Rapid Re-Housing for Domestic Violence Survivors and Their Children

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE
CAPSTONE 2015 -2016

Capstone Team: Claire Brennan, Anna Dardick, Madeline Morrissey, Hillary Murphy
Preceptors: Catherine Guerrero, MPA, Rachel Dooley, MPH
Faculty Adviser: Shelley Golden, PhD, MPH

UNC Honor Code Pledge

We certify that no unauthorized assistance has been received or given in the completion of this work.

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UNC Health Behavior Department

Shelley Golden, PhD, MPH
Meg Landfried, MPH
Susannah Zietz, MPH, PhD Candidate

North Carolina Coalition Against Domestic Violence

Catherine Guerrero, MPA
Rachel Dooley, MPH
Jen Counts, MPH
Dana Mangum, MA

OASIS (Opposing Abuse with Service, Information, and Shelter)

Jennifer Herman

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EXECUTIVE SUMMARY

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE

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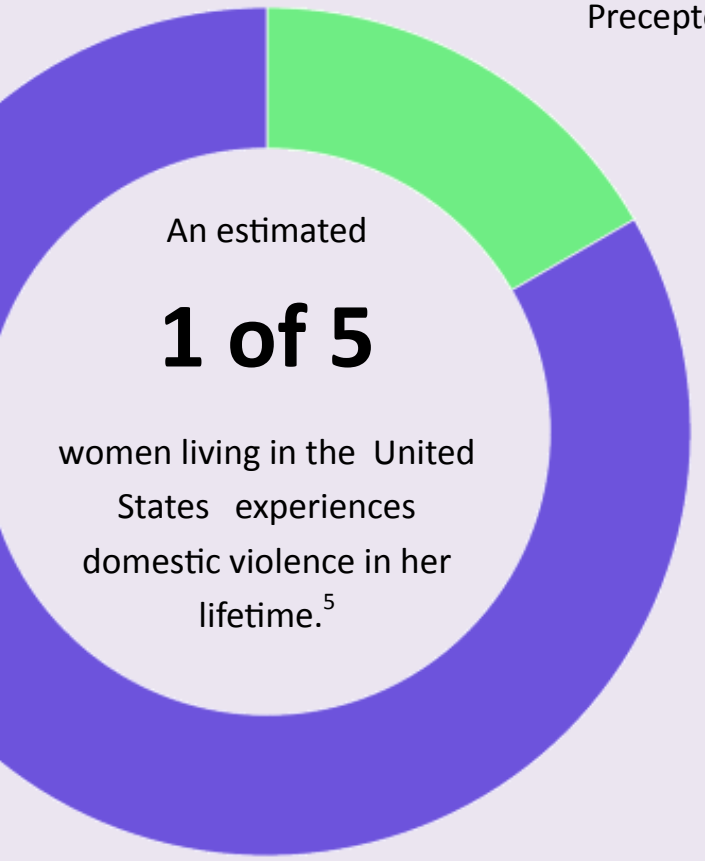

Domestic violence is a critical public health problem in the United States. Domestic violence survivors and their children are at high risk of other negative health and social outcomes, including housing instability.[1] In fact, in the United States, domestic violence is the leading cause of homelessness for women and children.[2,3] Homelessness leads to harmful outcomes for survivors and children, including stress, economic instability, food instability, stress on social support systems, and long-term poverty. The addition of domestic violence-related trauma creates a compounded, serious public health problem for individuals and families surviving domestic violence.

The rapid re-housing model is one mechanism for addressing homelessness by providing housing as quickly as possible to those in need, without pre-requisites or stipulations. As such, it is also a potentially effective intervention for addressing the housing needs of domestic violence survivors facing homelessness.[4]

Nationally, a number of communities have implemented rapid re-housing programs in response to homelessness, but there is a lack of evidence on the best practices for implementing rapid re-housing as a domestic violence intervention, especially for cases involving children. The intake procedures through which communities account for domestic violence exposure among survivors and their children vary, and there is limited consensus about which protocols result in the best outcomes for families.[6] The North Carolina Coalition Against Domestic Violence Capstone project deliverables synthesize existing policies and practices to recommend rapid re-housing implementation methods, standardize community readiness for rapid re-housing programs, and integrate domestic violence services into existing rapid re-housing programs.

The goal of this Capstone is to develop resources that enable the North Carolina Coalition Against Domestic Violence to **provide assistance to communities** as they implement rapid re-housing and/or integrate services for domestic violence survivors and their families into housing interventions, with the ultimate outcome of **reducing domestic violence-associated homelessness** in North Carolina.

PROJECT GOAL

DELIVERABLES & PURPOSES

1. **Literature Review:** To identify evidence-based homelessness interventions and housing-related best practices to answer the question, "What are the most effective housing-related strategies for reducing homelessness among domestic violence survivors and their children?"

2. **Summary of Current Rapid Re-housing Efforts in North Carolina:** To identify current policies and practices in North Carolina related to rapid re-housing, particularly as they pertain to domestic violence survivors and children, and to gain stakeholders' perspectives on the challenges of rapid re-housing.

3. **Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and Families:** To operationalize formative research findings into recommendations for communities and organizations considering rapid re-housing as a domestic violence intervention and to help them understand how to incorporate child-focused assessments into rapid re-housing intake procedures.

4. **Community Readiness Assessment Instrument:** To develop an assessment for measuring and increasing community readiness to implement rapid re-housing with integrated services for domestic violence survivors and their children.

ACTIVITIES

Develop search protocol

Collect articles

Analyze literature

Write final literature review

Create and pilot interview guide

Conduct semi-structured interviews

Develop codebook

Analyze findings for key themes

Write final summary report

Synthesize deliverables 1 & 2 to generate recommendations

Write and pilot report

Translate recommendations for community use

Investigate existing readiness assessment tools

Adapt existing readiness assessment to DV/ homelessness/child trauma context

Pilot instrument with community partner

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5. Centers for Disease Control and Prevention. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence — United States, 2005. *Morbidity and Mortality Weekly Report*, 57, 113–117.
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NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE

Acronyms

AIR	American Institutes for Research
ARRA	American Recovery and Reinvestment Act
CDC	Centers for Disease Control and Prevention
CKE	Community Knowledge of Efforts
CoC	Continuum of Care
DV	Domestic violence
DVHF	Domestic Violence Housing First
DOE	United States Department of Education
DOJ	United States Department of Justice
EHCY	Education of Homeless Children and Youth
ESG	Emergency Solutions Grants
FOS	Family Options Study
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing
HIPAA	Health Insurance Portability and Accountability Act
HMIS	Homeless Management Information System
HPRP	Homelessness Prevention and Rapid Re-Housing Program
HUD	United States Department of Housing and Urban Development
IQ	Interview question
NAEH	National Alliance to End Homelessness
NC	North Carolina
NCCADV	North Carolina Coalition Against Domestic Violence
NCCEH	North Carolina Coalition to End Homelessness
NC-HMIS	North Carolina Homeless Management Information System
NCH	National Coalition for the Homeless
NNEDV	National Network to End Domestic Violence
RHSA	Rural Housing Stability Assistance
RQ	Research questions
RRH	Rapid re-housing
RRHD	Rapid Re-Housing for Homeless Families Demonstration
S+C	Shelter plus Care
SSVF	Supportive Services for Veteran Families
USICH	United States Interagency Council on Homelessness
VA	United States Department of Veterans' Affairs
WHO	World Health Organization

