course, the adequacy, source³⁴, and stability/reliability of her income, i.e., public benefits, child support, occasional part time work versus stable, well-paid employment;³⁵); (c) whether the provider can be the initial leaseholder, if the survivor's credentials are too weak to secure a tenancy in her own name; (d) whether the provider can leverage relationships with local landlords; and (e) the amount/duration of rental assistance that the provider can offer to mitigate a potential landlord's risks in entering into a lease with the survivor.

Apart from these more "routine" considerations, a survivor who is still in a state of crisis after having recently fled an abusive situation, or who is suffering the effects of trauma and any co-occurring physical, mental, or emotional health problems might simply lack the wherewithal to initiate and invest the necessary energy in a housing search -- gathering her papers, putting her name on waiting lists, making decisions about where she might want to live, meeting with landlords, etc. - until she has had time to recover her strength.

The better the survivor's "credentials," the more she can afford to spend on housing, and the more progress she has been able to make on her housing search before she tries to enroll in a transitional housing or transition-in-place program, the less time it will take that program to assist with housing placement, and the more likely a program enrolling that survivor will be able to "take credit" for a housing placement.

- **Other Supportive Services in "Traditional" TH / Housing Stability Case Management in RRH:** HUD's **Rapid Rehousing Brief** ([HUD, 2014c](#)) frames the Department's thinking about the proper focus of a RRH grant-funded program:
 - "Resources are limited and should be used most efficiently to ensure that assistance can be provided to the greatest number of people experiencing homelessness. An operating principle is that households should receive "just enough" assistance to successfully exit homelessness and avoid returning to the streets, other places not meant for human habitation, and emergency shelters." (p.1)

³⁴ In most parts of the country, landlords are free to discriminate against prospective tenants who are receiving welfare assistance, or who plan to use a Housing Choice/Section 8 voucher to pay their rent; a few cities and states have laws against discrimination on the basis of "source of income" or "receipt of housing assistance," but they are hard to enforce.

³⁵ As discussed in the next section, many of the barriers to obtaining housing are also obstacles to an adequate income; The tighter the employment market, and the more limited her employability, the harder it is to overcome those barriers.

- "Rapid re-housing is not designed to comprehensively address all of a recipient's service needs or their poverty.³⁶ Instead, rapid re-housing solves the immediate crisis of homelessness, while connecting families or individuals with appropriate community resources to address other service needs." (p.2)
- "The primary barrier to permanent housing for many families experiencing homelessness is their limited finances. To address this barrier, rapid re-housing programs offer financial assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically for six months or less) necessary to allow individuals and families to move immediately out of homelessness and stabilize in permanent housing." (p.3)
- "The focus of services in rapid re-housing is primarily oriented toward helping families resolve their immediate crises, find and secure housing, and connect to services if/when appropriate. . . . This crisis-related, lighter-touch (typically six months or less) approach allows financial and staff resources to be directed to as many individuals/households ... as possible." (p.5)

While some providers cited experience in supporting successful transitions after only six months of program assistance, other providers said they could not provide adequate support to participants within that timeframe, and feared that the shorter period of assistance would set survivors up to fail.

In particular, some providers expressed concern that the goals of (a) enrolling the most vulnerable survivors and (b) shortening the timeframe for assistance were at cross-purposes, and said that if they had to shorten the timeframe for assistance, they would have to change their enrollment criteria, for example, to select participants who are employed or readily employable, instead of targeting participants with more significant barriers (who need more time and assistance to heal, to address housing and employment barriers, to resolve other priority concerns, like child custody issues, and/or to wait until their name came up for affordable housing or a subsidy).

Although a number of providers reported feeling such pressure, it wasn't clear from the conversation whether the shortened timeframe had been codified in a written standard, or whether, for example, a state, county, or city was acting informally, perhaps in response to political or budget pressure to

³⁶ [Davies \(2009\)](#) asserts that the focus of victim services must be broad enough to address the survivor's poverty:

"Safety is broadly defined. To be safe, victims need to be free from the violence and control of their partners, but they must also be able to meet their basic human needs. Reducing the risk of physical or sexual violence but leaving a victim and her children with no long-range financial support is not making her safe. Nor will it make her or her children safe to ignore mental health symptoms, substance use, or trauma issues. Safety requires the reduction of all risks of a partner's control, "batterer-generated risks" not solely physical violence. It also requires the reduction of "life-generated risks" or those circumstances of victims' lives over which they have little control, such as physical or mental health, poverty, or bias and discrimination." (p.5)

"To be effective, safety plans must be comprehensive, address basic human needs and provide a life plan, not just strategies to respond to physical violence." "These plans [must] include strategies to reduce the risk of physical violence and other harm caused by an abusive partner and also include strategies to address basic human needs for income, housing, health care, food, child care, and education for the children. The particulars of each plan vary depending on the victim's life circumstances and resources, her partner's level of violence and control and his abusive tactics, whether they have children, and whether the victim remains in the relationship or in contact." (p.6)

One of the ways in which the mission of OVW-funded transitional housing is broader than that of HUD-funded Rapid Rehousing, is that the OVW program explicitly includes services to address survivor income and wellbeing. Thus, the enabling statute ([42 U.S. Code §13975\(b\)\(3\)\(B\) and \(C\)](#)) and the description of "Purpose Areas" in the [OVW's annual solicitation for TH grant proposals](#) (p.2) state that grant funds may be used to provide support services designed to enable a survivor to "(B) secure employment, including obtaining employment counseling, occupational training, job retention counseling, and counseling concerning re-entry into the workforce; and (C) integrate into a community by providing ... services, such as transportation, counseling, child care services, case management, and other assistance...."

boost progress addressing homelessness, or whether the pressure was coming from a Continuum of Care trying to make its renewal application to HUD more competitive.

(B) Requiring provider participation in a coordinated entry/coordinated assessment system, or requiring victim services providers to create an alternate system.

§578.7(a)(8) of the [CoC Interim Rule](#) directs CoCs to "establish and operate either a centralized or coordinated assessment³⁷ system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services." §578.23(c)(9) of the [CoC Interim Rule](#) requires all recipients of CoC grant funding to sign an agreement committing to use that coordinated system, but allows victim service providers to "choose not to use the Continuum of Care's centralized or coordinated assessment system, provided that victim service providers in the area use a centralized or coordinated assessment system that meets HUD's minimum requirements and the victim service provider uses that system instead."³⁸ §576.400(d) of the [ESG Interim Rule](#) requires ESG-funded projects to use the relevant CoC's coordinated system, but allows victim services providers to "decline to participate."

The coordinated system that is envisioned by HUD included: (a) one or more points of entry for all individuals and families needing CoC assistance; (b) the use of some kind of standardized assessment tool by staff at the point of entry to assess the needs and vulnerability of such individuals and families, to determine the most appropriate type of CoC resource for serving that individual or family (e.g., shelter, TH, RRH, PSH, etc.), and to calculate the relative priority for assisting them, based on their needs and vulnerability, as compared to other persons who need similar resources;³⁹ and (c) to make appropriate referrals to that type of resource, depending on the priority assigned to serving that individual or family.

The purpose of this standardized process was: (a) to simplify the process of seeking help; (b) to rationalize the allocation of scarce CoC resources by using a standard, objective assessment process (that could express need in terms of a numeric score); and to ensure that persons with the highest priority needs receive appropriate access to help, rather than leaving it to each program to create and manage their own outreach process announcing openings, and their own approach for selecting clients.

Recognizing that not all survivors of domestic or sexual violence will enter the system as participants in a shelter or other program operated by a victim services provider, and that some survivors might enter the system as guests in a mainstream shelter or other program, §578.23(c)(9) of the [CoC Interim Rule](#) states that each "Continuum must develop a specific policy ... on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers."

³⁷ "Centralized Intake," "Coordinated Access," "Coordinated Assessment," and "Coordinated Entry" have been interchangeably used to refer to the coordinated system that CoCs are required by HUD to implement. Coordinated Entry seems to be the term of choice to define the system, and Coordinated Assessment is the term that describes the triaging tool/process that assesses a homeless individual's or family's needs and vulnerability, the type of CoC assistance that can best respond to those needs, and the urgency/priority for referring them to a provider that can offer that assistance.

³⁸ It is not clear whether all of the providers we interviewed knew that these exemptions existed. However, several providers stated their intention to work with other area victim service providers to develop an alternate system; none of these providers had yet developed such a system. Not all victim service providers receiving HUD grants are likely to have access to an alternate coordinated system; those that don't would not be exempt from the requirement.

³⁹ A [July 2014 HUD Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status \(HUD, 2014b\)](#) directed Continuums of Care (CoCs) to implement a common assessment tool that could, at a minimum, produce a **needs/vulnerability score** for each chronically homeless candidate for HUD-funded permanent supportive housing (PSH), but that could also be used to prioritize candidates for other CoC housing programs, including TH and RRH programs

For an overall explanation of coordinated entry see **HUD's Coordinated Entry Policy Brief** ([HUD, 2015b](#)) and see the **National Alliance to End Homelessness' Coordinated Assessment Toolkit** ([NAEH, 2013](#)).

One of the most widely used instruments for triaging individuals seeking CoC assistance is the VI-SPDAT, combining the Vulnerability Index, a proprietary software product owned by Community Solutions, and the SPDAT, a proprietary software product owned and supported by OrgCode Consulting. For examples and information about the VI-SPDAT Pre-Screen tool, see

- the **User Manual** for the **VI-SPDAT triaging (pre-screen) tool for Individuals** ([OrgCode, 2014](#))
- the actual **VI-SPDAT triaging (pre-screen) tool for Individuals** ([OrgCode, 2015a](#))
- the actual **VI-SPDAT triaging (pre-screen) tool for Families** ([OrgCode, 2015](#))

As described in a **February 2015 blogpost by the creator of the SPDAT and VI-SPDAT** ([OrgCode/DeJong, 2015](#)), the VI-SPDAT **Pre-Screen** is an issue-spotting triage tool (that is being used as the "coordinated assessment" tool by many CoCs, while the much more comprehensive SPDAT is an actual **assessment / case management** tool (which most providers do not use).⁴⁰

Providers that we interviewed expressed the following concerns about participating in their CoC's coordinated system:

- (a) that the system used by their CoC does not adequately prioritize survivors, particularly survivors at ongoing risk of harm,⁴¹

⁴⁰ In the August 2014 version of the User Manual for the VI-SPDAT triaging (pre-screen) tool ([OrgCode, 2014](#)), the authors include a section entitled, "What the VI-SPDAT Does - and Does NOT - Do." They explain that,

"The VI-SPDAT is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available."

They describe it as "a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates." The authors note that

"Sometimes the VI-SPDAT is confused with or used interchangeably with the SPDAT. Whereas the VI-SPDAT is a triage tool (also referred to as a pre-screen tool), the SPDAT is an assessment tool. The SPDAT digs deeper into the context, history, environment and severity of an issue in a more nuanced manner than the VI-SPDAT."

The reader can compare the much more detailed **Service Prioritization Decision Assistance Tool (SPDAT): Assessment for Single Adults** ([OrgCode, 2015b](#)) with the above-referenced VI-SPDAT triaging/pre-screen instruments.

The User Manual authors recommend that "the VI-SPDAT be used together in a community with the SPDAT, as they are complementary tools. However, communities may start with using only the VI-SPDAT and referring clients directly to different housing interventions based on their VI-SPDAT scores, although this approach is less precise than using a more comprehensive assessment."

⁴¹ The VI-SPDAT and Pre-Screen tools don't intrinsically "know" how to weight each need and vulnerability; that decision requires greater knowledge about the survivor and her situation, as filtered by the experience and judgment of the case manager or other project staff. **In the absence of specific decisions by the CoC to more highly prioritize some needs over other needs, all needs are weighted equally.** Over time, perhaps, the victim services provider community and other homeless services stakeholders will be able to work out a meaningful system of weighting the different risks and vulnerabilities that homeless individuals and families might be experiencing.

From HUD's perspective, the weighting algorithm should most highly prioritize chronically homeless persons, and in particular, chronically homeless persons who are at the greatest risk of harm or self-harm. **State and local officials** may wish to see high priority assigned to homeless individuals with significant behavioral health issues, who are heavy users of public safety, emergency health/mental health/substance abuse treatment systems, corrections, and other expensive publicly funded resources. By contrast, **victim services providers** might want to assign high priority to survivors who are at risk of further violence by their abusive partner. Reconciling those different perspectives about "weighting needs" will require difficult conversations.

- (b) that the process of doing the initial/triage assessment did not provide the privacy and confidentiality that survivors need in order to safely disclose domestic or sexual violence;⁴²
- (c) that because survivors are not adequately prioritized, by the time they reach the top of the queue for referral, they can no longer be contacted: they are no longer in the shelter or other emergency location from which they requested assistance, and it is unsafe to try to find them; and
- (d) that the system yields inappropriate referrals, for example, of persons whose experience of domestic or sexual violence is "old" and whose current homelessness is more economic in nature, or more related to mental health and addiction issues.

HUD's efforts to accommodate the needs of programs serving survivors of domestic and sexual violence are discussed in *HUD's FAQ on Coordinated Entry and Victim Services Providers* (HUD, 2015d).

Specific issues pertaining to the interface between the Coordinated Entry/Coordinated Assessment process and HMIS (Homeless Management Information System, HUD's designated framework for collecting and reporting on client-level data -- which victim service providers are not supposed to use, pursuant to VAWA privacy and confidentiality provisions) are addressed in *HUD's FAQs on Coordinated Entry and HMIS* (HUD, 2015c).

The ongoing evolution of the coordinated entry process poses both opportunities and significant challenges for improved collaboration between victim services providers and mainstream (HUD-funded) homeless services providers, as discussed in the section of this chapter on partnerships and collaboration.

(C) *Holding providers accountable to program performance standards based on participant housing and income outcomes.*

As described in [Chapter 1](#) ("Definition of Success and Performance Measurement") of this report, *HUD's APR (Annual Performance Report) Guidebook for CoC Grant-Funded Programs* (HUD, 2015) which provides guidance on performance reporting for CoC grant-funded projects, defines the following metrics for TH and RRH projects:

- TH Metric #1: For participants who exited the program during the reporting period, the APR reports on the **percentage and number of persons who obtained permanent housing upon exit**. In its annual competition for grant funding, HUD awards points to projects that show that 80% of participants who exited the project transitioned to permanent housing.^{43,44}

⁴² As discussed later on in this report, data sharing is an ongoing concern for victim services providers that want to better collaborate with their CoC partners, but that don't want to compromise the confidentiality of their clients by sharing data that could potentially identify the survivors. Several provider comments suggested that the legal and safety reasons for avoiding data sharing are not always understood and appreciated by mainstream CoC providers.

⁴³ See, for example, the *Notice of Funding Availability (NOFA) for the FY 2013 and 2014 CoC Program Competitions* (HUD, 2013b)

⁴⁴ Neither [OVW's semi-annual report form](#) (see items #31 "Destination Upon Program Exit" and #34 "Destination Upon Program Termination") nor HUD's prescribed data collection requirements (see item #3.12 on pages 30-31 of the *Homeless Management Information Systems (HMIS) Data Dictionary* (HUD, 2015g) distinguish between permanent housing outcomes involving a return to living with the abusive (ex-)partner versus other permanent housing outcomes.

On the one hand, as discussed in the next section of this chapter, returning to the household she fled is not the unequivocally "bad" outcome that an earlier generation of DV programs labeled it; as described, for example, by [Davies \(2009\)](#) and [Thomas, Goodman, & Putnins \(2015\)](#), there are complicated tradeoffs involved in the decision to return to versus permanently leave that relationship. On the other hand, if all such returns -- including returns that were the last resort of survivors who ran out of program options and perceived no viable alternative to prolonged homelessness -- are statistically aggregated as "permanent housing placements," then summary statistics about the housing outcomes of program participants will appear more positive than they actually were.

- TH Metric #2 - Projects can either report on "total income" or "earned income," depending on which metric they specified in their application for grant funding. The APR reports on the percentage and number of persons who **increased their total (earned) income**, compared to their income at entry. The APR reports separately on "leavers" (i.e., persons who exited the program during the reporting year) and "stayers" (i.e., persons still in the program when the reporting year ended).
- RRH Metric #1 - The APR reports on the **percentage and number of participants still housed** as of the end of the reporting year (or who were still housed when they exited the program during the reporting year). In its annual competition for program funding, HUD awards points for programs that show an 80% permanent housing retention rate.
- RRH Metric #2 - Programs either report on "total income" or "earned income," depending on which metric they specified in their application for grant funding. The APR reports on the **percentage and number of "leavers" and "stayers" (see definitions above) who maintained or increased their total (earned) income**, as compared to their income at entry.

There are several potential problems with measuring project performance using these metrics:

- (1) **The funder-defined outcomes might not reflect the priorities of program participants.** For example, a survivor might be more focused on healing or on re-establishing the relationship with her child, than on doing a housing search or finding employment. Or she might be engaged in a custody battle which requires all her attention. To the extent that program efforts are survivor-defined, rather than being governed by funder-defined goals, programs may appear to perform poorly, even though they provide participants with exactly the support they want. The more a program feels compelled to demonstrate "success" as defined by the funder, the more likely they will either be "tempted" to select participants that share the funder's goals and/or the more likely they "tempted" to more assertively push participants to work on the goals that the funder has prioritized, rather than being guided by the participants goals and motivations.
- (2) **The more extensive the barriers to housing and income a survivor enters with, the less likely the program will be able to demonstrate "success," even if the survivor embraces the goals defined by the funder.** A severely traumatized survivor -- who enters a program with depression and PTSD, who has never had the opportunity to work, whose education was interrupted, and whose credit history was severely damaged by actions that she was coerced into taking -- is less likely to attain the targeted outcomes than a much less traumatized survivor with a credible work history and a stash of money she was able to put aside for her future housing.

When providers believe that stronger performance on funder-defined outcomes increases their probability of being re-funded, it creates a perverse incentive to select participants who (a) have fewer barriers, and (b) embrace the funder's priorities. A project that targets survivors with the greatest needs may well have worse outcomes than a project that "cherry picks" participants.

Without the ability to account for differences between their respective clienteles, one cannot meaningfully compare the performance of two programs based on these standard metrics.

- (3) **Projects working in "easier" operating environments are likely to perform better, with respect to funder-defined outcomes, than projects in "difficult" operating environments.** Projects operating in service areas with highly competitive and expensive housing markets and/or highly competitive job markets offering few good opportunities for persons with weak credentials or other employment barriers are likely to have a harder time helping survivors find decent jobs and sustainable housing.

Likewise, programs operated by well-resourced "full-service" agencies that can contribute non-grant-funded staff time and expertise, or that operate in well-resourced communities, where they can leverage the expertise and support of other providers, are likely to perform better than less-well-resourced programs and programs operating in a "health and social services desert."

Without the ability to factor into the equation the impact of the operating environment on program performance, one cannot meaningfully compare the performance of two programs based on these standard metrics.

(viii) Challenges Posed by OVW Grant Funding

(A) Inability to Use OVW Funds to Help a Survivor Stay in Her Housing once the Abusive Partner is Gone.

Several providers expressed concern about the inability to use OVW grant funds to provide interim rental assistance and supportive services to assist survivors who have the option of remaining in the home or apartment where they had been abused, if the perpetrator is incarcerated or otherwise out of the picture.⁴⁵ Examples provided included:

- A situation in which the abusive partner had been incarcerated, and the survivor remained in the home. Without the income generated by the abusive partner, the survivor would be unable to sustain the rent. Instead of receiving interim assistance until she could develop a sufficient source of income or find/transition to less expensive housing, she would have to lose this housing and become homeless in order to receive help.
- A situation in which a survivor had fled an abusive relationship across state lines, and had used up the money she had been able to put aside to lease an apartment for a couple of months. Instead of being able to get help staying in that apartment while she developed a sufficient source of income, she would have to default on this housing and enter a shelter in order to receive assistance.

It appears that in both of these cases the survivor would have been determined to be "Category 2" homeless, that is, "At Imminent Risk of Homelessness," and eligible for rental assistance under the ESG Homelessness Prevention program (if such a program was operated by the state, county, or jurisdiction where she was living). As a "Category 2" homeless person, the survivor would also be eligible for CoC-funded (mainstream) Transitional Housing, which would require her to lose her housing.

Providers noted that enabling the survivor to sustain the housing would provide a substantial benefit to the family -- especially for the children -- by avoiding additional dislocation. They argued that it would be cheaper to assist a survivor in her existing apartment, rather than starting a new tenancy, and that requiring the survivor to be evicted would cause another trauma and add a barrier that would stand in the way of her getting new housing.

(B) Short Timeframe for Closing Down an OVW Grant that Is Not Renewed

The [FY 2015 OVW solicitation for TH grant proposals](#) warns that, "All awards are subject to the availability of appropriated funds and any modifications or additional requirements that may be imposed by law. There is no guarantee that funds will be available in the future. Therefore, OVW encourages applicants to develop a plan to sustain project activities if federal funding through the Transitional Housing Assistance Grant Program becomes no longer available." (p.10)

One provider that we interviewed, who was deeply grateful for the TH grant funding she had previously received, but who had to scramble to manage the process of closing down her grant program in the short timeframe (less than a month) after receiving notice of non-renewal, indicated that a somewhat longer notice period would have enabled her program to better support participants in their transitions.

⁴⁵ [42 USC §13975\(a\)\(1\)](#), the statute authorizing the OVW TH grant program, directs the Attorney General "(a) to carry out programs to provide assistance to minors, adults, and their dependents ... (1) who are homeless, or in need of transitional housing or other housing assistance, as a result of a situation of domestic violence, dating violence, sexual assault, or stalking; and (2) for whom emergency shelter services or other crisis intervention services are unavailable or insufficient.

Whether or not it is possible for the OVW to provide earlier notice of funding decisions, it might be helpful to arrange for a **training for grant recipients on sustainability planning**, and provide guidance on decision making about **participant enrollment during the second and third grant years**:

- The decision to stop enrolling new participants is difficult to time. If a program routinely provides 18 months of rental assistance, should that program stop enrolling new participants 19 months into the program? On the one hand, participants enrolled after more than 19 months have elapsed will not have the benefit of a full stay. On the other hand, many survivors would gladly accept 9 or 12 or 15 months of transitional housing.

Should a program continue to enroll new participants until the very end of the grant period, and just let them know that the fate of the renewal application is undecided? Should the program stop filling vacancies when there are fewer than six months left in the grant period, since the minimum term of transitional housing is supposed to be six months?

Does the answer to these questions depend on whether the unit is owned or leased by the provider, or would be leased by the participant with rental assistance from the provider?

- Should the program tell all survivors who enroll after month 13 that the grant funding may end abruptly at month 36, whether they are ready to transition or not -- and let survivors make an informed decision about whether they want to take a chance that non-renewal will mean a potentially shortened length of stay?
- If a program enrolls participants after month 18 or month 24, should they change their client selection process to prioritize survivors who need less help and who are farther along in their healing process and more likely to be able to obtain and sustain gainful employment and housing within the remaining window of time?
- If a provider has been providing rental assistance to transition-in-place participants who are not quite ready to assume full responsibility for the rent, is there a way to extend the term of the assistance for a few more months, so as not to precipitate the homelessness of the survivors?

For example, if a provider closes out intake, say, six months before the end of the grant term, could they ask for a no-cost extension to expend unspent funds to extend for a few months the rental assistance and services for participants already in TH units?

(b) Other Sources of Funding for Transitional Housing and Related Services

In addition to funding from the OVW TH Grant Assistance Program and HUD's CoC and ESG programs, different providers described their use of other funding from a range of possible sources.

- A number of the providers we interviewed are part of agencies accessing other [OVW formula and discretionary/competitive grant programs](#) which fund staff whose work bolsters the ability of the provider serve TH program participants. Some of the grants providers mentioned include (a) the **STOP Violence Against Women Formula Grant** (awarded to states and territories, which in turn, sub-grant monies to jurisdictions and non-profits for, among other things, victim services); (b) the **Sexual Assault Services Formula Grant** (awarded to states and territories for the purpose of supporting rape crisis centers and other nonprofit, non-governmental organizations or tribal programs, that provide services to survivors of sexual assault); (c) the competitive **Rural Assistance Grant**, which helps enhance the capacity of providers serving expansive, often-poor, under-resourced rural areas; and (d) other competitive grant programs (including grants to tribal entities) targeting resource to **address the needs of survivors from underserved populations**, including children and youth, elders, culturally defined subpopulations, and members of other subpopulations traditionally underserved due to geographic location, religion, sexual orientation/gender identity, racial or ethnic identity, language barriers, disabilities, or immigration status.

- A few providers mentioned the use of state administered VOCA grant funds. The Office of Justice Programs in the U.S. Department of Justice awards [Victims of Crime Act \(VOCA\)](#) grants to states and territories, which in turn, competitively sub-grant the funds to organizations providing victim services.
- Many of the providers we interviewed are part of organizations that receive FVPSA funding. The Family and Youth Services Bureau (FYSB) of the Administration on Children, Youth and Families (ACYF), which sits within the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (HHS) administers the [Family Violence Prevention and Services Act \(FVPSA\)](#) formula grant program. As noted previously, "FVPSA formula grants are awarded to over 200 Tribes and every State and Territory, which sub-grant funds to more than 1,600 community-based domestic violence shelters and 1,100 non-residential services programs, providing both a safe haven and an array of intervention and prevention services" for victims of domestic and family violence and their dependents. [FVPSA report to Congress 2009-2010](#) (p.8). The FVPSA program also funds the National Domestic Violence Hotline and the State Domestic Violence Coalitions in which most providers participate, and where they leverage much of their staff training.
- TANF (Temporary Assistance to Needy Families) was identified as a particularly important source of funding for TH programs for DV survivors in at least one state whose providers we interviewed. As described in a [2013 Memo from the HHS/ACF Office of Family Assistance](#), states are encouraged to use some of their TANF funds to prevent and address family homelessness.
- Other sources of funding described by providers include grants from states, counties, jurisdictions, foundations, and corporations; fundraising for gifts and donations from individuals; special event fundraisers; and agency operated social enterprises -- thrift shops and coffee shops -- that provide employment/training for program participants and income for the agency/program.

Each government, corporate, and foundation funder stipulates how their funds may (or may not) be used, and what kind of reporting requirements are attached to the use of that funding.

(c) Finding the Right Balance - Serving More Survivors versus More Extended / Deeper Assistance

Unfortunately, there is far greater need than can be met with available funds. The ***NNEDV One Day Count on September 14, 2014*** ([NNEDV, 2015](#)) counted nearly 12,000 households in DV shelters, nearly 5,400 households in TH programs for survivors, approximately 1,800 additional households whose requests for shelter could not be met, and another 800 households whose requests for transitional housing could not be met.

"For many survivors, the common length of stay in an emergency shelter is 30 to 60 days; however, it can take 6 to 10 months or more for a family to secure stable, permanent housing due to a shortage of affordable housing options. Without available transitional housing, many victims face the untenable choice between homelessness and returning to further violence." (p.6)

With the need for transitional housing so much greater than the supply, providers must make difficult decisions about how to use grant funds -- and any other resources they can leverage -- to their greatest advantage: choosing between serving more survivors -- who might otherwise perceive no viable alternative to returning to the abusive situation they fled -- or providing more extensive or longer term support to a smaller number of survivors, to give those individuals and families a better chance when they exit the program.

As noted previously, approximately 42% of the TH providers we interviewed use HUD grants to sustain their programs. Given HUD funding trends discussed elsewhere in this chapter, it is safe to say that Rapid Rehousing grants constitute an increasing percentage, if not the substantial majority of HUD funding for programs operated by victim services providers. As previously cited, HUD's ***Rapid Rehousing Brief*** ([HUD, 2014c](#)) provides insights into the HUD's thinking about the intended use of that resource:

- *"The majority of families and individuals ... become homeless due to a financial crisis or other crisis that leads to the loss of housing. Addressing homelessness for these households primarily entails addressing their housing barriers to help them return to permanent housing." (p.1)*
- *"Resources are limited and should be used most efficiently to ensure that assistance can be provided to the greatest number of people experiencing homelessness. An operating principle is that households should receive 'just enough' assistance to successfully exit homelessness and avoid returning to the streets, other places not meant for human habitation, and emergency shelters." (p.1)*
- *"The focus of services in rapid re-housing is primarily oriented toward helping families resolve their immediate crises, find and secure housing, and connect to services if/when appropriate. Case managers should monitor and provide ancillary services in the short run to promote obtaining and maintaining housing. This may be a contrast to many programs in which the focus is providing comprehensive support to each household and remaining engaged for a longer period of time. This crisis-related, lighter-touch (typically six months or less) approach allows financial and staff resources to be directed to as many individuals/households experiencing a housing crisis as possible." (p.5)*

The OVW TH grant program's more victim-centered, more comprehensive, and more flexible approach to assisting survivors in transitioning from trauma and the homelessness caused by fleeing violence to greater safety and stability is very different from the approach espoused in the Rapid Rehousing Brief.

One approach emphasizes "providing comprehensive support;" the other calls for "just-enough assistance." One approach emphasizes building trusting, supportive relationships; walking alongside survivors; and staying engaged for up to the full two years allowed by statute. The other proposes a "crisis-related, lighter-touch (typically six months or less) approach." One approach focuses on financial empowerment over the duration of an up-to-two year program. The other approach indicates that the program is not intended to address the participant's poverty, only to move them into a housing platform where they may be able to more successfully address their other needs.

Given all the survivors with unmet needs for help, there are likely some individual and families who can benefit from each approach. However, for a significant percentage of the survivors who have suffered long-term abuse and violence, who have experienced repeated sexual violence prior to and during their homelessness, and who have lived at the crossroads of poverty and violence for years, sustainably ending their homelessness entails more than "resolv[ing] their immediate crises, find[ing] and secur[ing] housing, and connect[ing] to services if/when appropriate," as prescribed in HUD's Rapid Rehousing Brief.

While some highly resilient survivors may have the wherewithal to quickly bounce back and find or resume gainful employment that allows them to afford decent housing, many other survivors are not able to efficiently rebound from the physical, emotional, and psychological toll of chronic abuse; lack the qualifications to enter or re-enter the workforce in a position that offers a livable salary; and are struggling with the difficult tradeoffs between safety and returning to the abusive relationship, fearing that if they leave their partner, they must leave behind their extended family and community and all the roles and relationships that matter to them. Although they may not need anything as extensive as permanent supportive housing, an intervention that provides only "just enough assistance" may leave them vulnerable to re-traumatizing financial and emotional crises and recurrent homelessness -- especially if they live in an area where there isn't much of a mainstream safety net.

Even if successfully resolving a survivor's homelessness were "simply" a matter of addressing their "housing barriers" and finding affordable housing, in most cases, that would not be a quick and easy process. As noted in [Clough et al. \(2013\)](#), the success of programs that attempt to "rapidly" rehouse participants depends on their ability to access housing that is affordable to the survivor; as the supply of such housing diminishes and the demand and competition for that housing (and/or for subsidies that allow very low income survivors to afford market rate housing) increase, the ability of programs to make sustainable placements is threatened.

Indeed, [Burt's \(2006\)](#) seminal report on the *Characteristics of Transitional Housing for Homeless Families* (not focused on DV survivors) observed that, "The reality of these transition-in-place programs, according to many program representatives we interviewed, is that most families end up moving anyway, because they do not have enough income to take over paying the rent once they are no longer subsidized by the TH program." (p.50) As documented in the *National Low Income Housing Coalition's annual Out of Reach report* ([NLIHC, 2015](#)), the disparity between housing costs and incomes/wages has only gotten worse since Burt's study.

Although they emphasized the importance of placement in properties with rents that participants could afford after temporary transition-in-place assistance ended, almost all of the providers interviewed for this project expressed concerns about survivors' increased difficulties finding decent, safe affordable housing (and similar difficulties finding employment paying a livable wage -- a concern also noted in [Clough et al. \(2013\)](#)).

Although only a few providers cited instances of participants being unable to take over rent payments when program assistance ended, it is unclear whether most providers would have known about loss of placement housing, say, 6-12 months after program assistance ended, given provider feedback about the relatively low percentage of participants who engage in follow-up services, and many providers' reluctance to track down and reach out to former participants who have discontinued contact, for fear of endangering them by inadvertently sending a message, text, email, or letter that the abusive (ex-)partner sees.

Rapid rehousing grants are an invaluable resource that often come with pressure to increase throughput and quickly move people to housing. OVW TH grants are an invaluable resource that come with the belief that progress in whatever direction a survivor wants to go benefits from a trusting relationship with staff and staff willingness to walk alongside program participants as they identify and act on their priorities -- whether those priorities relate to addressing their trauma, their other health- or mental health-related needs, their income and employment-related needs, their legal needs, their needs as parents of children who are also recovering from trauma, and, of course, any need for help overcoming the obstacles to finding sustainable housing.

Providers that have the luxury of being able to draw upon multiple sources of funding to support different kinds of transitional programs might, for example, target survivors who seem likely to make it with less assistance for their shorter-term, less expensive, less service-intensive scattered-site program, and target survivors that appear to need more and longer-term help for their higher cost, higher intensity program.

Well-resourced, full-service domestic violence/sexual assault agencies that can leverage the services of staff funded by other sources -- e.g., employment program staff, a child advocate, child care staff, counselors, clinical staff, a legal advocate, etc. -- and agencies located in service-rich communities that can leverage a broad range of supplementary services from local providers -- are at an advantage over agencies with very limited funding that serve under-resourced communities or regions.

In our interviews, we heard that most programs operate somewhere in the middle of that continuum -- using the parameters within their control, doing their best to find highly motivated and qualified staff, carefully managing the use of limited resources, leveraging relationships with landlords and any community allies, and in some cases, being strategic about participant selection -- in an attempt to balance, on the one hand, funder pressures to serve more survivors and generate favorable short-term outcomes, and on the other hand, their desire to offer the kind of assistance that will give survivors the best possible chance at longer-term success.

(d) Providers' Comments on Funding-Related Approaches and Challenges

Note: The provider staff interviewed ranged from executive directors to case managers and advocates, and so, the depth of our discussions about funding sources, and the nature of agency participation in networks and Continuums of Care varied from interview to interview.

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

(#01) Our TH program is 100% subsidized by the OVW grant. We are standalone agency, the only DV provider in our county, not state-funded.

(#02) Our program is solely funded by an OVW rural grant and the OVW TH grant.

(#03) The OVW grant is all we have, except for an endowment fund that we can draw from to supplement the services our OVW grant covers, which is how we're able to provide more than six months of financial assistance.

(#04) We operate a site-based, transition-in-place program, so when participants transition out of the program, they're still in the apartment complex, and maybe the same apartment. We have a mix of OVW, HUD, private funding, grants, and contributions. OVW-funded participants are in the program for about 18 months or so, and can remain for up to two years. Participants in the HUD-funded units stay for 120 to 160 days, although there might be medical exceptions, pregnancies, or behavioral issues (e.g., hoarding) that might require a longer stay. It's the same for both individuals and families.

Although some families are ready to make the transition to independence within a few months, other families can't get to a point where they're able to transition-in-place, pay their rent, and move forward within the 120 to 160-day period. That is a challenge, which is why we're currently exploring other avenues of funding; we want to be able to gradually increase participants' share of their rent and gradually decrease our share, while they receive the needed supportive services, until they can get to a point of self-sufficiency.

Another challenge with the HUD-funded units because of the shorter time frame is being able to provide adequate services: When you turn over participants every 3-4 months, that's a lot of turnover. In our program we provide the furnishings, the clothes, and food -- because they're homeless families; when they come in, they have little or nothing. We need enough staff to receive the new clients and to continue working with the exiting clients for at least the 12 months of follow-up that we provide to make sure they become stable.

(#05) Our agency has United Way funding, funding from the City, and ESG funding. In our state, a percentage of marriage license fees go to domestic violence shelters in every county, and we receive some of those funds. We raise a lot of our own money. We do a luncheon once a year, which will raise \$800,000. We have an annual fund and we raise about \$400,000. I think our agency budget is just a little over six million. And we're financially conservative. Everything that we have, we own. We don't have any debt.

(#06) With the exception of about \$10,000 to \$15,000 in operational expenses and maintenance of the duplexes that we fund with individual donations, our transitional housing program is entirely OVW funded.

(#07) Our agency receives CoC grant funding, ESG grant funding, CDBG grant funding, and funding from corporate giving, private foundations, and individual contributions.

(#08) We also have VOCA funding, a couple of VAWA grants, ESG funding, and a couple of state family and DV grants. And we also do a lot of fundraising.

(#09) Our transitional housing is funded by OVW and HUD grants and by local donations. Overall, our agency receives state funding, federal FVPSA funding, VOCA and VAWA⁴⁶ grants, funding from several United Way agencies, and donations from many sources. We also raise money through sales at two thrift stores.

(#10) We have an OVW transitional housing grant that pays for education, financial literacy, and economic empowerment programming; and a HUD CoC grant and County funds that pay for scattered-site rental assistance. It has become more challenging to serve people with really high barriers, and meet HUD's goal, which is to get people into housing quickly. We want to work with people who will be successful, because they want people to stay in housing. But we don't want to just serve low-needs survivors. But we're feeling we can't serve people with evictions or criminal histories as we could in transitional housing where someone had two years to clean up credit and more time to go back to school to get a degree that might enable them to earn more money in the long term. We have to look at what kind of 6-12 month program could help them get a job. Because our rapid re-housing is 6-12 months. We've gone from the "1-2 years, as long as you're meeting your goals" to needing to serve higher numbers of people and get them housed in less time.

(#11) Our OVW grant is the only source of funding for the transitional housing program.

(#12) For the transitional housing, we use both HUD Continuum of Care funding and OVW funding. We use a lot of in-kind gifts and donations that help us to survive. And we get state funding through the statewide DV coalition. In certain cases, we can use VOCA funding, if a participant has been a victim and they need help getting their victimization monies. But that would just be a couple hundred dollars here and there.

(#13) I'd say that about 95% of our transitional housing expenses are covered under the OVW grant. When a TH client needs something not covered under the OVW grant, we can help her with that using funds from the United Way, or contributions from churches or civic organizations or individuals. We receive ESG funding for a rapid rehousing program which is separate from our transitional program.

(#014) OVW funding poses very few challenges. They are the easiest group to work with. I would say it's a challenge, but it's a good push when OVW requires funded collaborations as part of their grant. I think that's ultimately a good thing because it pushes us to do some things we probably wouldn't do otherwise.

HUD is a little more difficult because they don't allow us to be as flexible with our services. For example, HUD requires that you either do all rental assistance, or all leasing. They don't allow for a mix of leasing and rental assistance: some of our clients could never get a lease in their own name, so they need us to have a place that they could move into that's in our name. Some of them could get a unit in their name and just need rental assistance. I think we end up not being able to transition people in place as much as we would like to, but we have state funding that does allow for that, so we're bouncing people between funders based on the limitations imposed by the funder. It's a juggling act that I wish we didn't have to do. The flip side is HUD allows for a lot of case management services, and one of our other grants does not.

All of the grants are a little bit of a challenge because when we write our budget, we base it on a guesstimate about what clients are going to be able to contribute towards their rent. All of our clients are put on a sliding fee with regard to rent. Some need very little support and some need a lot of support, and so there is always that balancing act towards the end of the grant. Do we spend it down? Do we need another unit? Because we

⁴⁶ Several providers referred to grants administered by the OVW as "VAWA grants."

can never know how quickly we're going to spend that rental amount down because we don't know who will be in the program and how much support they're going to need.

(#15) Outside of OVW funding, our most important partner has been the local housing authority, which owns our program units. The housing authority has been a longtime financial and in-kind supporter of the project; we only pay rent for some of the units they make available. We also supplement our OVW funding with health grant funding.

(#16) We are a member of the State DV coalition and part of the Continuum of Care. We participate in coordinated community intake meetings, where we may staff some cases, which allows us to receive referrals of DV survivors who are staying in a shelter other than our DV shelter.

The primary source of funding for our transitional program is our OVW grant. If OVW funds weren't available, it would greatly impact the number of victims/survivors that we can successfully transition to stable housing, because our Continuum of Care is using a vulnerability index to prioritize people for permanent housing. And if our clients score low on that index -- because they're not chronically homeless, not dealing with substance abuse or serious mental illness, have not been periodically incarcerated, etc. -- that may put them at the bottom of the list for housing assistance which may make them think, "I've got to go back to the relationship."