Portfolio Background

Domestic Violence and Homelessness

An estimated one out of every five women living in the United States experiences domestic violence in her lifetime (Centers for Disease Control and Prevention, 2008). Survivors of domestic violence are at greater risk of negative health and social outcomes associated with living in a violent home (World Health Organization, 2012). When survivors leave an abusive relationship, they may flee their homes without the time or resources to secure a safe place to live. Survivors without financial resources may have to choose between homelessness or returning to an abusive home, an impossible choice that is further exacerbated when survivors must also account for the safety and needs of their children. Though a violent home is a dangerous option, homelessness can be equally damaging to health and social outcomes. Homelessness is linked to negative outcomes including stress on survivors and children, economic instability, food instability, stress on social support systems, and long-term poverty. (Baker et al., 2009). The link between homelessness and domestic violence is clear. In fact, violence is the leading cause of homelessness for women and children and approximately 63% of homeless women have experienced domestic violence as adults (Maqbool, Viveiros, & Ault, 2015; Baker, Billhardt, Warren, Rollins, & Glass, 2009; National Coalition for the Homeless, 2009).

As in the rest of the country, many domestic violence survivors in North Carolina face the choice between remaining in a domestic violence situation or becoming homeless. The United States Department of Housing and Urban Development (HUD) estimates that there were 11,448 homeless individuals in North Carolina in 2014, 10% of which were domestic violence survivors (North Carolina Coalition to End Homelessness, 2014). Without safe and secure housing, domestic violence survivors are at substantial risk of negative health and social impacts, so it is essential for North Carolina organizations and communities to implement interventions to support their housing needs.

Housing First and Rapid Re-housing

In response to endemic homelessness, HUD recommends the Housing First model which provides people experiencing homelessness with housing as quickly as possible without prerequisites or stipulations (National Alliance to End Homelessness, 2014). Social support services are an essential component of Housing First, though support service adherence is not a requirement of housing eligibility. Rapid re-housing is a type of intervention following the Housing First model by helping people secure permanent housing rather than relying on impermanent interventions traditional transitional housing (Cunningham, Gillespie, & Anderson, 2015). Transitional housing program typically offer housing subsidies and require support service adherence under the assumption that people experiencing homelessness have more chronic needs than those in emergency shelters but are not yet equipped with the skills to be “housing ready” (Cunningham, Gillespie, & Anderson, 2015). Traditional transitional housing is typically characterized by a rigorous screening process: “many programs screen for motivation, conduct drug tests, and require demonstrated willingness to work with the program through engagement in services” (Cunningham, Gillespie, & Anderson, 2015, p. 5). Even for domestic violence survivors and their children, these screening processes do not account for imminent danger of abuse, which makes them an insufficient intervention.

Rapid re-housing components screening protocols, support service provision, and rapid housing placement are designed to eliminate barriers that keep people in a cycle of homelessness, emergency shelter, and transitional housing systems (Cunningham, Gillespie, & Anderson, 2015). Typically, rapid re-housing programs offer three main components: (1) housing identification services to increase access to

affordable housing through partnerships with rental agencies and landlords; (2) financial assistance to partially or fully subsidize housing costs; and (3) non-obligatory social support that offer services including financial literary education, vocational training, transportation support, health care, and other services as determined by intake and screening protocols (Cunningham, Gillespie, & Anderson, 2015).

North Carolina Coalition Against Domestic Violence Capstone

The North Carolina Coalition Against Domestic Violence Capstone team conducted formative research and synthesized findings to support integrating a focus on domestic violence survivors and their children into existing rapid re-housing programs. The Capstone team conducted a literature review of governmental policy papers, peer-reviewed literature, and rapid re-housing program evaluations and reports to research best practices and core components of successful rapid re-housing programs. To complement the literature review and examine rapid re-housing in North Carolina, the Capstone team conducted qualitative interviews with program administrators throughout the state, focusing specifically on efforts to address the needs of domestic violence survivors and their children and provide trauma-informed services. While both the literature review and qualitative interviews supported evidence of the link between domestic violence and homelessness, the need for best practices, readiness assessments, and actionable recommendations for communities and organizations to integrate domestic violence into existing housing interventions was also clear. The Capstone team synthesized formative research findings to create tools and recommendations to facilitate that effort as NCCADV supports communities and organizations throughout the state to improve their rapid re-housing programs to include domestic violence survivors and their children.

Appendix A. HEARTH Act Definition of Homelessness

The HEARTH Act (2009) updated the definition of homelessness to include the following:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
2. Individuals and families who will imminently lose their primary nighttime residence;
3. Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and
4. Individuals and families who are fleeing, or are 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.

Appendix B. Essential Definitions

- *Rapid re-housing:* "A program or intervention targeting homeless individuals or families by providing support to secure permanent housing and short-to-medium-term subsidies to retain that housing. It does not offer permanent subsidies, but rather targets people who are likely to be able to sustain housing once subsidies end. Rapid rehousing also provides connections to community resources and social services that may help beneficiaries solve other life problems or achieve other life goals; however, there is no requirement that beneficiaries engage in these resources."

- *Homelessness*: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outlines the definition of homelessness as individuals and families lacking or losing a "permanent nighttime residence" and, notably, includes "individuals and families who are fleeing, or are 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" (HEARTH Act of 2009) (for full definition, see Appendix A).

- *Domestic violence*: The Department of Justice defines domestic violence as a "domestic violence as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone" (Department of Justice [DOJ], 2015).

- *Trauma-informed:* The Substance Abuse and Mental Health Administration (SAMHSA) defines trauma informed as, "a program, organization, or system that is trauma informed:

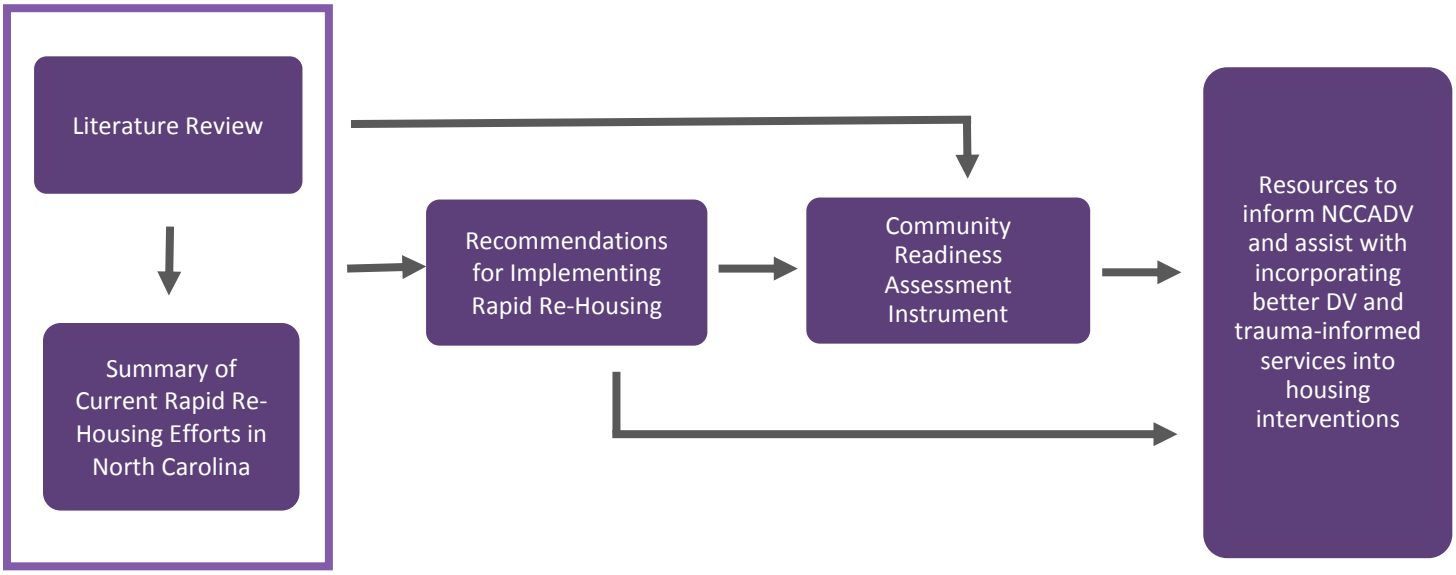
    1. Realizes the widespread impact of trauma and understand potential paths for recovery;

    2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

    3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and

    4. Seeks to actively resist re-traumatization" (SAMHSA, 2015)

Appendix C. Capstone Project Deliverable Diagram



Appendix D. Capstone Project Logic Model

Input	Activities	Outputs	Outcomes	Impact
Students' time and knowledge & skills from HB training & past experiences Time, mentorship & expertise from preceptor, faculty adviser, and teaching team Expertise from Consultants on Call Expertise from community partners & stakeholders	Reviewed and synthesized grey and peer reviewed literature to identify best practices Developed and pilot interview guide and codebook Conducted qualitative interviews and analyze findings Combined findings from literature review and summary of current rapid re-housing efforts in NC to inform recommendations for the community Combined findings from literature review and summary of current rapid re-housing efforts in NC to inform development of a community readiness assessment instrument	Literature review Summary of Current Rapid Re-Housing Efforts in North Carolina Recommendations for Implementing Rapid Re-Housing For Domestic Violence Survivors and Their Children Community Readiness Assessment Instrument	Provide resources to inform NCCADV about the current implementation of rapid re-housing in North Carolina, and recommendations and an assessment instrument to assist with incorporation of better domestic violence and trauma-informed services into housing interventions	Increased capacity of rapid re-housing programs in North Carolina to address the needs of domestic violence survivors and their children

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SPRING 2016

RAPID RE-HOUSING POLICIES & IMPLEMENTATION

A REVIEW OF THE LITERATURE

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE CAPSTONE

CLAIRE BRENNAN, ANNA DARDICK, MADELINE MORRISSEY & HILLARY MURPHY
University of North Carolina at Chapel Hill Gillings School of Global Public Health | Department of Health Behavior

DELIVERABLE 1

CONTRIBUTIONS	Claire Brennan and Madeline Morrissey led the protocol development, research, analysis, outlining, and writing of the literature review. Anna Dardick and Hillary Murphy contributed to the development of the search protocols and article collection.
DELIVERABLE PURPOSE & AUDIENCE	The literature review's purpose is to identify evidence-based homelessness prevention and housing intervention best practices answering the question, "What is the most effective housing strategy for domestic violence (DV) survivors and for children exposed to DV?" The literature review serves as a starting point for deliverable #2, the Summary of Current Rapid Re-housing Efforts in North Carolina, the foundation for deliverable #3, the Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children, and is used in the development of deliverable #4, the Community Readiness Assessment Instrument. The intended audience is the North Carolina Coalition Against Domestic Violence (NCCADV).
STEPS	1. Consulted with community partners to finalize focus of the literature review. 2. Developed search protocol and criteria for relevant articles. 3. Collected articles using social service and public health databases, governmental resources, and grey literature sources. 4. Read articles and analyzed findings to develop detailed outline. 5. Wrote final report on literature findings, evaluated by technical content expert. 6. Disseminated final report to NCCADV administrators.
RESULTS AND KEY FINDINGS	• The team found that rapid re-housing is an effective housing intervention and can be used for DV survivors and their families. Extensive regulations govern the use of federal funds for rapid re-housing and should be considered by NCCADV when designing rapid re-housing programs. • There is little research about the effectiveness of rapid re-housing as a housing option for children exposed to DV and other trauma. There is an opportunity for NCCADV to focus its efforts on social services and evaluation for children in rapid re-housing programs. • NCCADV should adopt best practices and recommendations from a wide range of current rapid re-housing programs, and tailor them to appropriate community contexts.
NEXT STEPS	NCCADV will use this formative research as a reference when designing rapid re-housing programs and providing technical assistance to other community organizations implementing rapid re-housing.

Table of Contents

Introduction

Background & Purpose

Domestic violence (DV) is a critical public health problem in the United States. An estimated one out of every five women living in the United States will experience DV in her lifetime (Centers for Disease Control and Prevention [CDC], 2008). DV survivors are at greater risk of other negative health and social outcomes, including housing instability (World Health Organization [WHO], 2012).

Rapid re-housing is one mechanism for addressing homelessness that follows the Housing First model of providing housing as quickly as possible to those in need, without other stipulations. It is also a potentially effective mechanism for addressing the housing needs of DV survivors facing homelessness (Cunningham, Gillespie, & Anderson, 2015).

Housing First & Rapid Re-Housing

Until the 1990s, homelessness in the United States was generally addressed through what has become known as the Housing Ready approach. This model was a linear continuum that operated on the premise that homelessness was caused by underlying factors, such as substance abuse or mental health issues, that needed to be addressed in order to make someone "ready" for permanent housing (United States Interagency Council on Homelessness [USICH], 2015). In practice, this often meant that individuals or families experiencing homelessness never made it through all of the steps in the continuum to become eligible for permanent housing, and thus continued to experience homelessness.