(#17) We're part of a network of DV providers, but not part of a Continuum of Care. There are, however, some other DV agencies that have HUD money and are part of that Continuum. In addition to our OVW grant, we receive funding from the state, the county, the city, and foundations.

With different sources types of funding sometimes come different programmatic and reporting requirements. Like our OVW and state grant tell us we have to have voluntary services. And then we have a city grant that focuses on outcomes and wonders why we're not making clients do things. One grant calls for a low threshold, and another funder asks why we enroll people with substance abuse issues, who might not be able to attend school or get a job ... and then we don't have the outcomes that funder expects.

We designed our program as an 18-month program, but when we got the OVW grant, we were told we had to inform our clients that they're allowed to stay with us for an additional six months if they've made a good faith effort to find housing.⁴⁷ So now we find clients staying well beyond that 18-month threshold. Of course, we want to be compliant with our OVW contract; but why would clients want to leave our program if we don't charge rent? We're in a generally safe area, and if we they're a family of four or five, we give them a 4BR apartment. Now where are they going to find a 4BR apartment if they're on public benefits? They'd likely end up having to rent a studio or 1BR. And that just isn't helpful for a family still struggling to recover from trauma and abuse. The lack of low cost housing will continue to pose problems for clients and our program.

(#18) Our transitional housing actually has three different components. We have a small HUD-funded program in a building we lease from the state for a dollar a year. We have an OVW-funded transition-in-place program and a HUD-funded rapid rehousing program, which pretty much use the same model. The two HUD-funded programs come through our local Continuum of Care.

⁴⁷ Subparagraph (c)(2) of [42 USC §13975](#), authorizing the OVW Transitional Housing Assistance grant program, allows -- but does not require -- "the recipient of a grant under this section [to] waive the [24-month limit on assistance] for not more than an additional 6 month period with respect to any minor, adult, or dependent, who: (A) has made a good-faith effort to acquire permanent housing; and (B) has been unable to acquire permanent housing. It is unclear whether the provider understood that this is a statutory requirement, and not an OVW-generated rule.

I've pushed back against that Continuum of Care, because they tend to focus on what percentage of a participant's income is going toward the housing they will eventually be fully responsible for. For the poorest of the poor, it's not realistic to say only 30% of their income will go towards housing. They can't get into any of the public assistance programs, they can't get in the rental subsidy programs, they can't get Section 8. At one point there was a 16-year waiting list. Saying to someone "you can only spend 30% of your income on housing" is not realistic. Most of the women, honestly, spend a lot more of their income on housing, and our goal is to try to reduce that as much as possible. Can we get you down to 60% or 50%? We help them secure things like free diapers, WIC food vouchers, free car seats, and other items for the children. When you don't have to spend your income on things that you could get in-kind through other organizations, it artificially "boosts your income," so that you can sustain your housing -- while we work toward getting you employed, so that your overall ratio of housing costs to income decreases towards 50%, 40%.

That's our strategy; we try to be realistic. I don't think it does anyone any good to say, "We're only going to take people who can pay for their housing with 30% of their income." Our outcomes would be artificial if we said, "You're only eligible for this program if you can afford \$1,000 a month rent." Our target clientele is not the women who already have the resources, but the women who are facing this. I'm worried about the CoC regulations becoming so strict that it's narrowing the range of people who can access our Rapid Rehousing or Housing First programs to the point that either we can only realistically serve a few families a year, because we have to spend so much money supporting them, or we can't serve people who really need help.

(#19) In addition to our OVW grant and HUD housing assistance, we receive state grants that helps pay for our parenting program and our legal advocacy services. We also receive a couple of different United Way grants: One small grant enables us to help pay for moving companies to help the women move into or out of their apartments. The second United Way grant builds on our partnership with a local medical care clinic, and a collaboration we have with a couple of counselors.

(#20) Mostly, we try not to allow the funding source to impinge on the work we do. However, to better meet HUD's goals for increasing participant income, we changed the way we select participants and how we work our program. At one time, our participants didn't have to have employment before entering the transitional housing program. Now, we select participants that are employed or employable, have them complete applications and meet with a financial counselor before they enter the program, and do more of the things on the front end that we used to do on the back end. Once they get into the programs, we set up financial services and start them looking for jobs.

(#21) Getting any housing retention activities funded, even case management, is a real challenge. It seems that funders feel that once you provide someone with four walls, you've ended their homelessness. We've found that that is just not true. Issues they faced when they were homeless are going to creep back again.

(#22) We operate two transitional housing programs for DV survivors. One program is jointly funded by OVW (30%) and HUD (70%) and provides up to 24 months of transitional housing for 9 families who became homeless as a result of fleeing DV. The second program is jointly funded by HUD and the county, and provides up to 12 months of transitional housing for 11 families who became homeless as a result of fleeing DV.

Some folks leave the OVW/HUD program before the 24 months, some max out the 24 months, depending on how soon they're able to get back on their feet. We have a lot of pressure from HUD to reduce our lengths of stay in the program, to reduce costs or serve more people. We make sure our folks don't stay more than 24 months in the program. The problem is finding affordable housing that participants can move to.

OVW requires us to use the voluntary services model, in which clients decide what they want to work on and what services they want to participate in. The HUD/County program is not entirely voluntary; the county expects us to provide certain mandated services to the clients. The challenge with the OVW/HUD program is that OVW and HUD have different expectations about performance. In our OVW/HUD program, a participant can focus on priorities other than increasing their income; we can't tell them to work on getting a job if their goal is to recover from what they went through. However, even though it is a DV-focused program, HUD doesn't measure success in terms of safety or healing; HUD measures increased income and housing stability.

(#23) The whole DV program does fundraising and that money is used for all our services. We're pretty dependent on government funding, but we have some foundation grants, and are trying to look at other options.

(#24) We operate a transition-in-place program with a combination of four or five grants -- a HUD CoC rapid rehousing grant, a HUD ESG grant, our OVW grant, and foundation grants that can sometimes help us assist participants with utilities. Somehow, we balance our existence in different grant worlds -- HUD versus OVW. They can be pretty opposing sometimes. The way we manage that is even though we're voluntary services, we have a monthly mandatory in-home meeting with participants, as long as it's safe and appropriate.

Meeting HUD's criteria of homelessness, which includes fleeing domestic violence, is subject to different interpretations. Suppose a woman flees an abusive situation and stays with mom. The homeless provider might say she's been successfully diverted from homelessness, and I say she isn't necessarily safe at mom's house because he probably knows where mom is, even though she may be safer than being in his home. The homeless provider says she's not fleeing domestic violence anymore, and I say this woman is still high risk, high lethality. Technically, it depends on whether she can stay there indefinitely, but there's "interpretation" around that, too. The regulations put victim services agencies like ours in a position to document that she is fleeing and can't remain indefinitely where she is. But what I hear from our local provider community is that she needs to be living with him and trying to get out. But that isn't safe. I would rather her be alive and at a friend's house than risking harm staying with him so she can qualify to get into our program. We thought the goal of the new regs was to let her keep her eligibility while she temporarily stayed in a safe place.

We have a very strong presence in our continuum of care, and I know that relations between DV organizations and homeless service providers can be spotty sometimes, if not adversarial. In our CoC, we have good relationships. I think part of the tension in some CoCs comes from HUD telling grantees that, "this is what we want you to do" and that message gets construed as this is what all CoC partners have to do, even if they're not HUD-funded. For example, there's this natural friction around data: HUD is really data driven and DV organizations are concerned about safety and confidentiality practices that we're bound by that I think homeless providers get frustrated with. Some of the homeless organizations think that the domestic violence programs are not being cooperative, but our resistance is based on safety considerations.

I think it's good and necessary that we make our decisions based on better data, and I like the VI-SPDAT Pre-Assessment and the training we've gotten with it. The assessment process helps me as a DV provider look at things that affect people's housing stability that are outside of the domestic violence -- take more of a holistic approach. I like that I will have a tool -- just a tool, not the be-all, end-all -- that can help me assess what people need. Historically, the way we've run our program, we tell people to refer the most vulnerable of the vulnerable -- lots of evictions, unpaid utility bills, felonies, all of that, and lots of chronic issues -- and although we were designed as a rapid rehousing program, we were serving people who needed permanent supportive housing, and we were seeing people we'd served as rapid rehousing clients end up in shelter again. So I think having an assessment tool is going to help with that.

But I think there are limitations with the VI-SPDAT Pre-Assessment, too. I don't think it asks enough about domestic violence; it doesn't ask about whether the woman will be safe in housing, or about the threat from

abusive partners who are at large; and it doesn't adequately address immigration and documentation issues. That's a gap; how do we assess participant safety, when lack of safety is the reason the person is in our program? How do we weigh lack of safety against other factors in the VI-SPDAT Pre-Assessment? The trainer from OrgCode [which created, programmed, and maintains the various SPDAT-related assessment instruments] and I have already spoken, and he took note of my concerns.

It feels like almost half my job is building relationships with the other homeless providers in our Continuum, and sitting on the grant committee and all the work groups to try and build bridges and relationships; but not every DV organization has the capacity to do that. The benefit of putting that energy into the CoC is that the DV piece doesn't get lost. Part of getting on the committees, investing the time, is reminding folks that we're not working with numbers, we're working with people with complex situations that they're dealing with.

(#25) In addition to the OVW grant, our transitional housing programs receive funding from the county and from the state's children and families department. Our counseling program, which can serve transitional clients, also has state and the county funding. And then there are other VAWA grants and VOCA grants that we get from the state's criminal justice agency.

(#26) There's been push-back on the rapid rehousing model from the DV community in regards to how it is affecting the type of support we can provide for survivors. I think the OVW model is definitely something we still aspire to, but in order to be part of the larger Continuum and to access CoC rapid rehousing funding, we have had to create some workarounds. With the push for less services and quicker turnaround, for getting more folks served in the program, and with the typical dropout rate, it's pretty daunting.

There are typically three barriers to being successful in transitional housing – the financial piece, the credit piece, and the criminal history piece. If a survivor doesn't have enough income to afford available housing, or if their credit is bad or they've been evicted, or if they have some type of criminal history, it makes it harder to get housing. For limited English-speaking survivors, the limited ability of many transitional housing programs to provide culturally appropriate services adds another barrier. With those barriers impacting survivors of color and immigrants and refugees a lot more than mainstream populations, and with the kinds of metrics that programs are supposed to meet, it feels like it's created a quicker revolving door for survivors of color.

What you're supposed to do, is get them in there, get them stabilized as quick as you can, and then shoot them out. And the rest of the services are not as prioritized as before. Because they take too long. I've been hearing that they're actually trying to do away with transitional housing, and change it to permanent housing. It used to be 24 month stays, now it's 18 months, and it's going down to a year. They're moving away from it.

When we work with survivors, we look at their income, and how we can improve it. Because, what the state and the county and the feds and everybody is saying is that you need to be in a position to pay and sustain your own rent. And so, we're constantly talking to survivors about where they're at, what skills they have, whether they're in a position to be working. We're like, "you've got to get a job in order to pay rent. That's the only way you're going to find a place." Otherwise they end up going back to their abusers.

They're afraid of the rapid rehousing because they say, "oh, they're going to help me pay my rent for three months, but I haven't worked in three years, and so, I'm going to get this job making minimum wage, and my rent is going to be at least \$1,000..." So they think, "I'd rather just go back, at least I have a roof over my head, and my children have someplace to be without sleeping in the car."

(#27) (Not a current OVW grantee) That's my biggest challenge, navigating HUD and the rules and barriers that HUD sometimes places on their housing. The Fair Market Rent and Housing Quality Standards⁴⁸ that make it a struggle to find affordable housing, and all the paperwork that goes with that. Our programs are in two different CoCs, so we have two different CoCs to answer to -- and both function really differently. So, that's a challenge for me to keep everything straight, and the programs all use different paperwork, so that's hard to navigate sometimes.

(#28) (Not a current OVW grantee) Because we are a small community, and everybody knows or is related to everybody else, the scattered-site model that we used with the OVW grant -- and our practice of doing month-to-month rentals, which HUD does not allow⁴⁹ -- worked well to address that challenge. If a client needed to move because she was being pressured too much by friends or family of the perpetrator, we could move her, or she could easily move to another place. If we had to sign a lease for a year (as required in HUD's rapid rehousing program), the client would be stuck in that place. The flexibility of the OVW model also addressed challenges created by the lack of public transportation. It allowed a woman to move to one village, and then if later on she got a job in another village, to relocate to be closer to her new job.

Another requirement of HUD's rapid rehousing program is that the apartments meet housing quality standards, which are fairly rigorous. We've been able to get some of our clients housed, but the money can only serve a very few clients; the standards that the housing has to meet make it a more expensive program. And therefore lessens the number of people you can serve.

(#29) It is difficult to find appropriate housing. The housing doesn't meet HUD Housing Quality Standards. And if it does meet those standards, it's maybe not meet their Fair Market Rent standard. Our shelters are advised by our housing authority to try to negotiate with the landlords to bring down the rent, so it's within Fair Market Rent if it's going to be funded through HUD. That happens a handful of times. The landlords don't want to do that, because they can make more money. And it also takes a lot of time. There's just very, very limited housing in general that is affordable and appropriate here. And the tribal areas—so whatever's affordable and appropriate in the rural areas and just in general in our counties, you can minus that by about 50 percent for the tribal areas. We've talked to HUD. Some of the housing that hasn't been appropriate, maybe we can use some of our emergency funding to help make it more appropriate. If they need security, if there's issues with the apartment, so they can move into it.

We do not directly receive any of the ESG grant funds for rapid rehousing. But many of the shelters that we work with are the recipients of those funds. I think that the state housing agency has 22 ESG sub-grantees, and 20 of those are domestic violence shelters. We work a lot with the shelters, because they're really struggling,

⁴⁸ See the discussions about HUD's Housing Quality Standards and Fair Market Rent provisions in the narrative preceding these comments.

⁴⁹ As noted in the narrative which precedes these comments, the definition of "permanent housing" in §578.3 of the [CoC Interim Rule](#) requires that "the program participant must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause." Although a one-year lease is required in conjunction with the use of CoC Rapid Rehousing funds, there is no one-year requirement for ESG RRH-assisted tenancies, except where rental assistance is "project-based" (which is rarely the case in OVW TH programs). See p.8 of the *HUD's Rapid Rehousing: ESG vs. CoC Brief* ([HUD, 2013a](#)).

There is no extended lease requirement for CoC-grant-funded Transitional Housing. §578.51(l)(2) of the [CoC Interim Rule](#) requires that participants in CoC-funded TH program "must enter into a lease agreement for a term of at least one month. The lease must be automatically renewable upon expiration, except on prior notice by either party, up to a maximum term of 24 months."

utilizing the rapid rehousing funds. Some of it is about finding appropriate housing. Some of it is a paperwork issue. Sometimes when they're signing someone up for rapid rehousing, before all the paperwork is processed, the survivor decides to return to the abuser. If the program has paid some expenses, they have to eat it. Then their board gets mad because they're eating these funds. And then they back away from using the rapid rehousing funds, and then they have to turn back some funds, and it doesn't work out well. It's difficult for DV providers to use rapid rehousing funds, because our clients are not always ready to leave. They sometimes turn back. It's part of the challenge. I believe that there might also be a bit of a difference in what is required in the case management for rapid rehousing, as compared to what VAWA voluntary services standards are for case management. And that has sometimes been felt to be a conflict.

(30) A portion of our program is HUD funded. We've had major funding cuts, which is a huge issue. We have tremendous need and even if I can get the funding, affordable housing that meets HUD standards⁵⁰ is impossible to find.

Last year, I was told by our Continuum of Care that I would have to change my program category from "transitional housing" to "rapid rehousing," which is the model that we have always used anyway. And, I was then told that we would no longer be able to serve undocumented immigrant women.⁵¹ We don't want to stop serving the immigrant women who are so extremely vulnerable, and who, by law, can stay in country. As long as they're cooperating, they can apply for their U Visa. I wish that HUD and DOJ could talk to each other.

In what we previously called our transitional housing program, participants lived in units that we blanket leased from some low income housing tax credit properties. Then, when our participants were stabilized and were ready to maintain their housing on their own, they would transition-in-place and take over the lease, and our program would access the next available unit within that complex for our next client. With the re-categorization of our program to "rapid rehousing," we can no longer hold the lease in our agency name; rapid rehousing participants must hold the leases in their own names. That's been another huge issue. There are some cases where it isn't a good idea for the client to be named in the lease.⁵²

Another problem is that the HUD rapid re-housing rules require the participant to pay 30% of their income, right from the start.⁵³ With the OVW grant (or even with the HUD transitional housing leasing model), the amount of assistance could be tailored to the needs of the participant. And under the OVW grant and transitional housing program model, our housing assistance could be longer. The duration of assistance varied from person to person, simply because people come to us with different states of trauma. Some survivors are able to pick up pretty quickly and get going and access education and job skills training and get on their feet. We've served others with dual diagnoses – post traumatic stress, bipolar, histories of addiction. We had one woman who had been held hostage for two years. To have any expectation that someone can immediately get on their feet in a few months' time, with the kind of trauma they've experienced, I think is unrealistic. Especially with the very low wages in our tourist based economy. I feel like the OVW and HUD transitional housing monies gave me the flexibility to be able to provide better services. In the program I run now, we have

⁵⁰ See the discussion of Housing Quality Standards in the narrative preceding the comments.

⁵¹ See the narrative discussion preceding these comments describing an August 2016 joint letter from the US Department of Justice, Department of Health and Human Services, and HUD affirming that shelter, transitional housing, and rapid rehousing programs can all serve survivors, regardless of their immigration status.

⁵² This concern is mentioned in the narrative.

⁵³ As noted in the narrative preceding these comments, the CoC Interim Rule exempts rapid rehousing programs from the usual requirement that participants receiving rental assistance pay 30% of their adjusted net income towards housing. If any such requirement exists, it was established as one of the written standards by a CoC (if this is a CoC grant), or by the state, county, or jurisdiction administering the ESG grant, if this project was funded by an ESG grant.

12 months to support their healing and get them ready for independent housing. We're being asked to cut that time to four months, and I'm concerned that we're being asked to do an impossible task.

Our Continuum is implementing coordinated access, and my concern with the SPDAT assessment tool is that it doesn't seem to place appropriate emphasis on the situation of someone fleeing domestic violence. I feel like the first question anyone should be asked is "Are you in a dangerous home situation or fleeing domestic violence or sexual assault?" And if that's the case, they'd be referred to a DV provider and their information could be contained. Also, I didn't see any weighting for lethality - the physical danger that some of the women we serve are facing. The only question on the original SPDAT that started to address issues of physical abuse and physical harm was near the end. When I look at the scoring approach in the SPDAT, I think "People we know who were victims of domestic violence, even victims who were murdered by the perpetrator, would not have qualified for assistance." I just feel very strongly that in the process of determining who would receive assistance, there needs to be a heavier weight given to those whose very lives were at risk.

(#31) It's been difficult trying to maintain both the OVW and HUD programs as their goals are so different. We had to let go of some of our HUD transitional housing units. It feels more realistic now with OVW; with the units we own, we pretty much follow the OVW model. When we were a HUD transitional housing program, we had a tough time reaching the goals we were expected to achieve, in terms of transitions to permanent housing and increased income, which was another reason we switched to rapid rehousing. It's not that I don't like the rapid rehousing model, I just think that under the HUD version of the model, we're only required to meet with families receiving rental assistance once a month, and I feel like it's more hands off.⁵⁴

When we transferred our HUD grant from transitional housing to rapid rehousing, we had tenants in those units that we had hoped could stay in those units. But the biggest barrier was the cost; most of the families we serve cannot pay the market rate rent. They need either Section 8 vouchers or other subsidized housing. You can't use rapid rehousing funds to assist participants in subsidized housing.⁵⁵ I think that the families that are going to be successful with rapid rehousing are more the families with two incomes, because the single women with children, if they don't get a Section 8 voucher or subsidized housing, can't afford housing.

Also, some families don't have the basic tenancy skills or experience paying their rent on time. When our agency is on the lease, and the participant is subleasing from the Y, it buys the extra time to develop those skills, and to address any housing barriers, like prior evictions or arrearages.

We have what's called an at risk housing coalition, it's a group that serves homeless individuals and families. It's a large group that meets quarterly. I sit on the board for the state continuum of care. And we've got four agencies here that receive CoC funding, so we also come together on a quarterly basis. Another agency in the community gets the ESG and TBRA funding; however, those funds are also being targeted for 2-4 month

⁵⁴ Actually, as noted in the narrative preceding these comments, §578.37(a)(1)(ii)(F) of the [CoC Interim Rule](#) exempts VAWA-covered CoC-funded rapid rehousing projects from the requirement to have program participants meet with a case manager not less than once per month." §576.401(e)(2) of the [ESG Interim Rule](#) provides that same exemption with respect to VAWA-covered ESG-funded rapid rehousing projects.

As also noted in the narrative, §578.53(b)(1) of the [CoC Interim Rule](#) states that transitional housing projects must make available supportive services throughout the term of participation, and §578.75(h) allow recipients and subrecipients to require that program participants take part in supportive services that are not disability-related, **but there is no HUD requirement for such participation.**

⁵⁵ §578.51(a)(1) of the [CoC Interim Rule](#) states that, "Rental assistance cannot be provided to a program participant who is already receiving rental assistance, or living in a housing unit receiving rental assistance or operating assistance through other federal, State, or local sources." Except for allowing payment of rental arrears to enable a tenancy that would otherwise be ineligible for rapid rehousing assistance due to an existing subsidy, §576.106(c) of the [ESG Interim Rule](#) contains a comparable prohibition. Note that these regulations do not prevent using rapid rehousing-funded rental assistance to aid a tenancy in an affordable rental unit developed through the tax credit program or inclusionary zoning.

assistance, just like our rapid rehousing fund. We collaborate; we try to meet with the agencies that manage those rental assistance programs to look at the applicants and determine which program best meets a family's needs, looking at the big picture -- income, DV, SA. We can work with TBRA, so we're just trying to make sure the money can go as far as it can within the community and reach as many families as possible.

(#32) (Not a current OVW grantee) In the past couple of years, we've been pressured so much by our government funders -- HUD, the county and the city -- into decreasing our stay lengths and focusing on housing as opposed to DV intervention. Program length of stay used to be the standard "between six and 24 months," based on participant needs. Now our program is only one year long. That's a big change because our population has a lot of barriers.

We certainly try to adopt trauma-informed services and we have visiting mental health therapists to our transitional program and we give referrals and have DV support groups, but there isn't much time for clients to take a couple of months off to focus on recovery. And we would be remiss if we just let them. Obviously we're not going to force anyone to do anything, but we do feel that we have an ethical responsibility to let them know the lay of the land and that the clock is ticking.

With our housing market here and in the surrounding counties, property and rent are very expensive, and there's little to no subsidized housing anymore, so if any of our clients are going to make it to permanent housing, they need to get a job and to be able to pay market rate rent. Developing job skills is pretty hard to do in a year for some of our clients. Some of them have a very low educational levels. They may not have any work experience at all. To get themselves work-ready is very difficult. Others have felonies or mental health issues or speak only limited English, and maybe don't have literacy in any language.

Under the old regime it was a bit more humane. Now, pretty much from week one, we explain very frankly: "you've only got so much time here, and in the space of a year, you need to be earning enough money to pay rent." Before, there was hope that if they were here for two years, they might get some form of low income or subsidized housing, but now we're realistic and we say you can forget that. That's not going to happen.

So our participants generally end up working in some type of pretty menial work: housekeeping and hotels, a convenience store or Dollar Tree type of store, waitressing, or retail; hard and unstable work. And we increasingly encourage them to find options like sharing a house with another family.

One of the consequences of this push toward rapid rehousing is that our Continuum has a lot of money we can use for move-in expenses, and there are also a number of programs that will subsidize families' rent for a few months. Sometimes just to get people out, where we see the situation isn't going to change and maybe they can't quite afford the rent, we'll say, "OK it's your time to go. What you can do is take advantage of this money now to cover your security deposit, first and last month's rent. Move into an apartment. We can help you get set up in terms of furniture and things." Then, if in the very next month or the month after that, they don't have enough money to pay the rent, they can be served by a number of the housing programs for eviction prevention. With eviction prevention assistance comes what they call housing stability funds.

It is a very disempowering process, an unintended use of resources -- there's just so many things wrong with this approach -- but it's what we have to do to help people. It's soul-destroying, as opposed to allowing us and the families the time to work and build skills. Because inevitably that family is going to get into difficulty again.

The two years wasn't always enough for all our families, but definitely the extra time did help a lot of people. And it really helped children. Two years is a long time in the life of a small child. Two years with us in terms of the stability and activities and educational advocacy and addressing special needs was huge for the children.

We decided not to re-apply for OVW funding, because unfortunately under our HUD contract, we have to do a number of things which make services somewhat mandatory: we're obliged to have individual responsibility

plans⁵⁶, and our metrics have become so outcome-based that we felt we were going away from the concept of voluntary services and couldn't honestly accept money from OVW and say our services were voluntary.

But, we've been lucky. We got a foundation grant for a quarter of a million dollars to use to stabilize people in permanent housing. That's been really useful with people who've left our transitional housing for permanent housing because we were given flexibility to use the money in any way we wanted.

I think OVW is really the leader in this area and they really understand the type of challenges our clients face and the type of challenges we face as programs. I wish they were able to bring more influence to bear on the other funders, like HUD and our local funders. Trying to juggle the competing demands of the different funders, we alter or shape our services in a way that I feel negatively impacts the clients. It's a burden on the taxpayer too. If they end up in the shelter system again, it's very expensive.

Another example: For a long time, we had a system of coordinated entry where we had to take our referrals from a centralized list maintained by the county. It was pretty disastrous: a homeless family couldn't call the shelters themselves; they had to call a central line and would be given an appointment to be assessed in maybe two weeks; then they would be assessed using a standardized assessment tool, and then placed on a waiting list. Then every time we have a space we would notify the county, which would refer somebody from the list, who was theoretically in need of DV transitional housing services. Then, either the family wouldn't get in contact with us, or they wouldn't show up, or they'd show up and be open with us about the fact that "the domestic violence happened years ago, the perpetrator is incarcerated, and we just need housing."

If we rejected the family and said, "This is a waste of our resources," we might have to wait another month for a referral, and in the meantime, had lower occupancy rates. Not just us but pretty much every program. Not because the county was inefficient, but because there is such an overwhelming demand from homeless people. The list they were managing got ridiculously long and totally out of control. So a homeless family might call, but might not get an appointment for an assessment for three weeks, and after they were placed on the list, they might not be contacted again for another nine months. In which case they would usually be pretty hard to contact, and if they did re-contact them, their circumstances would have changed completely in the interim, and now they might even be technically ineligible for housing assistance. They might have gotten a job or might have lost a kid to child protective services or might have shackled up with someone.

Recently, all the DV agencies got together and sought a waiver from that system. The law says victim service agencies can get an exemption from the HUD requirement to participate in the coordinated system if they set up an alternate coordinated system. We just got that waiver but haven't yet set up the alternate system.

(#33) (Not a current OVW grantee) Just to clarify -- we don't have a current OVW grant. Funding for our transitional housing grant was not renewed. When we found out that we were not going to get those dollars, we continued to provide these families with as much support as we possibly could without any additional funding. I carried about 13 families that I tried my best to provide ongoing support -- attending meetings on their behalf or with them, as they requested, providing them with some transportation to and from meetings they set up, at our own expense.

When we lost that funding, two of the Housing Authorities that had been involved in the program stepped up and gave our participants Section 8 vouchers, to enable them to keep their housing. Unfortunately, with the level of supportive services we sustained without grant funding, we were unable to prevent some of those individuals from losing their housing, typically because their landlords felt they weren't complying with lease requirements. So, not having somebody there for them really did impact their abilities to stay housed. One woman lost her voucher, when we weren't available to help her stay safe and look for alternate housing after

⁵⁶ The [CoC Interim Rule](#) does not mention any requirement for an "individual responsibility plan," so this is probably a requirement of the Continuum that the program is in.

her abuser found her. Another woman lost out on some job and educational opportunities when we could no longer help her with childcare and transportation, and is currently at risk of losing county aid and her housing.

With our prior OVW grant, we just continued on as though we were going to get it renewed, and we got lucky - we were notified that we had gotten the renewal two weeks before the old grant would have ended and the new grant was scheduled to start. With the next grant, we were notified the week before our grant expired that we did not get the next 36 month renewal.⁵⁷

About 5 to 6 months prior to the scheduled end-date of that second grant, we had taken on 6 or 7 new families, assuming we would get renewed again. If we had known that we probably weren't going to get that grant, we might have placed only one or two of those families in housing, depending on their barriers, and whether we thought they were capable of being okay by the time the grant ended in September. If they already had employment, child care, and transportation pretty much addressed, I would have said "we can do this."

Ideally, it would have been helpful for us to know at least three months before the grant term was up that we wouldn't be re-funded. I don't know if that's realistic or not, but at least then we could have been trying to do our best in three months' time to prepare participants and explore other options for money for emergencies, so that they don't end up being homeless again. It's all speculation, but I believe that a no-cost extension that would have allowed us to sustain supportive services longer might have made a difference.

We are constantly looking to find other means to provide those same services. We have approached our local United Way, we applied for another HUD grant, we visited a number of community agencies and businesses, we approached banks and other lending agencies that might do it as a "pay it forward" option -- but the money they've contributed is not enough to make that impact yet. We continue to have those conversations.

I am so grateful to have had that opportunity to receive the OVW grants and make an impact on the lives of as many individuals as we did, so I don't want to discount what OVW was able to provide for us; the impact was huge. The frustration isn't directed at OVW; the frustration is that the funding isn't there; period. OVW was able to provide us with so much insight on voluntary services. With previous grants from other funders, there were mandates and expectations and rules, and under those grants, we didn't see the kind of successes that we had under the OVW grant. I still run HUD-funded programs using the voluntary services approach, and we meet HUD's performance measures without mandating participation -- because participants are making the choice to work on certain areas in their lives and we're there for support and advocacy. We have a lot better relationships with the individuals we work with. They see us more as advocates and people they can trust, talk to, and receive guidance from -- and they know we won't be trying to tell them what they have to do.

(#34) We had a donor who purchased the land for us back in 1996 and then we were able to get a housing grant to pay him back. Once we had the property, we got a private foundation grant, a CDBG grant, a HOME grant, and a Continuum of Care grant to pay for construction of the facilities. The construction was all paid for by the grants and the mortgage. We do a lot of fundraising and that's how we pay our monthly mortgage. Part of the case manager/coordinator's salary is paid from a CoC grant and part from our OVW grant. And our CoC and OVW grants each pay a portion of the operating expenses - utilities and such for the apartments.

We are concerned about HUD's apparent push for shorter stays in transitional housing. In our community there's simply no place to go. At least once a year, we have a participant who has spent two years in our transitional housing program and has to ask for a waiver because there is simply no available affordable permanent housing in our community. In the beginning, our strategy was that folks could live in our transitional housing program, get on the Section 8 waiting list, which at that time was a 1½ to 2 years long, and

⁵⁷ See comments addressing this topic in the narrative preceding these comments, and the comment by provider #122

then transition out to permanent housing with a voucher. Now, our Section 8 waiting list is 4½ to 5 years long. The idea that they could transition to permanent housing in an even shorter time boggles my mind.

(#35) (Not a current OVW grantee) Only roughly 25% of our entire budget is paid for by government grants. So 75% of our funding is from the private sector -- foundation grants, corporate support, civic organizations, churches, and individual donors -- and those are the funds we use for all those things we can't use for government grants for. For example, we have flexibility to be on a lease for a while and then let the family take over the lease when they're ready, which is something we can't do with a HUD grant. And we can't use any of our agency-owned units under the HUD grant, because HUD funds can't be used to pay rent on units we own. So we put people in our agency's units when there's no funder restriction on that, and use HUD funds on privately rented units.

Our intent is to provide as individualized an approach as possible: those who can move out quickly should, and those who need longer should be able to stay longer. Most families stay around two years but it depends on the individual case. There are many cases in which somebody can't finish something in two years, so we give them additional support. In today's staff meeting, we were talking about a mom who got a dental assistant certificate, but frankly with five kids, you can't survive on the income of a dental assistant. She needs to become a dental hygienist, so we'll give her extra time in the program to complete the dental hygienist training, because it pays significantly more than a dental assistant. The ability to be flexible about the end date for people making good use of the time is another benefit of not depending on government funding.

(#36) When the CoC scores our program, we get dinged because, on average, our survivors stay in their transitional housing for a more time before they move on to permanent housing. So even though historically, our program has had the highest rate in our CoC for placement in permanent housing, we're told that "people get into your housing and say, 'I've got 24 months,' and so they're not motivated until the last four months." We don't see it that way. Our services are much more comprehensive than other TH programs in our CoC.

I'd say the biggest struggle is the time limits. We were one of the first agencies in our Continuum to do rapid rehousing, using HPRP [federal Stimulus] funds in 2009. As the program evolved, the emphasis on shorter stays increased. When HPRP ended and funding for rapid rehousing went to ESG, our CoC changed the eligibility from 50% of Area Median Income (AMI) for the entire time to 50% of AMI for the first 12 months, and then 30% of AMI for the next 12 months. And that was very counter to the orientation of our program, which is focused on financial empowerment and self-sufficiency, because hopefully, after a year of housing, most clients would be above 30% of AMI.⁵⁸ Now, our CoC wants to rapidly rehouse people in six months.

We've had clients exit after eight months, saying, "I'm good, I'm taking this job, my budget's good, so I'll leave the program early." But I think that if we want to meet people where they're at, and be truly voluntary and allow clients to go at their own speed while they recover, that's hard to do on a tight timeline; and the risk is

⁵⁸ As noted in the narrative preceding these comments, the requirement that participant income be at or below 30% of AMI is an ESG regulatory requirement spelled out in 24 CFR 574.401(b)(1): "The recipient or subrecipient must re-evaluate the program participant's eligibility and the types and amounts of assistance the program participant needs ... not less than once annually for program participants receiving rapid re-housing assistance. At a minimum, each re-evaluation of eligibility must establish that: (i) The program participant does not have an annual income that exceeds 30 percent of median family income for the area, as determined by HUD; and (ii) The program participant lacks sufficient resources and support networks necessary to retain housing without ESG assistance." The intent was not to penalize persons who have increased their income, but rather, to target more extended rapid rehousing assistance to the lowest income participants, who would have the greatest difficulty achieving self-sufficiency.

If a comparable requirement exists for CoC-funded rapid rehousing assistance in this provider's community, it is a result of the CoC's adoption of a written standard governing eligibility, as the [CoC Interim Rule](#) does not include an income test.

someone ending up homeless again. I'll be really interested to see how many rapidly rehoused people land back in shelter. So they get four months of assistance. They might pay the fifth month, something happens, they get evicted, and they end up back in shelter. From what I understand from our Continuum, they can be rapidly rehoused as many times as needed. I have trouble understanding how that's moving the needle, and our organization feels very strongly that that's not the best model for DV survivors. So our board has made a commitment to look into alternatives like a capital campaign to build something or to acquire property, so we can still have a percentage of our housing program that's up to 24 months. When we had a monitoring visit from OVW, this was one of our primary concerns, how we've made a commitment to OVW to offer up to 24 months of housing, but can't honor that commitment if we continue with HUD funding for leasing costs.

(#37) We receive a substantial amount of HUD ESG funding through the City for rapid rehousing and we use that funding primarily for rental assistance and utility assistance. We use the OVW money to support the staff. Our HUD money through ESG is limited to a smaller geography, so we supplement that with the OVW money to offer rental assistance to survivors who want to relocate outside that geography for safety reasons. It's nice to have two pots of money, so we have the flexibility to address specific needs of particular survivors. Because of the way the HUD funding works, we're often waiting for reimbursements, so the number of clients served is really driven by what we can sustain in terms of up-fronting the money for the city. We could probably serve more families if our contracts were processed faster and our reimbursement systems were faster. When we have to up-front several months of operating expenses, our cash flow will only allow us to do \$8,000-\$10,000 in rental assistance each month, so that's the biggest restriction. We didn't even spend all our rapid rehousing money last year because we didn't get the reimbursements in time to replenish our cash flow. We're a nonprofit and all our contracts are cost reimbursement, so we have to up-front the money.⁵⁹

The biggest barrier for our program is that many of these women stay in crisis for extended periods of time. We may get them stabilized in an apartment with employment and then their hours are cut back, or they lose their jobs, and then they're back in crisis. It's something we experience quite a bit, because these are women that don't have a lot of education. Even though we offer help with GED and employment opportunities, and try to enhance the types of jobs they can get, and help them get more stable jobs, they often end up in a service-related job, which is just not that stable. If we had the flexibility to extend rental assistance beyond the six months that our HUD funding allows, it would help some of those families with unstable income. Many of them would like to extend their education, but getting a job always has to come first for them.

(#38) For our HUD-funded transitional units, the CoC's coordinated assessment and centralized intake and referral system determines who's referred for placement. It's been a bear for us to try to place survivors referred by that system because they send people that have experienced domestic violence but aren't necessarily ready to be living independently, even though our units are very independent: they're scattered-site transitional apartments; they're not monitored 24/7 like many transitional housing programs are.

Their scoring system puts the people with the most barriers at the top of the list. So our very independent housing program is forced to take those folks with the highest barriers -- chemical dependency, untreated mental health issues, child protective services involvement -- even if that independent housing model isn't the best fit for them. When you have to take those folks into a scattered-site independent model, they blow out pretty quickly because there's not staff onsite to monitor and prevent things from happening -- like the partner coming back into the home and causing police involvement, drug use, not being able to follow the usual lease

⁵⁹ §576.203 (c) of the [ESG Interim Rule](#) requires that, "The recipient must pay each subrecipient for allowable costs within 30 days after receiving the subrecipient's complete payment request. This requirement also applies to each subrecipient that is a unit of general purpose local government." The situation described by the provider appears to violate that requirement.

requirements. That's been a challenge, and then on top of that, they want them successfully barrier free and able to move into permanent housing within six months of placement.

And although the scoring system asks, "Are you feeling safe or are you in an unsafe situation," that question covers all sorts of violence, not specifically domestic violence. On the intake form, it asks, "Are you a DV survivor? Are you fleeing domestic violence?" But for a lot of those folks, maybe the DV was a year ago. So, yes, there was domestic violence, but it's not necessarily the reason for my homelessness now. It's frustrating when we have two full DV shelters and we can't place any of those people in our transitional housing.

Luckily, we have our OVW transitional funds that are more flexible, and allow us to place survivors that could be undocumented, going through an identity change, or don't meet the city's eligibility criteria for our HUD-funded units, but need transitional housing -- survivors who fall in the middle: don't have high enough barriers to be prioritized for the HUD units -- untreated mental illness, criminal histories, active addiction, and the kinds of barriers associated with police and criminal justice involvement or emergency room use that give our HUD-referred clients those high scores.

And their barriers aren't low enough for rapid rehousing. They're in limbo -- and appropriate for transitional housing. Our scattered-site transitional model was great for these survivors: it gave them an independent unit in a secure building, close to the family and friends that are their supports, in a place they wanted to live.

(#39) Our state uses TANF money to fund our transitional supportive housing (TSH). Each funded program has to go through a one-page, very basic questionnaire with prospective clients. But they don't do a really detailed process to qualify them for TANF. It's just a very basic preliminary analysis of whether or not the person has economic need. It doesn't mean that the person will have a TANF case, it doesn't mean that they will have a TANF worker. The transitional housing program doesn't get involved in that stuff at all. We don't get involved in enforcing any of the rules that a TANF caseworker would. The only thing programs have to do is make sure that the woman has children living with her. If a woman has lost her children to CPS, we will generally allow 90 days for her to work toward getting the children back in the home, and beyond the 90 days the state generally says she's no longer TANF-eligible because she doesn't have children.