The Housing First approach emerged as a response to the Housing Ready model. Housing First addresses homelessness by providing people experiencing homelessness with housing as quickly as possible, and then providing support services to address other areas of their lives as needed (Cunningham, Gillespie, & Anderson, 2015). According to the United States Interagency Council on Homelessness (USICH), Housing First is based on six main principles:

1. Homelessness is a housing crisis and can be addressed through the provision of safe and affordable housing;
2. All people experiencing homelessness, regardless of their housing history and duration of homelessness, can achieve housing stability in permanent housing;
3. Everyone is 'housing ready,' meaning that sobriety, compliance in treatment, or even a clean criminal history is not necessary to succeed in housing;
4. Many people experience improvements in quality of life, in the areas of health, mental health, substance use, and employment as a result of achieving housing;
5. People experiencing homelessness have the right to self-determination and should be treated with dignity and respect; and
6. The exact configuration of housing and services depends upon the needs and preferences of the population (USICH, 2015).

Rapid re-housing is one type of intervention to address homelessness that follows the Housing First model. Typically, rapid re-housing programs assist individuals or families experiencing homelessness to identify safe and affordable housing, and then provide rent subsidies to help the individual or family remain in that housing permanently. Rental subsidies generally decrease over time, as residents overcome their housing crises and stabilize. Rapid re-housing programs also provide various wrap-around services to assist with the transition from homelessness, including financial management

and other types of counseling and support to find a job. Some other types of interventions that also follow the Housing First model include permanent housing subsidies, project-based housing, and shelter services (United States Department of Housing and Urban Development [HUD], 2015b). At the request of the North Carolina Coalition Against Domestic Violence (NCCADV), we identified peer-reviewed literature, gray literature, and reports from federal agencies and DV and homelessness organizations to inform recommendations about the use of rapid re-housing in North Carolina, with a particular focus on DV survivors and their families. See Appendix A for a complete description of our research methods.

This report is organized into six main sections: (1) Introduction and definitions, (2) Rapid re-housing as a DV intervention, (3) Federal policies to support rapid re-housing, (4) Review of current rapid re-housing programs, and (5) Recommendations and implications for NCCADV, and (6) Conclusion.

Definitions

Key terms in the literature review are defined below. The definitions provided here are accepted by the federal government.

- Homelessness: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act defines homelessness as individuals and families lacking or losing a "permanent nighttime residence" for a host of reasons (discussed in greater detail later in this report), including "individuals and families who are fleeing, or are 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" (United States Department of Housing & Urban Development [HUD], 2011a).
- Domestic violence: The Department of Justice defines DV as a "pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. DV can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone" (United States Department of Justice [DOJ], 2015).
- Rapid re-housing: The Department of Housing and Urban Development (HUD), the Department of Veterans' Affairs (VA), United States Interagency Council on Homelessness (USICH), and the National Alliance to End Homelessness (NAEH) define rapid re-housing as "an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household" (National Alliance to End Homelessness [NAEH], 2014).

Rapid Re-housing as a Domestic Violence Intervention

Why Housing?

Domestic violence is the leading cause of homelessness for women and children in the United States (Maqbool, Viveiros, & Ault, 2015; Baker, Billhardt, Warren, Rollins, & Glass, 2009). Among women with children experiencing homelessness, over 80% have also experienced DV (USICH, 2015). Housing insecurity and the threat of homelessness can be a major barrier to leaving a violent situation, and can also be a factor in decisions to return to violent homes (Thurstona, et al, 2013). Furthermore, DV

survivors face structural and policy barriers when trying to secure housing, many of which are related to the abuse they have experienced. These barriers may include limited public housing availability and perceived liability from landlords (Baker et al., 2009). Additionally, as DV often includes financial and psychological control, many survivors have poor credit histories, few financial resources, and limited support networks (Baker et al., 2009; USICH, 2015).

Unstable or inadequate housing is associated with stress for survivors, their children, and their support systems. It is also associated with economic instability, food instability, and long-term poverty, and compounds the negative outcomes that result from DV itself (Baker et al., 2009). When faced with homelessness as the alternative for leaving an abusive home, survivors may remain in a DV situation. For children of survivors, ongoing exposure to DV can result in increased risk of emotional and behavioral problems, as well as increased risk as becoming a perpetrator or victim of DV later in life (Holt, Buckley, & Whelan, 2008; UNICEF, 2006). Although there is limited literature on the impact of homelessness on children who have been exposed to DV, there is an association between homelessness and negative behavioral, academic, and health outcomes for children (American Institutes for Research [AIR], n.d.). While homelessness in children is associated with poor mental and physical health and lower achievement in school, these symptoms have been found to decline over time when housing is stabilized (AIR, n.d.; Shinn, Samuels, Fischer, Thompkins, and Fowler, 2015).

Types of Housing Interventions

There are many types of housing interventions in place to address the needs of homeless individuals and families, including survivors of DV. Some of the most common interventions are discussed below. Each of these types of interventions can be carried out in ways that adhere to the Housing First approach.

Emergency Interventions

Emergency housing interventions are shelter-based and include DV and homeless shelters, as well as motel vouchers (Baker et al., 2009). Emergency shelters offer day-to-day shelter for those without a safe, habitable nighttime residence. In the DV context, they provide immediate support for survivors and families who are fleeing DV. They offer an alternative to either staying in an abusive situation or spending the night on the street. Emergency shelters are essential for DV survivors because survivors are most at risk for physical harm and being killed by their abuser immediately after leaving an abusive situation (National Network to End Domestic Violence [NNEDV], 2008). Besides being an immediate source of shelter, emergency shelters offer resources for long-term stability such as support groups, access to support services, and safety planning. DV-specific shelters are ideally available 24-hours a day with unmarked, confidential locations and security systems. Women often report a positive experience in DV shelters (Lyon, Lane, & Menard, 2008).

The most common limitation of emergency shelters is space availability. In September 2008, the National Network to End Domestic Violence (NNEDV) conducted a national single-day study and found that 6,126 DV-related emergency shelter requests went unmet by current shelters (NNEDV, 2014). If a community has both DV and homeless shelters, the latter may offer additional space, but homeless shelters typically do not have the security necessary to protect DV survivors from abusers who may be attempting to locate them (Baker et al., 2009). The logistics of homeless shelters may also threaten DV survivors' safety; in many shelters, families are either split up by gender or genders are mixed without safety protocols (Baker et al, 2009). Homeless shelters are usually closed during the day, which can

make survivors vulnerable to their abusers, and some may not even accept DV survivors due to lack of DV-specific services and the risk of abusers attempting to locate survivors.

Motel vouchers may also provide expanded availability to emergency housing, but leave survivors and their families isolated from a supportive community and vulnerable to their abusers due to a lack of security (Baker et al., 2009). Homeless shelters are also a costly intervention and the costs increase for housing families with children, rather than just individuals (HUD, 2010).

Temporary Housing Interventions

Temporary or transitional housing interventions are designed to fill the gap between emergency shelters and permanent housing while providing support services such as counseling, vocational training, and/or household and financial management education (NNEDV, 2008; Cunningham, Gillespie, & Anderson, 2015). Temporary housing interventions may be facility-based, meaning that participants live in agency-run housing sites, or they may provide temporary rental subsidies for independent housing. Facility-based programs offer DV-specific counseling and services, and provide support groups and a sense of community (Baker et al., 2009), but require survivors to vacate after a set period of time.

Temporary rental subsidy programs provide support services while gradually cutting back on financial support, with a goal of helping survivors permanently remain in their housing units (Baker et al., 2009). Temporary rental subsidy programs straddle the line between temporary and permanent housing interventions, as support is temporary but the housing is ideally permanent. Rapid re-housing falls into the temporary rental subsidy category of housing interventions.

Temporary housing is sometimes characterized by a rigorous eligibility process that includes drug tests and screenings for motivation and willingness to engage with required support services (Burt 2010; Burt 2006). Programs that require use of these services do not meet Housing First standards, and these requirements can serve as a barrier to remaining in transitional housing. In one study of temporary housing programs, DV survivors reported satisfaction with transitional housing but were unhappy about mandates that they participate in social services (Melbin, Sullivan, & Cain, 2003).

Permanent Housing Interventions

The most well-known permanent housing intervention is the Housing Voucher Program (also known as Section 8) in which individuals receive partial or complete rental subsidies (Baker, et al., 2009). As long as they are eligible for full subsidies or can continue to pay their portion of the rent, individuals and families may remain in their rental units permanently. One limitation of the Housing Voucher Program is limited availability of vouchers. Another is difficulty identifying landlords who accept Section 8 vouchers. Time is the biggest barrier for making Section 8 a viable solution for DV survivors. The waiting list for Section 8 vouchers can be weeks, months, or even years long, depending on the community (Baker et al., 2009). Once vouchers are granted, there is a limited window to secure a rental unit. During both of these periods, DV survivors are vulnerable continued homelessness and to being located by their abusers (Baker et al., 2009).

Rapid Re-Housing

Background

Rapid re-housing is a type of intervention that follows the Housing First approach of providing housing as quickly as possible, regardless of other areas in which an individual or family might require support. Rapid re-housing merges components from temporary and permanent housing solutions. It enables quick access to housing and services, and provides temporary financial assistance so that

households gradually become self-sustaining and can remain in their housing units permanently. Rapid re-housing emerged as a strategy to combat homelessness as communities throughout the United States organically began the practice (NAEH, 2014). In 2008, the federal government funded the Rapid Re-housing for Homeless Families Demonstration (discussed as a case study later in this paper).

The 2009 Homelessness Prevention and Rapid Re-Housing Program (HPRP) and HEARTH Acts (both discussed in greater detail below) significantly expanded the use of rapid re-housing programs throughout the United States. In coordination with USICH, HUD, and the VA, the National Alliance to End Homelessness (NAEH, 2014) compiled a list of three core components for rapid re-housing programs. These components are:

1. Housing identification,
2. Rent and move-in assistance, and
3. Case management and supportive services.

A rapid re-housing program must have all three of these elements available, but it is not required for the same entity to provide them all, or for all individuals or families to utilize them (NAEH, 2014). For example, one agency might provide housing subsidies, while another agency provides support services. Similarly, one household may utilize housing subsidies but choose not to engage with support services.

In general, there are several groups or organizations that work together to provide rapid re-housing to those experiencing homelessness. Federal housing policies often dictate much of the work that is carried out at the local level, as local providers must meet federal guidelines in order to receive federal funding. State and local authorities also typically provide some funding, and may have their own policies in addition to federal policies. Often, continua of care (CoCs) are responsible for organizing a community's response to homelessness, and award contracts to agencies in the area to carry out interventions aimed to prevent or address homelessness. Regardless of what type of entity is carrying out a rapid re-housing program, the NAEH has compiled a list of best practices within each of the three main components. Summaries of these best practices are below, with a complete list in Appendix B.

Housing Identification Best Practices

Identification of safe, affordable, and appropriate housing for individuals and families is a crucial piece of rapid re-housing interventions. The process begins with locating private landlords that are willing to rent to individuals and families who will receive only partial rental subsidies, and who may have poor credit or rental histories. When individuals or families use the intake process to gain access to homelessness services, housing needs and preferences can be identified and matched with available properties. Rapid re-housing programs are responsible for making sure that the homes they move people into meet habitability standards. For the most part, rapid re-housing users sign standard lease agreements directly with landlords, so negotiation of fair and legal leases is another part of rapid re-housing programs.

The process of identifying housing for most homeless individuals and families can be challenging, as they often have poor credit or leasing history and often are financially insecure. Landlords may be especially wary of leasing to families or individuals under rapid re-housing programs, as rapid re-housing rent assistance is not permanent. Rapid re-housing programs must identify available, affordable rental units and recruit landlords who are willing to rent to homeless families and individuals. To this end, rapid re-housing programs should address landlord concerns about possible tenants and the short-term nature of financial assistance. One way to address these concerns is for programs give

landlords a direct contact person within the program and/or offer enhanced security deposits (NAEH, 2014).

In addition to recruiting landlords, rapid re-housing programs must match participants with housing that is appropriate for their needs. Rapid re-housing programs need to ensure that they can place individuals and families in homes that remain affordable once subsidies end, and these homes must be in habitable living condition. Particularly in the case of DV survivors, rapid re-housing homes must be safe and their locations must be confidential. In order to accomplish these aims, programs should recruit landlords that can provide a variety of housing options, and should serve as a resource to families during the housing search and application processes. When funding sources require an inspection of housing, rapid re-housing programs should work to expedite the inspection process in order to move individuals and families into permanent housing as quickly as possible, while still ensuring the safety and livability of homes (NAEH, 2014). Ensuring a quick transition to permanent housing is crucial for DV survivors, as they are vulnerable immediately after leaving an abusive relationship and prior to finding secure and permanent housing (Baker et al., 2009).

Rent and Move-In Assistance Best Practices

While the amount of rent and move-in assistance varies among rapid re-housing programs, all programs at a minimum should provide enough financial assistance for families to move immediately out of homelessness and stabilize in permanent housing. Assistance can include funds to help with move-in costs, security deposits, and rental and utility payments. Some programs cover rent and move-in assistance costs in full, while others subsidize these costs depending on the needs of each family. In order to serve as many families as possible, some programs provide a minimal amount of financial assistance initially and then reduce or increase assistance based on ongoing assessments of household needs. Most funding streams allow for rental assistance for up to 24 months if necessary, again based on the needs of each individual or family (NAEH, 2014).