We really encourages the transitional housing programs we fund to seek one of our "DV Comprehensive" grants, which are funded by FVPSA grant funds, additional TANF money, and general fund dollars from the state and a variety of other sources. DV Comprehensive grants pay for the basic services that must be provided: 24-hour crisis intervention services, a 24-hour crisis line, and access to shelter. (It doesn't have to be a physical shelter -- it could mean housing people in hotels -- but having staff and advocates available to work with survivors.) All of our TH projects have those grant dollars from us, and for many programs, it's hundreds of thousands of dollars. Part of what they're required to do is provide both individual and group counseling. If they're already running support groups or providing counseling, they don't have to necessarily hire new staff for their transitional housing. But they do have to make sure that if women need help getting to where that counseling or support group is located, or if they need childcare to participate in services or, perhaps, to maintain employment, the programs have to provide those transportation and childcare services.

Many of our state grantee programs get funding from HUD or a local United Way or other sources for their transitional housing program. We encourage programs to not have all their eggs in one basket, because you never want to be completely dependent on any one funding source. And each funding sources allows them to do things that our state funding might not allow them to do, given restrictions associated with TANF dollars.

If we're going to terminate grant funding to one of our programs, we're committed to honoring the full housing assistance commitment to participants in that program's transitional housing. When we had programs who lost funding - and it's only a handful - what we do is we ask them to turn in a budget that tells us that as of their last day of funding, say September 30, "we have one woman who has four months that she's entitled to and three women who are entitled to another six months." We will continue to pay and honor the 24 month

commitment the program made for each of those women. That to us is really important, because it isn't just the program that's affected – that's the least of it - it's that woman and her kids.

So we built right into our model that we always set aside funds to make sure we can cover that. When we know somebody is losing the funding, we get those calculations from them before we make our final awards because, for instance, we may only be able to fund the top 18 instead of the top 20 programs, because the two or three programs that lost funding, we've got to meet their obligations for the 24 months. It is a tricky thing to do, but we feel very, very strongly that nobody should ever be in that position.

(#40) When we got our first HUD McKinney grant, we were able to buy furniture and pay for childcare and do other things with the funds that we are no longer allowed to do. Unfortunately, some of our community funders have adopted those same narrower eligibility and allowable cost parameters to make things more uniform. Even some local public funders have adopted some of those limitations disallowing things we used to be able to pay for. Survivors face all kind of economic barriers, not just around rent and utilities; so losing that flexibility has been hard. Over the years, we've tried to seek foundation funding and to use some of our little bit of discretionary funding to fill those kinds of needs for survivors, but it's tough when all you can use your larger pots of funding for is the utility allowance and rent assistance, but you can't help, for example, with folks' debts or arrearages. That's been a difficult-to-cope-with change in the years we've been doing this.

And we can't help survivors unless they are homeless or have entered into the process of being evicted and officially having their housing threatened. But not if they're struggling and on the edge. The HEARTH Act says that anyone who has fled domestic violence and is staying with family or friends but can't stay there except temporarily is considered homeless. That applies to both OVW and HUD grants. But a woman who fled a situation and set up new housing with the help of an emergency grant that gave her move-in money would not be eligible for HUD or OVW transitional housing assistance, since she has a roof over her head and is not doubled up; she wouldn't be considered homeless until she is facing eviction.

We hear a lot about the challenges posed by HUD housing standards in some of the rural areas providing housing services for survivors. That's another place where having ultra-flexible funding can be helpful because you can say to a landlord who is offering sub-standard housing, "We can pay to fix some of these things," so it's a livable place for the survivor. A lot of the affordable housing is pretty sub-standard; we can do repairs with some sources of funds and we can't do it with other sources of funds. But the trend has been toward less flexibility. So we're talking as a community about what kind of local public funding can go into creating pots of flexible funds where those kinds of things are more possible.

(#41) Our CoC's coordinated assessment process does not adequately prioritize risk and the needs of survivors and I am not happy with the assessment. I feel like it's re-victimizing. I understand the thinking behind it. But there needs to be a different tool. There are a lot of questions that are not suited to asking someone who has been a victim of violent crime. It's supposed to take the emotion out and just assess for the situation but some of the questions are rather gruff. I think the questions are better suited for chronically homeless individuals than survivors of domestic violence or any sort of violence.

For example, the assessment asks if you've traded money or sex for a place to sleep. If you've got someone who's been sexually assaulted, that's re-traumatizing. It seems to have been a hot topic, as well, at the OVW Transitional Housing Grantee Orientation. We've not experienced this with our program but some of the other programs that spoke feared that since this assessment was part of the survivor's file -- and you need to answer the questions truthfully in order to access services or to be ranked appropriately for priority -- that if your

abuser went to court and had your files subpoenaed, the answers could be used against you. I see why that's a concern and I almost feel like the DV programs should be exempt to that sort of assessment.⁶⁰

Questions to Consider

1. If your agency receives CoC grant funding, do you know what the "written standards" that your CoC adopted call for?
 - How do those written standards impact survivors of domestic violence?
 - When will those written standards be formally reviewed and potentially revised by the CoC?
2. If your agency receives ESG grant funding, do you know what the "written standards" governing that grant call for?
 - How do those written standards impact survivors of domestic violence?
 - When will those written standards be formally reviewed and potentially revised by the state, county, or jurisdiction administering your grant?
3. What are the pros and cons of coordinated entry/coordinated assessment as operated in your CoC? For victim service providers? For survivors in DV shelters? For survivors in mainstream shelters? For mainstream providers?
4. Which is preferable and why: uniform standards for the amount or percent of rental assistance provided to each participant, or flexibility to work out an individualized rental assistance agreement with each survivor?
 - If uniform standards are best, should they be developed by each provider for their particular program(s), or should the same standard apply across all programs funded through the CoC?
5. Where does your philosophy place you on the "serve more survivors" versus "provide deeper, longer help" continuum? Where does your program fit into that continuum?
 - Some people claim that longer term assistance encourages participants to procrastinate in looking for housing and taking care of the necessary prerequisites; what does your experience tell you?
6. If you are funded through the HUD CoC program, to what extent is your commitment to voluntary services compromised by accountability to HUD performance metrics?
 - To what extent does accountability to HUD metrics influence your participant selection process?
 - If you have a CoC RRH grant, to what extent does the requirement for a one-year lease influence participant selection?
7. If you are funded through the HUD ESG program, how does that influence your commitment to voluntary services or your participant selection process?
8. Some providers have criticized the VI-SPDAT for not taking into consideration a survivor's risk from future violence.
 - How could that information be collected during the coordinated entry / coordinated assessment process?
 - What, if anything should trigger a decision to use an instrument like the Danger Assessment developed by Jacqueline Campbell⁶¹ to assess a homeless person's risk of harm from a perpetrator of violence, as part of the coordinated entry / coordinated assessment process?
 - When, if ever, does your program use that kind of tool?

⁶⁰ As noted elsewhere, both the [ESG Interim Rule](#) (§576.400(d)) and the [CoC Interim Rule](#) (§578.23(c)(9)) include provisions that allow victim services providers to be exempt from the requirement to participate in the CoC's coordinated entry / coordinated assessment system. The ESG Interim Rule exemption is unqualified. The CoC Interim Rule requires an opting out provider participate in a comparable system that meets HUD's minimum requirements and that is used by victim services providers serving that geography.

⁶¹ See "[What is the Danger Assessment](#)" for information about Campbell's instrument

3. Partnerships and Collaborations

(a) Overview

No transitional housing programs has the resources to provide every service that participants need. Sometimes a referral to an outside provider is sufficient to facilitate access to a needed services. Some survivors don't even need a referral, and are perfectly able to self-refer for services. However, sometimes, even if services are nominally available in the community, they are inaccessible to TH program participants, due to long waits, or high cost, or insurance coverage barriers, or because they are not offered in a culturally and linguistically competent manner, or because the mainstream providers offering the service lacks an adequate understanding of the trauma that survivors of domestic/sexual violence may carry, how that trauma may affect a survivor's ability to participate in and benefit from the services, and how services can be more effectively delivered by utilizing a trauma-informed approach.

Sometimes, a TH program can contract with a community provider to ensure that provider's availability to offer gap-filling services to program participants, and perhaps, the provider's willingness to come onsite to deliver those services. That kind of funded MOU (Memorandum of Understanding) relationship -- which is especially important if TH program staff expect most, if not all, program participants will need the services -- can create an opportunity to invite the community provider to attend agency trainings that offer insight into the impact of chronic domestic and sexual violence, what survivors may struggle with in the aftermath of fleeing an abusive relationship, and how chronic or complex trauma might affect interactions with survivors and their participation in services.

By requiring applicants for TH grants to enter into a funded MOU with at least one provider, the OVW has made linkages with mainstream providers an integral part of the Transitional Housing program.⁶² And by basing over 20% of an applicant's score on its description of the MOU collaboration and how it will benefit survivors, the OVW signals its recognition of the important contribution an MOU partnership can make.⁶³

Collaborations described by TH providers and discussed in subsequent sections of this chapter involve agencies and consultants providing housing and/or housing search support; education and training services;

⁶² The [OVW FY 2015 solicitation](#) for TH Assistance grants explains the requirement for MOU partnerships as follows:

- **Required Partnerships:** "Nonprofit or tribal sexual assault, domestic violence, dating violence, and/or stalking victim service organizations must be involved in the development and implementation of the project. All applicants that are not nonprofit or tribal organizations serving survivors of sexual assault, domestic violence, dating violence, and/or stalking, must enter into a formal collaboration with such an organization and make clear they are intricately involved in the implementation of the program and project activities. All applicants that are nonprofit or tribal organizations serving survivors of sexual assault, domestic violence, dating violence, and/or stalking must collaborate with at least one other organization to expand the scope of services available to victims (e.g., job training organization, housing authority, or legal services agency). Formal Memorandum of Understanding (MOU) partner(s) must be clearly identified in the MOU and throughout the application...."
- **Partner Compensation:** "Applicants must include compensation for at least one, if not all of their project partners, for time and travel to participate in project development, training, and implementation.... Compensation to formal project partner(s) with grant funds, if awarded, must be clearly identified in both the budget and the MOU submitted with the application." [**Note:** Although the MOU requirement has been part of TH grant solicitations since at least 2009, the requirement that at least one MOU arrangement be funded by the grant is more recent.]

⁶³ The OVW assigns 20 points (out of 100 total points) to the section describing MOU collaborations; in addition, a portion of the 10 points assigned to the section "Who Will Implement the Project" depends on the applicant's description of "the expertise of each project partner organization, [their] respective roles and responsibilities ... in the implementation of the project, and the relevant expertise of any individual consultants who will be directly involved with the project." In addition to describing the details of their partnership with the MOU organization(s), applicants must address 16 required MOU elements, including information about "relevant local government agencies participating in project development or implementation" and "other community agencies or organizations that will assist with implementation of the project."

employment services; life skills and financial empowerment services; health, dental health, and/or mental health services; substance abuse treatment services; child-related services; and legal services. [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence") includes provider comments describing examples of collaborative arrangements with organizations serving specific ethnic, cultural, linguistic, and/or disability-related subpopulations that help TH programs reach and more competently serve segments of the community that might ordinarily not know about or trust their agency, or that TH program staff might not have the knowledge, sensibilities, or language skills to appropriately serve.

Partnerships with clinical consultants, financial services providers, health and behavioral health care providers, lawyers and legal services offices, and employment assistance agencies, for example, not only allow TH programs to make available gap-filling services, but to offer participants the opportunity to obtain such services from a different or differently credentialed person or organization that might have more credibility in such specialized areas than generalist TH program staff. Depending on the information-sharing arrangement that the participant has consented to, obtaining specialized services from MOU providers may afford the participant a level of privacy they might not feel they had if they were working with in-house staff.

Partnerships allow TH providers -- especially smaller agencies -- to facilitate participant access to the kinds of specialists that they can't financially afford to keep on their own payroll. This was true when [Correia and Melbin \(2005\)](#) heard from the programs they surveyed that such collaborations were "critical to the success" of the TH program; and it is true today. Whereas a case manager/advocate is essential to the day-to-day operation of a TH program, client interactions with therapists or employment specialists are much more limited, and it may not make sense for a small agency to keep such specialists on its payroll. Similarly, if a small agency wishes to provide clinical supervision and support to staff, it might make more sense to engage that clinician as a consultant, rather than as a salaried staff member, given the very part-time nature of the role. However, without the formality of an MOU or contractual arrangement, these adjunct providers would not necessarily be available when needed.

The preceding discussion focused on the rationale for collaborations and the OVW's use of an MOU requirement as a means of encouraging funded collaborations between victim services providers and a broad range of community-based providers who can make available gap filling health and social services.

Much of the rest of this chapter will address the opportunities and challenges attendant to collaborations between victim services providers and the mainstream homeless provider community, the benefit of membership in domestic violence and sexual assault coalitions, and the specific kinds of collaborations that enable domestic and sexual violence-focused transitional housing programs to address participants' service needs that can't be met in-house. Before moving on to those topics, the following section discusses client confidentiality and privacy requirements and practices.

(b) Ground Rules for Collaboration: VAWA, HUD, and Other Privacy/Confidentiality Requirements

Unpublished survey data from [DeCandia, Beach, & Clervil's \(2013\)](#) study of the opportunities of obstacles to collaboration between victim services providers and mainstream homeless services providers indicates that some of the most frequently cited substantive barriers to collaboration in surveyed providers' narrative responses (other than lack of staff time and lack of funding for taking on more work) were: (a) issues related to client confidentiality and client safety (e.g., physical safety, information-sharing, etc.) and (b) issues related to inadequate understanding of -- and/or perceived differences in -- program mission/focus and funding-related constraints/requirements. This section focuses on confidentiality issues.

(i) Survivor Confidentiality: VAWA Framework

The [VAWA Reauthorization of 2013](#) clarified and extended certain confidentiality- and privacy-related protections on behalf of victims/survivors of domestic and sexual violence who receive OVW grant-funded

housing/services⁶⁴, including:

- "[Nondisclosure of] any personally identifying information or individual information collected in connection with services requested, utilized, or denied through grantees' and subgrantees' programs, regardless of whether the information has been encoded, encrypted, hashed, or otherwise protected;"
- "[Nondisclosure of] individual client information without the informed, written, reasonably time-limited consent of the person (or in the case of an unemancipated minor, the minor and the parent or guardian or in the case of legal incapacity, a court-appointed guardian) about whom information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program, except that consent for release may not be given by the abuser of the minor, incapacitated person, or the abuser of the other parent of the minor;"
- "[Prohibition of any requirement that a victim/survivor] consent to release his or her personally identifying information as a condition of eligibility for the services provided by the grantee or subgrantee;" and
- "[Prohibition of sharing] any personally identifying information ... in order to comply with Federal, tribal, or State reporting, evaluation, or data collection requirements, whether for this program or any other Federal, tribal, or State grant program."

The [VAWA Reauthorization of 2013](#) affirmed the responsibility of grantees and subgrantees to comply and document their compliance with these and other privacy- and confidentiality-related protections; clarified the kind of information that can be shared or released; described the responsibility of grantees and subgrantees in the event that release of individual information is compelled by a court or law; and affirmed the responsibility of grantees to ensure that their subgrantees are aware of, comply with, and document their compliance with those protections. For more information, see the *NNEDV FAQ on current VAWA and FVPSA confidentiality requirements* ([NNEDV, 2016](#)) and the *NNEDV FAQ on Confidentiality Releases* ([NNEDV, 2008, rev. 2015](#)).

(ii) Survivor Confidentiality: HUD Provisions

HUD requires CoC- and ESG-funded victim services providers⁶⁵ to collect all of the same data that other CoC- or ESG-funded projects are required to collect (see the *Homeless Management Information System (HMIS) Data Standards Manual* ([HUD, 2015f](#)), *HMIS Data Dictionary* ([HUD, 2015g](#)), and *ESG Program HMIS Manual* ([HUD, 2015e](#))), but in compliance with VAWA, broadly exempts such providers from requirements to participate in the shared data collection system that all other HUD-funded providers must use (the HMIS), directing them, instead, to enter data into a "**comparable database**," that meets or exceeds the HUD's current **HMIS data and technical standards**⁶⁶ ([HUD, 2004, pp. 45927-45934 in the Federal Register](#)) and which allows them to generate "unduplicated aggregate reports based on the data," which must then be provided to the entity administering their ESG grant or CoC grant. Per §578.57(a)(3) of the [CoC Interim Rule](#), "If the recipient or subrecipient is a

⁶⁴ OVW grantees are required to sign an affirmation of their organization's awareness of and intent to comply with the confidentiality-related provisions of VAWA. See ["Acknowledgement of Notice of Statutory Requirement to Comply with the Confidentiality and Privacy Provisions of the Violence Against Women Act, as Amended."](#)

⁶⁵ "Victim service provider" is defined in §578.3 of the [CoC Interim Rule](#) as "a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. **This term includes rape crisis centers, battered women's shelters, domestic violence transitional housing programs, and other programs.**" That is, HUD's definition of "victim services provider" includes OVW-funded TH programs operated by a provider like a YWCA, which would ordinarily not be considered a "victim services provider". The definition would cover any project funded with a VAWA or FVPSA-authorized grant to serve survivors of domestic and sexual violence.

⁶⁶ See, for example, §576.400(f) of the [ESG Interim Rule](#) and §578.57(a)(3) of the [CoC Interim Rule](#) for requirements to comply with current data and technical standards. As indicated in the text, the reference to "technical standards" largely refers to requirements defined in a [2004 Federal Register notice](#). HUD is in the process of updating those requirements.

victim services provider, or a legal services provider, it may use Continuum of Care funds to establish and operate a comparable database that complies with HUD'S HMIS requirements."

As amended by the [VAWA Reauthorization Act of 2013](#), subparagraph (b)(2) of [42 U.S.C. §13925](#) governing the nondisclosure of confidential or private information pertaining to persons served under OVW grants⁶⁷ in programs that might also receive HUD or other funding (and might therefore be subject to other data sharing or reporting requirements) is as follows:

(2) Nondisclosure of Confidential or Private Information

(A) In general - *In order to ensure the safety of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families, grantees and subgrantees under this subchapter shall protect the confidentiality and privacy of persons receiving services.*

(B) Nondisclosure - *Subject to subparagraphs (C) and (D), grantees and subgrantees shall not—*

(i) disclose, reveal, or release any personally identifying information or individual information collected in connection with services requested, utilized, or denied through grantees' and subgrantees' programs, regardless of whether the information has been encoded, encrypted, hashed, or otherwise protected; or

(ii) disclose, reveal, or release individual client information without the informed, written, reasonably time-limited consent of the person (or in the case of an unemancipated minor, the minor and the parent or guardian or in the case of legal incapacity, a court-appointed guardian) about whom information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program, except that consent for release may not be given by the abuser of the minor, incapacitated person, or the abuser of the other parent of the minor.

If a minor or a person with a legally appointed guardian is permitted by law to receive services without the parent's or guardian's consent, the minor or person with a guardian may release information without additional consent.

(C) Release - *If release of information described in subparagraph (B) is compelled by statutory or court mandate—*

(i) grantees and subgrantees shall make reasonable attempts to provide notice to victims affected by the disclosure of information; and

(ii) grantees and subgrantees shall take steps necessary to protect the privacy and safety of the persons affected by the release of the information.

(D) Information sharing

(i) Grantees and subgrantees may share—

(I) non-personally identifying data in the aggregate regarding services to their clients and non-personally identifying demographic information in order to comply with Federal, State, tribal, or territorial reporting, evaluation, or data collection requirements;

(II) court-generated information and law enforcement-generated information contained in secure, governmental registries for protection order enforcement purposes; and

(III) law enforcement-generated and prosecution-generated information necessary for law enforcement and prosecution purposes.

(ii) In no circumstances may—

(I) an adult, youth, or child victim of domestic violence, dating violence, sexual assault, or stalking be required to provide a consent to release his or her personally identifying information as a condition of eligibility for the services provided by the grantee or subgrantee;

⁶⁷ The Family Violence Prevention Reauthorization of 2010 amended subparagraph (c)(5) of 42 U.S.C. §10406 to provide similar privacy and confidentiality protections with regard to disclosure of personally identifying information.

(II) any personally identifying information be shared in order to comply with Federal, tribal, or State reporting, evaluation, or data collection requirements, whether for this program or any other Federal, tribal, or State grant program."

However, victim services advocates have long expressed concern that although HUD regulations protect the confidentiality of survivors who are fortunate to be enrolled in a program operated by a victim services provider, they don't offer comparable protections to survivors who happen to be in a mainstream program -- and who may need the very same protections to avoid being discovered by a stalker or the perpetrator that they fled. HUD guidance on **Coordinated Entry and Victim Service Providers** ([HUD, 2015d](#)) clarifies that:

"All households, regardless of their DV status, have the right to refuse to disclose their information in HMIS and may refuse to allow the CoC to share their information among providers within the CoC. In fact, all service providers are prohibited from denying assistance to program applicants and program participants if they refuse to permit the provider to enter their information in to HMIS or refuse to allow their information to be shared with other providers. However, some information may be required by the project, or by public or private funders to determine eligibility for housing or services, or to assess needed services. In those instances, the information must still be collected by the recipient to determine whether the individual or family is eligible, but it must not be entered into HMIS if the program participant objects to having information entered into the HMIS. For instance, if a provider needs to verify the presence of a disability in the process of determining eligibility for PSH, the information itself must be collected but not recorded in HMIS. In other words, it should be retained in a separate paper file or closed database." (Q&A #3)

Some of the providers we interviewed suggested that there is inadequate awareness among CoC providers of these rights to withhold information or to withhold permission for providers to broadly share any such information which is voluntarily furnished. Although ideally, applicants for CoC assistance would be explicitly informed of those rights, providers might be concerned that such a proactive advisory statement would needlessly discourage client disclosure of information useful to assessment of their needs, program-level reporting, and/or tracking of overall homelessness. All of these provider concerns are, of course, secondary to protecting the privacy, confidentiality, and safety of survivors.

The NNEDV advises advocates to make sure that survivors seeking mainstream services know how to assert those important privacy-related rights.

(iii) Survivor Confidentiality: Other Legislated Protections

FVPSA and VAWA are not the only federal laws affecting disclosure of personal information. There are laws protecting survivors' medical records (HIPAA); addressing the privacy of their primary, secondary, and certain post-secondary school records (FERPA); and addressing the disclosure by schools of information about on-campus cases of rape or sexual assault. A [2011 NNEDV Fact Sheet on federal confidentiality-related laws](#) (other than VAWA) summarizes:

- Current information about FVPSA protections
- Relevant provisions of VAWA (However, since the fact sheet pre-dates to 2013 VAWA Reauthorization, it is not as up-to-date on VAWA provisions as the aforementioned **NNEDV FAQ on current VAWA and FVPSA confidentiality requirements** ([NNEDV, 2016](#)), which also addresses the interface between VAWA and FVPSA protections and HMIS.
- Current information about the **Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act** ([Clery Center, 2012](#)) which, among other things, specifically addresses campus policies and procedures with respect to rape and sexual assault);
- Relevant information about **HIPAA - the Health Insurance Portability and Accountability Act** ([HHS-OCR, 2013](#)), which addresses disclosure of personal protected information, including sensitive health

information). **Note:** The above-mentioned 2011 NNEDV Fact Sheet pre-dates the 2013 revisions to HIPAA the [Final Omnibus Rule](#) implementing the so-called HITECH Act to strengthen the privacy and security protections for health information, including finalizing the [Breach Notification Rule](#). ([HHS Press Release](#))

- Relevant information about **FERPA -- the Family Educational Rights and Privacy Act** ([DOE, 2015](#)), which addresses disclosure of personal identification and other information in the educational records of students who attended U.S. Department of Education-funded K-12 and post-secondary programs).

Note: The above-listed 2011 NNEDV fact sheet pre-dates **regulatory changes effective January 2012** (described in [Mendelsohn, 2012](#)).

State laws governing the privacy and confidentiality of information pertaining to domestic and sexual violence vary widely. The Training and Technical Assistance Center of the Office for Victims of Crime in the Office of Justice Programs in the U.S. Department of Justice maintains a webpage called [VictimLaw](#) ([DOJ/OJP/OVC/TTAC, n.d.](#)) which allows users to search for federal, state, territory, and tribal laws addressing a host of issues pertaining to victimization (e.g., right to [restitution](#), right to [be heard](#), right to [protection](#), right to [privacy](#), etc.).

(iv) Survivor Confidentiality: Privileged Conversations with Lawyers, Advocates, Certain Other Providers

Although our interviews did not specifically address provider involvement with lawyers or legal advocates who might be assisting program participants in obtaining orders of protection or in prosecuting a perpetrator, it is important to note the impact of VAWA and FVPSA and other privacy/confidentiality requirements, as well as the impact of privileged conversations between the survivor and program staff: [Kristiansson \(2013\)](#) describes the implications of federal privacy/confidentiality laws as they relate to the investigation and prosecution of criminal domestic and sexual violence. The article's stated purpose is

"to help professionals in the criminal justice system understand what information a victim considers to be private and be able to explain to the victim as well as to other professionals within the system what information is private under the law. Having this discussion with victims up front will prepare them for what to expect, help encourage their cooperation throughout the process, and prevent them from feeling that the system misled or betrayed them. This knowledge may also empower victims to take control of their circumstances and make informed decisions, voluntary assertions, or waivers. It will also help the professionals with whom victims come into contact protect their safety and privacy to the best of their ability."

[Kristiansson \(2013a\)](#) discusses

"legal privileges that exist in the following relationships: qualified community advocate/ client, clergy/penitent, psychiatrist/patient, physician/patient, spousal, and attorney/client.... The holder or owner of the privilege is the client, and the professional in the privileged relationship, even under court subpoena, cannot divulge protected privileged communications unless: (a) the client gives express permission for the communications to be disclosed; (b) the client waives the privilege; or (c) there is a recognized public policy exception to the privilege, such as a duty to warn a third party of specified harm that the client is going to commit. In recognition of the benefits of these privileged relationships, communications between individuals in protected relationships are essentially elevated over the public's need to obtain this information, even if the information is otherwise relevant to the truth-seeking process in a court of law."

(v) Survivor Confidentiality: Mental Health and Substance Abuse Treatment-Related Protections

As is noted in other parts of this resource guide, survivors not infrequently come to transitional housing programs with concomitant behavioral health issues, which may stem from, or have been exacerbated by, their experience of domestic or sexual violence. It is, therefore, important to also understand the various federal and state laws pertaining to the privacy of client-level information about substance abuse- and mental health-related conditions and treatment. SAMHSA maintains a **webpage describing federal requirements**

pertaining to mental health and substance use treatment-related information ([SAMHSA-HRSA, n.d.](#)) and an *FAQ on Substance Abuse Confidentiality Regulations* ([SAMHSA, 2015, updated 2018](#)).

Note: It is not clear whether these websites are up-to-date vis-à-vis HIPAA/HITECH or other recent changes.

Of course, providers need to be aware of any additional state law requirements pertaining to the confidentiality of information about mental health and substance abuse conditions and treatment.

(vi) Survivor Confidentiality: HIV/AIDS Treatment-Related Protections

Because some survivors may have HIV/AIDS, providers should also be aware of the U.S. Department of Health and Human Services' (DHHS) webpage on *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS* ([HHS-OCR, 2015](#))

As with other sensitive health-related information, there are also state law requirements which providers should understand.

(vii) Provider Comments about Confidentiality

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

(#01) We have really strict confidentiality policies in place. We follow VAWA's confidentiality guidelines, and use the confidentiality forms that NNEDV developed. And when we collaborate, we talk about how we can't discuss the specifics without women's consent. That's just a black and white issue for us. We start with women giving us permission to work with other people.

(#02) To protect participant privacy and confidentiality when we collaborate with other providers, we get a release of information from the participant. It's the participant's choice if they want to go down this road. We make sure they understand what that is, and that we have a release on file.

(#03) Confidentiality has never been an issue in collaborations with outside service providers because the client decides whether she wants to sign a release or not. And we can't deny or confirm that anyone's participating in our program unless they allow us to.

(#04) We only share client information that we have written permission from the client to share. We use the OVW sample policy for confidentiality. We often don't give out any identifying information, even though we may have client permission to do so. Instead, we give the clients the information about a particular agency, and then the clients, on their own, reach out to that agency.

When we're talking to an agency about a situation, we'll present a hypothetical case and ask for guidance, but we're very guarded about providing any identifying information to our partner agencies. We find that the client has to want to take advantage of a service, and the best way to empower her to do so is to give her the referral, and let her make the initial contact on her own.

(#05) Our policy is that we don't talk to any other agency without a release form signed by the participant that is specific to the agency and to what we're going to talk about with that agency. We don't believe that there are any secrets with her. If there's a concern, we'll tell her about it. Of course, the most common example is if we have to call the state's child protective services agency. We'll say, "Here's the concern, and here's why I'm going to call them." I explain that I'm a mandated reporter, but I really don't want to go there. I want us to be talking about it together.

When it comes to our transitional housing, we see it as equivalent to permanent housing as far as their rights. So if law enforcement comes and asks if someone lives here, we confirm that she lives here, but we don't give out any private information. Same thing with CPS: we'll confirm if she lives here.⁶⁸ Period.

(#06) Sometimes we run into confidentiality issues with collaborating organizations that want more information than we can provide. Particularly around housing referrals. And sometimes they'll want information that's just flat out confidential and that would put us in violation of VAWA. But sometimes they're unaware of confidentiality and privacy protections for survivors. Particularly if we're referring to a non-DV-focused transitional housing program, they'll want to know about active addiction and mental health issues, they'll want our opinions about the survivor, and they'll ask us about behavior we've observed between the survivor and her kids.

We don't want our participants not to have access to these programs, they're so few and far between, but we can't share that information. We've done things like tried to train these providers -- we got a grant through our local homeless system a few years ago to train all the family shelter providers on the housing protections, both local and federal. It was one-time funding so it's not something we could do ongoing, but those trainings were so fantastic, because we were not only able to educate them about housing protections, we were also able to address how these non-DV providers were trying to screen out DV survivors. They were afraid to have them in their programs.

First we had to educate them that what they were doing was illegal, but then we were able to share information about domestic violence, and the fact that whether they screen DV victims out or not, there are DV victims in their program. And we shared some tools and ways to support survivors. They were fabulous trainings and I think we made some progress, but it really requires ongoing support. We just wrote a HUD grant proposal, through their fair housing program to continue to do those trainings. If we get that grant, we will be so excited to start those up again.

(#07) (Not a current OVW grantee) We only utilize certain staff and offices. We won't take clients to the main hospital clinic, because if we walked in with somebody, they would recognize our staff and seeing that our clients were with us, would conclude that they must be battered or victims of sexual assault. We make appointments at off times like Saturdays or evenings, or arrange for providers to come to the shelter and see our clients. We always worry about safety and confidentiality. On a small island, you're always going to run up against that issue, because everybody knows most everyone else and where they work.

(#08) We are not one of the communities where the DV system no longer can decide who to admit to their programs; we have not been folded into the coordinated access system that they've set up here.⁶⁹ We're developing our own system where we have a shared assessment tool and we can make referrals to each other's programs while maintaining the prerogative to say, "No, this is not a good fit." We've had the process and the tool vetted by the Fair Housing Council and also by a trauma-informed expert as to its ability to avoid some of the pitfalls of over-interrogating people when they come seeking assistance.

⁶⁸ Some providers would argue that disclosing to a law enforcement provider, without the survivor's consent, that a survivor lives in a TH program is a violation of the survivor's confidentiality and privacy.

⁶⁹ "Centralized Intake," "Coordinated Access," "Coordinated Assessment," and "Coordinated Entry" are terms used somewhat interchangeably to refer to the system that Continuums of Care are required by HUD to implement, utilizing a standardized assessment protocol and triaging process to determine the kind of housing and services a homeless person or family needs and ascribing a level of urgency/priority to that individual's or family's situation. See the discussion about "Collaboration Between OVW/HUD-Funded Programs in the Era of Coordinated Entry" earlier in this chapter.

Overall, our CoC partners say that 60 to 70% of the homeless families they work with in their Continuum programs are survivors. Our agency, on behalf of the homeless survivors we serve -- and those 60-70% of homeless families served by mainstream homeless providers -- rely a lot on being able to access services funded on the homeless side, i.e., not specifically for DV survivors.

One of the things we're trying to do with our Continuum's new coordinated access process is to determine who the survivors are that really need the protections and the DV lens that the DV system can provide, so we can target our specialized housing and services to those folks. Through piloting this new tool across all the programs, we hope to figure out how well we're able to make that determination about who needs to be served by the DV system. At the same time, we want to work with our mainstream provider partners to help them be more sensitized to survivors' issues. We'll be providing training, TA, and consultation to them, but there are no resources for any of this, so it's all stuff we try to do on top of running our programs.

I think a lot of determining who would need specialized DV system resources would be about danger and vulnerability and who, particularly when we're talking about shelter, needs the confidentiality that comes with a DV versus a non-DV shelter. Some of that is looking at where the abuser is and whether the abuser is circulating within the homeless system, because that is often the case in this general population. Additionally, we know that in our DV services, we are constantly applying that DV lens, being trauma-informed, and not entering data into a shared database. At present, we don't have great confidence that mainstream homeless providers are on a regular basis doing adequate informed consent with survivors to make sure they know their data doesn't have to go into the HMIS; I think it's pretty routine for survivors to be asked to disclose all their private information.

I think it's important to have some of the same standards for DV survivors whether they're in our DV system or the Continuum homeless system. I feel strongly about that around HMIS, around the availability of safety planning, and whatever other protections there might be. I don't see any sense in having a survivor if she is sitting in my chair get all kinds of protections that she loses if she goes over to the homeless side. I think that's a huge problem; the same standards should be held to, regardless.

I think one of the things we can do if we're sending a survivor over to the homeless system for services that we can't provide for her is to let her know about some of the protections she can ask for. She can ask not to have her information be put into a shared database. She can ask that there be a Release of Information before they talk to somebody about her private information -- those kinds of things. We try to do that but even better would be for the homeless system to be adopting some of those same safety provisions within their own policies.

(#09) Sometimes state agencies don't understand our guidelines. Obviously we cannot confirm or deny that anyone has requested or received our services without a signed consent from a participant. Sometimes the state's Child Protective Services may refer someone to us because they have identified domestic violence in the home and think the family needs services; so it becomes part of their case plan for the family to seek services from us. If CPS calls and wants to verify that the family came and received services, we can't confirm or deny that unless there's written consent from the participant. So CPS doesn't always like it when we tell them that we can't provide that information. If we know on the front end -- if the participants says, "I was told to come here by CPS" -- then we can have a conversation with them and say, "usually they'll call and want verification that you came. It's your choice. Do you want us to provide that sort of documentation for you?" If so, we can ask them to sign a consent form for that.

Questions to Consider

1. When entering into an MOU with a service provider, what arrangements are appropriate with respect to confidentiality? Specifically, should conversations between the MOU provider and survivors be confidential, or should

- the MOU provider be treated as part of the "transitional housing program team" so that s/he can share the content of those conversations with the case manager and other provider staff working with that survivor? Why?
2. What is the best way to make sure that when survivors participate in the CoC's coordinated entry / coordinated assessment system (regardless of whether they are staying in a program operated by a victim services provider or a mainstream provider), they understand their rights to withhold person information and/or to prohibit the CoC and any of its providers from sharing that information?
 3. Under what circumstances is it okay to reveal to an inquiring police officer that a woman they are asking about is a resident in the program? Would there be a different standard if the person inquiring was from Child Protective Services?
 - Does staying in a shelter program ensure any greater level of privacy and confidentiality with respect to inquiring officials, as compared to staying in a transitional housing program?
 - Does your answer depend on whether Jane Doe is living in a provider-owned congregate facility, a provider-leased apartment, or a survivor-leased apartment that your agency is assisting with rental assistance?
 4. Many survivors in mainstream programs never disclose their history of trauma from domestic and sexual violence, even though it may be impacting their ability to achieve the goals and objectives that they or the mainstream program they are have defined. In order that their mainstream provider be able to appropriately accommodate their needs, they need background information about the impacts of trauma, and how to address it.
 - What would be the best way for mainstream providers to ask about trauma history?
 - To what extent should the trauma history be documented in the HMIS or participant files, given that all of the participant's personal information has previously been collected, unless they refused to consent?
 - When would it be better for a mainstream provider operating, say, a rapid rehousing program to refer such a survivor for outpatient services from a victim services provider?
 5. How is contracting with an MOU provider versus making a referral to a community provider different in terms of the information-sharing that might be necessary to provide well-coordinated services?
 - To what extent does getting a participant's permission for such information sharing create a barrier to delivering services that would not exist if the services were delivered in-house?
 - Should different in-house staff get permission from participants to talk to each other about that participant, or is it just assumed that they talk to each other?

(c) Coordination Between OVW-Funded TH Programs and the Mainstream Homeless System

The benefits of and obstacles to collaborations between victim services providers and the "mainstream" homeless housing and services system, and strategies for navigating those challenges, were the subject of [DeCandia, Beach, & Clervil \(2013\)](#), an OVW-grant-funded technical assistance project entitled ***Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness: A Toolkit for Transitional Housing Programs***.

We begin our discussion about collaboration by attempting to understand and reconcile the findings of that study with the somewhat different findings from our interviews with OVW-funded TH providers.

(i) "Closing the Gap" Revisited: Coordination and Collaboration vis-a-vis TH Programs: Part 1

Citing the research of [Baker et al. \(2010\)](#), [DeCandia, Beach, & Clervil \(2013\)](#) observed that while the mainstream homelessness system and the DV-focused system "often serve the same population and aim to achieve similar outcomes for families (stability and safety, housing and recovery), they operate philosophically and practically under different principles" (p.5) and that "the DV and homeless service systems are generally not integrated, operate in silos, and are not connected to mainstream services in most communities." (p.2)

What we heard from the transitional housing providers we interviewed was not as black-and-white as the summary statement in [DeCandia, Beach, & Clervil \(2013\)](#). Probably the most important reason for that difference in findings is that the two projects studied different segments of the provider community.⁷⁰ The respondents in the [DeCandia, Beach, & Clervil \(2013\)](#) study included a mix of victim services providers (~54%) and mainstream providers (~45%). Victim services providers operating **transitional housing** constituted about one-sixth (17.4%) of survey respondents (and actual TH program staff from those providers probably constituted only 10-15% of respondents⁷¹) in the [DeCandia, Beach, & Clervil \(2013\)](#) study. By contrast, 122 of the 124 (98%) interviews used for **this project** were with provider staff from current or formerly funded transitional housing (TH) programs for survivors of domestic or sexual violence.⁷²

For a range of reasons, survivor-focused TH programs appear to be better connected to mainstream homelessness-related (and non-homelessness-related) service providers than DV shelters, notwithstanding the differences in philosophical and practical operating principles cited by [DeCandia, Beach, & Clervil \(2013\)](#).⁷³

For one thing, the DV shelter experience is inherently more insulated from the outside world than the TH program experience. DV shelters serve as safe zones for survivors who have just left an abusive situation, who are still in crisis, and who are statistically in the greatest danger of serious violence at the hands of the perpetrator they fled.⁷⁴ DV shelters are often sited in undisclosed locations, in unidentified buildings, with full

⁷⁰ There also was an approximately 2-2½ year difference in the timeframe for data collection for the two projects. When [DeCandia, Beach, & Clervil \(2013\)](#) collected their survey data (Spring 2012), HUD's expanded definition of homelessness (broadening inclusion of survivors of domestic and sexual violence) had only been in place for a few months (the effective date of the [Defining 'Homeless' Final Rule \(HUD, 2011a\)](#) was 12/5/2011), so it's safe to assume that many CoC providers hadn't "culturally" assimilated the understanding that DV survivors who had fled to temporary living situations with family or friends were "HUD homeless." By late Spring 2014, when interviews for **this project** began, the revised definition of homelessness, which includes DV survivors who had fled to temporary situations, was firmly in place.

⁷¹ Unpublished data from [DeCandia, Beach, & Clervil \(2013\)](#) indicates that of the 552 providers responding to their survey, 247 providers (44.8%) were mainstream (i.e., non-DV-focused) shelters, supportive housing, and supportive services programs; 203 providers (36.8%) were DV-focused emergency shelters and supportive services programs; and only 96 providers (17.4%) operated DV/SA-focused TH. (The missing 1% of respondents did not identify a program type.) Of the 96 DV/SA-focused TH providers, 37 (38.5%) also operated DV shelters; in some cases, they answered for both the shelter program and the TH programs in other cases not; so probably only 10-15% of the **actual** respondents were staff in a DV/SA-focused TH program.

⁷² Of the 124 interviews utilized for **this report**: one was with an OVW-funded law center that partners with a transitional housing (TH) provider that serves survivors of sexual assault, and one was a joint interview with two non-OVW-funded providers specializing in serving LGBTQ survivors. Of the other 122 interviews, 111 were with current OVW TH grantees; two were with providers who operate DV/SA-focused TH, but have never received OVW funding; and nine were with providers who lost their OVW TH grant funding in the year prior to our conversations (half of whom continue to operate DV/SA-focused TH programs using other funding, and half of whom no longer operate such programs).

⁷³ Perhaps the most apparent differences in practical operating principles are HUD's prescriptive performance metrics on housing placement/stability and increased income (versus the flexibility that OVW grantees have to focus on participants' stated goals) and HUD's emphasis on shorter timeframes (versus the flexibility that OVW grantees have to routinely extend assistance to 24 months, and up to 30 months, with a waiver). Although voluntary services is more embedded in the gestalt of the OVW TH program than in HUD's CoC program, it is codified in the HUD regulatory framework for RRH programs operated by victim service providers (see §578.37(a)(1)(ii)(F) in the [CoC Interim Rule](#)), it is part of the Housing First model for serving chronically homeless persons in permanent supportive housing, and it was even incorporated into **Notice of Funding Availability for the 2015 Continuum of Care Program Competition (HUD, 2015a)** as a basis for earning a higher competitive score (see, especially, pages 10, 19, and 45). As discussed earlier in this chapter, however, it is clear from HUD guidance in its **Rapid Rehousing Brief (HUD, 2014c)** (see excerpts in the Section 2 narrative of this chapter), for example, that the two funding sources understand "voluntary services" to mean very different things.

⁷⁴ For example, the [2012 Annual Report of the Domestic Violence Death Review Committee of the Ontario Office of the Coroner \(Ontario Ministry, 2014\)](#) reported that in 72% of the DV-related deaths from 2003-2012, involved couples with an actual or pending separation.

security; they are intended to be hard-to-find and hard-to-enter for unauthorized persons.⁷⁵ In keeping with that more protective and insulated approach, DV shelters are, on average, less interactive with mainstream providers than are TH programs.

Ideally, DV shelters are places where survivors can gain immediate safety and focus on healing from the trauma. In reality, many such shelter can only offer a few weeks of sanctuary.⁷⁶ It is an unavoidable reality of stays in a time-limited shelter that survivors must think about where they will go next, once their time in shelter runs out. If they can't get into transitional housing (or a mainstream extended-stay shelter), survivors have that much less time to resolve safety issues, legal and custody issues, income and employment challenges, and the question of where they will live when they leave shelter.

A majority of DV shelters have Family Violence Prevention and Services Act (FVPSA) funding, which pays for a portion of the cost of staff who can assist with those matters. Survivors in shelters operated by full-service domestic violence / sexual assault agencies are typically afforded a broader range of in-house services than survivors in less-well-funded programs.

Source of funding is perhaps one of the most important reasons why survivor-focused TH programs are more connected to mainstream homeless providers than are DV shelters. Fifty-one (42%) of the 122 providers we interviewed who operated one or more DV/SA-focused TH programs receive HUD Rapid Rehousing (RRH) or Transitional Housing (TH) grants to help pay for that transitional housing (and in many cases, the HUD funding exceeded the OVW funding), which means they are **part of the mainstream homeless housing/services system**. Many, if not most, of these 51 providers have been receiving HUD grant funding since long before the [DeCandia, Beach, & Clervil \(2013\)](#) survey, and their HUD funding essentially **requires** involvement with the local Continuum of Care as well as with other mainstream providers.⁷⁷

Although some of the nearly 1,600 DV shelters funded under the Family Violence Prevention and Services Act (FVPSA)⁷⁸ may also receive HUD Emergency Solutions Grant (ESG) funding to support shelter operations or

⁷⁵ As noted in a [February 2014 article in USA Today \(Pieper, 2014\)](#), a "small but growing number" of DV shelters have decided to be more public about their location.

⁷⁶ The possible length of stay (LOS) in shelter varies widely, depending on the source and level of funding. Unpublished data from [DeCandia, Beach, & Clervil \(2013\)](#) indicated that in the 200 DV shelters surveyed, about 26.5% of actual stays (versus maximum LOS) were under 30 days, 44% were 31-60 days, 24.5% were 61-180 days, and 5% were six months or longer. By comparison, among the 65 non-DV-focused family shelters surveyed, on average, about 20.0% of actual stays were under 30 days, 9.2% were 31-60 days, 38.4% were 61-180 days, and 32.3% were six months or longer.

⁷⁷ Many of these 51 projects were receiving "transitional housing" (TH) grants under HUD's Supportive Housing Program (SHP), the precursor to HUD's Continuum of Care (CoC) program, during the time when [DeCandia, Beach, & Clervil \(2013\)](#) were collecting survey data. Although some of these TH programs were converted to rapid rehousing (RRH) programs pursuant to the provisions of the [CoC Interim Rule](#) (which became effective 8/30/2012), **few would have been operating as CoC RRH projects at when DeCandia et al. did their survey**. RRH projects were also added to the menu of HUD's new "Emergency Solutions Grant" (ESG) program, which replaced the old Emergency **Shelter** Grant program. Under HUD's [ESG Interim Rule](#) (which became effective 1/4/2012), states, counties, and jurisdictions were authorized and encouraged to use their ESG funds for RRH projects, and a few of those grants were used to create RRH/transition-in-place projects for homeless survivors. **Again, few ESG RRH projects would have been operating when DeCandia et al. did their survey**.

(For historical completeness, it should be noted that a handful of CoCs received demonstration grants to pilot the rapid rehousing model prior to the CoC Interim Rule, but these grants did not specifically target survivors of domestic/sexual violence. Rapid rehousing projects, including projects that might have helped house homeless survivors, were more substantially funded under the short-lived HUD Homelessness Prevention and Rapid Rehousing Program (HPRP), as part of the American Recovery and Reinvestment Act of 2009 (ARRA), which addressed Recession-exacerbated housing needs; however, HPRP funds would have been all-but-exhausted when [DeCandia, Beach, & Clervil \(2013\)](#) surveyed providers.)

⁷⁸ According to footnote #92 in [Fernandes-Alcantara \(2014\)](#), a February 2014 Congressional Research Service report on the FVPSA program, FVPSA grants for states, territories, and tribes funded 1,564 domestic violence shelters in FY2012. According to the FYSB's [2009-2010 Report to Congress](#) on the FVPSA program ([HHS/ACF/FYSB, 2009-10, p.8](#)), FVPSA grants to states, territories, and tribes help fund 1,600 DV shelters.

staffing costs, those small ESG grants are not as strong a link to the mainstream system as the aforementioned RRH and TH grants utilized by 42% of our sample group of DV/SA-focused TH providers.

Projects that receive HUD CoC TH or RRH grants must file standard HUD Annual Performance Reports (APRs) with their local Continuum of Care (CoC) and HUD. Their performance (and the performance of TH programs funded with ESG RRH grants) is tracked using standard HUD metrics measuring the rate of permanent housing placement or retention, and increases in overall income and/or employment income. CoC grantees are expected to leverage services from other mainstream sources.

CoC-funded projects go through an annual evaluation process which informs the CoC's decision as to whether and how to prioritize the project for renewal funding in its annual application to HUD. That decision is based on a variety of considerations: (a) the project's performance, as measured by standard HUD metrics and any other metrics established by the CoC; (b) whether the project served as many households as promised in the prior funding application; (c) whether the project leveraged the cash and in-kind contributions promised in the prior funding application; (d) the project's adherence to HUD regulatory requirements for recordkeeping, reporting, and fiscal/billing practices, and whether it complied with the "written standards" developed and adopted by the CoC, as required by HUD (e.g., setting further limits on the amount, duration, and scope of services); (e) the participation of project staff in CoC meetings and activities, like the annual point-in-time count; and (f) whether the CoC believes that HUD will see that project as an "effective" use of its grant funds.

The need to receive favorable consideration from that kind of evaluation process is a strong incentive for ongoing provider engagement with the CoC.

By contrast, ESG-funded shelters, which typically receive much smaller grants, are not subject to that same level of scrutiny. While the process for awarding ESG grants is competitive at the state, county, or local level, the review is typically far less comprehensive, and there are typically much lower expectations with respect to ongoing provider engagement.

In their comments, transitional housing (including transition-in-place) providers receiving HUD funding (and some providers receiving only OVW funding) described a range of involvement in their CoC: some are actively involved in advocating for survivors, shaping the CoC's coordinated assessment / coordinated entry system, and in one case, actually administering that system. Several providers described sharing tips with other CoC providers about housing opportunities and about "bad" landlords to avoid and "good" landlords to work with. Other providers described a more passive role in their CoC (possibly because other staff in their agency are more active). Given that some of these HUD grants dates back to the late 1990s or early 2000s, it is not surprising that the [Correia & Melbin \(2005\)](#) study reported that, "Collaboration with a Continuum of Care group or local homelessness coalition was mentioned most often as a vital relationship by the transitional housing programs surveyed. These partnerships are viewed as crucial for building community support and soliciting HUD funding." (p.13)

In other words, a substantial percentage of OVW-funded TH providers are ***part of the mainstream homeless housing/services system*** and/or are actively engaged in collaborating with system providers. On the one hand, the fact that these TH providers participate in the mainstream homeless system is evidence of cross-system collaboration; on the other hand, the pressures they feeling from that system -- to define success and measure performance using standard metrics, to shorten stays, to shift from the traditional transitional housing model to a transition-in-place model that is more compatible with rapid rehousing, as described elsewhere in this chapter -- is a reflection of the conflicting philosophies and approaches described by [Baker et al. \(2010\)](#) and cited by [DeCandia, Beach, & Clervil \(2013\)](#). That is, the relationship between the mainstream homeless system and TH providers targeting survivors of domestic and sexual violence isn't accurately described by a simple either/or collaborating versus operating-in-silos characterization.

(ii) "Closing the Gap" Revisited: Coordination and Collaboration vis-a-vis TH Programs: Part 2

Although it is unfair to characterize the DV/SA-focused TH provider community and the mainstream homeless housing/services system as operating in silos, neither is it true that there is broad-based collaboration. Baker et al.'s diagnosis of the barriers to collaboration -- different frameworks based on "differences in history, philosophy, and practices," and the fact that both systems are working with issues that overwhelm their funded capacities -- still rings true. However, Baker et al.'s characterization of DV programs (as excerpted below⁷⁹) doesn't adequately reflect the broader purpose of DV/SA-focused TH programs, pursuant to the OVW TH grant enabling legislation (section (b) of [42 USC §13975](#)) and the [OVW annual grant solicitation](#), which calls for support services that enable survivors to: "(a) locate and secure permanent housing; (b) secure employment, including obtaining employment counseling, occupational training, job retention counseling, and counseling concerning re-entry in to the workforce; and (c) integrate into a community..." (p. 2):

Comments from the providers we interviewed suggest that the most significant barriers to more collaboration between DV/SA-focused transitional housing programs and mainstream (HUD- and non-HUD-funded) homeless services programs are (a) the nationwide scarcity of affordable housing and housing subsidies, which increases the cost-per-client of assisting survivors in TH/RRH programs, and exacerbates the lack of adequate resources *in both systems*⁸⁰ to fully address the needs of the constituencies the systems are funded to serve; (b) program policies and procedures adopted pursuant to HUD regulatory requirements and guidance that make sense in terms of HUD's goal of maximizing the numbers of households transitioned from homelessness

⁷⁹ "Domestic violence programs are focused on safety planning and crisis intervention, and offer a wide array of advocacy services that victims need and want, including assistance in obtaining emergency and/or other types of housing (although they may not know the range of housing options and programs or work-related resources in their community). Housing and homeless service providers are focused on a move to stable housing and improved financial stability, but may have little knowledge or expertise in providing services to survivors." ([Baker et al., 2010, p.435](#))

⁸⁰ See, for example, the [2016 brief by the National Alliance to End Homelessness](#) and [2015 brief by the Pew Charitable Trusts](#) on homelessness-related state-of-emergency declarations in various parts of the country. Inadequate capacity is not just an issue for HUD-funded programs, but also pertains to state-, county-, city-, and privately funded shelters. Insufficient capacity in the mainstream system to address individual and family homelessness ([NAEH, 2015](#)) has pushed back target dates for achieving national goals for ending homelessness ([USICH 2015](#)). Concerns about the large numbers of unstably housed families who cannot access shelter have fueled calls for legislation expanding the definition of family homelessness (e.g., [Homeless Children and Youth Act of 2015](#)). The [NNEDEV's \(2015\)](#) annual One Day Count documents the insufficient capacity of DV shelters and specialized TH programs to meet the needs of survivors fleeing or hoping to flee violent relationships.

In an effort to leverage greater impact in addressing homelessness with limited resources, HUD has encouraged the use of a RRH model focusing on shorter (6-12 month) periods of assistance and more limited supportive services, relying on the ability to leverage community-based services. ([HUD, 2014c, p.3](#)) Per provider comments, however, access to many of the supportive services that survivors might need (e.g., health, behavioral health, dental health, education, job training, childcare) is geographically uneven, and limited by barriers, including cost, inadequate insurance or other coverage, waiting lists, transportation issues, capacity constraints, lack of cultural/linguistic competence, and inadequate use of trauma-informed practices. Even as HUD increases its focus on RRH, the HUD-funded [Family Options study](#) ([Gubtis et al., 2015](#)) on the comparative cost/benefits of rapid rehousing, traditional transitional housing, and permanent housing subsidies found that permanent subsidies -- for which there are ever-longer waiting lists due to federal funding limits -- are the most effective intervention to stabilize housing.

In turn, the need for subsidies and subsidized housing has increased due to the increasing gap in the affordability of housing, as compared to wages. ([NLIHC, 2015](#)) As described in provider comments (see [Chapter 10](#) ("Challenges and Approaches to Obtaining Housing and Financial Security")), that gap is even more daunting for survivors and other homeless persons with barriers that limit their income and employability. Many providers commented on the increased difficulty in finding decent apartments for program participants in safe neighborhoods with adequate access to services, employment, etc. that survivors would be able to afford when program assistance ends.

to housing, but that make it harder to **appropriately** serve survivors,⁸¹ and that create conflicting pressures to focus on housing- and income-related outcomes, rather than the survivor-defined priorities that programs adhering to the voluntary services requirement should focus on; and (c) mainstream providers' inadequate understanding of the profound impacts of chronic exposure to domestic and sexual violence, and too-limited adoption of a trauma-informed approach.

In discussing the state of collaboration between survivor-focused transitional housing and the mainstream homeless housing/services system, it is helpful to ask what "better" collaboration might look like, in light of some of the concerns expressed by victim services providers, and what it would take to achieve that "better" collaboration. In other words, (a) how could the mainstream homeless housing/services system be a more useful and more available resource to DV/SA-focused TH programs and the survivors they serve? (b) how could DV/SA-focused TH programs be a more useful resource to mainstream homeless housing/service providers and the individuals and families they serve?

For the purposes of exploring possible answers to those questions, we consider the following elements of the "mainstream" system: (a) outreach programs; (b) shelters for individuals and families; (c) transitional housing; (d) rapid rehousing; (e) permanent supportive housing; and (f) non-residential supportive services programs (e.g., health care for the homeless programs, housing assistance programs, employment assistance programs, and behavioral health programs).

A quick review of these component elements suggests that **given present-day levels of funding and need, there is not that much additional potential for collaboration with OVW-funded TH programs.**

- **Mainstream outreach programs** typically target runaway and homeless youth, unsheltered or unstably sheltered persons with serious mental illness, and/or unsheltered or unstably sheltered homeless adults.⁸² These are not the kinds of programs that could assist survivors in transitional housing. (Outreach workers targeting services to runaway and homeless youth and young adults do, however, reach out to exploited youth and young adults, who might subsequently be assisted in transitional housing.)
- **Mainstream shelters for individuals** are generally funded by states, counties, or charitable organizations and operate under rules defined by the funder. Any HUD funding for staffing or operations is typically very limited. Most such shelters have bare-bones budgets, enabling them to provide only dinner, breakfast, and a safe place to wash and sleep overnight. Most are not staffed or open during the day, except during extreme weather. Some shelters assign beds on a night-by-night basis; others allow more extended stays, ranging from a week or two to several months. Only a small percentage of these shelters have (typically

⁸¹ **HUD-related challenges pertaining to TH and RRH programs include:** (a) pressure to reduce the duration of program assistance, even if that means that a survivor remains vulnerable as a result of financial inability to sustain her housing without relying on the assistance of a potentially abusive partner; (b) use of standardized performance metrics linked to participant outcomes that may not reflect participant priorities, and that hold programs to the same level of outcome regardless of participant barriers (e.g., severe depression or PTSD, ruined credit, lack of work history, etc.) and regardless of the challenges posed by the operating environment (e.g., acute shortage of affordable housing, highly competitive housing market, few if any local jobs for low skill workers, etc.), thereby unintentionally encouraging programs to "cherry pick" participants to facilitate "better" outcomes; (c) loss of HUD funding for the traditional TH model despite need for a mix of approaches, including programs utilizing provider-owned or provider leased housing to address needs for more extensive support, participant inability or lack of readiness to obtain a lease, safety issues, etc.; (d) an ESG RRH provision limiting assistance to one year if the program participant's income exceeds 30% of the Area Median Income (which still leaves her financially vulnerable); and (e) a CoC RRH requirement for one-year leases, which landlords are reluctant to offer to persons with poor tenancy credentials, particularly if rental assistance isn't guaranteed for the full lease period, and which therefore raises the threshold for program entry.

⁸² There are generally three types of street outreach: (a) HUD CoC- and ESG-funded generalized street outreach to unsheltered persons; (b) **outreach to runaway and homeless youth and young adults** ([HHS/ACF/FYSB, 2015](#)) funded by the Family and Youth Services Bureau; and (c) **PATH program** ([HHS/SAMHSA, n.d.](#)) outreach and mental health services targeting homeless (especially unsheltered) and unstably housed adults with serious mental illness.

private) funding for a case manager who can assist guests in accessing mainstream benefits, employment, housing, or community-based health and social services to meet their other needs. Staff in most such shelters are poorly paid, have little training, and are primarily focused on safety, sanitation, and feeding.

Although significant numbers of the homeless and chronically homeless women who use these shelters have histories that include domestic and sexual violence, including sexual assaults that occurred while they were homeless, such shelters would be a poor fallback alternative for a survivor⁸³ in a TH program who could not find permanent housing or some other acceptable destination within the allotted time.

- **Mainstream shelters for families** are typically funded by state, county, or large city government (often using federal TANF funds⁸⁴) or by charitable organizations. As with individual shelters, family shelters operate under rules set by the funder, typically including strict eligibility guidelines based on income and circumstances surrounding the need for shelter, and often limiting the duration of stays and sometimes also limiting the possibility of subsequent stays. Some family shelters are congregate, some are scattered-site programs, and sometimes "shelter" means a voucher-funded motel room. Congregate shelters are typically staffed 24/7 (on-call or onsite) to ensure basic safety and order. Some shelter programs are funded to provide daytime case management to help with accessing resources, employment, and housing. Many such shelters (especially if TANF funds are involved) mandate participation in housing search and/or employment or job search or community service activities.

Although many of the families who stay in such shelters have experienced domestic or family violence, these programs are not typically prepared to provide trauma-informed services; in most cases, the focus is on moving families into housing as quickly as possible, so as to reduce the financial burden on the state or jurisdiction. Depending on rules governing eligibility/access, and depending on the availability of funds to shelter additional families (New York City and Massachusetts are among the extremely small number of jurisdictions that guarantee shelter access for eligible families), mainstream family shelters might or might not be a fallback alternative for survivors in a TH program who could not find permanent housing or an acceptable alternate destination within the allotted time.⁸⁵

- **Mainstream TH programs** might be the best mainstream fallback alternative for survivors in DV/SA-focused

⁸³ Although these shelters don't target survivors of domestic or sexual violence and don't offer services intended to address their trauma, a significant percentage of the homeless and chronically homeless women they **do** serve are survivors of domestic and/or sexual violence, including sexual violence that occurred while they were homeless. (See, for example, [Goodman, Fels & Glenn \(2006\)](#), [Jasinski et al. \(2005\)](#), and [D'Ercole & Struening \(1990\)](#)).

⁸⁴ See the 2/20/2013 TANF guidance document, "[Use of TANF Funds to Serve Homeless Families and Families at Risk of Experiencing Homelessness](#)," promulgated by the Office of Family Assistance in the DHHS.

⁸⁵ There is no national data on the ability of mainstream family shelters to accommodate additional homeless families. According to the Opening Doors: Federal Strategic Plan to Prevent and End Homelessness ([USICH, 2015](#)), the 2014 annual point-in-time count identified 68,353 families, 88% of whom were in mainstream or DV-focused family shelters or transitional housing, and 12% of whom were unsheltered. Overall the number of people tracked in these annual counts of homeless families has declined by 11% since 2010, largely due to a 52% decline in the number of people counted in unsheltered families (i.e., living in cars, outdoors, etc.). Sheltered family homelessness has remained steady since 2010. The USICH report notes that 81% of the 1.26 million students counted by public school districts as being homeless during the 2012-13 school year were living in doubled up situations (75%) or motels (6%), and **would not have been counted** in the HUD annual point-in-time report -- and neither would their parents/caregivers, if they were in that same doubled-up or motel situation (unless their motel stay was government-funded in the absence of other shelter). If doubled-up families look like families in shelter or TH -- with 51% of children under age five -- then there are **even more doubled-up families** -- with children too young to be in school -- that would have been **missed by school district homeless counts**.

A good many of these tens (or hundreds) of thousands of homeless families would, presumably, have taken advantage of shelter if it were available to them, and the fact that they were instead doubled-up may be evidence of the lack of capacity of the local shelter system -- suggesting that **mainstream family shelter is not a realistic fallback** for families in DV/SA-focused TH who could not transition to permanent housing within the program timeframe.

TH programs who cannot successfully transition-in-place or relocate to permanent housing within the allotted time -- if there were available capacity. Although non-DV-focused HUD-funded TH programs are typically not staffed to address the trauma-related needs of a survivor, an individual or family exiting a DV/SA-focused TH program could conceivably receive follow-up services from the non-residence-based programs of the DV/SA agency whose TH program they had to leave. However, as discussed elsewhere, traditional HUD-funded TH (in congregate or clustered provider-owned or leased units) is a dwindling resource⁸⁶, and many such programs have changed over to a rapid rehousing model -- which, as indicated in the next paragraph, would not be able to enroll participants exiting a TH program.

- **Mainstream Rapid Rehousing (RRH)** is funded by both CoC and ESG grants that can pay for time-limited financial assistance and supportive services (up to 24 months, by regulation, but typically between 6 and 12 months, in practice) to jumpstart tenancies for homeless individuals or families in permanent housing. As noted earlier in this chapter, according to HUD's *Rapid Rehousing Brief* ([HUD, 2014c](#)), HUD-funded RRH is targeted for homeless individuals and families that can become independent and self-sufficient within a relatively short timeframe (i.e., six months) and with relatively limited supportive services ("just enough assistance to exit homelessness"), or that can be linked to community-based resources that can help the household sustain their housing while they build their capacity for eventual self-sufficiency and stability.

RRH projects are intended to serve individuals and families in shelter or unsheltered settings; according to HUD's *Coordinated Entry Policy Brief* ([HUD, 2015b](#)) "**people coming from transitional housing are not eligible for most rapid re-housing funded under the ESG and CoC Programs....**" (p.5)

- **Mainstream Permanent Supportive Housing (PSH)** is intended to provide long-term housing assistance and supportive services to homeless persons/families **with mental or physical disabling conditions that will indefinitely prevent them from managing independently in housing**. A substantial portion of HUD PSH is reserved or prioritized for [chronically homeless](#) individuals or families; by definition, a survivor in a TH

⁸⁶ Exhibit 7.3 on p. 59 of *Volume 1 of the 2014 Annual Homeless Assessment Report (AHAR)* ([HUD, 2014d](#)) notes the **loss of 37,981 TH beds (18% decrease)** for individuals and families between 2007 and 2014. According to *SNAPS In Focus: FY 2015 CoC Program Competition Recap* ([HUD, 2016](#)), as a result of funding decisions in the 2015 competition, **HUD funding for transitional housing further decreased by nearly 50% between 2014 and 2016:**

"Funding for transitional housing projects declined by \$155 million to \$171 million. As a result, CoC Program-funded transitional housing will serve approximately 15,000 fewer households than the previous year."

program is no longer chronically homeless.⁸⁷ Not all units of PSH are designated for chronically homeless persons or families -- some are available to other homeless persons with significant barriers to obtaining and maintaining housing -- but demand for such units is likely to far exceed availability, and there is considerable pressure⁸⁸ to convert those units to units designated for chronically homeless persons.

Pursuant to a July 2014 [HUD Notice](#) and a companion [FAQ reference document](#), candidates for HUD-funded PSH reserved or prioritized for chronically homeless persons must be prioritized for access based on a consistently applied scoring system that assesses need and urgency of placement. HUD recommends, but does not require, that candidates for other HUD-funded PSH (i.e., units of PSH not reserved or prioritized for chronically homeless persons) be similarly prioritized. Although Section (V)(F)(4)(a)(ii) of the [Notice of Funding Availability for the 2015 Continuum of Care Program Competition](#) indicates that "homeless individuals and families with a qualifying disability who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions and are living in transitional housing are eligible for permanent supportive housing [whether or not they] live[d] on the streets, emergency shelters, or safe havens prior to entry in the transitional housing," the reality is that except in extraordinary circumstances, ***PSH is targeted for individuals and families in shelter or unsheltered settings, but not as a housing placement for TH participants.***⁸⁹

- ***Mainstream Non-Residential Supportive Services*** are a disappearing resource, as Continuums of Care (and HUD funding cuts) trim away their so-called "Supportive Services Only" (SSO) or "stand-alone supportive services" projects. HUD rules allow any homeless person to access services offered by an SSO project, and at one time, CoC's might have operated case management programs, housing search/stabilization programs, education and employment programs, behavioral health programs, etc. that survivors in victim services provider-operated TH and RRH programs could have accessed. However, in response to urging from HUD (and some funding cuts which eliminated non-housing-focused programs), CoCs now almost exclusively use their HUD funding for housing and case management for the homeless persons in that housing, and try to leverage any additional services from other sources.

⁸⁷ As defined in *HUD's Defining "Chronically Homeless" Final Rule* ([HUD, 2015h](#)) "Chronically homeless means:

- (1) A "homeless individual with a disability" ... who: (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living as described in paragraph (1)(i) ... continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in [such] homelessness ... included at least 7 consecutive nights of not living as described in paragraph (1)(i); [provided that] stays in [residential treatment or incarceration] for fewer than 90 days will not [be treated] as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering [such] facility;
- (2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) ... before entering that facility; or
- (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless."

Because a transitional housing (TH) program is not any of the following -- a place not meant for human habitation, a safe haven, or an emergency shelter -- a participant currently in a TH program cannot be classified as chronically homeless, regardless of how long they lived on the street or in shelter prior to entering the TH program, which severely limits TH participants' access to permanent supportive housing.

⁸⁸ See [HUD \(2014b\)](#), "Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status"

⁸⁹ See, for example, language on p. 5 of *HUD's Coordinated Entry Policy Brief* ([HUD, 2015b](#)) cautioning providers "to consider the impact of placement in TH on an individual's chronic homeless status or future eligibility in other programs."

That is,

- Apart from the jointly operated TH / RRH programs that already focus on addressing the needs of survivors, the mainstream homeless system — outreach programs, shelters, TH, RRH, PSH, and Supportive Services programs — simply doesn't have the capacity, let alone the specialized programming, to adequately address the needs of survivors who require additional housing / services beyond what victim service provider-operated TH and RRH programs ("specialized TH / RRH programs") can provide, and probably can only address a very small portion of the unmet need (i.e., the survivors who couldn't get into specialized TH / RRH programs, for lack of capacity).
- If specialized TH / RRH programs had additional capacity, there are likely many homeless survivors of domestic and sexual violence currently in mainstream shelters, TH, RRH, and outreach programs who could benefit from referral to victim service providers that could offer specialized, trauma-informed housing and services.
- And if the staff of victim service providers and/or state coalitions had additional capacity, perhaps they could contract to provide staff training or direct services to address the needs of survivors and other trauma victims in mainstream programs, so those programs could build the capacity to better serve victims / survivors.

The latter two possibilities are discussed in the section on "Collaborations that Might Benefit Survivors in Mainstream Homeless Programs."

(iii) Impact on Collaboration Between OVW/HUD-Funded Programs of Coordinated Entry

Whereas access to specific TH, RRH, and PSH programs used to be the exclusive decision of staff from those programs, HUD regulations (§578.7(a)(8) of the [CoC Interim Rule](#) and §576.400(d) of the [ESG Interim Rule](#)) direct each Continuum of Care to establish a coordinated system for assessing and referring homeless individuals and families for HUD-funded (and other) housing, and directing each ESG-funded entity to participate in the geographically relevant CoC's Coordinated Entry system. Anticipating concerns about the risk to the confidentiality of survivors who are referred to the CoC's coordinated system, HUD's regulations exempt ESG-funded victim services providers from the requirement to use the coordinated system, and allow CoC-funded victim service providers to use CoC grant funds to establish a comparable coordinated entry system

with other area victim services providers.^{90,91}

At the same time, *HUD Brief on Coordinated Entry and Victim Service Providers* (HUD, 2015d) encourages "the full participation and integration of victim service providers into the CoC coordinated entry process."

"The form this integration takes will vary by community, but the overarching goal is for individuals and families presenting to the homeless and victim services system to have full and complete access to the housing and service resources available through both systems. Specifically, HUD encourages CoCs to work with victim service providers within the CoC's geographic area to **establish client-driven, trauma-informed and culturally-relevant assessment and screening tools, as well as referral policies and procedures, to ensure that the coordinated entry process addresses the physical and emotional safety, and privacy and confidentiality needs of participants**. This includes separate access points, if necessary and appropriate, and access to all available and appropriate housing options and related supportive services, regardless of whether the individual or family presents for intake at a victim services access point or at a more general access point."⁹²

The reality, however, as noted in the prior section, is that mainstream HUD-funded RRH and PSH programs target their assistance to unsheltered persons and persons staying in shelter, and not to survivors at the end of their stay in a TH program or in an unsustainable transition-in-place placement, so options for collaborating with DV/SA-focused TH programs are essentially limited to shelter and mainstream TH programs.

Although survivors are intended to have full access to CoC housing resources, practically speaking, HUD-funded permanent housing projects -- rapid rehousing and permanent supportive housing -- are largely unavailable to individuals or families running out of time in DV/SA-focused TH programs or in unsustainable transition-in-place

⁹⁰ § 578.7(a)(8) of the [CoC Interim Rule](#) states that the Continuum of Care must, "in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD Notice."

§578.23(c)(9) of the [CoC Interim Rule](#) states that, "[CoC grant] recipients will be required to sign a grant agreement in which the recipient agrees to use the centralized or coordinated assessment system established by the Continuum of Care as set forth in § 578.7(a)(8). A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system, provided that victim service providers in the area use a centralized or coordinated assessment system that meets HUD's minimum requirements and the victim service provider uses that system instead."

In turn, §576.400(d) of the [ESG Interim Rule](#) states that "Once the Continuum of Care has developed a centralized assessment system or a coordinated assessment system in accordance with requirements to be established by HUD, each ESG-funded program or project within the Continuum of Care's area must use that assessment system. The recipient and subrecipient must work with the Continuum of Care to ensure the screening, assessment and referral of program participants are consistent with the written standards required by paragraph (e) of this section. A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system."

⁹¹ See *HUD's Coordinated Entry Policy Brief* (HUD, 2015b) for more on HUD's ideas about how that system should work.

⁹² See Question #2 in FAQ in the *HUD's Brief on Coordinated Entry and Victim Service Providers* (HUD, 2015d). Whether the coordinated entry process meets those standards (i.e., trauma-informed, culturally relevant, etc.) will vary from CoC to CoC. And whether there is program capacity to serve survivors will likewise vary from CoC to CoC, and will depend on the CoC's mix of housing resources, the demand for that housing, and each survivor's priority for assistance, based on the CoC's criteria for defining severity of need.

tenancies, because such households will likely be deemed ineligible.⁹³ Survivors at the end of their time in OVW-funded TH programs will continue to be situationally eligible for mainstream TH and emergency shelter programs, subject to program-specific eligibility and prioritization criteria. However, since demand for units in those programs routinely exceeds the number of openings, participant selection will be highly competitive, and this will not likely engender significant additional collaboration between the systems, in the absence of expanded capacity.

That said, it is crucial to recognize the already-significant level of collaboration between victim services providers operating TH programs and the mainstream (HUD-funded) homelessness system. If the providers we interviewed are representative of the overall picture, almost half of all domestic and sexual violence providers operating TH and transition-in-place programs receive HUD funding and are part of their respective CoCs. A substantial portion of that funding and of OVW TH program funding pays to lease housing or provide rental assistance for survivors. If there were not a nationwide scarcity of affordable housing and an acute shortage of housing subsidies, those HUD and OVW grants might be able to serve many more survivors -- and the needs of at least some of those survivors might be able to be met in mainstream housing in conjunction with non-residential DV/SA services.

From a "big picture" perspective, lack of additional collaboration between DV/SA-focused TH programs and the mainstream (HUD-funded) homelessness system is not a reflection of poor coordination or poor intentions. Rather, that lack of additional collaboration is a manifestation of: (a) the nationwide scarcity of affordable housing and housing subsidies, which increases the cost/client while survivors are in TH/RRH programs; (b) the lack of adequate resources in both systems, as compared to the needs the systems are attempting to address; (c) HUD's necessary articulation of system priorities and regulatory resource use constraints (which unfortunately don't match the priorities of the OVW TH program), in an attempt to leverage the greatest impact with its limited resources; and (d) the resulting inadequate overall capacity of mainstream transition-in-place and TH programs to serve survivors who need more time and/or more support and/or multiple opportunities to participate in supported housing, until they are able to make successful transitions to stable living situations.

(iv) HUD's Vision for Collaboration Between OVW/HUD-Funded Programs of Coordinated Entry

Notwithstanding the inadequacy of resources to accommodate significant new utilization of HUD transitional or permanent housing programs by survivors currently being served in [DV shelters or] TH programs operated by victim services providers, ***HUD's FAQ on Coordinated Entry and Victim Service Providers*** ([HUD, 2015d](#)) describes a very positive vision for how the two systems can interact, and articulates important protections not just for the clients who use the coordinated entry system, but for any individual or family who is identified as a victim/survivor during their interaction with a CoC's Coordinated Entry system. It calls for

- Training of the staff implementing the coordinated assessment and entry system by knowledgeable persons with appropriate expertise in the complex nature of domestic violence, on privacy and confidentiality requirements, and on safety planning;
- A coordinated system that is trauma-informed and culturally relevant, and that includes confidential and/or virtual entry points, so that a survivor's safety is not jeopardized by her attempt to seek help; and
- Use of an assessment tool that doesn't re-traumatize the survivor with its questions.

⁹³ As noted before, someone in what HUD considers "transitional housing" -- whether that TH program targets survivors of domestic or sexual violence or is part of the mainstream system -- would be ineligible for rapid rehousing (RRH), and would be a low priority for permanent supportive housing (PSH). Someone in an unsustainable transition-in-place apartment -- whether they were placed in that unit by a victim service provider or a mainstream RRH program -- would have to lose their housing and return to shelter to establish eligibility for HUD-funded PSH and/or a new RRH placement. However, a local ESG-funded homelessness prevention program, if one existed, might be able to help pay down an arrearage and provide short-term rental assistance to help the survivor keep her unit. That is, these barriers to accessing HUD-funded RRH and PSH are not a manifestation of poor coordination between the DV/SA system and the mainstream homeless system; they are a manifestation of HUD priorities that equally affect survivors and non-survivors who don't have the wherewithal to "succeed" in transitional housing or transition-in-place programs.

An "FAQ" is a guidance document, not a "Notice" or a "Regulation," so these are HUD's intentions and not requirements. As this report nears completion, CoCs are still in various stages of implementing their coordinated systems, and, as noted elsewhere, some of the providers we interviewed described experiences with their CoC's coordinated entry system that fall short of the stated intentions:

- Referral protocols that jeopardized survivor confidentiality by entering their information into the HMIS;
- Inadequate attention to risks from future violence, resulting in lower prioritization and delayed referral;⁹⁴
- Referrals that came too late (so that the victim could no longer be reached);⁹⁵ and
- Referrals of survivors whose experience of domestic/sexual violence was long enough ago, that the nexus between that violence and their current homelessness could not be documented to a CoC's satisfaction.

Notwithstanding these limitations, the guidance in that FAQ -- see the answers to questions 4-6, reprinted from *HUD's FAQ on Coordinated Entry and Victim Service Providers* ([HUD, 2015d](#)) below -- serves as a standard for the kind of collaboration that HUD envisions and that victim services providers can point to as they work with their local CoC. However, as long as CoC housing programs don't have the capacity -- with current funding levels, current system priorities, and current regulatory constraints -- to serve survivors who have been unable to resolve their housing and income needs while in DV/SA-focused transitional housing or transition-in-place programs, even a trauma-informed coordinated assessment/coordinated entry process will, more often than not, result in a dead end for those survivors. On the other hand, a more trauma-aware coordinated entry system is likely to identify more individuals and families whose homelessness is linked to domestic and sexual violence, and is therefore likely to result in more referrals to under-resourced DV/SA-focused programs.⁹⁶

4. How do coordinated entry staff determine when domestic violence or trauma experiences are best addressed by a victim service provider rather than a general homeless assistance provider?

Individuals and families fleeing or healing from domestic violence⁹⁷ or trauma should have access to the full range of housing and service intervention options available in their community, including prevention, diversion, rapid re-housing, and other housing and mainstream services. However, special consideration must be given to their unique and often

⁹⁴ Coordinated assessment systems typically prioritize the risks and behaviors that make chronically homeless persons expensive to serve while they are still on the street or in shelter: that is, serious mental health and substance abuse-related issues, resulting in frequent visits to emergency rooms and detox facilities, and frequent encounters with law enforcement resulting in short-term incarcerations. A survivor who doesn't fit that profile would likely be assessed as a low priority for referral to HUD-funded rapid rehousing or permanent supportive housing, or even transitional housing.

⁹⁵ A coordinated entry system has to be able to respond promptly to a call for help from a domestic violence victim. Because abusive relationships are highly controlling and coercive, and because reprisals for leaving can be more violent than the abuse that a victim suffers when she remains in her home situation, the coordinated entry system must have the capacity to respond quickly to the request, and to capitalize on the survivor's perception that she has an opportunity to leave. Attempting to re-contact the victim later on may be impossible, or may put her at risk of retaliation.

⁹⁶ In the meantime, a number of HUD-funded providers interviewed for this project indicated their intention to participate in a separate coordinated entry system for victim services providers, as allowed by HUD, and as described previously in this document.

⁹⁷ The phrase "fleeing or healing from domestic violence or trauma" reflecting the change codified in Section 602 of the [2013 VAWA Reauthorization legislation](#), which struck the word "fleeing" from the statute, thereby clarifying that OVW TH grant-funded programs should make assistance available to survivors "who are homeless, or in need of transitional housing or other housing assistance, as a result of fleeing a situation of domestic violence, dating violence, sexual assault, or stalking," and should **not** limit such assistance to only persons actively "fleeing" that violence.

Although Section 602 of the [2013 VAWA Reauthorization Act](#) and this language in Q&A #4 indicate that assistance should not be limited to only persons "fleeing" violence, **HUD never amended its November 2011 Defining "Homeless" Final Rule (HUD, 2011a) which codified "fleeing" as part of the definition (and documentation requirements⁹⁷) of "Category 4" homelessness and eligibility for assistance as a survivor of domestic and sexual violence.**

complex physical and emotional safety needs. In particular, they might benefit from participation in housing programs that offer trauma-informed and culturally-relevant services.