Case Management and Support Services Best Practices

Case management and support services are crucial aspects of rapid re-housing programs. One of the first jobs of case management is to ensure that participants are placed in homes that meet the needs of their financial situations and lifestyles. Therefore, rapid re-housing programs should offer individuals and families a variety of housing options. Programs should also help participants address issues that may impede access to housing, such as poor credit history, arrears, and legal issues. In some cases, programs may be able to find landlords willing to overlook unfavorable credit history, or they may even be able to help remove debts that inhibit participants from accessing permanent housing (NAEH, 2014).

Rapid re-housing case management should also help participants negotiate appropriate leases with landlords, and ensure that leases grant rapid re-housing households the same rights and responsibilities as all other tenants, in line with federal and state leasing policies. Programs should make themselves available to help resolve disputes between households and landlords, and provide households with training on skills necessary to be good renters, if desired. If eviction is threatened, rapid re-housing programs should help relocate households prior to an eviction occurring (NAEH, 2014).

Flexibility is a key part of running a rapid re-housing program, as each household's needs are unique. Linking participants to community resources can be an effective means to ensure that households receive the support they need. Utilization of all support services must be voluntary, and tenants must know that their housing does not depend on their participation or interaction with other

support services. At the same time, rapid re-housing programs are in the position to assist with facets of participants' lives outside of housing, and should make themselves available to assist with situations that threaten stability, even after financial assistance to a household ends. Possible threats include employment issues, barriers to benefits, transportation challenges, and family conflict. Such assistance can be crucial in preventing a recurrence of homelessness (NAEH, 2014).

Community resources are a critical part of rapid re-housing programs. Those carrying out rapid re-housing programs should have relationships with other service providers, benefits counselors, employment agencies, and other community-based services in order to better serve their participants. Opportunities for individuals and families to engage with these services should be available, but must never be required for a family to remain in housing. Finally, rapid re-housing programs should ensure that services are participant-directed, voluntary, and always respectful of individuals' rights to self-determination. Programs must adhere to all applicable laws and regulations (NAEH, 2014).

Why Rapid Re-housing for Domestic Violence Survivors?

Rapid re-housing offers many benefits over other homelessness services, including low rates of return to homelessness and high housing placement. For DV survivors, one of the most important benefits is that rapid re-housing is an immediate stable housing intervention for those in critical, time-sensitive need (Cunningham, Gillespie, & Anderson, 2015). Rapid re-housing has also been shown to support increased incomes among families who participate in rapid re-housing services over those who participate in other housing options, including permanent housing subsidies (HUD, 2015b).

Federal Policies to Support Rapid Re-housing

History of Federal Homelessness Housing Policies

Federal housing assistance to low-income families has existed since the 1930s in response to the Great Depression. The Section 8 Housing Choice Voucher Program was established in 1974. However, the Homeless Eligibility Clarification Act, the first federal policy to explicitly address homelessness, was not passed until 1986. The Homeless Eligibility Clarification Act removed requirements for a permanent address and other barriers to receive assistance from federal programs already in place, such as Supplemental Security Income, Food Stamps, Veterans Benefits, Medicaid, and Aid to Families with Dependent Children (National Coalition for the Homeless [NCH], 2006).

Also in 1986, the United States Congress adopted the Homeless Housing Act, which created the Emergency Shelter Grants program (later renamed the Emergency Solutions Grants [ESG] program, and discussed in greater detail below) and a transitional housing demonstration program.

McKinney-Vento Act (1987)

What came to be called the McKinney-Vento Act, the major legislation that governed the federal response to homelessness until 2009, was passed in 1987 with broad bipartisan support. The McKinney-Vento Act defined homelessness in six main categories. While none of those categories explicitly included individuals or families fleeing DV, it did make provision, outside of the six enumerated categories, for "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing" to be deemed as homeless and able to receive benefits under the Act (NCH, 2006).

The McKinney-Vento Act established USICH, which coordinates federal response to homelessness and attempts to create partnerships between all levels of government and the private sector. In 2010, USICH published *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (USICH, 2015). This document guides federal efforts to prevent and end homelessness, and provides resources to those serving homeless people in the United States. It also identifies rapid re-housing as an effective method of reducing homelessness, based on the Rapid Re-housing for Homeless Families Demonstration (discussed below) and other pilot rapid re-housing projects (USICH, 2015).

The McKinney-Vento Act authorized several programs to respond to homelessness. Many of these programs were administered by HUD, including the Emergency Solutions Grant program (an expansion of the program created by the 1986 Homeless Housing Act) and others. The Department of Education was authorized to administer the Education of Homeless Children and Youth (EHCY) program, which grants money to states to ensure that homeless children have equal access to free and appropriate public education, in part by addressing problems due to transportation needs, immunization and residency requirements, lack of birth certificates and school records, and guardianship issues (United States Department of Education [DOE], 2015). In 1994, changes to the EHCY program specified the rights of homeless preschoolers to a free and appropriate public preschool education and gave parents of homeless children and youth a voice regarding their children's school placement (NCH, 2006). The EHCY program is important for DV survivors and their families, as it removes the potential barrier of having to remove children from school upon fleeing a violent situation.

Homelessness Prevention and Rapid Re-Housing Program (2009)

The Homelessness Prevention and Rapid Re-Housing Program (HPRP) was authorized under the American Recovery and Reinvestment Act (ARRA) (2009) to address increased homelessness and risk of homelessness stemming from the housing market crash and financial crisis that occurred in 2007 and 2008. HPRP consisted of a one-time $1.5 billion allotment that was distributed to communities following an almost identical formula as the ESG program disbursements discussed below (HUD, n.d.g). The differences between ESG and HPRP rapid re-housing program requirements were minimal, and as HPRP has ended and all grants were required to be closed out by September 30, 2012 (HUD, n.d.g), these differences are no longer relevant. However, programs carried out under HPRP provided evidence that rapid re-housing is an effective method of reducing homelessness (HUD, n.d.i), and contributed to the inclusion of rapid re-housing as a promising practice in USICH's 2010 *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* report (USICH, 2015).

Current Federal Homelessness Housing Policies and Programs

Federal Priorities

The *Opening Doors* report identified four overarching goals to guide the federal response to homelessness through 2020. The goals included ending veteran homelessness; ending chronic homelessness; preventing and ending homelessness among families, youth, and children; and setting a path to end all types of homelessness. These goals play a role in determining the focus of HUD programs and how federal funding can be used and how much is available for programs for each group. The HEARTH Act, described in detail below, provides the legal basis for achieving the goals laid out in the *Opening Doors* report.