All coordinated entry staff should be trained on the complex dynamics of domestic violence, privacy and confidentiality, and safety planning, including how to handle emergency situations at an access point(s), whether a physical or virtual location. CoCs should also partner with their local victim service provider agencies to ensure that trainings for relevant staff are provided by informed experts in the field of domestic violence, dating violence, sexual assault, stalking, and human trafficking. If a household is determined to be at risk of harm⁹⁸ when an assessment is being conducted, then the coordinated entry staff should refer the household to a victim service provider using referral criteria established for that community based on system design, program capacity, resource limitations, and placement and geography considerations.

The coordinated entry process should also have a procedure to safely refer the household to the identified victim service provider, preferably with a warm hand-off including a phone call, transportation, or other transition to the victim service provider. Communities should consult with their local victim service providers or state coalitions against domestic violence to develop models for building a quality assessment process, including screening questions around domestic and sexual violence. Finally, coordinated entry staff should have up-to-date information on domestic violence shelters and general homeless shelters and housing options that are best equipped to serve households experiencing domestic violence based on their location, program model, and linkages to other supportive services.

5. What safeguards must our CoC build into our coordinated entry process to protect victims of domestic violence?

Domestic violence is often very traumatic for households, including children exposed to domestic violence. It is imperative that coordinated entry processes be designed to prevent further trauma and to provide households with control over the process and referrals. Trauma-informed practices that are sensitive to the lived experience of all people presenting for services need to be incorporated into every aspect of the coordinated entry process. The assessment tool and process should not re-traumatize the individual or family, must inform the person up-front about how the information will be used, and must allow them the option to refuse to answer questions or choose not to disclose personal information.

The coordinated entry process must also include protocols to ensure the safety of all individuals and families seeking assistance, and these protocols must specifically address how individuals and families fleeing domestic violence will have safe and confidential access to the coordinated entry process along with safe and secure referrals to appropriate housing and services. Further, the process must include procedures for how referrals will be made to victim service providers that are not participating in the coordinated entry process. CoCs should work with victim service providers in their community to determine the most appropriate procedures to implement.

6. How can our CoC serve victims of domestic violence when our coordinated entry location is known to the entire community, potentially endangering those victim households?

CoCs will find the victim service providers and state domestic and sexual violence coalitions in their communities to be excellent resources in developing a coordinated entry process that has protocols in place to ensure the safety of the individuals seeking assistance. CoCs should engage with these organizations as well as other experienced stakeholders and providers to determine the best options for victims fleeing domestic violence. Protocols to protect the safety of households seeking assistance should be in place for every phase of the coordinated entry process, including addressing safety concerns associated with the coordinated entry access point(s).

Communities may choose to use the same coordinated entry access point or points for all populations or may choose to establish a separate access point or points for households fleeing domestic violence. Similarly, the domestic violence access point(s) can be one or more physical location or virtual, such as a 211 line. Each scenario requires different protocols to ensure safety. For instance, if using a common access point that has a physical location, assessment staff should treat all persons presenting for assistance with strict confidentiality and privacy, conducting their assessments out of sight and ear shot of other persons at the physical location. If using a separate access point for households fleeing domestic violence, that access point should be a virtual or phone-based access point to protect the household's physical

⁹⁸ While "risk of harm" should certainly be a basis for referral to the victim services provider system, there are many survivors who may not be at risk of further harm, but who may be in need of the kind of trauma-informed support that they could only receive from a specialized program.

safety.

Communities should strongly consider using a local domestic violence hotline as an access point, even if other access points are available, to ensure the safety of households fleeing domestic violence. In all cases, whether a common access point or a separate access point is used to assess victims of domestic violence, data must be collected in accordance with the confidentiality requirements established in the CoC and ESG Program interim rules (24 CFR 578.103(b) and 24 CFR 576.500(x)) and data collected by a victim service provider must be collected in accordance with VAWA, which prohibits victim service providers from entering client-level data into HMIS.

(v) Collaboration in a Voluntary Services Program Environment

The Violence Against Women Act (VAWA) defined a voluntary services requirement for OVW grant-funded TH programs. As noted earlier, the CoC Interim Rule **leaves it to each CoC-funded TH program** to decide whether or not to require client participation in services, and both the CoC Interim Rule and the ESG Interim Rule **exempt RRH programs operated by victim services providers** (or programs otherwise covered by the VAWA protections) from the usual requirement for monthly meetings with program participants.

Interestingly, that voluntary services approach -- which is not inherently dissimilar to the low threshold Housing First approach to permanent supportive housing (PSH) programs serving chronically homeless persons that SAMHSA established as an evidence-based practice⁹⁹ -- was also cited by HUD in the 2015 Notice of Funding Availability (NOFA) as a recommended practice for transitional and permanent housing programs seeking HUD Continuum of Care (CoC) start-up or renewal funding.

In fact, the **2015 Continuum of Care NOFA (HUD, 2015a) awarded extra points for embracing a voluntary services model**, indicating that a transitional housing project seeking funding, "can receive up to 10 points for how the project demonstrates that it is low-barrier, prioritizes rapid placement and stabilization in permanent housing **and does not have service participation requirements** or preconditions to entry (such as sobriety or a minimum income threshold)." (p. 10) The **2015 Continuum of Care NOFA (HUD, 2015a)** also awarded extra points (p. 45) to a CoC in which 75% of the permanent and transitional housing projects utilize a Housing First approach, which it defined as "an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and **does not have service participation requirements** or preconditions such as sobriety or a minimum income threshold. Projects using a Housing First approach often have supportive services; however, participation in these services is based on the needs and desires of the program participant." (p. 19)

On the one hand, this apparent embrace of "voluntary services" by the mainstream system (HUD) might be seen an endorsement of the philosophy of services underlying OVW's and VAWA's policies. On the other hand, the term "voluntary services" can mean very different things to different providers (and funders):

- To providers/funders that embrace quick turnaround rapid rehousing, it could mean making sure that participants know that assistance is available if they want or need it, but then taking a largely hands-off approach unless such assistance is requested.
- To providers who embrace a wrap-around trauma-informed approach, the voluntary services model requires a consistent, time-intensive effort at relationship- and trust-building between staff and survivors,

⁹⁹ The Housing First model, pioneered by Sam Tsemberis and Pathways to Housing (in New York City), evolved its voluntary services model in response to consumer "dissatisfaction and frustration with services that undermine consumers' autonomy," which helped lead to "the birth of consumer movements that called for an increase in choice and control over treatment and after-care options for mentally ill individuals." (p. 225 in [Greenwood et al. \(2005\)](#) citing [Chamberlin & Rogers \(1990\)](#)). Two decades of research, including research **confirming the Pathways to Housing model as a SAMHSA Evidence-Based Practice** [Padgett, Henwood, & Tsemberis \(2015\)](#) has established that perceived choice in treatment and housing -- consumer decision making -- is associated with greater housing stability and reduced psychiatric symptoms in persons with mental illness.

so that the relationship becomes "the foundation to assist survivors in reaching their goals." "Services are consistently made available to encourage participation and ensure [that] assistance is as relevant and accessible as possible. Staff are encouraged to make suggestions and express concerns or encouragement as appropriate, but to never require participation."¹⁰⁰

- To providers resistant to the underlying philosophy of the model, "voluntary services" may mean that participants are free to choose whether or not to access services, but those who choose not to access services are afforded only a reduced level and/or duration of housing assistance, while participation in services and efforts/progress towards goals are "rewarded" by "renewal" of housing assistance for additional periods of time and/or increased provider contributions to defray the cost of housing.

A victim services provider serving survivors in a HUD-funded TH or RRH program faces significant challenges to maintaining a "voluntary services" approach, while meeting HUD performance expectations and/or the expectations of the Continuum of Care or state/county/jurisdiction overseeing its HUD funding:

- (1) As noted previously, HUD is more prescriptive than OVW with respect to performance measurement: CoC project performance is measured in terms of rate of placement in (or retention of) permanent housing, and increase in participant income or employment -- which are fine goals, but not necessarily reflective of program participants' priorities. While some participants may wish to focus on developing employment and finding independent housing, other participants may, for example, prioritize healing from trauma, resolving legal issues, or undoing damage caused by their child's exposure to trauma.

When services are voluntary, participants determine whether and when to work on growing their income or taking the steps needed to secure appropriate housing. If one or more participants do not take those steps in time to gain housing before timing out of the program, the program's performance -- if it is measured in terms of placement rate -- will suffer, possibly jeopardizing continued funding.

Provider comments in this chapter and [Chapter 2](#) ("Survivor Access and Participant Selection") described the tightrope that program staff walk as they try to balance their focus on supporting survivor-defined goals versus their focus on meeting HUD performance objectives, and how that challenge is sometimes resolved by a participant selection process that prioritizes survivors who are "ready" and "motivated" to focus on the kind of housing and income/employment outcomes HUD targets -- which is not really how the voluntary services approach was meant to work.

- (2) Unlike OVW, which supports provider decisions to afford participants the time they need in transitional housing for healing and to work on their other goals, HUD and the CoCs, states, counties, and cities that administer HUD grants focus on efforts that will yield the biggest possible decreases in homelessness. Reducing homelessness is, of course, a praiseworthy goal. The more households served and housed the better. The faster homeless individuals and families can be placed in housing, the better. And shortening the duration of assistance -- whether via formal "written standards" adopted at the CoC level or by the state, county, or city administering ESG grant funds, or by informal pressure exerted on programs that report "excessive" lengths of stay -- is an effective way to ensure that programs serve more households.

While those approaches may yield dramatic bottom line reductions in homelessness, they leave out survivors (and other homeless persons) facing more significant barriers, who can't make or sustain that kind of quick-turnaround progress.

In a tight housing market and a difficult job market for persons with limited skills, shortening the program timeframe while trying to meet performance expectations, without sacrificing the voluntary services approach only works if participants are committed to the targeted goals, and have few enough barriers to be able to achieve those goals within the allotted time. Indeed, a number of providers told us that

¹⁰⁰ See the NNEDV's 2013 update of its publication, "[The Basics of the Voluntary Services Approach](#)"

they rely on the judgement of their agency's shelter staff in identifying survivors who have an adequate level of motivation and the follow-through to make meaningful progress. While cherry-picking participants who can help the program achieve its performance targets may be a successful strategy for earning renewal funding and helping the administering CoC or state/county/city achieve targeted reductions in homelessness, again, it is not the way the voluntary services model was meant to work.

(vi) Collaborations that Might Benefit Survivors in Mainstream Homeless Programs

Much of the preceding discussion has focused on the collaboration-related challenges faced by OVW-funded TH programs and the benefits to that program and its participants that might result from such collaborations (including HUD funding). Next, we explore how collaboration with an OVW-funded TH program could benefit mainstream homeless programs and the survivors they serve.

As noted earlier, although *mainstream shelters for individuals* are typically not staffed or resourced to serve survivors of domestic or sexual violence, and don't typically offer services to address the trauma and concomitants of their exposure to violence, significant numbers of the homeless and chronically homeless persons these mainstream shelters *do* serve have histories that include domestic and/or non-IPV-related sexual violence, including assaults that occurred while they were homeless.¹⁰¹

Likewise, although *mainstream family shelters and HUD-funded TH and RRH programs* are not set up or resourced to serve survivors, *significant percentages of homeless families in those programs have experienced domestic or sexual violence*, which may or may not have been the precipitating factor in the current instance of their homelessness.¹⁰² Although most family shelters, and all HUD-funded TH and RRH programs include some case management, staff are not typically trained to address the trauma and concomitants associated with the experience of domestic and/or sexual violence.

Most of the DV/SA-focused TH providers interviewed for this project do not solicit or receive referrals from mainstream shelters or TH programs. When asked where participants for their transitional programs came from, the overwhelming majority of those providers cited referrals from DV shelters (often from shelters operated by the same agency that receives the OVW grant to operate the TH program), and referrals from DV-focused outreach programs (also often operated by the same agency) or DV hotlines.

Our interview with [Victim Rights Law Center](#) staff raised a question about the extent to which survivors of non-IPV sexual assault are served by OVW-funded TH programs. Although, according to the *National Intimate Partner and Sexual Violence Survey*,¹⁰³ rape and other sexual violence by a non-intimate partner is at least as

¹⁰¹ See, for example, [Goodman, Fels, & Glenn \(2006\)](#), [Jasinski et al. \(2005\)](#), and [D'Ercole & Struening \(1990\)](#).

¹⁰² For example, [Gubits et al. \(2015\)](#) indicates that 49% of adult respondents in the *HUD-funded Family Options Study* reported adult experience of intimate partner violence (IPV), although that violence may or may not have precipitated the episode of shelter homelessness analyzed in the study. In fact, the authors suggest that the 49% statistic *understates* the importance of IPV as a contributing factor to family homelessness among study participants because shelters that targeted DV survivors were excluded from the study for confidentiality reasons, and because some shelters included in the study did not accept families fleeing DV, due to concerns about their inability to ensure those families' safety.

Although only 17% of the family TH programs in [Burt's \(2010\)](#) landmark study *targeted* survivors of domestic violence (p. 39), 36% of all homeless mothers in the study cited domestic violence as leading to the family's most recent episode of homelessness. (Table 3.8 on p. 32). Many of these mothers would have been in mainstream TH programs

The seminal study of homeless mothers and mothers receiving public assistance in Worcester, Mass. by [Bassuk et al. \(1996\)](#) found that 63% of the homeless mothers and 58% of the mothers on public assistance had been severely physically assaulted by an intimate partner as an adult, and that 25% (homeless) and 20% (public assistance) of the mothers had been sexually assaulted as an adult by a non-intimate partner. (Over 60% of both study populations had experienced severe physical violence by a household member as a child, and over 42% had been sexually molested.)

¹⁰³ See prevalence statistics on rape and sexual violence in [Breiding et al. \(2014\)](#)

prevalent as rape and other sexual violence by an intimate partner, the four VAWAMEI semi-annual reports for the period 7/1/2012 - 6/30/2014 indicate that upwards of 85% of survivors served by OVW-funded TH programs had experienced domestic violence, whereas less than 10% were victimized by someone other than an intimate partner or dating partner.¹⁰⁴

One reason for the preponderance of DV survivors in OVW-funded TH programs -- which are **statutorily authorized** ([by 42 U.S. Code §13975](#)) to serve survivors of both sexual assault and domestic violence¹⁰⁵ -- is that the DV shelters from which TH enrollees are often selected are typically funded with FVPSA grants,¹⁰⁶ and FVPSA funds must be used to serve survivors of domestic or dating or family violence, and **not** survivors of sexual assault by an acquaintance or stranger.¹⁰⁷ One OVW-funded TH provider that also operates a mainstream shelter reported that her shelter serves homeless and chronically homeless survivors of sexual assault who could not be served by DV shelters, or who felt that DV shelters "weren't for them." As observed by [Goodman, Fels, & Glenn \(2011\)](#), sexual assault is an all-too-common corollary of homelessness among women in mainstream shelter.¹⁰⁸

On the one hand, OVW-funded TH/RRH programs could expand their recruitment/selection processes to more actively target survivors of sexual assault in mainstream shelters (or living in unsheltered situations); or to target the homeless families in mainstream shelters whose experience of domestic and sexual violence contributed to their becoming homeless, even if it wasn't the immediate precipitant; or to target survivors who "time out" of mainstream TH programs or who are unable to sustain their mainstream RRH placement, in part because of the barriers and concomitants of the trauma they have suffered through.

On the other hand, in the same way that, without new capacity (i.e., additional resources for housing and services), mainstream TH and RRH programs would have to forego serving some of the homeless individuals and families they now serve, in order to enroll survivors referred by victim services providers, so, without new capacity, OVW/HUD-funded TH and transition-in-place programs would have to forego serving some of the

¹⁰⁴ The percentages listed in the semi-annual reports are based on the total number of known relationships between the survivor and the abuser, and so, add up to 100%. In a number of cases, survivors were victims of abuse by multiple perpetrators, and so more than one relationship is defined. If we instead use as the denominator the total number of persons served, we would count 85-88% of households in the program as experiencing IPV over the two-year period.

¹⁰⁵ None of the interviewed providers discussed instances in which they served a survivor of stalking where the stalker was a person other than the perpetrator of the domestic or sexual violence that the survivor had fled. None of the interviewed providers mentioned serving survivors of dating violence in their transitional housing programs, although many of the programs were part of agencies who do outreach into the schools in their region to address teen dating violence. Interestingly, the VAWAMEI statistics for the period July 1, 2012 - June 30, 2014 show that between 7.1% and 8.7% (see prior footnote about denominator) of transitionally housed survivors were victims of dating violence. Perhaps, because of the sometimes blurred distinction between dating and an intimate relationship, providers didn't feel the need to distinguish one from the other during the interview. In retrospect, we probably should have asked for clarification.

¹⁰⁶ According to footnote #92 in a February 2014 Congressional Research Service report, **Family Violence Prevention and Services Act (FVPSA): Background and Funding** ([Fernandes-Alcantara, 2014](#)), FVPSA grants for states, territories, and tribes funded 1,564 domestic violence shelters in FY2012. According to ([HHS/ACF/FYSB, 2009-10](#)) the Family and Youth Services Bureau's [2009-2010 Report to Congress](#) on the FVPSA program (p.8), FVPSA grants to states, territories, and tribes help fund 1,600 DV shelters. Both documents retrieved 1/16/2016.

¹⁰⁷ "Family violence and domestic violence are used interchangeably within the FVPSA program announcements. It is important to know that the emphasis of the FVPSA program is on family violence, domestic violence, and dating violence as they occur in the context of intimate partner relationships." **2012 FVPSA Guide for Administrators** ([HHS/ACYF, 2012](#)) Footnote on p.1

¹⁰⁸ Drawing from an exhaustive review of the literature and direct provider experience, [Goodman, Fels, & Glenn \(2006\)](#) assert that homeless women, and especially chronically homeless women, who access mainstream shelters or sleep in the rough are "particularly vulnerable to multiple forms of interpersonal victimization, including sexual and physical assault at the hands of strangers, acquaintances, pimps, sex traffickers, and intimate partners on the street, in shelters, or in precarious housing situations..."

survivors they now serve -- including victims referred from their agency's own shelter -- in order to enroll survivors referred by mainstream providers or by their CoC's coordinated entry system.

Effective recruitment of survivors currently served by mainstream outreach, shelter, and TH providers would also require an improvement in the mainstream system's ability to identify and address the needs of domestic and sexual violence survivors. However, as long as survivors in such programs believe that "the system" is unprepared to address their specific needs, there is little incentive to self-identify as victims of violence, and thereby risk labeling and stigmatization, without improved access to the specialized help they might need.

Providing non-residential victim services to survivors in mainstream programs would be another possible form of collaboration. Although the TH program staff employed by full service victim services providers wouldn't have the time to provide direct services to survivors in mainstream shelter and TH programs, their colleagues in the non-residential division of their agency might be able to offer trauma recovery, counseling, and support group services to survivors of domestic or sexual violence who happen to be in mainstream shelters, transitional housing, or rapid rehousing programs. Assessing whether existing funding for such non-residential services is adequate to support such a collaborative effort is outside the scope of this project.

Providing training to mainstream providers is another way of collaborating. Given that mainstream providers serve a significant numbers of individuals and families who have survived domestic and sexual violence, one type of collaboration between the mainstream and victim services systems could involve training mainstream provider staff about trauma, the profound impacts of chronic exposure to domestic/sexual violence, what it means to take a trauma-informed approach, and why it matters.

To the extent that trauma (from any source¹⁰⁹) and its concomitants may account for the inability of some participants in mainstream programs to achieve hoped-for levels of progress in overcoming their obstacles to housing, trainings that help providers recognize and more appropriately respond to signs of trauma could have a beneficial impact on overall efforts to address homelessness, as well as more specific efforts to address domestic/sexual violence-related homelessness.

We encountered one example of an (unfunded) collaboration in which a victim services provider was offering training to help mainstream homeless provider staff better understand domestic and sexual violence, its ramifications, and strategies for asking about and responding to information from clients about such victimization. (Perhaps, if we had interviewed staff from the non-residential services component of full-service DV/SA agencies, instead of TH program staff, we would have heard about more such examples.) A collaboration involving training by OVW- or FVPSA-funded providers or state or national coalition staff could help fill such a need -- but that is a topic for separate investigation, as is exploration of how a trauma-informed approach might be regulatorily integrated into the frameworks for addressing homelessness that govern the provision of mainstream outreach, shelter, TH, and RRH programs.

In the meantime, the vision outlined (see subsection (c)(iv)) in HUD's aforementioned ***Brief on Coordinated Entry and Victim Service Providers*** ([HUD, 2015d](#)) provides a great start on such a blueprint for change.

¹⁰⁹ Trauma could be a result of physical or sexual or emotional abuse during childhood or adulthood, abusive treatment in school, exposure to street violence, exposure to trauma in the military (or as a result of sexual assault in the military), intimate partner violence, incarceration and the exposure to violence perpetrated by inmates or corrections staff, traumatic experiences with residential mental health care, victimization in wartime, etc. Some of the concomitants of trauma -- depression, PTSD, dependence on alcohol or drugs to numb the pain, poor coping skills, poor information processing abilities, diminished impulse control, etc. -- can contribute to additional traumatizing experiences: being expelled from a shelter for disruptive behavior, being discharged from a TH program for lack of compliance with program requirements, being jailed for drug use or drunk and disorderly behavior, etc.

(d) Benefits of Participation in a Domestic/Sexual Violence State Coalition or CoC

(i) Overview

All CoC- and ESG-funded programs must participate as members of their geographically relevant Continuum(s) of Care. And just about every OVW- or FVPSA-funded agency is a member of a statewide or tribal domestic violence and/or sexual violence coalition.

CoCs range from the very small -- with few or no paid staff, and with only a handful of HUD-funded programs -- to the very large -- with multiple staff, and grants totaling in the tens of millions of dollars. Some CoCs have the capacity to develop and implement sophisticated systems for coordinating intake and access to services, for assessing client needs, for tracking services and analyzing changing client characteristics and outcomes, for implementing standardized grants management protocols, and for organizing regional trainings and conferences. Other CoCs have all they can do to meet the basic requirements that HUD has established.

Similarly, some domestic violence and sexual assault coalitions have the resources to offer extensive trainings, organize conferences, create and implement innovative grant-funded initiatives, develop model program materials (e.g., templates for agency policies and procedures, multilingual resources for participants, assessment tools, survivor satisfaction surveys, etc.), offer guidance on emerging or neglected issues, maintain sophisticated resource-rich websites, and provide comprehensive technical assistance -- while others provide a much more limited array of services for their member providers. Some coalitions have a more hands-on role, coordinating and administering regional or statewide transitional housing grant programs, particularly in rural states, allocating and overseeing the use of OVW funds by local providers that serve small numbers of clients, but don't have the infrastructure to manage an entire grant. Other coalitions contribute cutting edge thinking about addressing domestic and sexual violence and/or are leading advocates for funding, legislation, and policy changes.

This huge variation in the capacity and focus and temperament of different Continuums and DV/SA Coalitions is reflected in the diversity of comments by the providers we interviewed.

As described in some of those comments, participating in a domestic violence and/or sexual assault provider coalition affords member programs access to coalition resources, including trainings, information-sharing, technical assistance, and the opportunity to come together to discuss issues of mutual interest or concern. DV/SA coalitions are able to leverage foundation, corporate, and government funding which they, in turn, make available to member organizations. One provider's comment describes their coalition's ability to leverage AmeriCorps staff for its member programs. Coalitions also mobilize member agencies to advocate for legislation or policy changes which will better protect the interests of victims/survivors. DV/SA coalitions have the staff to keep abreast of new research, resources, and approaches by sister organizations across the country, and disseminate those findings and resources to member agencies.

Participation in a Continuum of Care affords providers a different mix of benefits. Not infrequently, a CoC's membership includes only one or two providers focused on the needs of domestic violence and sexual assault victims/survivors, so those providers' participation is critical to ensuring that the interests of survivors are represented, and that the constraints on data sharing and the VAWA restrictions on requiring participation in services are followed. To the extent that CoCs engage employment and housing and health and social service agencies from the community, they create opportunities for member providers, including victim service providers, to develop referral or service relationships that can benefit program participants. To the extent that CoCs engage members of the business community, faith providers, representatives from local universities and colleges, and other interested members of the lay community, they create opportunities for member providers to cultivate relationships that may result in funding and in-kind donations of valuable services, as well as general goodwill.

Participation in a CoC allows victim service providers to get current information about resources -- openings in housing programs; sources of donated furniture and household furnishings; sources of affordable mental

health or addictions services; sources of assistance for survivors from ethnic, cultural, or linguistic minorities -- that might benefit their participants. Providers who have good (or bad) experiences with local landlords can share their knowledge, and make informed recommendations about, and introductions to, landlords that a DV provider might want to approach or refer a participant to.

To the extent that CoCs facilitate community dialogues about the causes and solutions to homelessness, they create opportunities for victim services providers to raise awareness about the prevalence of domestic and sexual violence, and how it is not just a problem affecting the clients of a handful of specialized providers, and that there are survivors in many of the Continuum's programs, on the staffs of some of those programs, and perhaps even sitting around the CoC table. Victim services providers can offer trainings and encouragement for staff from mainstream programs that can strengthen the CoC's overall ability to offer trauma-informed services to homeless families and individuals whose experiences of domestic or sexual violence may continue to impair their forward progress.

The ability of victim services providers to advocate for the interests of survivors is critically important as the CoC develops and periodically reviews and revises its HUD-required "written standards" (defining eligibility constraints and the amount, duration, and scope of assistance),¹¹⁰ and as it develops and refines its systems for coordinated assessment and referral for HUD-, VA-, SAMHSA-, and possibly OVW-funded housing assistance and services.¹¹¹

Although, as a few comments suggested, some victim services providers may experience participation in the CoC as a "challenge," their ability to advocate for the interests of survivors and the providers that serve them is truly a "benefit." Other provider comments hint at that role, and describe some of the successes that victim services providers have experienced as a result of their participation.

Being part of a CoC puts a provider agency in a better position to collaborate with other CoC members in joint projects. For example, provider comments describe a collaborative application for HUD funding for housing units dedicated to DV survivors, and a non-HUD-funded project to create a transportation resource that made a local housing authority more accessible to participants from diverse programs.

CoCs are required by HUD to conduct an annual point-in-time count of homeless persons in the geography covered by their CoC. The source of much of that point-in-time data is typically the HMIS -- the Homeless Management Information System in which data about homeless persons being served by CoC providers is entered. Because victim services providers do not enter client data into the HMIS, it is important for them to contribute aggregate data about the survivors they are serving in shelter, transitional housing, and outreach programs. Because many survivors in mainstream programs do not disclose their history of violence, the information from victim services providers may be the only data about the extent to which survivors are part of the CoC's clientele. As one provider's comment illustrates, that kind of information -- which at least begins to document the extent to which domestic and sexual violence are linked to homelessness in the CoC -- can be an important source of leverage in arguing for a more adequate share of resources for homeless survivors.

(ii) Provider Comments about the Benefits of Participation in a DV/SA Coalition or Continuum of Care

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

(#01) Our agency is a member of the statewide DV coalition, and also part of the county Continuum of Care.

¹¹⁰ See the discussion about CoC and ESG grant funding in the Sources of Funding portion of this chapter.

¹¹¹ See the discussions about Coordinated Assessment/Coordinated Entry in earlier portions of this narrative. See also the ***National Alliance to End Homelessness Coordinated Assessment Toolkit*** ([NAEH, 2013](#)) for a collection of materials describing expectations and approaches pertaining to Coordinated Assessment/Coordinated Entry.

(#02) We're members of the state coalition against domestic violence, serving a fairly large county. We get together with other providers in the state quarterly and discuss lots of different things. We're also members of state coalition to end homelessness. And we're part of the Balance of State Continuum of Care; we are the only homeless provider in our area that focuses on domestic violence. If someone doesn't qualify for our program or if we don't have additional funding available to provide rental assistance, we refer to another TH provider in our Continuum. They're homeless-focused, not DV-focused, but we can provide the DV support even if we are not providing the rental assistance.

(#03) We are members of the statewide coalition, the County's Domestic Violence Council, and the City's DV task force. We are also part of a national Asian Pacific Islander organization, the API DV Institute, and part of a county network of organizations that work with Asian DV survivors, including non-shelter-based providers, like legal services providers and some government agencies.

(#04) We are members of the statewide coalition of DV and sexual assault service providers; we also sit on a number of local coalitions. We also participate with the local homeless services provider network and Continuum of Care, because a number of our programs are funded by HUD CoC and ESG grants.

(#05) We are part of a local network with the tribal government that extends to four counties; we only focus on one county. We work closely with the DV shelter through a community partner addressing family violence, and with a tribal housing department, funded through HUD's Native American Self-Determination Housing Assistance Program.

(#06) We are not a part of any regional network of DV providers, but we do collaborate with other DV providers, like the local Children's Hospital and with the shelter system in the city.

(#07) We're part of a collaborative of 60 organizations working to end all sorts of violence in our community. I'm part of the board that oversees the Continuum of Care, and I chair our rapid rehousing work group. We have services in several counties, including one totally rural county about an hour and 45 minutes away from the city. It's a different world out there, very different.

(#08) We're part of our statewide coalition; they're a technical assistance liaison, not an overseer of our program. And we are part of our local CoC.

(#09) We are part of a regional network that includes the county where we're located; we're also part of a statewide DV coalition and a Continuum of Care.

(#010) We're part of the statewide DV coalition and a CoC.

(#011) We cover a seven county area; it's very rural so there are not a lot of providers so we all work closely together. We meet almost every month as part of a housing and homeless alliance. We update each other on program and policy updates, openings, and provide support for difficult situations.

For the past two years, I've had a seat on a transportation advisory group through the local DOT; it helps me understand what's happening in the world of transportation, and how we can address the needs. Through our

work on the committee and with a local housing provider, we were able to create an affordable transit route -- \$3 per ride, with pick-ups in different towns -- that enabled residents to drop off their applications for housing vouchers on the one day a week when applications are accepted. The local Section 8 housing provider was able to tap into some funding to help make it affordable so people could come in to drop off applications.

Our program itself is not part of a continuum of care because we don't receive any ESG funding.¹¹² The other providers we work closely with do, and we're regularly updated on what's happening with the state.

Our TH program only receives OVW funding. OVW is probably the best organization to receive funding from because they have such a great mindset about the rules and expectations you can have for clients.

(#12) We are not part of a local or regional network of DV-focused providers; however, our agency is a service provider in a Shelter Plus Care permanent supported housing program in the Balance of State Continuum of Care.¹¹³ Our emergency shelter is part of that CoC as well.

(#13) We're part of a statewide coalition. We work semi-regularly with other programs in bigger areas that also have TH or emergency shelter programs (within driving distance) which we make referrals to if we're full. It's a small county, everyone knows everyone else; so if someone needs to disappear we need to refer them out of county. Our agency's DV and sexual assault-related programs gets the OVW TH grant and an OVW rural grant. State grants we get include the VOCA (Victims of Crime Act) funding, as well as FVPSA funding. I also request matching support from various private foundations for the ESG grant and for direct service funds.

(#14) We're part of a state coalition and a CoC. In the CoC, we work with other agencies that provide HUD-funded transitional or permanent housing. We asked what landlords they work with or recommend so we can find new landlords to work with. Our transitional housing is only funded by OVW; we receive no HUD funds.

(#15) We are part of a statewide coalition against domestic violence and a member of a rural Continuum.

(#16) We are participants in the statewide DV coalition and part of a CoC.

(#17) We're a member of the state DV Coalition. I'm president of the board of directors of that coalition this year. Our new executive director has really done a phenomenal job strengthening our coalition.

We receive ESG funding for a rapid rehousing program which is separate from our transitional program. So we're part of the local continuum of care.

(#18) We are linked to other domestic violence providers through our affiliation with the state domestic violence and sexual assault coalition. We are the domestic violence representative on the Continuum of Care steering committee. We're seen as the lead agency when it comes to domestic violence services, so we make a point of being on all the committees, so that the voice of survivors is always heard, for example in planning for

¹¹² A program can be part of the Continuum of Care whether or not it receives HUD funding. Any program helping to address homelessness **can** be part of the CoC. Any program receiving HUD ESG or CoC funding **must** be part of the CoC.

¹¹³ "Shelter Plus Care" is the old name for a HUD-funded permanent supportive housing program which was subsumed under the Continuum of Care grant program. A "Balance of State" Continuum of Care is the CoC that covers all of a state's geography that is not specifically covered in city-, or county- or multi-jurisdictional Continuums of Care that are defined by these smaller geographies within that state.

centralized intake and community coordination. We're present in almost every aspect of what the CoC does, because we don't want the voice of domestic violence survivors to get lost in the shuffle. And because we want to make sure that CoC policies and procedures account for the provisions of the VAWA legislation. No one else is there reminding people about HMIS-related issues. Staying trauma informed and protecting confidentiality – most of the housing providers lose sight of those things, and we have to keep reminding and retraining people about how to handle DV cases. Part of our issue is, yes we are the DV provider, but we're not the only ones serving homeless DV survivors, and we want to make sure that the other systems dealing with survivors are equally sensitive.

I think by being present what we have been able to do is form collaborations with other CoC members to do joint projects. We were just awarded an ESG rapid rehousing grant which we requested in a collaborative application with one of our Continuum partners. Now there will be rapid rehousing available exclusively for DV survivors. It's only by our presence in the CoC and community that we get those opportunities.

Another such example was our partnership with one of the largest CoC housing providers to make one of their new permanent housing projects exclusively available to DV survivors. We didn't develop it, but we are the sole source of referrals – and that partnership was a result of our very active participation in the CoC.

Another place that we insert ourselves is when our community does its point in time count of homeless persons. Our numbers are not captured in the HMIS system. We make sure that every homeless survivor in our DV shelter and another DV shelter in town and our transitional housing program is counted. So that the Continuum has a more accurate understanding of the number of survivors that are homeless, and the percentage of homeless persons who are actually DV survivors. That makes our arguments much stronger and our partnerships much stronger when we can point to community statistics that show that 25% of the homeless folks we're serving are survivors, so 25% of the funding should be going in that direction. If we couldn't make that case, we would be left out of the discussion.

The people in our system are not only people who have suffered domestic violence, but if they're in our system, they're victims of recent domestic violence that have to hide. If they're homeless and their DV is less recent, they're probably not coming to our shelter, because the DV isn't a current threat. We only take people who are in danger. When 25% of the homeless folks in our community are served by DV shelters and DV-focused transitional housing, just imagine how many more victims/survivors are out there, but aren't served by us. It's making those arguments to the whole CoC that helps keeps the issue relevant.

(#19) We are part of a statewide DV network and a Continuum of Care.

(#20) The OVW grant is our principle source of funding for the transitional housing program. We are part of local, regional, and statewide networks of DV-focused providers and part of a Continuum of Care. The statewide DV network provides trainings for our staff. We are also a member of a Continuum of Care.

(#21) We're part of the statewide domestic and sexual violence coalition, but each program is free-standing. The county program has been a huge partner, and a proposed new partnership with the statewide coalition would allow us to extend our services into another county, if their pending grant is funded. We're not part of the Continuum of Care, but do get emails about them. Their housing resources here are limited.

(#22) We are active members of our statewide coalition against domestic violence, and receive funding through our Continuum of Care for the transitional housing we provide in the units we own. A statewide coalition for the homeless leads workshops for our participants about their rights and tenant issues; it prepares them to find a landlord they can work with.

(#23) We are part of different networks. The agency is networked with the state DV coalition and also participates in the Continuum of Care. Each person in the agency in different programs specializes in whatever networks they work with. So my responsibilities, for example, are to be in the CoC network of housing services here in the county, to go to meetings of the network for parenting services, and the network of social services. Then as an agency, we meet two times a month, a direct services briefing meeting, where we exchange information, we train each other, and catch each other up on what we've learned.

(#24) We're part of the statewide DV coalition. Our national organization has affiliates in a number of cities and states that also sponsor housing and services for survivors of domestic violence, and our director participates in meetings with her counterparts at the national level and state level. We also participate in the coalition to end homelessness and attend monthly meetings of the Continuum of Care.

I'm involved with the CoC's centralized intake system and I go to those meetings to represent the interests of domestic violence survivors and the laws regarding domestic violence, VAWA requirements, landlord/tenant law, and fair housing law. In our county, DV survivors do not have to go through the CoC's centralized intake – they can directly call the domestic violence shelters. However, if they want access to other non DV-specific housing programs funded through the Continuum, they do have to go thru that coordinated access point and participate in an assessment. Right now, there are vouchers available, so things are good. But we're bumping up against the local CoC looking at prioritizing the use of transitional housing for serving unaccompanied minors, and prioritizing all other CoC housing assistance for rapid rehousing or permanent supportive housing.

(#25) We're part of a domestic violence coalition and a Continuum of Care. One small [United Way] grant enables us to help pay for moving companies to help the women move into or out of their apartments. A lot of our families utilize a Furniture Bank, which is almost an hour away from us, so having that moving service has really helped. The second United Way grant builds on our partnership with a local medical care clinic, and a collaboration we have with a couple of counselors. Under our partnership with the clinic, we use our United Way grant to pay a reduced rate for primary medical care for our families. Under our collaboration with the counselors, we use United Way funding to pay on the family's behalf for the women to go to counseling.

(#26) We are a Domestic Violence/Sexual Assault Coalition. We receive transitional housing grant funding from OVW and administer our program by providing funds to the member programs in our state that request funds to support survivors in their local communities. Our Coalition has no regulatory authority over our program. Most of the work that we've done is around training and TA with programs. We're not on any local continuum of care committee but I sit on the governor's task force and so continuum of care work and practices of local CoCs is discussed. Neither I nor any of the other coalition staff are on any local CoCs. However, many of our local programs are part of their CoC – if there is a CoC in their community. We have an AmeriCorps program which is fairly unique, I think, for coalitions. AmeriCorps is like a domestic Peace Corps program where our coalition does the administrative work and then a grant provides 15 AmeriCorps service members, who work at the local programs across the state.

Coalitions generally do policy work, training and TA, and we're definitely in line with that. We spend a lot of time around program readiness. We use the readiness model from the [Tri-Ethnic Center](#) to guide that work: you have to understand people's readiness and meet people where they're at; if you don't, your messaging and trainings are just not effective. So we make sure we understand our programs' readiness and capacity. And we try to use that information to make best use of their resources. They're able to provide transitional housing and support services to survivors in their communities but program staff aren't having to spend a day a week doing the administrative work that goes with the grants. That's important, given that these mostly 1- and 2-person programs don't realistically have the capacity for that additional administrative work.

(#27) In addition to our OVW transitional housing grant, we receive, HUD ESG grant funding for housing assistance and rapid rehousing. We do a lot of fundraising. Anything that's in our budget that's not covered by a grant is covered through fundraising. We have a development department here that does several events and looks for donors. We're part of the national and state domestic violence and sexual assault coalitions. We're also part of our local continuum of care. Being part of the CoC has been very helpful; if we have a need, we're able to learn from what the different agencies in the community are doing. And if our shelter is full, we can reach out to another domestic violence shelter that we have a relationship with to get a person in. They'll do the same with us. Or if we have a client who needs one month's rent assistance or help paying for utilities or help paying down an arrearage or a utility deposit, networking in the Continuum allows us to connect with the program that can help. And the CoC has provided training on how to track our outcomes, how to capture our data, and how to do our reporting. And just ways to better serve our participants and find new resources.

In addition, at our continuum meetings, they'll let us know about different housing grants that we can apply for. For example, we applied for the ESG Rapid Rehousing grant that allowed us to house more participants.

(#28) The OVW grant and a HUD grant through our Continuum of Care are our principal sources of funding for the transitional housing program. Being part of Continuum of Care allows us to provide input into their decision-making, and advocate for what we need and what our clients need. We're the only one at the table speaking on behalf of the domestic violence issue. By being there, we're just making sure that we maintain the transitional beds, and the funding we need to provide services for our DV clients. Our biggest challenge is decreasing funds. The funding that the Continuum gets from HUD decreases every year. They have to figure out what to cut, so we're there advocating to keep DV as a priority population. With that advocacy is a measure of education around DV services and client needs that are unique in DV.

I think that because we don't contribute to the HMIS database in the same way that the other providers do, there's sometimes a sense that the DV agencies are not helping, that we think we're special, or that we're not part of the overall homeless system's team. We have confidentiality expectations that are very different. We know a lot of our other homeless services partners are looking to involve fathers and men more significantly in shelter life, and we know we can't do that in the same way. We know that domestic violence plays a role in a lot of people's homelessness and is part of their trauma history, whether or not they enter the Continuum through the DV system or through a mainstream shelter. We try to share that perspective not because we think, "We're smarter than you. We know all this is going on." And not to make it more difficult for them to do their important work of collecting data. But it sometimes is a challenge to just get our unique circumstances understood, and to find a good way to still collaborate. We just have to continue to be at the table.

(#29) The primary funder outside of OVW is the state; we also have some smaller funders, including the United Way, the Petit Family Foundation, as well as a couple of smaller grants that also support the program.

We are a member program of the state DV coalition; they're like our parent agency that oversees our program standards. They offer a dynamite collection of trainings, which we send our staff to, on such topics as lethality assessment, nuts and bolts of advocacy, working with immigrant populations, etc.

(#30) Other than our OVW grant, the primary sources of funding are local donations. Our community does a wonderful job of supporting us, both with financial contributions and in-kind donations.

We are part of a state coalition of domestic violence service providers, but there isn't an active Continuum of Care in this area. There is a local homeless coordinating board that we participate in. Networking with similar service providers is very important to us. As the Director, I go to state meetings a lot and interact with other

Directors and steal great ideas from them. However, we don't seem to have the time or the resources to offer that same kind of networking opportunity to our most important staff – the people actually doing the work.

(#31) OVW does a good job of paying for pretty much all of the costs of our transitional housing. Our agency covers the maintenance issues that OVW doesn't pay for, like cutting the grass and fixing this or that, painting, and whatnot. United Way sponsors a *Day of Caring*, and we often engage them to do some things at the apartment building we rent and the house we own; otherwise we'll pay for that with unrestricted funding. We are a member of the state DV and sexual assault coalitions, the Homeless Coalition, and the regional CoC.

We're the only DV service provider member of our Homeless Coalition/CoC. A lot of training opportunities roll down from the Coalition/CoC, and our participation with the Coalition/CoC is required for HUD funding. Both the Homeless and DV Coalitions have standards with which we, the member programs, must comply. Some of our funding is based on compliance with those standards, but it's also about minimum levels of service.

(#32) We're part of the state DV Coalition, but we also work with a lot of other groups in town, a lot of different collaborations. Sometimes, if one of their programs is full, or if they have a referral for a candidate that has a job closer to us, they can refer her to us. But the overall benefit of being part of the coalition is just having someone to bounce things off, to collaborate on legislation. We are also part of a non-DV focused Continuum of Care. The CoC is a really great way to connect with agencies that we can call on or make referrals to: the mental health association, the housing authority, family and children's services, the veterans' agency. Lots of services we can just pick up the phone and say, "this is what our client needs, can you help?"

(#33) We belong to the state coalition against domestic and sexual violence, a regional network of individuals and organizations committed to ending domestic and sexual violence, and city and county Continuums of Care. Through our regional network, we learn about a lot of resources that we can refer our clients to. If there are things we can't do, we might find out about other organizations that can help, whether it be counseling, utility assistance or something else. Our state coalition provides us with a lot of information about changes to the laws, advocacy suggestions, and other things that could affect our survivors.

(#34) I find participating in the Continuum of Care very helpful. They do a lot of free trainings. We go to them all the time. We have a shelter director meeting that happens, and each one of us takes a topic and we do trainings based on those. We share intake forms. Some people use rules, some people don't use rules; so there have been a lot of good discussion about that. We really support each other. We've also come up with a universal referral process – a way to do referrals to each other that's not confusing; that had been a problem.

Being part of a CoC increases our pool of resources, because we all come to the table with different resources. We're all on this email list, so if a housing spot comes up, we'll all get an email. Each person presents on what their services are, so we've also picked up resources for addiction treatment, food pantries, financial literacy, and employment-related assistance - setting up interviews, working on resumes, and a Dress for Success program where participants can go and get fitted for interview clothing.

This is a very high-income, high housing cost area. Our Continuum has created a coordinated system that's been able to bring in county money for housing and rapid rehousing, and we're part of that system. They're starting to run all kinds of programs, some programs working with landlords to enable us to place people with bad credit or criminal records. There's a program now where if a participant has bad credit, the county will sign off and commit to being responsible for three months of rent if the person abandons their housing. There's a new program that's like a step-down program where they'll pay so much of your rent the first six months and then it'll go down the next couple months and then they'll pay a percentage. By us being part of this coordinated system, we can access those services which help us gain housing for our participants.

It doesn't solve all of our challenges with housing. We still have a problem with all the people in the middle income range, who don't qualify for any of these programs. They earn \$30,000 or \$40,000, but their income isn't enough to live on their own. So we have to continue to work with the system, with the landlords.

(#35) We're part of a state/regional DV network that makes referrals. The other transitional programs are similar to ours, and we're all pretty much full. At our monthly meetings we announce our openings, and if we're actively taking referrals. But mostly, we don't have openings that we can't fill with our own waitlist. We're a small state so our DV network provides a lot of consultation services, as well as some actual financial resources that we can use to help participants. We have a Continuum of Care group that's a bit more systems-focused and less consumer-focused. We also have weekly meetings with a lot of the organizations in our community that deal with housing. It's an offshoot of the CoC.

There's only one city in our service area that submits a consolidated plan, and we've been a part of that off and on. The housing group from our CoC is trying to work with the city to explore whether we can create some subsidized and some regular housing. The city was instrumental in helping us get our shelter through the community development block grant. So, they're willing to work with groups like ours.

(#36) We're part of a DV coalition that helps coordinate shelter placements and that sponsors trainings. As far as the transitional living housing programs, we're all very different. We're also part of a Continuum of Care, which has helped us find out about community resources and collaborate with other agencies. Being part of the Continuum has been a nice way to sneak in a bit of DV education, giving staff the tools to recognize how people that are chronically couch surfing or in unstable living situations may have some safety issues.

The only thing that has not been helpful in our CoC is the push towards rapid rehousing as a one-size-fits-all solution. Placing someone who's fled an abusive situation in housing before they have a restraining order, and before their abuser has been served, and while they're still afraid of being stalked could endanger them.

(#37) Some of our clients who are involved with Child Protective Services have met with that agency's domestic violence liaisons. And, on the flip side, sometimes one of the domestic violence liaisons has a child abuse case which involves a caregiver who experienced domestic violence, and they might refer that family to us for an opening in transitional housing.

We belong to the state DV and sexual assault coalitions. In our county, the Continuum of Care is really focused on rapid rehousing and on serving the chronically homeless, which isn't really our population. But we belong to that committee, and we think it's important to continue to remind everybody that we're here and serving homeless domestic violence and sexual assault survivors, and to hopefully see how, in the future, some of our services could be part of what's funded. But that isn't happening at present, so that's a challenge.

(#38) The OVW grant is our only funding for the transitional program. We're a member of the state DV network and work well with a lot of the sister organizations that provide services. The services, education, and technical support that the network has provided, along with what OVW has provided, have helped us replace archaic concepts that were keeping us stagnant. They've helped us stay on top of current understandings about the needs of survivors. And I've gotten a lot of really great information about technology and stalking and serving non-English-speaking survivors, just good resources and tools for when we have those situations.

(#39) In addition to the HUD and OVW grants, our program receives funding from foundation grants, the United Way and local contributors. In addition, 26% of our \$2.6 million agency budget comes from revenue from our thrift store. Over the years, we've had really strong support from the community; our original offices

were in free space donated by a local business. We're pretty fortunate because with a grant from UPS and some other resources, we were able to purchase the building housing our thrift store, and we own one of our shelters and our admin building with our family safety center. Financially, it makes a huge difference. Just insuring all of these buildings is a huge cost. If we had to pay rent on them, it would even be worse.

We're actively engaged in our Continuum of Care, and that that engagement has been helpful. I've actually served on the local homeless coalition since I started in 2005. And then our development director is also part of the state homeless coalition as well. So we're pretty involved with whatever's happening. Our community is working on setting up coordinated assessment, and we're involved with that as well. We're hopeful that the system that finally gets put in place will give an adequate priority to survivors of domestic violence and sexual assault, so that they can access CoC housing resources, even in the absence of our HMIS participation.

(#40) There are two statewide coalitions, one for domestic violence and one for sexual assault. They meet with legislators and negotiate and apply for different statewide grants and make it available to us and our sister agencies to apply for. All of our state funding from the Department of Social Services goes through those coalitions. With their computer systems, they can make sure we meet certain standards. They monitor us and, if it ever came down to that, have the ability to withhold funding. They offer trainings on a range of DV-related topics: DV basics, trauma, the court system, trauma-informed care, motivational interviewing. They have a large facility and open their trainings to agencies across the state, not only our sister agencies.

(#41) (Not a current OVW grantee) We have three sister agencies that operate DV-focused transitional living programs statewide and we meet with them on a quarterly basis. Just by virtue of who we get referrals from, we're always in contact with the emergency DV providers in our areas. So we have close working relationships, but we're not part of a CoC. And because our domestic violence program is through the state agency and not HUD, we're not required to participate in the CoC's coordinated assessment process. I think some of those questions are really intrusive, to say the least, so I hope it's not something we'll have to use, in addition to the other assessment tools we use now. It would just be overwhelming for the women and an impediment to our building trust with them.

(#42) We're members of the Homeless Coalition; we get funding through them for our shelter and also partly for transitional housing. We're part of the board and we chair coalition meetings for the community. We're strong partners with all the shelters because of that; sometimes they have individuals they need to refer to us, and vice versa. Our TH grant is written so that participants can stay in the program for up to two years, and HUD and the Coalition have never tried to change that. It's a small grant in our Continuum. We choose the outcomes we track, and so far, there haven't been questions about that. We were clear years ago, that we would not put DV data in the HMIS and that has never been an issue; we give them aggregate data every year.

(#43) Our transitional housing program is entirely funded by OVW. The other DV services we offer -- the counseling and therapy and the childcare and all that -- are funded through VOCA and VAWA grants. Our rapid rehousing program is funded through the state with a HUD ESG grant. Under our state's rules, the rental assistance is available for only three months, instead of the one year that the federal program does.¹¹⁴ The

¹¹⁴ Actually, §576.106(a) of the [HUD ESG Interim Rule](#) states that "the recipient or subrecipient may provide a program participant with up to 24 months of rental assistance during any 3-year period. This assistance may be short-term rental assistance, medium-term rental assistance, payment of rental arrears, or any combination of this assistance.

(1) Short-term rental assistance is assistance for up to 3 months of rent.

(2) Medium-term rental assistance is assistance for more than 3 months but not more than 24 months of rent."

state has been cutting back on what it covers. They used to pay utilities and storage, but don't anymore. The state program just helps with is the cost of moving and the rent. It's hard to get women to qualify because of the low income limits; and it doesn't provide as many supportive services as the transitional housing grant.

Our philosophy is, let's set these women up to succeed. The graduated assistance in our OVW-funded scattered-site program is something we see as helpful, because we don't want them to suddenly go from zero rent for 12 months to \$600. And we're flexible; if they need another month with a 100% or 80% subsidy, we work with them. We don't want to set them back. We've got 12 months and, in fact, up to 24 months, if we need it, to help them get there. Graduated assistance is how we also assist with transportation and utilities. With childcare, we pretty much pay the whole time; but with these other costs, our assistance is graduated.

Although we don't prefer rapid rehousing, we do use it; we talk with the women about what will happen at the end of the three months. Sometimes, before they even go into that program, we start looking at other housing alternatives. We don't go into it thinking that this will be their permanent housing like we do with the OVW transition-in-place program. Our hope is that they can save money during those three months and that their income will be substantial enough, so at the end of three months they can afford their rent and utilities, and remain in their apartment. Unfortunately with only three months of support, it's very difficult to predict whether they'll be able to sustain it, but the challenge comes from our state guidelines and not the federal.

We're part of the state's DV coalition, and also part of a Continuum of Care. The benefit to our clients is tremendous. For example, we've been able to work with an organization that serves the Spanish-speaking community to help an undocumented program participant a work permit, so she can hold a job legally. Without that partnership or network, we might have been struggling to help her through the immigration process. We offer trainings on domestic violence that other providers can come to, and they train us on the services they offer, on serving the Spanish-speaking population and on the process of getting a visa.

We're very concerned about how the continuum of care's system of following a person through their homelessness will affect DV victims' confidentiality. We've been working with a mental health association to develop a database that we can use to enter client information, but still maintain their confidentiality; I think developing that central database has been one of our biggest steps forward with our CoC.

(#44) We are a member of our statewide DV coalition, but don't get HUD funding and are not part of a Continuum of Care. The coalition's technical assistance and webinars and trainings have all been useful. They have an advocate certification course that several of our staff have gone through. We're subgrantees to the coalition on VOCA and FVPSA grants and on the OVW transitional grant. Our children's program is primarily funded by FVPSA, with additional funds from VOCA. An OVW STOP grant funds our protection order project. Private foundations grants support projects at the TH facility, like a community garden and fitness program. As in many states, we receive funds from a fee on marriage licenses. We just received a large grant from a private foundation which will allow us to assist eligible participants in their transition to permanent housing. We'll be able help them with first month's rent and security deposit, 50% of their second month's rent, and 25% of their third month's rent, if they will continue with our case management services during that time.

(#45) We use our OVW funds to pay for staff, particularly two case managers, as well as for services from a couple of community MOU partners. Our scattered-site units are funded by various HUD grants: a rapid rehousing grant through the Continuum, and separate ESG grants from the state, county, and city. We also have some private foundation grants. We also own 10 small apartments in a three-building complex that provide transitional housing for single women or women with one or two small children. The property was acquired with HOME funds, and has a 20-year use restriction requiring our Continuum to operate those units as transitional housing, and we agreed to do so. That's the only transitional housing we have left, because in the last 2½ to 3 years, all our scattered-site units transitioned over to a rapid rehousing model, which HUD

considers to be permanent housing. The scattered-site model has worked well, because we serve a very large county, and a scattered-site approach allows a survivor to seek housing wherever she feels comfortable living.

We've had years of experience with transitional housing using case management funding from OVW and scattered-site leasing funding from HUD, and we've had a lot of success with that model. We held out for as long as we could, but it was finally to the point that the county brought us all together and said we needed to switch to rapid rehousing or the funding would be re-allocated for permanent supportive housing for single, chronically homeless and we would lose the housing for families who are survivors of domestic violence.

So we've worked with our CoC as they set up coordinated access, and we agreed that when a DV survivor contacts the homeless hotline, they will route them to us, and we get them into one of our two shelters and then try to rapidly rehouse them, if that's what they need or request. A lot of people we see in shelter aren't requesting a housing program, because they may plan to go back to the relationship or move out of state.

We're pretty much the only comprehensive DV service provider – and we operate the only DV shelter in our county. So there aren't multiple voices within our CoC advocating for survivors. We participate as much as we can in all the CoC activities and taskforces and committees. One of our program directors was elected to the CoC Board. So we try to be as involved as we can to ensure that the voices of survivors are heard.

(#46) With our Continuum of Care focused on ending homelessness and using HUD's broader definition of homelessness that includes victims fleeing violence, we work really hard to reach out to the most vulnerable families. We want to base our assessment of vulnerability on their score on an evidence-based screening tool. The VI-SPDAT is one of the tools used by CoCs to assess for vulnerability; but that screening tool doesn't ask the necessary questions about their risk of danger and whether they are appropriate for our program. So we use the VI-SPDAT to assess risk and vulnerability as applied to homelessness. And then we use [Dr. Jackie Campbell's lethality assessment tool](#) to look at danger levels. There are several evidence-based tools to measure lethality risk, but we use that one because a lot of law enforcement providers also use it in their lethality assessment protocols.

There's work to be done by our Continuum of Care to understand the similarities and differences between the needs of DV victims/survivors and other homeless persons. The great thing is that we're at the table.

I chair the coordinated assessment and referral program. I know there are separate regulations and provisions for victims of domestic violence. To be at the table is important. In addition to that, the city had to contract with an agency to run coordinated assessment and community referral – that was a HUD regulation - and even before HUD told us we had to do it, we had state funders that said we had to do it. Earlier on, back in 2009, we started that effort here, and I chaired the first Central Intake committee, and we went after the contract in 2011 because we're so good at answering the 24 hour hotline for victims of domestic violence.

What a great complement to have victims of violence contacting the same number as homeless people, which we were doing on our hotline anyway. Since then, it has grown and become so much more extensive, that we now have separated out our coordinated assessment and community referrals for homeless people, individuals and families. And that is a contract we maintain. And then we have our crisis line for victims of domestic violence. We have that contract, also. We keep a really close eye on what happens to people who call. If a victim of violence calls our coordinated assessment and community referral, we only get to three questions. "Are you homeless because you're unsafe," and if that's yes, "are you homeless because there's someone who's hurting you in some way," and if that's yes, we turn the call over to our 24 hour hotline.

Being involved in that was a strategic decision we made early on. And it was the only way to protect our population; we could see the writing on the wall about what was going to be happening to homeless services with the decrease in resources: how they were going to start selecting the most vulnerable people. So, we wanted to make sure that our population was protected. And our CoC's been very open to that.

(#47) Our transitional living program has two funding sources: the OVW grant and a tribal federal grant. The OVW transitional housing grant defines "fleeing" as the person has to leave the residence. So even if the person reports the abuse and would be able to stay in that same residence with their children, they aren't eligible for transitional assistance unless they flee the residence. They have to actually be homeless before they can be assisted with OVW funds -- even if the abuser was the financial support, was incarcerated after the report of abuse, and the survivor ends up with an eviction notice.

Our tribal federal grant doesn't require that: we define "fleeing" as *someone actively trying to separate from the abuse*. So if the survivor reports the abuse, does a no-contact, does a safety plan and follows through on it, and doesn't initiate contact other than what's necessary for shared property or children, they're showing us that they're "fleeing," even if they stay in the house where the abuse occurred, as long as if and when the abuser returns, they decline to provide him access, if safe to do so; they're doing whatever they need to do to be safe; and they follow through on that safety plan. So we have a little more flexibility under the tribal grant.

Also, while people are on the waitlist for transitional housing, our OVW TH grant doesn't allow us to work with them, but our tribal grant does, so we use those funds to pay for our help in getting all their paperwork taken care of, so they have access to every housing source available to them. We encourage all survivors to get on the Section 8 waitlist and all the waitlists for long-term housing. A lot of them don't have identification, Social Security cards, birth certificate records, and they don't have a postal address to establish residency. If they don't have a source of ID, it can take up to six months to get all their paperwork to complete a Section 8 application. We're a TLP that serves DV/sexual assault survivors, so we're deemed a shelter by our Section 8 and state housing, so our participants can be expedited through the system. So it's extremely beneficial for them to go through that process; we provide a lot of support to make it as minimally overwhelming as we can.

(e) Challenges and Strategies for Collaborating with Mainstream Providers More Generally

(i) Overview of Challenges

This section of the chapter looks at collaborations more generally -- with mainstream homeless services providers, but also with mainstream mental health and substance abuse providers, mainstream employment services providers, mainstream disability services providers, etc.

The Alaska Network on Domestic Violence and Sexual Assault's comprehensive resource guide on "Responding to Multi-Abuse Trauma," (hereinafter [Edmund & Bland, 2011](#)) contains an excellent discussion about the challenges of collaboration and strategies for overcoming them (see pp. 119-128). Two of the important barriers they discuss are lack of trust among different providers and cultural differences (using the term "cultural differences" to refer to not just ethnic/racial/linguistic community-related differences, but also differences in provider cultures):

- *"Lack of trust. Providers from different disciplines such as victim's advocates, substance abuse counselors, mental health providers and criminal justice personnel often have differing philosophies and theoretical orientations and may not trust each other because of this ([Warshaw, Moroney, & Barnes, 2003](#)). For example, drug and alcohol treatment providers may be focused on accountability, while the criminal justice system is often focused on punishment, and victim's advocates are focused on healing and empowerment.*
- *Cultural differences. Additional trust issues may develop stemming from cultural differences between providers – for example, 'wounded healers' versus 'professionalized' staff, 'expert' role versus 'peer' role, and services within indigenous communities versus those provided by the dominant culture ([Duran, 2006](#)). Many 'mainstream' philosophies tend to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit. ([Comas-Diaz, 2007](#))."* (p.120)

Unpublished survey data from [DeCandia, Beach, & Clervil \(2013\)](#) indicates that some of the most frequently cited substantive barriers to collaboration in surveyed providers' narrative responses (other than lack of staff time and lack of funding for taking on more work) were issues related to inadequate understanding of, and/or perceived differences in, program mission/focus and funding-related constraints/requirements.

Our interviews with providers indicated broad appreciation of the expertise, perspectives, and services that collaborators can add to a program, tempered by caution borne of mixed experience. Collaborations can fill gaps, but they can also result in fragmentation of care; can engender complications related to confidentiality, information-sharing, and the need for explicit client consent; and can be counterproductive if collaborators' lack adequate understanding of domestic and sexual violence and its impact on survivors and/or lack understanding or are unprepared to provide trauma informed services.^{115,116} Collaborations that engender a referral to an outside provider may add one-too-many logistical barriers to client follow-through in accessing assistance (e.g., making an appointment with an outside provider, figuring out transportation and possibly childcare in order to attend the appointment, and actually keeping the appointment).

(ii) Strategies for Overcoming the Challenges

Providers seeking to overcome some of these obstacles have taken various steps to more fully integrate collaborators with their client services team, including having them attend team meetings, having them attend some of the same trainings as in-house staff, and arranging for them to deliver their services onsite, or if that isn't possible, arranging for them to present at participant gatherings, so that clients can get to meet and know them, and hopefully overcome any anxiety about scheduling an "outside" appointment.

To address these barriers, [Edmund & Bland \(2011\)](#) recommend the approach described by a local Alaskan provider¹¹⁷ who explained that,

"Insisting that our way of doing things is 'better' than what others are doing, or that our priorities are more important, can create barriers to cooperation: 'It is helpful to understand each of us is coming to the table with different agendas, and none of those agendas is designed to hurt the victim. When we come to the table with the attitude that we are the only ones who have the best interest of the victim at heart, then we get ourselves into trouble. It's easy for us advocates to do that because that's our job title. But if you look at the forensic nurses, that's their job title too. They are here to help sexual assault victims. They do have to stay objective, they do have to ask the tough questions. So if we are on a crusade to be the only people in the game to protect victims, then we are going to be in a constant war with all the other disciplines that are trying to do the same thing, only in a different way.' " (p.121)

As an example of the importance of different lenses, [Edmund & Bland \(2011\)](#) cite an [Issues Brief on Trauma and Re-Traumatization \(National GAINS Center, 2006\)](#)¹¹⁸ which explained how symptoms of trauma could be misunderstood by clinicians (whose focus and training is on mental health) as evidence of mental illness:

¹¹⁵ Concerns about lack of understanding of domestic violence, victimization, and trauma were most reflected in comments about collaborations with behavioral health providers: mental health and substance abuse treatment.

¹¹⁶ Even legal advocacy can utilize a trauma-informed approach. As described in [Kristiansson & Whitman-Barr \(2015\)](#), "The understanding of the histories and life-altering victimization of sexually exploited girls and women has led to the passage of expungement laws and diversion courts to support survivors through trauma-informed, holistic care and programming." (p.2)

¹¹⁷ Personal communication between the authors of [Edmund & Bland \(2011\)](#) and Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at Standing Together Against Rape (S.T.A.R.) in Anchorage, AK.

¹¹⁸ The authors of [National GAINS Center \(2006\)](#) cite as original authors, N. Kammerer & R. Mazelis, authors of *Trauma and Re-traumatization*, a resource paper presented at the *After the Crisis Initiative: Healing from Trauma after Disasters* expert panel meeting, June 8, 2006. Center for Mental Health Services, SAMHSA.

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

[Edmund & Bland \(2011\)](#) therefore embrace two of the Issue Brief's recommendations:

- (1) Conducting "trauma-informed" education for both advocates and other providers to increase everyone's knowledge and understanding of the prevalence of trauma, re-traumatization, and coping adaptations (and their negative consequences) by individuals who have experienced trauma; and
- (2) Establishing a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact.

Some of [Edmund & Bland's \(2011, pp.123-126\)](#) recommendations for addressing barriers to collaboration are:

- "Acknowledge[ing] controversies rather than pretending they don't exist – 'wounded healers' versus 'professionals,' 'peers' versus 'experts,' theoretical differences, etc. Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of individuals who receive our services."
- "When seeking to resolve differences, choose your battles. Is the "difference" truly harming someone we serve? Can the providers 'agree to disagree' on some issues such as language or terminology?"
- "Do not imply that other social service providers are bad people, or negligent in some way. They may be unable to provide certain services for valid reasons, such as ethical concerns about providing services beyond their level of expertise." [Or there may be constraints related to their source of funding]
- "Focus on what we can learn from each other. Assume that we can benefit from the other provider's knowledge as much as they can from ours. As human beings, we tend to be resistant to learning things from people who don't want to learn from us. That's just human nature."
- "Recognize the limits of each philosophy or theoretical orientation. Karen Foley is a behavioral health specialist and founder of Triple Play Connections, a Seattle-based nonprofit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State. She says: 'I think it's extremely important to look at different approaches for the different issues. For example, I believe that if you try to treat domestic violence through the lens of addiction, using a medical model, you will do a disservice. For example, trying to get someone to accept responsibility for things that are not theirs to own is a form of victim blaming. On the opposite end, when you try to solely use an empowerment-based model on someone who is dealing with the disease of addiction, they don't get help for their addiction, and often end up back in an abusive situation.' "
- "Different issues may require different priorities and different approaches. For example, it's perfectly appropriate that an advocate would be focused on safety for victims of violence while a substance abuse counselor focuses on sobriety for people with substance use disorders, a child welfare caseworker focuses on the best interest of children and a criminal justice professional focuses on community safety. . . . A key to reconciling differing priorities is to take a *both/and* approach rather than an *either/or* approach, so that priorities and philosophies are not necessarily seen as being in conflict with each other. For example, an

advocate's priority of helping a parent get safe from violence is certainly compatible with a child welfare caseworker's priority of protecting the best interest of the children." ¹¹⁹

(iii) A Look at Some Successful Collaborations, and What it Took to Create and Sustain Them

The Wilder Foundation ([Mattessich et al., 2001](#)) publishes an insightful chart¹²⁰ that explains how **cooperation, coordination, and collaboration** are similar and different, in terms of (a) the vision and relationships of the organizations involved; (b) the structure, responsibilities, and pattern of communication of the participating organizations; (c) the locus of authority, leadership, and accountability; and (d) how resources and rewards are distributed among the partners.

- In a **cooperative** venture, the participating organizations continue to focus on their own interests: there is no revision to their mission or goals, interactions and sharing of information are on an as-needed basis, no joint planning is required, each organization retains its own authority and accountability, and resources are separate. An example might be the informal arrangements between an OVW-funded TH program and a local mental health services provider, under which the two organizations use already-existing protocols to make referrals to one another, but do not agree to any pre-specified level of services, and don't establish any particular protocols for flagging or responding to such referrals.
- In a more **coordinated** venture -- typically around one specific project or task -- the mission and goals of each organization might be reviewed for compatibility, there would be some level of project planning, communication roles and channels would be established, there would be some sharing of leadership and risk, although most authority and accountability would remain organization-specific, and resources could be targeted for the project.

An example of a **coordinated** effort might be a funded MOU between the aforementioned TH program and mental health services provider, spelling out a distinctive referral process or a commitment by the MH provider to regularly send staff onsite to the TH program; calling for TH program staff to provide a specific number of trainings in domestic and sexual violence issues to the staff of the MH services program; and re-defining the role of the respective programs so that the MH services provider would routinely include assessment of the trauma-related origins of mental health issues, and the TH program would routinely encourage participants to meet with the MH services provider, with the assurance that the MH program staff would avoid routine labeling with diagnoses, given that a survivor's symptoms are often manifestations of the trauma she is carrying from the abuse she experienced.

- In a **collaborative** venture, a common new mission and goals are created, involving one or more projects over a longer term; there is comprehensive planning and agreement on new structures, responsibilities, and measures of success; there are multiple levels of communication and information-sharing; there is shared leadership, responsibility, and risk; resources are pooled or jointly raised, and there is a sharing of credit for accomplishments of the collaborative.
 - One example would be [Project Peer \(2011\)](#), a collaboration between eight Washington DC-area organizations that address domestic and sexual violence, provide clinical or peer-driven mental health and/or substance abuse-related services, provide services for persons with developmental disabilities, and/or engage and support consumers in advocating for themselves and other persons

¹¹⁹ However, as discussed in [Chapter 11](#) ("Trauma-Specific and Trauma-Informed Services for Survivors and Their Children"), providers who implement a voluntary services model in serving families, and who identify the adult parent/caregiver as the primary client, and therefore the final authority as far as whether their children are assessed or receive services, may be at odds with children's advocates, who assume the existence of adverse impacts from exposure to violence which should be identified and addressed.

¹²⁰ As explained by [Mattessich et al. \(2001\)](#) this chart originally appeared on p.40 of [Mattesich & Monsey \(1992\)](#), a publication supported by the Wilder Foundation.

with similar circumstances. Their [2010 Project Peer Strategic Plan](#) describes how they came together to seek OVW grant funding "to end our artificially fragmented approach to supporting survivors with cognitive/developmental disabilities and/or mental health issues, transform our daily practices, and change the awareness and operating cultures of our organizations."

Much as described by the Wilder Foundation model, the participating organizations created a collaboration charter documenting their shared commitments, roles, and responsibilities; defining a shared vision and mission; identifying core values; assessing what was needed and what steps would need to be taken to achieve the desired outcomes; establishing priorities; and with the help of technical assistance from the Vera Institute of Justice, developed an implementation plan and "[guiding principles](#) that our partners will use to improve their organizational policies and practices related to access, identification, response, accommodation, and referrals for survivors of domestic violence and/or sexual assault who have developmental disabilities and/or mental health issues."

- Another example (also aided by the Vera Institute of Justice) would be the [King County, Washington collaboration](#) between five organizations serving the Seattle/King County-area and providing domestic violence-related services and advocacy, and mental health and substance abuse treatment services, including a specific focus on serving Latinos and LGBT residents. Their report, ***Change Is Possible: Successes, Lessons Learned And Plans: Domestic Violence & Mental Health Collaboration Project*** ([King Co. Coalition Against Domestic Violence, 2010](#)) described how the five organizations created a representative Collaborative Team, developed a collaborative charter "outlining why we were working together and how we would do our work," conducted a needs and strengths assessment "to learn what we were doing well and where we could do better," and created a strategic plan focusing on implementation of four sustainable systems change initiatives:
 - (a) creating welcoming environments (e.g., signage, furniture, accessibility, indoor climate, privacy, cultural artwork, and website);
 - (b) enhancing staff knowledge in areas of expertise that one or more of the partners had, but that one or more of the other partners lacked (e.g., creating and offering online courses that, in at least one case, offered CEUs for staff; integrating courses into staff orientation, and attending conferences together);
 - (c) strengthening issues identification and response (e.g., reviewing current practices, identifying legal rights for persons with disabilities, creating flow charts to help staff respond to concerns in areas where they were less fluent, researching promising practices, developing an online domestic violence response course of MH providers and an online mental health response course for DV advocates, creating videos to accompany the courses, and integrating the courses into staff orientation); and
 - (d) collaboration (e.g., meetings among the agency directors, holding a commitment ceremony and signing an MOU, creating and storing relevant agency forms on an online shared files storage platform, holding relationship-building events -- "with a fun networking component, and educational component, and special refreshments" -- to encourage collaboration, attending trainings and conferences together, and establishing a liaison system and implementing a process for monthly case reviews).

Their report notes that,

"Creating collaborative change can be challenging under the most ideal circumstances. We started our work on this project shortly before the country entered an economic recession. Although our fields regularly experience funding challenges, we did not anticipate that our partner agencies would be faced with significant threats to their funding in the midst of embarking on this project. Both fields strongly felt the impact of the recession.

These economic impacts have made it challenging for the partner agencies to devote time, attention, energy, and staff to the work of the collaboration project. It is difficult to prioritize proactive, collaborative work when agencies have to react to threats to their overall stability and service delivery. However, despite all of these challenges, the partners did make the project a priority and did actively participate in creating changes together."

Among other things, the Collaborative Team attributed their ability to withstand these challenges and be successful to belief in and commitment to the project and to the people involved in the project, the influential role of the members of the Collaborative Team at their respective agencies, strong leadership and coordination and a project coordinator (based at the King County Coalition Against Domestic Violence) that kept the partners on track, the grant funding that covered project expenses, the recognition that the effort was important to addressing needs identified by direct services staff, the potential for success, a positive outlook and a strengths-based approach that included use of **Appreciative Inquiry** ([Cooperrider & Whitney, n.d.](#)). mutual trust, regular self-evaluation, use of fun and humor, and "funding to spend time thinking, instead of just reacting."

- [Center on Victimization and Safety, Vera Institute of Justice \(2011\) Forging New Collaborations: A Guide for Rape Crisis, Domestic Violence, and Disability Organizations.](#) (from the website):

"People with disabilities experience domestic and sexual violence at alarming rates. Yet they are less likely to receive the services, supports, and justice that their counterparts without disabilities receive. However, victim services and disability organizations across the country have begun collaborating to ensure people with disabilities have equal access to the community-based supports and criminal justice responses that are critical to surviving violence and healing after trauma. The U.S. Department of Justice's Office on Violence Against Women (OVW) has led this effort by providing communities with funding for collaborative efforts to improve services for survivors with disabilities. Through its Accessing Safety Initiative, Vera's Center on Victimization and Safety supports these efforts by providing training and consultation on collaboration and capacity-building at the intersection of violence and disability.

By the end of 2010, OVW's Disability Grant Program had fostered more than 40 such collaborations. This report is based upon Vera's work with and observations of those collaborations from 2006 through 2010, as well as in-depth interviews with representatives from 10 of the groups and an extensive literature review on effective collaboration. It is designed for policy makers, practitioners, and first responders interested in using collaboration to address violence against people with disabilities. It offers concrete recommendations for how to build effective collaboration between victim services and disability organizations, practical strategies for overcoming common obstacles, and steps to begin the collaboration process." (p.2)

- [Goodmark, L. and Rosewater, A. for the National Council of Juvenile and Family Court Judges \(2008\) Bringing the Greenbook to Life: A Resource Guide for Communities.](#) (from the website):

"The Greenbook, a publication released in 1999 by the National Council of Juvenile and Family Court Judges and formally entitled Effective Interventions in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice, explored the links between domestic violence and child abuse and neglect, and promoted collaboration among child welfare systems, domestic violence advocates, and dependency courts in order to serve battered mothers and their children more effectively. The concepts underpinning the Greenbook include the following: (a) Interventions should focus on removing batterers from their households and holding them accountable for their violence. (b) Child welfare agencies can best protect children by offering their battered mothers appropriate services and protection. (c) Being a victim of domestic violence does not equate to being a neglectful parent. (d) Separating battered mothers from their children should be the alternative of last resort.

In order to create a laboratory for the implementation of the Greenbook's philosophy and guidelines, in 2001 the federal government funded six communities to evolve blueprints for putting the Greenbook into practice: El Paso County, Colorado; Grafton County, New Hampshire; St. Louis County, Missouri; the city of San Francisco and Santa Clara County, California; and Lane County, Oregon. Representatives from child welfare agencies, dependency courts, and domestic violence agencies came together, with the help of federal technical assistance providers, to grapple with the myriad issues surrounding implementation of the Greenbook's vision. Other community and governmental agencies and members of the affected communities were invited as well, in order to inform the work of the pilot communities.

The six communities ... built a fundamental framework for the future based on the interdependent safety needs of mothers and children. They promoted and tested an underlying premise: keeping children safe relies on keeping their non-offending parent, usually the mother, safe... each of these efforts has provided valuable lessons for improving responses for battered mothers, men who abuse their partners, and their children.

Through the implementation process, these communities learned about trust-building, collaboration, and systems change. They developed strategies, policies, and protocols to drive the changes they envisioned. They struggled with issues of community, cultural difference, and power. These communities amassed a wealth of information and experience about how to operationalize the Greenbook, wealth which it is the intention of this Guide to share with other communities that understand the principles of the Greenbook and now want to know how to make those principles a reality.

The Guide explores a number of the major policy and practice issues confronted by the communities that have implemented the Greenbook; details the various ways in which the communities have attempted to address these issues; and, where protocols, tools, and exercises exist, includes them, along with commentary on using them successfully. The idea is to enable communities to begin the process of change without having to 'reinvent the wheel.' The Guide is organized into eight sections: I. Understanding Each Other; II. Laying the Foundations; III. Collaboration; IV. Assessing System Readiness; V. Confronting the -isms; VI. Changing Practice; VII. Widening the Circle; and VIII. The Unresolved Questions." (pp.4-5)

(iv) Provider Comments about Partnerships and Collaborations

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

(A) General Comments

(#01) I've done DV and sexual assault work for about 18 years. In the last 6 months I've developed a network to service our clients, and I've noticed since we started building these collaborations the staff burnout is significantly less. DV agencies need to collaborate more with other agencies as funding gets tighter.

(#02) We contract a supervisor from the local mental health agency to do training and clinical supervision.

(#03) We have all sorts of people from the community helping. An attorney, mental health counselors.

(#04) People donate their time. They give things that reduce cost. We just network with the other social service agencies in our area. I put a lot of money into our budget for consultants and contracts, and coming to

the end of our transitional housing grant, most of the money we have left over is in our consultant line item because people don't want us to pay them for the work they do.

(#05) We find that our best collaborations lead to many more referrals to us because domestic violence survivors are everywhere. Whenever we're collaborating with someone, we also do DV education for them: how to screen for DV and how to access our services. That works well for both of us.

(#06) We're part of the National Coalition Against Domestic Violence, and get referrals from the national crisis hotlines. A great deal of what we do is our coordinated community response work, reaching out to make sure that all of the relevant service providers -- court and law enforcement personnel, counselors, human services programs in general -- know about our services, have our cards and telephone numbers, and have the information they need to make appropriate referrals.

Our relationship with law enforcement varies from county to county. Whether they think of us as helpful people, and whether they think domestic violence is that big a deal is another question. We have very good relationships in most of our counties. In one of our counties, they don't want anything to do with us. Turnover among law enforcement officers is quite high, so each time new officers come in, we help them understand what we can and cannot do, that we're not here to do their jobs, but that we could help make their jobs a little easier by supporting survivors and doing what we do.

(#07) One good thing about our community is that a lot of the service providers we refer our clients to, are also our neighbors. We share common office space, or we're in the same complex, the same parking area. We can walk over to those community partners' offices and have conversations directly with them, letting them know who we are, what services we provide, and vice versa. The partnership is strengthened by our close proximity to one another. We have a vested interest in working together, either for funding opportunities or just to be able to support each other's clients.

(#08) Networking goes a really long way; we really value the relationships we have with other agencies. Being cordial and responsive goes a long way in leveraging resources for our clients. Our staff can't do everything. We try to be comprehensive, but we need our partners and other agencies in our network to support the healing and empowerment work and the self-sufficiency-related work. Without that, we really can't do a good job. And it takes money for that.

(#09) Sometimes participants cannot pay the rent, so we refer them to an agency that we know can help them financially. We have donations of clothes, but sometimes, they need a specific thing, so we will refer out for that. It's mainly finances.

(#10) There's a local private foundation that targets assistance to programs serving vulnerable populations; they make available a center, at no charge, where we do retreats. We try to do a staff retreat once every quarter, if not more often. The foundation also offer a series on staff self-care to which we can send a staff person for free.

(#11) Through our County Continuum of Care, there's a ton of mainstream resources that the whole county uses. It's a collaboration, so we have set up informal coordination of services for employment, education and housing, Food banks, and childcare. It's just a great network.

(#12) We collaborate with other agencies to provide onsite therapy, legal services, immigration services, and chiropractic services for clients. We also have onsite support groups led by our HUD grant-funded therapist. And we collaborate with a local career center to help clients with employment.