Homeless Emergency Assistance and Rapid Transition (HEARTH) Act (2009)

The Homeless Emergency Assistance and Rapid Transition (HEARTH) Act was signed into law in May of 2009. The HEARTH Act re-authorized and amended the McKinney-Vento Act, with substantial changes. The HEARTH Act updated the definition of homelessness to include the following:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for individuals who resided in an emergency shelter or a place not meant for human habitation and who are exiting an institution where they temporarily resided;
2. Individuals and families who will imminently lose their primary nighttime residence;
3. Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and
4. Individuals and families who are fleeing, or are 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 (HUD, 2011).

Individuals falling into the first category are generally referred to as "literally homeless." The fourth category breaks from the definition of homelessness in the McKinney-Vento Act by explicitly defining those fleeing DV as homeless. While requirements for verifying homelessness were updated for all categories, most relevant here are the requirements to verify membership in the fourth group listed above. The HEARTH Act requires that all individuals and families seeking homeless services provide oral statements, and additionally requires that the individual or head of household certify that he or she has not identified a subsequent residence and lacks the resources or support networks to obtain housing.

For DV-related homelessness, the DV, 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 from a housing or service provider, social worker, healthcare provider, law enforcement agency, legal assistance provider, pastoral counselor, or any other organization from whom the individual has sought assistance. The only exception to this requirement is if the safety of the individual or family would be jeopardized by giving such a statement. The written referral does not need to contain specific details about the incidence(s) of violence that occurred prior to the victim fleeing or attempting to flee (HUD, 2011).

The HEARTH Act also consolidated the grants programs administered by HUD, increased the resources dedicated to homelessness prevention, simplified the matching funds process whereby states contribute to HUD's programs, and placed an emphasis on program performance monitoring and evaluation (HUD, n.d.b). The HEARTH Act focuses on four main components (HUD, 2011b):

1. Continuum of Care program, which consolidates Supportive Housing programs, including permanent and transitional supportive housing programs, the Shelter Plus Care (S+C) program, and the Single Room Occupancy program;
2. Emergency Solutions Grants (ESG, formerly the Emergency Shelter Grants program) program;
3. Homeless Management Information Systems; and
4. Rural Housing Stability Assistance program.

Each of these components and their relationship to rapid re-housing is described in greater detail in the sections below. All North Carolina recipients of CoC and/or ESG funding are listed in Appendix C, along with a complete list of all current North Carolina CoCs.

Rapid Re-Housing in HUD Programs

Continuum of Care Program

The Continuum of Care (CoC) program is designed to promote community commitment and coordination to end homelessness. It provides a mechanism for securing and dispersing HUD funding for local and state governments and other nonprofit organizations to re-house individuals and families with as little trauma and dislocation as possible. CoCs are responsible for the design and implementation of a coordinated intake process of homeless individuals and families within their respective communities (discussed in greater detail below) that directs participants to appropriate resources, programs, and services, including those not provided by the CoC (HUD, n.d.c). Each CoC should provide coordinated intake of individuals seeking homelessness services, as well as each of the three types of housing options discussed above (emergency, temporary, and permanent) (NAEH, 2010).

CoCs are also responsible for tracking homelessness and responses to homelessness in their communities, including biennial counts of the homeless population and an annual accounting of available emergency services, housing units, and beds that comprise services available for the homeless (NAEH, 2010). CoCs submit annual plans to HUD to request funding for permanent and transitional support housing programs, the Shelter Plus Care (S+C) program, and the Single Room Occupancy program.

Individuals or families who are defined as homeless under any of the four categories of homelessness as laid out in the HEARTH Act are eligible to receive rapid re-housing assistance under the CoC program, after undergoing an initial evaluation. Under CoCs, rapid re-housing participants may receive up to 24 months of rental assistance. For a complete list of costs that may be paid for with CoC funding to support rapid re-housing, including both costs incurred by the program and participant services, as well as leasing and housing requirements, see “Rapid Re-housing: ESG vs. CoC” (HUD, 2013). All participants receiving rapid re-housing assistance under CoCs are at a minimum required to attend monthly housing case management meetings (HUD, 2013). At least annually, CoCs must re-evaluate the needs of participants receiving rapid re-housing assistance. Those participants who continue to demonstrate lack of support networks or resources to retain housing without assistance may continue to receive assistance, but levels of assistance may be adjusted.

As part of internal written standards, CoCs may establish income rules to determine which individuals and families are eligible for rapid re-housing assistance. Income evaluations are therefore allowable but not required under the CoC Program. In May 2015, HUD encouraged all CoCs to adopt a Housing First approach in as much of their programming as possible. HUD specifically promotes rapid re-housing as a Housing First strategy to be utilized, particularly for housing families with children (NAEH, 2015b).

Homeless Management Information Systems

Each CoC is required to choose a Homeless Management Information System (HMIS) to collect household-level data and data on the provision of housing and other services to individuals and families who are homeless or at risk of homelessness. Each selected HMIS must comply with HUD data collection, data management, and data reporting standards (HUD, n.d.e). HMIS systems can assist with coordinated intake processes (discussed in greater detail below) and are useful for tracking and analyzing data about the various forms of housing assistance. They are also useful in determining how many DV survivors are utilizing each type of homelessness assistance. Use of an HMIS is required for both CoC and ESG funding.

Emergency Solutions Grants Program

HUD's Emergency Solutions Grants (ESG) program provides funding for outreach to homeless populations, and to improve the quantity and quality of emergency shelters, assist in operating emergency shelters, and provide services to shelter residents. Additionally, it funds projects to rapidly re-house individuals and families and to prevent individuals and families from becoming homeless. While ESG funding is separate from CoC funding, often both types of funding filter through a community's CoC. Metropolitan cities, urban counties, territories, and states are eligible to apply for ESG funds, and may re-allocate funding to private service providers (HUD, n.d.d).

Like CoCs, ESG programs must re-evaluate their rapid re-housing households at least annually in order to determine whether or not beneficiaries have the support networks and resources to continue to qualify for rapid re-housing assistance. Under the ESG program, households must have an annual income of less than or equal to 30% of the area median income. ESG programs may set stricter eligibility requirements if they choose (HUD, 2013).

Rapid re-housing is eligible to be funded through the ESG program, however eligibility requirements for participants are different from those in the CoC program. Only individuals and families that fall under the first category of homelessness as defined by the HEARTH Act ("literally homeless") can receive rapid re-housing assistance through ESGs. Individuals and families that are fleeing domestic violence are eligible for rapid re-housing assistance only if they also fall under the first category and lack a permanent nighttime residence (HUD, 2013). In practice, this means that once an individual or family has fled a domestic violence situation and has entered a shelter, they are eligible for rapid re-housing services provided by ESG funds.

Like CoCs, ESG programs may provide rapid re-housing participants with financial assistance for up to 24 months, and all rapid re-housing participants are required to attend monthly case management meetings. For a complete list of costs that may be incurred with ESG funding to support rapid re-housing, as well as leasing and housing requirements, see "Rapid Re-housing: ESG vs. CoC" (HUD, n.d.d).

Coordinated Intake

Coordinated intake is a centralized assessment system or process that ensures all individuals and families trying to access homelessness services are evaluated equally and have equal access to available resources in a community, such as those provided with CoC and ESG funding. Coordinated intake processes make assistance more effective and accessible and allow for prioritizing assistance based on vulnerability and severity of need. Coordinated intake systems can also provide information on gaps in service based on demand in order to help with better planning (HUD, 2015). In all of these ways, coordinated intake makes it more likely that individuals and families will be able to access the services that they need (NCEH, 2011).

In general, there are two different models for coordinated intake: those with centralized and decentralized access points. A centralized entry system has one specific location, or one phone number or website, where those seeking services can be evaluated, while a decentralized entry system has several access points. One advantage of a centralized intake system is that it is easier to ensure that all those seeking assistance receive the same assessment and the same data is collected. However, decentralized intakes can be useful for larger communities or those without effective public transit systems (NCEH, 2011). Each community should determine which type of system is most likely to provide equal and equitable assessment and access to services.

Rural Housing Stability Assistance Program

The Rural Housing Stability Assistance (RHSA) program awards grants through a competitive process. RHSA funds can be used in areas meeting HUD's definition of rural (HUD, n.d.f). Counties, private nonprofit organizations, and local government entities are eligible to apply for RHSA funding. Rapid re-housing is not listed as a specific strategy for RHSA, but the three main components of rapid re-housing may be carried out using RHSA funding (HUD, n.d.f). Currently there is no RHSA funding in North Carolina, but it may be an avenue of funding to explore for areas meeting the federal definition of rural.

Rapid Re-Housing for Veterans

A major goal of the strategy laid out in USICH's *Opening Doors* was to end homelessness among veterans by the end of 2015. The Supportive Services for Veteran Families (SSVF) program, funded through the VA, is one program that funds rapid re-housing of veterans and their families. The SSVF program specifically targets very low income veteran families (veteran families whose income does not exceed 50% of the area median income) (United States Department of Veterans' Affairs, 2015). SSVF programming is carried out in coordination with a community's CoC. Funding can be used for outreach as well as provision of rapid re-housing. More information on this program, as well as other rapid re-housing programs designed specifically for veterans, can be found on the Veterans' Affairs website (www.va.gov).

Program Studies

National Program 1: Family Options Study

Program Context & Population Served

In 2008, HUD implemented the Family Options Study (FOS), a random assignment study designed to compare outcomes for homeless families across four housing intervention conditions (HUD, 2015b). The study was conducted across 12 sites, each located in an urban area of the United States. 2,282 families, including more than 5,000 children, were randomly assigned to one of the following conditions: (1) subsidy-only, in which families received permanent subsidies for housing but no support services; (2) community-based rapid re-housing, in which families received temporary rental assistance for up to 18 months with limited housing-related support services; (3) project-based transitional housing, in which families received temporary facility-based housing for up to 24 months with optional intensive support services; or (4) usual care, in which families received any housing options (generally beds in emergency shelters) or services without referral to one of the other conditions (HUD, 2015b). In the study sample, women led 91% of households and 49% reported experiencing DV (HUD, 2015b). In the rapid re-housing condition, all families received a formal assessment at the beginning of the program and periodic evaluations throughout the study period. Approximately half of the families referred to rapid re-housing had children's needs assessed, with subsequent goals set around children's needs and progress.

Funding & Outcomes

FOS was funded by HUD, with supplemental funding through the Homelessness Prevention and Rapid Re-housing Program (HPRP) and the Eunice Kennedy Shriver National Institute for Child Health and Human Development. As a crisis intervention strategy, families assigned to rapid re-housing saw the

same or only slightly better housing retention and stability outcomes than those in the usual care condition (NAEH, 2015a).

Families in the rapid re-housing condition were slightly more likely to realize housing stability and have fewer subsequent stays in shelters or unsuitable living conditions than in the usual care condition (HUD, 2015b). FOS found that the percentage of families exiting rapid re-housing into permanent housing was high, and that rates of return to the homeless system, including stays in emergency shelters, was lower than in the usual care condition (Cunningham, Gillespie, & Anderson, 2015). Across the study conditions, rapid re-housing was the most cost-effective model, averaging $6,578 per stay by a family, about $10,000 less than the next least-expensive model. Rapid re-housing also produced more rapid exits from emergency shelters than the usual care condition. In an analysis of FOH, the NAEH identified rapid re-housing as the most promising type of housing intervention for solving family homelessness, given its outcomes and cost-effectiveness (NAEH, 2015a).

Because the rapid re-housing condition evaluated families' need for assistance every three months, families reported anxiety caused by such frequent evaluation. FOS found that employment and income gains among those in the rapid re-housing condition were moderate and may be insufficient to afford the portion of rent for which families were responsible. Employment concerns were a major source of anxiety for participants and they expressed that the burden of rent required them to find jobs quickly, but that the income from the jobs available could not sustain their rent responsibility.

While rapid re-housing may be the most cost-effective model over time, FOS found that the permanent housing subsidy model produced the most significantly improved outcomes (HUD, 2015b). Permanent housing subsidy programs saw the highest uptake and continued use for families exiting emergency shelters. Permanent housing subsidy programs also saw the greatest reductions in housing instability, food insecurity, and economic stress. They also achieved significantly reduced family separation and foster care placements, psychological distress, substance problems, school instability for children, and domestic violence (HUD, 2015b.)

FOS did not specify the details of the family or children assessments, nor the goals or outcomes for children specifically in their evaluation report, so the extent to which rapid re-housing directly impacted children in families assigned to that condition is unavailable. The indirect impact of rapid re-housing on children (expected to increase with housing stability, for example) showed no positive effect (HUD, 2015b). In some qualitative interviews that were not generalizable to FOS as a whole, participants at some sites reported negative experiences with neighborhoods that felt unsafe for their families and children (Fisher, Mayberry, Shinn, & Khadduri, 2014). While there is a lack of data about the impact of neighborhood on rapid re-housing participants and their children, there is evidence that neighborhood quality is an important factor for the health and well-being of children (Sard & Rice, 2014; Cunningham, Gillespie, & Anderson, 2015).

While FOS found that permanent housing subsidies was the most effective housing option, there are several limitations to this finding. The first is that FOS reported outcomes at 18 months. In terms of cost-effectiveness, this may not be enough time to fully account for the fact that rapid re-housing costs per family