(#13) Being part of the Continuum provider network has been really helpful with housing resources, and we've also picked up resources for addiction treatment, food pantries, financial literacy, and employment-related assistance - setting up interviews, working on resumes, and a Dress for Success program where participants can go and get fitted for interview clothing.

(#14) The community we serve is small, but really good. You do have to know people, though. I do tell the caseworkers, especially when they're new, people aren't going to call you back if they don't know who you are. That's one issue here. It's a little harder to break in and build those contacts, but in terms of collaboration, I think we have a really good community.

(#15) We strive to do a lot of co-case management with our community partners. Literally just bringing everybody to the table together with the participant, and saying, all right, how can we all do this best for you? What do you need? And I think that works really well, just to get everybody together and say, here are all your people, put us to work; what do you want us to do?

The biggest challenge with that is just a misunderstanding or lack of information about domestic violence and how that impacts people... not understanding how trauma can impact people and how it can manifest in ways that may look weird when you're asking clients to do something and they can't do it. So we try really hard to help explain and educate people about that.

(#16) (Not a current OVW grantee) Our clinical supervisor is an LICSW consultant with 30 years of experience, who comes every other week. She meets with most of the direct service staff. We chose to go with a consultant for supervision rather than bringing someone like her on staff because she can give external, neutral support to our staff. She has the clinical experience to help staff with mental health issues and she also has substance abuse treatment experience, so she brings several specialties all in one person. She can sometimes see things from a bird's eye view; when you're working for an agency, it can be hard to detach and step back, and see things in a neutral, objective way. And she has the knowledge and experience to help staff experiencing burnout-related issues.

We rely a lot on metro area agencies and our sister DV agencies in the larger region for help in addressing participants' needs related to substance abuse, employment, legal issues, immigration, language translation and interpretation, education, daycare, food, and more.

(#17) We have three MOU partners. One is the behavioral health/mental health program at the local hospital. The second one is with a faith-based organization that provides our clients with the opportunity to select from their stock of donated clothing and furnishings and food. They're based in a rural portion of our service area, so we usually bring the clients there. Our third MOU partner is a pre-school program that helps with childcare. I mentioned that we use Skype and FaceTime to stay in touch with clients who are living in more remote locations in our region. I am not a tech person but we certainly have a lot of people who are and they're very willing to assist. We also have an internet company that we work with locally and they've been very generous.

(#18) (Not a current OVW grantee) Our hope is to do as much as we possibly can ourselves with in-house staff, because we want to make it as easy as possible for the families to access services. With the exception of legal, we pretty much provide everything. We have our own case managers, child services staff, after-school teen program, nursery, pre-K program, and ESL teachers. We have a psychotherapist, a credit counselor, an unemployment counselor; Of course, in some cases we do supplement our own services with other resources.

The idea is that if they can all be under one roof and we can all be working together as a team, then the person doing the financial literacy and the debt reduction can be talking with the case managers as can the people who are doing the employment training or the people who are doing the legal services, so we can have a unified approach to helping the family.

Second, if we want to make it easy for mom to come to the office for services, we have to be prepared to address her need for age-appropriate children's services while she's here. So while mom is meeting with the credit counselor or case manager, her teenage son can be in our teen after-school program, her fourth-grader could be getting tutored, and her two-year-old could be in our nursery.

Even though we have an ESL teacher who teaches classes in the evenings, if we have families where the adults can't attend an evening class, then we'll hook them up with a collaborating adult literacy program. And we don't do any of our own legal services, so we're always working with law firms who can provide some kind of pro bono assistance. And even though we have a psychotherapist on staff, we don't have anybody to do psych evals, so we have to work with somebody else who can do that.

(#19) What we love about our one-stop family justice center model ¹²¹ is that we have all these services, with staff funded through probably 15 different grants, pieced together so that to the person walking in the door, it looks like one integrated service delivery system. So if they're seeing a civil legal attorney who's doing a protective order and the woman breaks down, the attorney can call in one of the trauma counselors, and we make her available to come and help the woman get back together, so they can go on with the legal work. We offer education and employment services. We have a childcare program, so when the women are going to be here for a couple of hours, they know their children are taken care of. We have snacks on hand. If they have transportation issues, we try to arrange appointments times that are convenient to them, including after

¹²¹ The [Family Justice Center](#) is a national model which has been identified as a best practice by the OVW. As described in a February 2007 report entitled "**The President's Family Justice Center Initiative: Best Practices**" ([DOJ/OVW, 2007](#)) released by the OVW and outlining the 10 component best practices associated with the model,

"In October, 2003, President George W. Bush announced the creation of the President's Family Justice Center Initiative. The \$20 million Initiative created specialized "one stop shop," co-located, multi-disciplinary service centers for victims of family violence and their children. The centers, commonly referred to as "family justice centers," are based on the San Diego Family Justice Center model; they are designed to reduce the number of places victims of domestic violence, sexual assault and elder abuse must go to receive needed services. After a reduction of nearly 95% in domestic violence homicides over the last 15 years, the San Diego Family Justice Center is hailed as a national and international model of a comprehensive victim service and support center. Since 2004, the President's Family Justice Center Initiative has opened 15 family justice centers in urban, rural, suburban, and tribal communities...."

Congress recognized the importance of the family justice center model in Title I of the Violence Against Women Act (VAWA 2005). Family justice centers are now identified as a "purpose area" under VAWA 2005. Using a "wraparound" service delivery model, the family justice center concept seeks to marshal all available resources in a community into a coordinated, centralized service delivery system with accountability to victims and survivors for the effectiveness of the model. As stated by Mary Beth Buchanan, Acting Director of the Office on Violence Against Women: 'The family justice center is, at its core, a concept that increases community capacity while also providing diverse, culturally competent services to victims and their children from a single location. It is common sense that such an approach, if executed properly, will provide greater assistance to those in need.' The family justice center model is identified as a best practice in the field of domestic violence intervention and prevention services."

hours. We provide bus tokens and transportation assistance. We have private foundation grants that allow us to offer gas cards.

(#20) I think our challenge with referrals is that there's just not enough services in general. There's not enough funding and given the limitations of our geographical location, there's no referrals anywhere to make for people. All of our clients have the same needs that a client would have in New York City or in Boston, but there, they would have a lot of other services that they could choose from. Here it's just really limited. In fact, our Coalition is the agency that people are referred to for counseling. There are no real formal employment programs on the island. We've tried to do that through our life skills program. Our staff and other consultants help with resumes and job readiness and that sort of thing. We do our best to try to provide those services; we know what the limitations are in our community and we just have to work with that.

(B) Children's Services

(#01) Our shelter advocates work very closely with the schools to make sure that kids in shelter get into school in an expedited fashion, that they get the support they need in school, and that the shelter is notified about any potential problems. We had a call from a school counselor the other day about a child that had recently come into shelter; the counselor felt there was something going on because the child was extremely agitated; we connected her with one of our clinicians and found out the child had been sexually assaulted by the mother's boyfriend.

We have a strong relationship with the [Children's Advocacy Center](#), a regional non-profit that serves as a one-stop center for addressing incidents of sexual assault, so a child only has to tell their story once, because all the people who need to be at the table -- district attorney, police, etc. -- are there and can observe the assessment.

We have a really good relationship with the school-based adjustment counselors, and with non-profits that can supplement our services. We work with the YWCA and local summer camps to ensure that every child goes to camp, with scholarships, or using a family fund that we have. For many children, it's the first time that they've gone to camp.

All of the services that are available to children in our shelter continue to be available to families in our transitional housing. In fact, these services are open to families in the community, as well.

(#02) We work with the school when asked. We don't want to overstep our boundaries with the parents. We encourage parents to do it on their own, and if they need help we step in.

(#03) Our program manager has a good relationship with the local Early Intervention program. We also have a close relationship with the homeless liaison in our school district. We talk with her every time we get a new family so she knows who the kids are and can provide the resources they need at school. We also coordinate transportation with our school district.

Whenever we work with one of these programs, we make sure we have a signed release from the beginning. If mom identifies school transportation as an issue, we have to get her permission to talk to liaison first. We can't give her our families' names without their permission.

(#04) Some of our kids who are really having a hard time need deep end mental health services from people who are trauma-informed. I think they do better there than in traditional domestic violence therapy.

(#05) Each school system here is starting very early on assessing whether children have special developmental needs. Preschools do their own mandated developmental testing. On top of that, we have a local non-profit that focuses on children with developmental issues, like autism, and their families; they do home visits, educational programs, parenting classes, and they can provide help with the cost of childcare; they also offer full-time caregiver respite. They have people serving both urban areas and the outlying counties. It's been real helpful to us. Of course, we also have programs like Head Start for young school-age children, and for the pre-teen/teenage youth, there's programs like AWARE and DARE, which have counselors and mentoring components. So there are a handful of very good programs for youth and children.

(#06) There are a couple of different counseling and therapy agencies that we refer participants' children out to. There's also a tutoring agency that we collaborate with. On a case by case basis depending on what the child needs, there are different kinds of resources we can refer them to. But, we work most closely with the counseling and therapy agencies and the tutoring agency. Unfortunately, they're often backed up, so even if we make a referral, it can take up to 2 to 3 months for a child to begin counseling or therapy. Sometimes we can leverage our relationship to expedite things.

(#07) With the children's mental health providers, we have referral forms. When talking to the mom, we'll ask if she would like for us to refer the child to that program, and if so, we'll get her to sign a release of information and then we'll send out that referral so that the provider can contact her to schedule the appointments.

If it's someone that we don't have a partnership with or that we don't have a referral form for, we'll have mom contact the provider. We encourage them to have the release of information form signed, in case the advocate does need to support mom during the conversation, or if mom asks our advocate to have a conversation with the provider, but do it as more of a team versus just giving out the information. Sometimes our participants are comfortable making the calls, but then when you talk to them about what they'll say or what their major concern is, they freeze. Sometimes they just need you sitting there for support. And sometimes they make the call and don't need or want our help.

(#08) We don't provide direct service to children, but we can refer participants to different community partners and child therapists, depending on what they seem to need. We can also make referrals for parents struggling with some of those issues, and we also work with Title I services, which pretty much takes care of all of our transportation needs for children attending public schools.

When we see problematic behaviors, we share our concerns with the parents, offer support and information about available services, and ask whether they would like help accessing those services. So far, that approach has been well received because it's non-judgmental. It's not pointing a finger; it's just saying that "We've noticed these things, and thought you may need additional support. Would you like additional support?"

We can assist with bus tokens for travel back and forth to appointments, and we've even transported and accompanied them to appointments to make sure that the transition to another service provider is done in a way that the survivor feels supported.

(#09) There is an Early Intervention program, operated through our local Head Start program, which can work with children up to age three with developmental delays. There are other Early Intervention and Early Head Start programs serving our outer rural communities, the towns, and the tribe.

(C) Education

(#01) Over time, we've developed a unique partnership with a local tribal college. We provide DV-related training for college staff and security personnel and do classroom presentations about domestic violence for their nursing and criminal justice programs. In turn, they provide dormitory housing for Native American women who are completing stays in our shelter or transitional housing and who are enrolled in their programs, and who might not otherwise be able to find suitable housing while they attend classes. We've been very fortunate with this partnership to be able to offer our Native American participants the opportunity to register for classes -- and access to campus housing -- not only at the beginning of the school year, but also mid-term. And when women become students at the college and have their housing on campus, they also have access to child care. There's also an affiliated elementary school where children of matriculating students can attend classes. If the women are still actively participating in our shelter or transitional housing, the college furnishes bus transportation to and from the campus.

(#02) We've got a local community college that's been great about helping our clients and getting people into classrooms so they can take that first step. After being out of class for a while, it's kind of scary, but taking those first few courses while they're in our program and while they have our support will help them to go on and continue their college education.

(#03) There's a local chapter of the [Soroptimist Club](#), a women's social and economic empowerment organization that's kind of like the Rotary Club, but it's all women. And they offer an annual scholarship. It's not exclusively for domestic violence survivors, but it's often been awarded to a DV survivor, I'd say three years out of five. It's awarded to women who've overcome adversity, are the primary wage-earner in the family, and are working to improve their education. So as a practical matter, in a community our size, a lot of the applications that they get are coming from folks who have had some involvement with our agency.

(#04) We try to connect participants with job training or work with them on scholarships for education, depending on what their goals are, and what it will take to get there. We've had some success in working with the [Sunshine Lady Foundation](#) to get scholarships for some of our participants. In turn, our housing partner will allow those families to stay in their apartment, because they still qualify as low income. The Sunshine Ladies Foundation will give them money for tuition and rent and some supplies, and if they are working part-time while going to school, then when they are done with our transitional housing program, they may be able to stay in the apartment.

(D) Employment

(#01) We have a relationship with the local Goodwill Industries career center, so sometimes we'll refer clients there if they want to work with someone on resumes or job searches. I can do that kind of work with them, or we can refer them. We also do referrals to the local vocational school for education -- primarily English and computer classes, certifications, nursing programs, etc.

(#02) We have a collaborative relationship with a local women's resource center that does job training and empowerment training for women. The last OVV grant required MOU partnerships and that was really our first step in bringing that resource center on board in a formal kind of way with the intent to collaborate around specifically addressing intergenerational poverty -- to modify what they do to better address the domestic violence our participants have experienced, and looking at the motivational components. It was fortunate that the OVV grant pushed us to do that.

There are programs like [Bridges Out of Poverty](#)¹²² that we've partnered with in the past; they work for some people and not for others.

(#03) We do employment counseling. And we take participants down to the local job service program, which is very good about providing job education. We have a small community college here with a career development program that we also make some referrals to. If someone's thinking of attending college or a training program, we'll work hard with them to make it happen. We want them to do their own applications -- that's part of empowering them -- but our advocate is right beside them all the way.

(#04) We have a partnership with our [Workforce Investment Board \(WIB\)](#) and career center, where we are on-site partners. What that makes available – for our clients and our volunteers – is volunteering to work with other individuals who are looking for jobs. This experience gets the participant focused on employment and helps her build up her resume, showing that even though she may not be employed, she's isn't just sitting around; she's engaging in activities that show her commitment to employment. She can put on her resume that she volunteered with the WIB, assisting with teaching or supporting our staff in delivering one of the WIB's workshops. The whole job services piece is very common when you're looking to help someone get back into employment: the resume, job history, and skill-building. The WIB offers classes free to our clients.

We also have another community partner, a local non-profit that provides very intense job services training, and skill-building. We haven't connected completely yet to have our clients participate in that. We're working on some of the transportation issues and we're also just establishing a schedule for our clients to participate in that particular program. They will provide workshops and classes in computer skills, basic English, basic business language, and individualized help securing and sustaining employment.

(#05) We don't want to take the place of agencies like the career centers; our role is to support their employment goals by making referrals; but through our OVW grant, we can also pay for their classes or a job training program a participant wants to attend. We can also help pay for their books and school supplies, because part of helping them become self-sufficient is helping them get the job skills they need to obtain employment. Our employment program regularly provides them with information about employment opportunities, resume building, how to dress for an interview. We bring in speakers who can talk to them about that.

We have an MOU with a nearby vocational training school, and they provide counseling about what classes to take, depending on the particular career a participant wants to pursue. The school staff act as academic and job counselors for our clients, and they're our MOU partner with our OVW grant. Our city grant also focuses on economic independence and self-sufficiency, and we get a lot of emails about job fairs and job openings, which we pass along to clients.

We have two really large career centers near us that provide free computer access and classes on resume building and how to conduct yourself in an interview. And they list many different job openings. That's a key source of information for clients who want to go straight into employment.

(#06) We contract with a nonprofit organization that offers a series of workshops for women interested in learning about and entering the trades, and which can support the participants throughout that process if they choose. We also work with (but don't pay) the county's employment connections program. We take the

¹²² The [Bridges Out of Poverty](#) program is based on the book: Payne, R. K., DeVol, P. E., & Smith, T. D. (2001). *Bridges out of poverty: Strategies for professionals and communities*. Aha Process Inc.

residents there, and they provide help with resumes and other employment-related services. We have quarterly meetings, where they inform us about what's going on, when new things are coming up, we give them feedback about what services our residents need that they are not offering. Sometimes, they have job fairs, and one of our staff will provide transportation and stay there with them while they participate.

(#07) We refer to community partners for job retention, job training, and job readiness services. Some are written into our project as subcontractors, and we pay them to provide the services; some are just with programs whose services we leverage.

(#08) We have a service provider who used to be a grant partner -- they're no longer -- but we maintain the relationship. They assist clients in securing employment, attending Voc Tech schools, etc.

(#09) We work with a great program staffed by a woman who knows all the ins and outs of education and getting it paid for, and what's happening in the employment world, and where the hits are.

(#10) Although we don't provide any formal type of employment assistance, we do help them get to the employment office here in town, or to our local college where we have programs for dislocated workers and displaced homemakers. We have an arrangement with that college for them to go there to be tested or to get some kind of training options.

(#11) We can work with them one-on-one to build resumes and start job searches. But we also partner with a career center to help with more specific issues.

(#12) We work closely with the career center that helps clients build resumes and get job training; if a participant isn't interested in college, I encourage them to work with the career center. And if they don't have internet or a computer to do online job applications, they know they can go there to do applications online.

(#13) We have two MOU partners for our OVW grant that specifically work with survivors on education and employment matters. One provider, runs an employment solutions program for women that provides assistance with resume writing, employment readiness, helping connect clients with jobs based upon their skillset, preparing them for interviewing, helping them to secure those jobs, and once they've secured the jobs, providing ongoing job coaching. The other MOU partner provides GED education, ESL classes, and also basic computer skills, which will hopefully help our clients become more employable.

(#14) For job placement and education we work with Goodwill's job training program; they come to our program to assist clients on a weekly basis with job readiness, resume development, and interview practice. They also help with identifying job opportunities, and can leverage their connections with employers in the area. And they provide ongoing support for our clients. Our residents have had tremendous success, both in our transitional housing program and in our shelter program, in finding employment through Goodwill, thanks to the support that they provide. They are one of our transitional housing program grant partners.

Credit problems, eviction histories, and criminal justice involvement are all obstacles to employment, just as they are to housing. That's another reason why we work so closely with Goodwill -- because they have such a strong employment network, and can talk an employer into giving our participants a chance. Our participants have been through training, and we really believe they can be successful, but their strengths can be overshadowed by their record. I can't say enough about the importance of those connections and the networking.

(#15) Our women's opportunity center gets quite a bit of HUD funding as a job readiness program in their support services program, and we have several TANF-funded advocates that cross over to the women's opportunity center. Instead of pursuing exemptions from the work requirement, which are harder to get, we developed a program that enables them to get their employment hours at our agency, which is a safe location, and where we can support them in learning more skills. And if they have significant PTSD, which a lot of our survivors do, this is a much calmer environment -- with safer and smaller classes, with only women -- so that they have a community of survivors with which to get those services, but in a healing way.

(E) Health Services

(#01) We have a medical outreach clinic in our shelter. I think there are only two in the state. It's an internship program with the local hospital, and they come once a week and hold a medical clinic for our clients and their children. It's only for our shelter and transitional clients. There's no charge; the doctor doesn't even take insurance or Medicaid. If there's something more than he can treat or deal with, he'll refer you out and if you can't pay, they'll work something out. Some of our women didn't have access to health care before they came to our shelter; some children too. It could be because they weren't eligible, or because they didn't know how to get into a program, or because their abuser wouldn't let them go to the doctor, or wouldn't take the children.

(#02) We just did a grant with the state Health Department for HIV testing, because HIV is linked to domestic violence survivors, so we're really excited.

(#03) We recently developed an MOU with the local Department of Health for dental work on participants; we collaborate with them and local clinics to offer wellness exams for the women.

(#04) We contract with a dentist that provides dental work for women, a therapist that provides ongoing therapy, and a dietician that comes in several times a year to do workshops on preparing food on a budget.

(#05) We are fortunate that our local health clinic has a federally funded program to serve the homeless. Even if a survivor doesn't go through our shelter, and they just go into our transitional housing, they're still considered homeless, and they're able to get full healthcare services, including dental, throughout the year that they are in the program. But then once they fully take over their tenancy, and they're paying their own rent, they still have follow up care in that program for a year after that. So for two years they can get healthcare through our local healthcare organizations.

(#06) For a while, women without children weren't eligible in this State. But they are now. Women are eligible for the State's Medicaid program if they have no income, but if a women earns minimum wage, she make too much money. So we partnered with a program called [MeMD](#). It's an online health care program, founded by a local practitioner who offers it totally free to the women in our program. It's more of a web-based and you do a "FaceTime" with a doctor and who assesses what they can through FaceTime. Now we're working on how to buy the medications, because he gives the women antibiotics but he doesn't have unlimited supply. He created this company but there are many doctors affiliated with it. You or I could pay a fee and you can see a doctor within 30 minutes online. At first I was skeptical of it, but it's working so well he wants to make it available to every DV program around the country for free.

(F) Housing

(#01) If someone doesn't qualify for our program or if we don't have additional funding available to provide rental assistance, we refer them to one of the other Continuum of Care TH providers, and they also have a permanent housing program. They're not DV-focused, they're just homelessness-focused, but we can provide the DV support even if we are not providing the rental assistance.

(#02) Habitat for Humanity has been a very helpful permanent housing resource.

(#03) One of our partner agencies does a lot with housing and they have a specialist who can help with tenancy skills, landlord/tenant mediation, and other housing-related matters

(#04) We have partnered with a local property management company that offers the lowest cost apartments. The units aren't subsidized, but they are at least lower cost.

(#05) The state homeless coalition has a computer-based housing locator program that tells clients where the affordable housing is located. We sit down with the clients, show them how to use it, and then they can look for apartments. We have a collaboration with the coalition: they come in and do presentations on different housing-related topics, so our participants can learn about their rights as a tenant, how to figure out how much rent they can afford, that sort of thing.

(#06) The housing authority is our grant partner, and we work with them to identify low-income housing complexes and programs that our clients could possibly qualify for.

(#07) Our grant partner is a housing agency that provides a range of services assisting area residents in obtaining and sustaining housing. They provide both counseling and training for our staff, so that we understand what resources are available. They work with our clients to prepare them for employment and to be able to maintain permanent housing. So they do vocational training and individualized permanent housing counseling - work with participants on their housing budget to make sure that they can stay on a budget, and plan for an emergency. They run a lot of group workshops. We find that many of our clients -- because they're coming into the transition straight from homelessness, usually in our shelter, but not always -- are not quite ready at the beginning of the program for the intensity of our partner's services, and that it takes a few months; but there's a lot to do in the beginning. We've learned a lot from our partner, and our clients do, as well.

(#08) We have an MOU with our county housing authority. We have a good relationship and we usually work together with them when we send referrals over. A case manager is required to be at each client appointment for housing, if the client chooses. The case manager helps them fill out the paperwork, and everything else requested.

(#09) Our housing authority has a program that offers landlords a guarantee if they lease to a tenant that has completed the housing authority's six-week, 15-hour tenant education course. If that tenant blows out of housing, the landlord can recoup next month's rent and any damages up to \$2,000. It's a fantastic program. And we have property managers who accept people because they've gone through the program. The guarantee is not used very often because most people want to keep their housing.

(#10) We've worked out a special arrangement with our local Housing Authority to give our participants priority for vouchers. Typically when the women enter the emergency shelter, the family advocate or the program manager gets all of them on the Section 8 waiting list. The Section 8 program contacts the ladies to come in for their briefing, and shortly after that, they get the voucher. It's according to preference points, so for example, if you're a veteran, that's a point. If you live in the county, that's a point. If you're homeless, that's a point. Typically when you're homeless, you're moved to the top of the list. Homeless as HUD defines it, not couch surfing. When they're in the DV shelter or the transitional housing, they're considered homeless, so most of the ladies have been on the list for quite some time and have just come up for their vouchers. Once they go to the briefing, they can get their voucher, and start to look for permanent housing.

(#11) We collaborate on a great housing location service in the County. The agency that operates that service is one of our partner organizations; they provide that service for all the homeless housing agencies in the county. Their staff members are assigned to different geographic regions in the county, and staff from their agency come here and meet with our clients and their case managers. That has lessened our burden, because our staff don't have to do all of the housing search work with the clients. Sometimes that agency also helps by providing a portion of the security deposit, first month's rent, and/or moving cost. Prior to last year's Sequestration, almost all our clients would graduate into Section 8 housing or public housing. But with the sequestration, there was a stay in issuance of housing choice vouchers.

(G) Legal Services

(#01) If we have an undocumented client, we can connect them with advocates and attorneys who can help them with the U-Visa and VAWA Visa process.

(#02) We have a partnership with a legal assistance program which can help participants file a restraining order or answer their questions about restraining orders. We found that people don't report domestic violence because they're afraid they'll lose their housing if the police are called. So this legal assistance program does education around that, and helps people navigate the legal system and protect their rights in federally assisted housing.

(#03) Through our collaborative work with the county's domestic violence program, we partners on a civil legal grant. We have a couple of attorneys available, through an application process, who can assist our participants through any dissolution and/or parenting plan they have to do.

(#04) We have partnered with a legal service agency that serves the working poor; they provide services to our clients and represent them in court on divorce and custody matters.

(#05) If participants choose, they can receive legal advocacy services through our agency or through a partnering community legal aid agency. They can sometimes help participants expunge an old criminal record to remove that barrier to housing or employment.

(#06) (Not a current OVW grantee) Trying to establish legal status for a client is one of the most significant challenges that our program faces. Sometimes they come in, and they're not aware of what's available to them, and they could have gotten access to all that a long time ago, so us linking them to all those resources, and sometimes they made decisions that we can no longer take back, and they're not able to receive the services. For example, if there was a domestic violence incident, and the victim withdrew the charges, she can

no longer have a U-Visa or have her work permit through VAWA because she took the charges away, and we can no longer help that person. We can provide the services at the shelter, but when it comes to her having a legal status, it's hard. Maybe she was afraid, or badly advised, given the wrong information. But at that point, there's very little that we can do for them.

We refer participants who need help with immigration status to a local Legal Aid office and to other small nonprofit organizations that can help with that.

(H) Life Skills

(#01) We have lots of community participation and collaboration in our Economic Empowerment classes, with different speakers coming from local banks, the Housing Authority, the library, the Sheriff's Office, etc. and covering lots of different topics.

(#02) We partner with a financial empowerment center that helps our clients get their credit in order and helps them budget. And as part of the application process to our transitional program, people have to meet with a counselor from the financial empowerment center and create a budget. We encourage them to continue working with center staff, so they can save enough money while they're not paying rent or utilities, to prepare for later on when they have to pay those costs.

(#03) We have partnerships with a local credit union to assist women in setting up savings and checking accounts, and offering small loans to help build or improve credit. We have a partnership with a local consumer credit counseling service, and we bring them in to talk about spending plans and credit concerns, and to help with reading and pulling their credit reports. We had a partnership for a savings account program that offered matched contributions; hopefully, the community will get that program back again soon.

(#04) Our OVW-funded partnership is with an organization that assists clients in repairing their credit history. They do financial education and budgeting and help clients with credit checks and with filing their taxes; they have a loan program and an [IDA](#) program. It has been really helpful. Our clients report that those services, especially the credit and budgeting, were a critical part of the help they received from us. They come onsite to us every month and they do a group, so that's where some of the financial education happens. But they also come onsite to work with any client that wants to meet individually for budgeting or financial education or credit-related work.

(#05) We have an MOU with a local organization that offers financial fitness classes on a quarterly basis. They also work with the women one-on-one in addressing financial barriers. Some women take advantage of that, others don't, typically because they feel like they don't have the money to address it.

(#06) Our local YWCA does a lot of financial education and financial coaching, and we connect our clients to those services, if that's something they want. We were able to connect with a local program that makes car loans to women without regard to credit; they particularly target women who may not have any credit or have really poor credit. If the women complete the financial empowerment curriculum and financial education, they can get a loan for a reliable vehicle with a payment no higher than \$300 a month. This helps them avoid predatory loans; instead of paying 28%, they can end up with a vehicle that they're paying off at a rate 6 or 7%.

(#07) We have a women's opportunity center, which is linked with state's social services department and a local community college; we have a computer lab there and teach a responsible renter's class that talks about

credit and budgeting, classes on financial and life skills, healthy relationships, and other topics. We also use the space for support groups. Some classes are taught by shelter staff, some by our transitional program staff.

(#08) We have a paid partner from a local bank that will be coming and doing financial empowerment groups with the survivors; they'll bill us for those groups, and we have some money in that grant to access a language line in case we have someone that doesn't speak English.

(I) Mental Health & Substance Abuse Services

(#09) Referrals to mental health or substance abuse professionals are something we have a hard time with because many counselors don't understand the domestic violence, just the mental health or substance abuse. We provide referrals because we don't have those services in-house. We ask the victim to sign a release so we can work in partnership with the other counselor -- the mental health or substance abuse provider. It's not required, just best practice.

(#10) We've got partnerships to address conditions like substance abuse and mental health. We have a partnership with the local university, which uses our agency for psychology PhD externship placements, and that allows us to provide free mental health services. We also provide care around substance abuse in the context of DV, which is a huge barrier a lot of our clients experienced.

(#11) We have five contracted part time therapists who run support groups and provide individual and family therapy. 99% of what they do is on site but they don't have offices here. They use the spaces we provide.

(#12) For mental health counseling there's some -- not many -- resources available. We have a free counseling clinic here, and AA and NA meetings for substance-abuse.

(#13) We have two different clinical therapists that come to our offices monthly to do clinical supervision for staff and to lead discussions about relevant issues.

(#14) We have a consultant who is a licensed marriage and family therapist; she is available nights and weekends, which is just crucial for people who are working. We have a Licensed Professional Counselor (LPC) funded under one of our other grants, who is available for our transitional clients. We have individuals that come in and run groups for our shelter clients. And if a transitional client has been a shelter client, they can come back to the shelter and participate in groups. We have a contract with a self-defense trainer, who runs one class per quarter for our transitional clients. We have developed new MOUs with other consultants as our grant progresses: a second LPC, a counseling firm. A lot of our new MOUs have been for counseling.

For the purposes of information sharing, consultants are considered part of our staff. If we have an LPC that's been meeting with one of our transitional housing clients, we talk openly with her on a need-to-know basis about that situation without requiring a separate signed consent.

(#15) Many of our women need more than therapy; we work really hard to find other systems that are trauma-informed. Sometimes, more typical mental health services, which aren't trauma-informed, don't help, and even compound problems. Our staff don't have a lot of experience with substance abuse treatment, but many

of our women have substance abuse issues. We are constantly referring out, but we would like to find more providers that we can refer participants to who understand the domestic violence as part of that.

(#16) We have a partnership with a DV program that runs a safe house shelter and that also provides DV services - empowerment workshops, DV counseling with people that need assistance in breaking the cycle or figuring out their next step. They also run groups in some of our transitional housing.

(#17) We don't have clinicians on staff, and can't cover the cost of it, but we do a great many referrals, especially to clinicians based in our largest town, where the main office is. Once you get to the outlying counties, the resources are more limited.

(#18) Under a collaboration with the county, they have made available two of their therapists to provide group therapy for the moms here; they run sessions twice a week. There's one therapist who does the group in Spanish and one who does it in English. We approached the county for help, because the residents wanted access to therapy, but they didn't want to have to go outside of the program to access it, because it was really difficult with children, no cars -- so we were able to get the county to offer these two therapists to come to our site at no charge. It's an ongoing collaboration that will last as long as we need it.

(#19) If we need a detailed psychosocial so a participant can provide evidence of trauma to Immigration, we contract with a PhD psychologist to do the psychosocial and the report. We also contract with interpreters and translators to work with clients who don't speak English. Other than that, we stay away from contracting.

(#20) We have one clinician that works with our mothers and children in the shelter that is funded through OVW, and she's a part of a different agency that we contract with. Most of the time, we just refer them to outside agencies to address their clinical needs.

(#21) We serve a lot of clients who have mental health issues. We have an MOU with a medical advocacy project, which is with a healthcare and behavioral healthcare facility. If participants have underlying barriers -- mental health or drug and alcohol -- if it gets to the point where we can't serve them in our program because we don't have the resources or the training, we try to get them into other programs that can help them.

(#22) We don't have a therapist, but we send surveys out to local therapists and other providers and they indicate how much experience they have with domestic violence and sexual assault and trauma in general, what their payment plan is, if they have a sliding scale fee, and what insurance they take. Then we compile it in a little binder for clients. We don't specifically say, "This is a good therapist," because that could always bite us in the butt. Participants make their own choices.

(#23) There's an equine-assisted therapy program, and one of our counselors went through a training to be a facilitator in that program. And we have a collaboration with a stable. We've operated one cycle of therapy, and we're looking for funding to continue that. We've been working with a professor doing research about the effectiveness of equine-assisted psychotherapy.

(#24) Participants can receive counseling free of charge, and that's either through our agency or through a rape crisis center, which is a transitional housing partner.

(#25) We have a full time and a part time licensed counselor on staff, and both the housing department and the domestic violence department can make referrals to those counselors for clinical and mental health services. For participants that require the assistance of a psychiatrist, we have a partnership with our local mental health authority that can see our clients in their clinic. We have staff at the master's level and if they need the assistance of an MD, we can make the referral.

(#26) We work very closely with a community mental health provider. At times, we've had to transfer people to their program who were acting out to the point that people couldn't sleep or the moms were afraid for their kids. Other times, staff from that agency come to our program to assist participants in their search for permanent housing, or in overcoming challenges that arise in the context of our communal living program.

(#27) A local agency offers mental health services and they're able to come onsite to serve our clients; our county hospital has a program through their psychiatric unit that clients can access to receive mental health support and medications. So, many of our clients that are moving into housing from the shelter have had the option of accessing services, and they get assessed and enrolled. Most recently, the hospital program has added some prescription copays for clients, so that's a bit of a struggle we're trying to work around; on the other side, the local mental health agency might have a limit on how many prescriptions they get per month. A lot of our folks access those services, and our case managers work with them to ensure they don't lose the benefit: if they don't fill out a certain form at six months, they might get dropped and have to start over.

Most of our clients who need mental health services can access those services, although sometimes there's a bit of a wait time; the stopgap is that they can go through the county program until the local agency program kicks in. It's not perfect, but I wouldn't say that clients are left hanging without access. We also have a mental health team that comes out, so if anyone is in severe crisis, the team will come onsite or to a person's home.

(#28) We have a couple of really strong partnerships in the community that are specific to emotional wellbeing and illustrative of how trauma informs the work we are doing. We work very closely with a female health program in our county and with local therapists. We have staff from those organizations that meet with our clients on a weekly basis, and we make referrals to them.

We have a longstanding relationship with our local substance abuse program, and we provide joint services, meaning that we provide consultation support to the local substance abuse program on issues of safety and sobriety and they provide substance abuse services on our shelter campus and to our clients in outreach. If we have a person with substance issues in our transitional program, they can participate in those dual services. And those dual services are typically support groups that are co-facilitated by a staff member from the local substance abuse program and one of our staff. Also, that substance abuse provider has transitional housing, and they give our shelter clients priority. If we don't have any transitional units, and we have an individual in our shelter struggling with sobriety or maintaining sobriety but dealing with poverty issues, we can often work with them to get priority placement into their transitional housing units.

(#29) We have two 5BR homes for single women and two 5BR homes for women with children. One of the homes is geared towards female vets, but the thing that all the women have in common is that they're all battered or sexually abused and have substance abuse issues. Participants have to be sober to stay in the homes. We partner with local treatment programs and detox places and we've let women back two, three, and four times. They do have to leave, until they can come back in the program clean. It could be 24 hours or 72 hours, depending on their drug of choice. But they don't lose their bed.

Initially, the probation officers told us, "We're not sending our women to some flophouse." They wanted women to be UA'd [urine analysis], but with OVW funding, we can't require the women to do UA's. I talked to OVW, and asked for help in figuring it out. Our resident advisory committee recommended that people randomly get UA'd and so we partnered with a local company that does it. The probation officers tell them that OVW can't prevent another agency from forcing them to have UA's.

I'd say 99% of the female vets we serve were sexually abused or raped by our own troops, and the PTSD issues are just overwhelming for us. So we partner with a Veterans organization and we collaborate on groups and different services for those women. They get free transportation, too, whether it's doctor's appointments or just the different things they do for vets that we don't have services for.

Questions to Consider

1. How do the effects of trauma on participants' emotional, psychological, and physical health impact their ability to participate in your program?
2. How does your program accommodate survivors who experience those impacts of trauma?
 - How do the effects of trauma impact their ability to participate in mainstream programs?
3. How do mainstream programs accommodate survivors who experience those impacts of trauma?
 - In what ways could collaboration between mainstream and victim services providers encourage more helpful -- or less counterproductive -- responses to survivor behaviors that are manifestations of the impacts of trauma?
 - How can agencies serving survivors of domestic and sexual violence partner with their CoC to promote the delivery of trauma informed services to survivors of domestic and sexual violence served by other CoC providers?
 - Are there other individuals or families served by CoC providers who would benefit from a trauma-informed approach? (Are there any who would not?)
4. What aspects of participation in a Continuum of Care are mutually beneficial to DV/SA-focused providers and other non-DV/SA-focused providers?
5. What do DV/SA-focused providers have to offer to non-DV/SA-focused providers? And what do non-DV/SA-focused provider have to offer to victim services providers?
6. What would it take in your CoC to bring about HUD's vision for the way coordinated entry / coordinated assessment should work (as articulated in its **Coordinated Entry and Victim Services Providers FAQ** ([HUD, 2015d](#)) in an integrated system with mainstream and victim services providers?
7. Are there flaws or gaps in HUD's vision for coordinated entry / coordinated assessment that you believe need to be addressed?
8. How could your program leverage greater benefit from participating in your Continuum of Care?
9. What are the pros and cons of utilizing in-house versus MOU providers addressing the following participant needs: (a) Children's services, (b) Educational Services, (c) Employment Services, (d) Housing search assistance, (e) Health Services, (f) Legal assistance, (g) Life skills training and support, (h) Mental health or substance abuse
10. Is establishing a trusting provider/survivor relationship with a community provider more or less sustainable than a relationship with a consultant or program staff? What determines your answer?
11. In what instances does working with an MOU provider complicate coordination of services?
12. What steps can a victims services provider take to ensure that the organizations with which it partners assign staff who understand the implications of domestic and sexual violence, and who can provide trauma-informed services? What if staff "don't get it?"
13. What kind of training does your agency provide to MOU providers before they start delivering services, or soon thereafter (e.g., policies and procedures, DV 101, trauma 101, etc.)? Who pays for that training?

4. Appendix A: Project Description and Methodology

(a) Project Description: Summary

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

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

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

- [Chapter #01](#) - **Definition of Success & Performance Measurement** - Explores how funders and providers define and measure success and program performance; how participant-defined goals are tracked; how participant feedback is collected; and how the definition and measurement of success affects program decisions. Highlights innovative performance and participant outcome metrics. Discusses approaches to collecting, storing, releasing, and destroying data, and the software used to collect, analyze, and report on program data.
- [Chapter #02](#) - **Survivor Access and Participant Selection** - Explores the distinct and overlapping roles of domestic violence (DV) shelters and transitional housing; the pathways that survivors take to get to transitional housing, and how providers select participants from among "competing" applicants for assistance; why providers might decline to serve certain candidates; who is and isn't served; and the regulatory and legal framework within which those processes occur.
- [Chapter #03](#) - **Program Housing Models** - Explores the strengths and challenges of alternate approaches to housing survivors in transitional housing and transition-in-place programs. Examines the pros and cons of time-limited housing vs. transition-in-place housing, congregate vs. clustered vs. scattered site housing, and provider-owned vs. provider-leased vs. participant-leased housing. Discusses how the type of housing can affect participant selection and the services offered.
- [Chapter #04](#) - **Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement** - Examines the challenges, strategies, and implications of taking a survivor-centered/voluntary services approach, and how such an approach is integral to operating a trauma-informed program. Explores the potential impacts of funder expectations, choice of housing model, staffing patterns, and diverse participant needs and circumstances. Presents comments illustrating the range of providers' interpretations of and responses to the voluntary services requirement, including their approaches to supporting participant engagement and to addressing apparent lack of engagement. Discusses the concept of empowerment, presents comments illustrating the diverse ways that providers see and support survivor empowerment, and cites an innovative approach to measuring safety-related empowerment.
- [Chapter #05](#) - **Program Staffing** - Explores program staffing levels and the kinds of positions providers maintain; the attributes and qualifications that providers look for in the hiring process; and how they

assess the value of having a clinician on staff, having child-focused staff, and having survivors on staff. Examines how programs support and supervise staff, and their approaches to staff training. Presents comments illustrating providers' diverse perspectives about utilizing volunteers, and describing how programs that do use volunteers screen, train, and support them.

- [Chapter #06](#) - ***Length of Stay*** - Explores funders' and providers' approaches to limiting or extending the duration of housing assistance and services, and the implication of those approaches.
- [Chapter #07](#) - ***Subpopulations and Cultural/Linguistic Competence*** – Discusses cultural and linguistic competence and how providers understand and work to achieve it in their programs. Presents diverse perspectives from the literature and online resources and from provider interviews about the challenges and approaches in serving specific subpopulations, including African American, Latina, Asian American, Native American/Alaska Native, Immigrant, LGBTQ, older adult, deaf, disabled, and ex-offender survivors. Includes an extensive review of the challenges, approaches, and legal framework (e.g., non-discrimination, reasonable accommodation, fair housing) in serving survivors with disabling conditions that affect their mental health, cognition, and/or behavior, including trauma/PTSD, substance dependence, traumatic brain injury, and/or mental illness. Highlights OVW-funded collaborations to enhance the capacity of victim services providers to serve survivors with disabilities and of disability-focused agencies to serve consumers who are also survivors.
- [Chapter #08](#) - ***OVW Constituencies*** - Focuses on the needs and approaches to meeting the needs of survivors of sexual violence -- including survivors of rape and sexual assault, homeless victims of sexual violence, survivors of Military Sexual Trauma, and survivors of human sexual trafficking. Explores possible reasons why survivors of sexual assault constitute only a small percentage of the participants in OVW TH grant-funded programs, even though provider comments generally indicate an openness to serving such survivors. Includes a conversation with senior staff from the Victim Rights Law Center discussing possible options for expanding system capacity to serve sexual assault survivors.
- [Chapter #09](#) - ***Approach to Services: Providing Basic Support and Assistance*** - Explores different frameworks for providing advocacy /case management support (e.g., voluntary services, survivor empowerment, Housing First, Full Frame) and how motivational interviewing techniques could be helpful. Discusses survivor safety and how safety is assessed and addressed (e.g., danger and lethality assessment instruments, addressing batterer- and life-generated risks as part of safety planning, safe use of technology). Looks at strategies and practices for supporting community integration, and providing follow-up support to program alumni.
- [Chapter #10](#) - ***Challenges and Approaches to Obtaining Housing and Financial Sustainability*** - Examines the challenges survivors face in obtaining safe, decent, affordable housing and the approaches providers take to help them, and some useful resources. Explores the added challenges posed by poverty, and approaches and resources leveraged by providers to facilitate access to mainstream benefits, education and training, and decent employment. Other areas of focus include childcare and transportation, resources for persons with criminal records, workplace-related safety planning, and approaches and resources for supporting survivors in enhancing key skills, including financial management.
- [Chapter #11](#) - ***Trauma-Specific and Trauma-Informed Services for Survivors and Their Children*** – Discusses the nature, impacts, and manifestations of trauma; approaches to addressing trauma; what it means to be trauma-informed; and the steps providers take -- and can take -- to become more trauma-informed. Reviews the impact of trauma on children and families, especially the trauma of witnessing abuse of a parent; and discusses the challenges posed and approaches taken in addressing the effects of that trauma. Includes brief sections on custody and visitation.
- [Chapter #12](#) - ***Funding and Collaboration: Opportunities and Challenges*** - Examines sources of funding for TH programs, focusing on OVW and HUD grants -- the regulatory requirements, strengths and

constraints of each funding source, and the challenges of operating a program with combined OVW/HUD funding. Explores the potential benefits, challenges, and limitations of partnerships and collaborations with mainstream housing/service providers, including confidentiality issues. Presents provider comments citing the benefits of being part of a statewide coalition; discussing the opportunities and challenges of participating in a Continuum of Care; and illustrating the range of gap-filling service agreements and collaborations with mainstream providers. Highlights published reports describing successful collaborations.

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

(b) Project Description: Overall Approach

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

Survivors from different demographics and circumstances may experience domestic and sexual violence differently and may respond differently to different service approaches. Age, class, race, cultural and linguistic background, religious affiliation, gender identity, sexual orientation, military status, disability status, and, of course, life experience all play a role in defining who a survivor is, how they experienced victimization, and what they might need to support healing and recovery. Each survivor's history of violence and trauma and its impact on their physical, physiological, emotional, and psychological wellbeing is different, and their path to recovery may require different types or intensities of support.

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

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

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

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

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

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

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

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

(i) Development and Implementation of the Interview Protocol

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

Because there were so many potential subjects to discuss and only an hour to have those conversations, we divided the topics into separate interview protocols. In addition to basic descriptive information ("universal

topics")¹²³ that would be collected in each interview, we defined four distinct sets of topics¹²⁴ that would be sequentially assigned as interviews were scheduled. Over time, we eliminated certain areas of questioning from the interview protocol if we were not getting new information, and added topics or questions, as we identified gaps in our information. By the time half the interviews had been completed, the four lists of topics/subtopics had been condensed into three lists/interview protocols.

Pursuant to early discussions with the OVW, we agreed that the initial protocol would be "field-tested" by conducting interviews of staff from nine TH providers that the OVW identified and reached out to on our behalf. We also agreed that our interviews would be conversational and driven by the providers we were interviewing. That is, ***although we had lists of topics and questions that we might want to address, we would follow the lead of the provider to make sure we covered any issues or concerns or approaches that they wanted to highlight. Rather than asking a uniform series of questions, we would use our protocols as guides, rather than as interview scripts.*** To realize this objective, our team worked together to make sure we had the same general understandings of the protocol and the purpose of the interviews. The nine initial interviews were all conducted by pairs of team members, to facilitate full-team participation in our review of those interviews and in any revisions to the protocol based on that review.

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

Each interview began with an introduction of the project; an explanation of how we intended to create a resource document that would describe the what, how, and why of providers' efforts ***in their own words***; a

¹²³ **"Universal" Topics:** Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary versus transition-in-place; congregate versus clustered versus scattered-site; provider-owned versus provider-leased versus participant-leased); target constituency (e.g., survivors of domestic violence, sexual assault, etc.); type/number of direct services staff, use of consultants, involvement of other agency staff; other DV- or non-DV-focused programs operated by agency; how survivors access program and participant selection/prioritization; how staff understand the different roles of DV shelter versus TH; characterization of service area (e.g., metropolitan area, small city, suburban, rural, mixed); program definition of a "successful" outcome and how program promotes success; how program implements voluntary services; maximum, typical, and targeted length of stay; other sources of funding; involvement with local or regional network of DV-focused providers and/or with Continuum of Care; most significant challenges faced by program; perceived differences between TH for other homeless populations and TH for survivors of domestic violence/sexual assault.

¹²⁴ **Group 1 Topics:** staffing details (roles, training, support, etc.); use of volunteers (roles, reasons for/against using, training and support); program philosophy and underlying approach (e.g., trauma-informed, empowerment, survivor-centered, etc.); consumer involvement (Board membership, advisory roles, options for current participants).

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

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

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

request to record the conversation; and an assurance that ***once the project was over, recordings and transcripts would be deleted, so that all that would be left would be anonymous comments***. We followed this same procedure throughout the project, eventually reaching out to almost 250 providers and securing the participation¹²⁵ of over 50%. Early on, we modified the process, per the request of some of the providers, and began sending a tentative list of topic areas along with the email confirming the date and time of each interview. The email emphasized, however, that the provider should feel free to steer the conversation as they saw fit, to make sure we covered any issues, concerns, or approaches that they wanted to highlight.

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

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

(ii) Processing of Interview Data

All interviews were submitted to a transcription service and the transcript was reviewed for accuracy (and corrected, as needed) by the project director. Transcripts of the interviews were entered into NVivo, a qualitative data analysis software, and then sentences or paragraphs that pertained to each of 27-30 project-defined topic areas¹²⁶ were coded as being related to that topic area. The project director performed the large majority of coding, and reviewed (and, as needed, modified) all of the coding decisions by the project associate, thereby ensuring coding consistency.

The selected provider comments pertaining to each topic area constituted a voluminous amount of data, and had to be boiled down, so that they could be shared with our Project Advisory Team members, and eventually incorporated into the report. Interview comments were edited for clarity and brevity, with an absolute emphasis on retaining the voice and essential message of provider comments. The interviewer's voice was removed. Names of people, places, and programs were removed and replaced with generic references to ensure confidentiality and anonymity, as had been promised to providers at the outset of each interview, and in our outreach correspondence. The project director did the overwhelming majority of all such editing, and reviewed (and, as needed, modified) all edits proposed by the project associate.

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

¹²⁵ We actually secured the participation of 130 providers; however, six interviews were not included in the analysis because the interviewee was not adequately familiar with the TH program, or the program was too new to have any experience, or the provider no longer operated the TH program and no longer had staff who could answer our questions.

¹²⁶ Several codes were consolidated as the coding process evolved.

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

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

5. References

- Baker, C. K., Billhardt, K. A., Warren, J., Rollins, C., & Glass, N. E. (2010). Domestic violence, housing instability, and homelessness: A review of housing policies and program practices for meeting the needs of survivors. *Aggression and Violent Behavior*, 15(6), 430-439. Retrieved May 21, 2018, from https://b3cdn.net/naeh/416990124d53c2f67d_72m6b5uib.pdf
- Bassuk, E. L., Weinreb, L. F., Buckner, J. C., Browne, A., Salomon, A., & Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Jama*, 276(8), 640-646. Retrieved April 8, 2016, from <http://www.ncbi.nlm.nih.gov/pubmed/8773638>
- Breiding, M.J., Smith, S.G., Basile, K.C., Walters, M.L., Chen, J., & Merrick, M.T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization -- National intimate partner and sexual violence survey, United States, 2011. *Center for Disease Control and Prevention: Morbidity and Mortality Weekly Report. Surveillance Summaries*. 63 (8): 1-18. Retrieved March 2, 2016, from <http://www.cdc.gov/mmwr/pdf/ss/ss6308.pdf>
- Burt, M.R. (2006). *Characteristics of Transitional Housing for Homeless Families*. Washington, DC: Urban Institute. Retrieved February 17, 2016, from <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411369-Characteristics-of-Transitional-Housing-for-Homeless-Families.PDF>
- Burt, M.R. (2010). *Life After Transitional Housing for Homeless Families*. Washington, D.C.: Urban Institute. Retrieved April 8, 2016, from <http://www.urban.org/research/publication/life-after-transitional-housing-homeless-families>
- Campbell, J.C. (2004). *Danger Assessment* [Tool]. Retrieved February 17, 2016, from <https://www.dangerassessment.org/>
- Center on Victimization and Safety, Vera Institute of Justice (2011) Forging New Collaborations: A Guide for Rape Crisis, Domestic Violence, and Disability Organizations. Retrieved September 15, 2016, from <https://www.vera.org/publications/forging-new-collaborations-a-guide-for-rape-crisis-domestic-violence-and-disability-organizations>
- Chamberlin, J., & Rogers, J. A. (1990). Planning a community-based mental health system: Perspective of service recipients. *American Psychologist*, 45(11), 1241. Retrieved April 8, 2016, from <http://www.ncbi.nlm.nih.gov/pubmed/2268093>
- Clery Center for Security on Campus. (2012). *Jeanne Clery Act*. Retrieved April 8, 2016, from <http://clerycenter.org/jeanne-clery-act>
- Clough, A., Draughon, J., Njie-Carr, V., Rollins, C., & Glass, N. (2013). 'Having housing made everything else possible': Affordable, safe and stable housing for women survivors of violence. *Qualitative Social Work*. Available at <http://qsw.sagepub.com/content/early/2013/09/19/1473325013503003.full.pdf>
- College of Natural Sciences Tri-Ethnic Center. (n.d.). *Community Readiness*. Retrieved February 17, 2016, from http://triethniccenter.colostate.edu/communityReadiness_home.htm
- Comas-Diaz, L. (2007). Ethnopolitical psychology: Healing and transformation. In *Advancing Social Justice through Clinical Practice* (E. Aldarondo, Ed.). New York: Routledge, Taylor & Francis Group.

- Congress.Gov. (2015-2016). *H.R. 1047: Housing Assistance Efficiency Act*. Retrieved February 16, 2016, from <https://www.congress.gov/bill/114th-congress/house-bill/1047>
- Cooperrider, D.L. and Whitney, D. (n.d.). *What is Appreciative Inquiry?* Retrieved April 12, 2016, from <https://appreciativeinquiry.case.edu/intro/whatisai.cfm>
- Corporation for Enterprise Development (CFED). (2016). *Individual Development Accounts (IDAs)*. Retrieved April 12, 2016, from <https://cfed.org/programs/idas/>
- Correia, A., and Melbin, A. (2005). *Transitional Housing Services for Victims of Domestic Violence: A Report from the Housing Committee of the National Task Force to End Sexual and Domestic Violence*. Retrieved December 5, 2016, from <http://vawnet.org/material/transitional-housing-services-victims-domestic-violence-report-housing-committee-national>
- Danger Assessment. (2016). *View the instrument / download the danger assessment*. Retrieved July 29, 2016, from <https://www.dangerassessment.org/DATools.aspx>
- Danger Assessment. (2016). *What is the danger assessment?* Retrieved July 29, 2016, from <https://www.dangerassessment.org/about.aspx>
- Davies, J. (2009). *Advocacy beyond leaving: Helping battered women in contact with current or former partners a guide for domestic violence advocates*. Family Violence Prevention Fund. Retrieved August 23, 2016, from https://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Advocates%20Guide%281%29.pdf
- DeCandia, C. J. Beach, C. A. & Clervil, R. (2013). *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experience Homelessness*. Needham, MA: The National Center on Family Homelessness. Retrieved March 9, 2016, from <http://www.air.org/resource/closing-gap-integrating-services-survivors-domestic-violence>
- D'Ercole, A., & Struening, E. (1990). Victimization among homeless women: Implications for service delivery. *Journal of Community Psychology*, 18(2), 141-152. Retrieved February 16, 2016, from <http://onlinelibrary.wiley.com/doi/10.1002/1520-6629%28199004%2918:2%3C141::AID-JCOP2290180206%3E3.0.CO;2-O/abstract;jsessionid=56EC325A645EBDBD8CB1F801BEBB9F6C.f03t03>
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native people*. Teachers College Press.
- Edmund, D.S. & Bland, P.J. (2011). *Real tools: Responding to multi-abuse trauma*. Juneau, AK: Alaska Network on Domestic Violence and Sexual Assault. Retrieved April 12, 2016 from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/09/RealTools_RespondingtoMultiAbuseTrauma_BlandandEdmund.pdf
- Family Justice Center Alliance. (2016). [Website homepage]. Retrieved April 12, 2016, from <http://www.familyjusticecenter.org/>
- Fernandes-Alcantara, A. L. (2014). *Family Violence Prevention and Services Act (FVPSA): Background and Funding*. Washington, DC: Congressional Research Service. Retrieved March 9, 2016, from <https://www.hsdl.org/?view&did=751765>
- Goodman, L., Fels, K., & Glenn, C. (2006). *No safe place: Sexual assault in the lives of homeless women*. Harrisburg, PA: National Online Resource Center on Violence Against Women. Retrieved February 16, 2016, from http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=558
- Goodmark, L. and Rosewater, A. for the National Council of Juvenile and Family Court Judges (2008) *Bringing the Greenbook to Life: A Resource Guide for Communities*. Retrieved September 15, 2016, from <http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1075&context=books>
- Govtrack. (n.d.). *Text of the Violence Against Women Reauthorization Act of 2013*. Retrieved February 16, 2016, from <https://www.govtrack.us/congress/bills/113/s47/text>
- Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. J. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American journal of community psychology*, 36(3-4), 223-238. Retrieved December 5, 2016, from <https://www.ncbi.nlm.nih.gov/pubmed/16389497>
- Gubtis, D. et al. (2015). **Family Options Study: Short-Term Impacts of Housing and Services Interventions for Homeless Families**. Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Policy Development and

- Research. Retrieved April 8, 2016, from http://www.huduser.gov/portal/portal/sites/default/files/pdf/FamilyOptionsStudy_final.pdf
- Jasinski, J.L., Wesely, J.K., Mustaine, E., Wright J.D. (2005). *The experience of violence in the lives of homeless women: A research report*. Report submitted to National Institute of Justice. Retrieved February 16, 2016, from <https://www.ncjrs.gov/pdffiles1/nij/grants/211976.pdf>
- Jost, T.S., (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, Appendix B Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws..* Washington, D.C.: The National Academy Press. Retrieved April 8, 2016, from http://www.ncbi.nlm.nih.gov/books/NBK19830/pdf/Bookshelf_NBK19830.pdf
- King County Coalition Against Domestic Violence. 2010 Change Is Possible: Successes, Lessons Learned And Plans: Domestic Violence & Mental Health Collaboration Project: 2007-2010 Retrieved October 30, 2016, from <http://www.kccadv.org/wp-content/uploads/2010/09/Change-is-Possible1.pdf>
- Kristiansson, V. & Whitman-Bar, C. (2015). Integrating a Trauma-Informed Response in Violence Against Women and Human Trafficking Prosecutions. *Strategies: The Prosecutors' Newsletter on Violence Against Women* (Issue 13). Retrieved April 12, 2016 from <http://www.aequitasresource.org/Integrating-A-Trauma-Informed-Response-In-VAW-and-HT-Strategies.pdf>
- Kristiansson, V. (2013). Walking the Tightrope: Balancing Victim Privacy and Offender Accountability in Domestic Violence and Sexual Assault Prosecutions: Part I, An Overview of the Importance of Confidentiality and Privilege Laws. *Strategies: The Prosecutors' Newsletter on Violence Against Women* (Issue 9). Retrieved April 8, 2016, from <http://guides.baker.edu/c.php?g=304134&p=2025531>
- Kristiansson, V. (2013a). Walking the Tightrope: Balancing Victim Privacy and Offender Accountability in Domestic Violence and Sexual Assault Prosecutions: Part II, Protecting Privileges and Victims Who Assert Them. *Strategies: The Prosecutors' Newsletter on Violence Against Women* (Issue 10). Retrieved April 8, 2016, from http://www.aequitasresource.org/Issue_10_Walking_A_Tightrope_Balancing_Victim_Privacy_and_Offender_Accountability_in_Domestic_Violence_and_Sexual_Assault_Prosecutions_Part_II_May_2013.pdf
- Mattessich et al. (2001). *Table 1.2 Cooperation, Coordination and Collaboration: A table describing the elements of each*. Retrieved April 12, 2016, from http://www.conservationgateway.org/Documents/3Cs_Table.pdf
- Mbilinyi, Lyungai. (2015). *The Washington State Domestic Violence Housing first Program Cohort 2 Agencies Final Evaluation Report: September 2011 – September 2014*. The Washington State Domestic Violence Housing First Program. Retrieved February 1, 2016, from http://wscadv.org/wp-content/uploads/2015/05/DVHF_FinalEvaluation.pdf
- MeMD. (2016). [Website homepage]. Retrieved from <http://www.memd.me/>
- Mendelsohn, S.A. (2012, January 2). U.S. Department of Education Amends its FERPA Regulations to Allow for Certain Additional Student Disclosures. *The National Law Review*. Retrieved April 8, 2016, from <http://www.natlawreview.com/article/us-department-education-amends-its-ferpa-regulations-to-allow-certain-additional-student-dis>
- Missouri Coalition Against Domestic and Sexual Violence (MCADSV). (2015). *Understanding the Nature and Dynamics of Domestic Violence*. Retrieved April 20, 2016, from <http://www.mocadsv.org/FileStream.aspx?FileID=387>
- National Alliance to End Homelessness. (2013). *Coordinated Assessment Toolkit*. Retrieved February 17, 2016, from <http://www.endhomelessness.org/library/entry/coordinated-assessment-toolkit>
- National Alliance to End Homelessness. (2015). *Just Released: The State of Homelessness in America 2015*. Retrieved March 9, 2016, from <http://www.endhomelessness.org/blog/entry/just-released-the-state-of-homelessness-in-america-2015#.VtCCjfrJD8>
- National Alliance to End Homelessness. (2016). *Homelessness: A State of Emergency*. Retrieved May 21, 2018, from <https://endhomelessness.org/resource/homelessness-a-state-of-emergency/> and webinar: <https://endhomelessness.org/resource/homelessness-as-a-state-of-emergency-webinar/>

- National GAINS Center. (2006). *After the Crisis: Trauma and Retraumatization Issue Brief*. Retrieved April 12, 2016, from <https://www.yumpu.com/en/document/view/42854426/trauma-and-retraumatization-issue-brief-samhsas-gains> or <http://www.traumainformed.org/wp-content/uploads/2015/04/Trauma-and-Retraumatization-Issue-Brief.pdf>
- National Low Income Housing Coalition. (2015). *Out of Reach 2015*. Washington D.C. Retrieved February 17, 2016, from http://nlihc.org/sites/default/files/oor/OOR_2015_FULL.pdf
- National Network to End Domestic Violence (NNEDV). (2008, revised 2015). *FAQ's on Survivor Confidentiality Releases: The Confidentiality Institute & The Safety Net Project at the National Network to End Domestic Violence*. Retrieved May 21, 2015, from <https://nnedv.org/mdocs-posts/faqs-on-survivors-confidentiality-releases/>
- National Network to End Domestic Violence (NNEDV). (2011). *Frequently Asked Questions about U.S. Federal Laws & Confidentiality for Survivors*. Retrieved May 21, 2018, from <https://nnedv.org/mdocs-posts/faqs-about-us-federal-laws-and-confidentiality-for-survivors/>
- National Network to End Domestic Violence (NNEDV). (2013). *The Basics of the Voluntary Services Approach*. Retrieved May 21, 2018, from <https://nnedv.org/mdocs-posts/understanding-the-basic-of-the-voluntary-services-approach/>
- National Network to End Domestic Violence (NNEDV). (2015). *Domestic Violence Counts 2014: A 24-Hour Census of Domestic Violence Shelters and Services*. Retrieved May 21, 2018, from <https://nnedv.org/content/domestic-violence-counts-2014-census-report/>
- National Network to End Domestic Violence (NNEDV). (2016). *VAWA & FVPSA Confidentiality*. Retrieved May 21, 2018, from <https://nnedv.org/mdocs-posts/confidentiality-vawa-fvpsa/>
- Ontario Ministry of Community Safety & Correctional Services. (2014). *Office of the Chief Coroner Domestic Violence Death Review Committee Annual Report 2012*. Retrieved March 9, 2016, from http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/DVDR/2012Report/DVDR_2012.html
- OrgCode Consulting, Inc. (2014). *Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT): Manual for Prescreen Triage Tool for Single Person Households*. Retrieved May 21, 2018, from https://docs.google.com/file/d/0B7mVvcTz_ivDUWx4UmE1V0ZjTHM/edit
- OrgCode Consulting, Inc. (2015). *Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT): Prescreen Triage Tool for Families*. Retrieved May 21, 2018, from <https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479851219/VI-SPDAT-v2.01-Family-US-Fillable.pdf?1479851219>
- OrgCode Consulting, Inc. (2015a). *Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT): Prescreen Triage Tool for Single Adults*. Retrieved May 21, 2018, from <https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479851108/VI-SPDAT-v2.01-Single-US-Fillable.pdf?1479851108>
- OrgCode Consulting, Inc. (2015b). *Service Prioritization Decision Assistance Tool (SPDAT): Assessment for Single Adults*. Retrieved May 21, 2018, from <https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479850999/SPDAT-v4.01-Single-Fillable.pdf?1479850999>
- OrgCode Consulting, Inc. / DeJong, I. (2015). Blogpost: *VI-SPDAT and Rapid Re-Housing Recommendations*. Retrieved May 21, 2018, from http://www.orgcode.com/vi_spdat_and_rapid_re_housing_recommendations
- Padgett, D., Henwood, B., & Tsemberis, S. (2015) *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives*. Oxford University Press. DOI:10.1093/acprof:oso/9780199989805.001.0001. Available as of December 5, 2016, from <http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199989805.001.0001/acprof-9780199989805>
- Pew Charitable Trust/Beitsch, R. (2015). *Cities, States Turn to Emergency Declarations to Tackle Homeless Crisis*. Philadelphia, PA: The Pew Charitable Trusts. Retrieved March 9, 2016, from <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/11/11/cities-states-turn-to-emergency-declarations-to-tackle-homeless-crisis>

- Pieper, K. (2014, February 3). Domestic violence shelter comes out of hiding. *USA Today*. Retrieved March 9, 2016, from <http://www.usatoday.com/story/news/nation/2014/02/03/domestic-violence-shelter-comes-out-of-hiding/5189191/>
- Project Peer. (2010). *Project Peer Washington, DC Strategic Plan 2010*. Retrieved April 12, 2016, from <http://www.endabusepwd.org/wp-content/uploads/2015/10/Project-Peer-Washington-District-of-Columbia-Strategic-Plan.pdf>
- Project Peer. (2011). *Guiding Principles for Identifying and Accommodating Survivors with Developmental Disabilities and Mental Health Issues*. Retrieved April 12, 2016, from <http://www.dccadv.org/img/fck/file/Project%20Peer%20Policy%20Principles.pdf>
- Soroptimist. (2012). [Website homepage]. Retrieved from <http://www.soroptimist.org/>
- Sunshine Lady Foundation, Inc. (2016). [Website homepage]. Retrieved from <http://www.sunshinelady.org/>
- Thomas, K. A., Goodman, L., & Putnins, S. (2015). "I have lost everything": Trade-offs of seeking safety from intimate partner violence. *American journal of orthopsychiatry*, 85(2), 170-180. Retrieved August 23, 2016, from <http://www.ncbi.nlm.nih.gov/pubmed/25580522>
- U.S. Department of Education. (2015). *Family Education Rights and Privacy Act (FERPA)*. Retrieved April 8, 2016, from <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>
- U.S. Department of Health & Human Services. Office for Civil Rights. (n.d.). *Protecting the Civil Rights and Health Information Privacy Rights of People Living with HIV/AIDS*. Retrieved April 8, 2016, from <http://www.hhs.gov/civil-rights/for-individuals/special-topics/HIV/index.html>
- U.S. Department of Health & Human Services. Office for Civil Rights. (HHS-OCR, 2013). *HIPAA Administrative Simplification - Regulation Text - 45 CFR Parts 160, 162, and 164 (Unofficial Version, as amended through March 26, 2013)*. Retrieved October 30, 2016, from <http://www.hhs.gov/sites/default/files/hipaa-simplification-201303.pdf>
- U.S. Department of Health and Human Services, Administration for Children & Families, Family & Youth Services Bureau. (2015). *About the Runaway and Homeless Youth Program*. Retrieved March 9, 2016, from <http://www.acf.hhs.gov/programs/fysb/programs/runaway-homeless-youth/about>
- U.S. Department of Health and Human Services, Administration for Children and Families, Family and Youth Services Bureau. (2015). *FVPSA State and Territory Formula Grant Program Fact Sheet*. Retrieved May 21, 2018, from https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_state_tribal_20170216.pdf
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families. (2009-2010). *Family Violence Prevention and Services Act: Report to Congress 2009-2010*. Retrieved February 2, 2016, from http://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_report_to_congress_09_10.pdf
- U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2012). *Navigating the Family Violence Prevention and Services Program: A Guide for State and Territorial Administrators*. Retrieved April 8, 2016, from http://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_admin_guide_20121119_0.pdf
- U.S. Department of Health and Human Services, Office of Family Assistance. (2013). *TANF-ACF-IM-2013-01 (Use of TANF Funds to Serve Homeless Families and Families at Risk of Experiencing Homelessness)*. Retrieved February 17, 2016, from <http://www.acf.hhs.gov/programs/ofa/resource/tanf-acf-im-2013-01>
- U.S. Department of Health and Human Services, SAMHSA-Health Resources Services Administration (HRSA), Center for Integrated Health Solutions. (n.d.). *Confidentiality FAQ*. Retrieved May 21, 2018, from <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs>
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Substance Abuse Confidentiality Regulations*. Retrieved April 8, 2016, from <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). *About PATH (Projects for Assistance in Transition for Homelessness)*. Retrieved March 9, 2016, from <http://pathprogram.samhsa.gov/super/path/about.aspx>

- U.S. Department of Housing and Urban Development / U.S. Department of Health and Human Services / U.S. Department of Justice. (2016) *Joint letter Regarding Access to Federally Funded Life-Saving Services and Housing for Immigrants*. Retrieved August 25, 2016, from <https://www.hudexchange.info/resources/documents/HUD-HHS-DOJ-Letter-Regarding-Immigrant-Access-to-Housing-and-Services.pdf>
- U.S. Department of Housing and Urban Development. (2001). "Housing Quality Standards" in 24 CFR §982.401 (1995, amended 1996-99). Retrieved May 10, 2016, from <https://www.gpo.gov/fdsys/pkg/CFR-2010-title24-vol4/pdf/CFR-2010-title24-vol4-sec982-401.pdf>
- U.S. Department of Housing and Urban Development. (2004). *HMIS Data and Technical Standards*. Retrieved February 17, 2016, from <https://www.hudexchange.info/programs/hmis/hmis-data-and-technical-standards/>
- U.S. Department of Housing and Urban Development. (2011). *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Emergency Solutions Grants (ESG) Program and Consolidated Plan Conforming Amendments. (ESG Interim Rule)*. Retrieved March 8, 2016, from <https://www.hudexchange.info/resource/1927/hearth-esg-program-and-consolidated-plan-conforming-amendments/>
- U.S. Department of Housing and Urban Development. (2011a). *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining "Homeless" Final Rule*. Retrieved March 9, 2016, from <https://www.hudexchange.info/resource/1928/hearth-defining-homeless-final-rule/>
- U.S. Department of Housing and Urban Development. (2012). *Criteria and Recordkeeping Requirements for Definition of Homelessness*. Retrieved February 16, 2016, from <https://www.hudexchange.info/resource/1974/criteria-and-recordkeeping-requirements-for-definition-of-homeless/>
- U.S. Department of Housing and Urban Development. (2012a). *Homeless Definition and Eligibility for SHP (Supportive Housing Program), SPC (Shelter Plus Care), and ESG (Emergency Solutions Grant)*. Retrieved February 16, 2016, from <https://www.hudexchange.info/resource/2020/the-homeless-definition-and-eligibility-for-shp-spc-and-esg/>
- U.S. Department of Housing and Urban Development. (2012b). **CoC Interim Rule (Formatted Version)**. Retrieved March 8, 2016, from <https://www.hudexchange.info/resource/2035/coc-program-interim-rule-formatted-version/>
- U.S. Department of Housing and Urban Development. (2012c). *Leasing and rental assistance: Transition guidance for existing SHP grantees using leasing funds for transitional or permanent housing*. Retrieved February 18, 2016, from <https://www.hudexchange.info/resources/documents/LeasingandRentalAssistanceTransitionGuidanceforSHPGrantees.pdf>
- U.S. Department of Housing and Urban Development. (2013). *SNAPS Weekly Focus: What About Transitional Housing?* Retrieved February 16, 2016, from <https://www.hudexchange.info/news/snaps-weekly-focus-what-about-transitional-housing/>
- U.S. Department of Housing and Urban Development. (2013a). *Rapid Re-Housing: ESG vs. CoC Guide*. Retrieved February 16, 2016, from <https://www.hudexchange.info/resource/2889/rapid-rehousing-esg-vs-coc/>
- U.S. Department of Housing and Urban Development. (2013b). *Notice of Funding Availability (NOFA) for the FY 2013 and 2014 CoC Program Competitions*. Retrieved February 16, 2016, from [Notice of Funding Availability \(NOFA\) for the FY 2013 and 2014 CoC Program Competition](https://www.hudexchange.info/resource/2889/rapid-rehousing-esg-vs-coc/)
- U.S. Department of Housing and Urban Development. (2014). *CoC FAQs*. Retrieved February 16, 2016, from <https://www.hudexchange.info/faqs/1525/i-am-a-recipient-of-funds-for-rental-assistance-under-the-coc-program/>
- U.S. Department of Housing and Urban Development. (2014-15). *Frequently Asked Questions on the Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status*. Retrieved April 5, 2016, from <https://www.hudexchange.info/resources/documents/FAQs-Notice-CPD-14-012.pdf>
- U.S. Department of Housing and Urban Development. (2014a). *CoC FAQ on the match requirement*. Retrieved February 16, 2016, from <https://www.hudexchange.info/faqs/1552/what-are-the-match-requirements-in-the-coc-program/>
- U.S. Department of Housing and Urban Development. (2014b). *Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status*. Retrieved April 5, 2016, from <https://www.hudexchange.info/resource/3897/notice-cpd-14-012-prioritizing-persons-experiencing-chronic-homelessness-in-psh-and-recordkeeping-requirements/>

- U.S. Department of Housing and Urban Development. (2014c). *Rapid Re-Housing Brief*. Retrieved March 9, 2016, from <https://www.hudexchange.info/resource/3891/rapid-re-housing-brief/>
- U.S. Department of Housing and Urban Development. (2014d). *The 2014 Annual Homeless Assessment Report (AHAR) to Congress, Part 1 Point-in-Time Estimates of Homelessness*. Retrieved April 5, 2016, from <https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf>
- U.S. Department of Housing and Urban Development. (2015). *CoC APR [Annual Performance Report] Guidebook for CoC Grant-Funded Programs*. Retrieved February 16, 2016, from <https://www.hudexchange.info/resource/1850/e-snaps-coc-apr-guidebook-for-coc-grant-funded-programs/>
- U.S. Department of Housing and Urban Development. (2015a). *Community Planning and Development Notice of Funding Availability for the 2015 Continuum of Care Program Competition FR-5900-N-25*. Retrieved March 9, 2016, from <http://portal.hud.gov/hudportal/documents/huddoc?id=2015coccompnofa.pdf>
- U.S. Department of Housing and Urban Development. (2015b). *Coordinated Entry Policy Brief*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/>
- U.S. Department of Housing and Urban Development. (2015c). *Coordinated Entry and HMIS FAQs*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/4430/coordinated-entry-and-hmis-faqs/>
- U.S. Department of Housing and Urban Development. (2015d). *Coordinated Entry and Victim Service Providers FAQs*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/4831/coordinated-entry-and-victim-service-providers-faqs/>
- U.S. Department of Housing and Urban Development. (2015e). *ESG Program HMIS Manual*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/4447/esg-program-hmis-manual/>
- U.S. Department of Housing and Urban Development. (2015f). *HMIS Data Standards Manual*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/3826/hmis-data-standards-manual/>
- U.S. Department of Housing and Urban Development. (2015g). *HMIS Data Dictionary*. Retrieved February 17, 2016, from <https://www.hudexchange.info/resource/3824/hmis-data-dictionary/>
- U.S. Department of Housing and Urban Development. (2015h). *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining "Chronically Homeless" Final Rule*. Retrieved April 5, 2016, from <https://www.hudexchange.info/resource/4847/hearth-defining-chronically-homeless-final-rule/>
- U.S. Department of Housing and Urban Development. (2015i). *2014 AHAR: Part 2 – Estimates of Homelessness in the U.S.* Retrieved February 16, 2016, from <https://www.hudexchange.info/resource/4828/2014-ahar-part-2-estimates-of-homelessness/>
- U.S. Department of Housing and Urban Development. (2016). *SNAPS In Focus: FY 2015 CoC Program Competition Recap*. Retrieved August 18, 2016, from <https://www.hudexchange.info/news/snaps-in-focus-fy-2015-coc-program-competition-recap/>
- U.S. Department of Housing and Urban Development. (2016a). *SNAPS In Focus: Addressing the Needs of Persons Fleeing Domestic Violence*. Retrieved August 18, 2016, from <https://www.hudexchange.info/onecpd/assets/File/SNAPS-In-Focus-Addressing-the-Needs-of-Persons-Fleeing-Domestic-Violence.pdf>
- U.S. Department of Housing and Urban Development. (2016b). *Fair Market Rent (FMR) FY 2016 and Income Limit (IL) FY 2016 Summary System -- Select Geography*. Retrieved October 30, 2016, from https://www.huduser.gov/datasets/fmr/fmr_il_history/select_Geography.odn
- U.S. Department of Housing and Urban Development. (2016c). *News release: HUD, DOJ, and HHS Release Joint Letter Providing Information Regarding Access to Federally Funded Life-Saving Services and Housing for Immigrants*. Retrieved August 25, 2016, from <https://www.hudexchange.info/news/hud-doj-and-hhs-release-joint-letter-providing-information-regarding-access-to-federally-funded-life-saving-services-and-housing-for-immigrants/>
- U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime. (2015). *Application (for designated State agencies) for FY 2015 VOCA Victim Assistance Formula grants*. Retrieved April 8, 2016, from http://ojp.gov/ovc/grants/pdf/FY15_Victim_Assistance_Formula_Grant_Solicitation_Revised_508.pdf

- U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, Training and Technical Assistance Center (n.d.). *VictimLaw*. Retrieved April 8, 2016, from <https://www.victimlaw.org/victimlaw/start.do>
- U.S. Department of Justice, Office on Violence Against Women. (2007). *The President's Family Justice Center Initiative Best Practices*. Retrieved April 12, 2016, from https://www.justice.gov/archive/ovw/docs/family_justice_center_overview_12_07.pdf
- U.S. Department of Justice, Office on Violence Against Women. (2013). *Acknowledgement of Notice of Statutory Requirement to Comply with the Confidentiality and Privacy Provisions of the Violence Against Women Act, as Amended*. Retrieved April 8, 2016, from <https://www.justice.gov/sites/default/files/ovw/legacy/2013/09/24/conf-acknowledgement.pdf>
- U.S. Department of Justice, Office on Violence Against Women. (2015). *OVW Fiscal Year 2015 Transitional Housing Assistance Grants for Victims of Sexual Assault, Domestic Violence, Dating Violence, and Stalking: Solicitation*. Retrieved on January 29, 2016, from <http://www.justice.gov/sites/default/files/ovw/pages/attachments/2015/01/14/th-solicitation-finalv2.pdf>
- U.S. Department of Justice, Office on Violence Against Women. (2016). *OVW Fiscal Year 2016 Transitional Housing Assistance Grants for Victims of Sexual Assault, Domestic Violence, Dating Violence, and Stalking: Solicitation*. Retrieved on August 22, 2016, from <https://www.justice.gov/ovw/file/800641/download>
- U.S. Department of Justice. (2015). *Grant Programs*. Retrieved February 17, 2016, from <http://www.justice.gov/ovw/grant-programs>
- U.S. Government Publishing Office. (n.d.). *Violence Against Women Reauthorization Act of 2013*. Retrieved February 18, 2016, from <https://www.gpo.gov/fdsys/pkg/BILLS-113s47enr/pdf/BILLS-113s47enr.pdf>
- United States Interagency Council on Homelessness. (2015). *Opening Doors Federal Strategic Plan to Prevent and End Homelessness*. Washington D.C. Retrieved April 5, 2016, from https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf#page=12
- Violence Against Women Act Measuring Effectiveness Institute. (2015). *Transitional housing program: Summary data reports*. Retrieved February 16, 2016, from <http://muskie.usm.maine.edu/vawamei/thousinggraphs.htm>
- Violence Against Women Act Measuring Effectiveness Institute. (2015a). *Transitional housing program: Form and Instruction*. Retrieved February 16, 2016, from <http://muskie.usm.maine.edu/vawamei/thousingform.htm>
- Warshaw, C., Moroney, M. G., & Barnes, M. H. (2003). Report on mental health issues and service needs in Chicago area: Domestic violence advocacy programs. *Chicago: Domestic Violence & Mental Health Policy Initiative*. Chicago, IL: Domestic Violence & Mental Health Policy Initiative, Cook County Hospital. Retrieved April 12, 2016, from <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/DVMHPI-Needs-Assessment.pdf>
- Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). *A systematic review of trauma-focused interventions for domestic violence survivors*. National Center on Domestic Violence, Trauma & Mental Health. Retrieved June 20, 2016, from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf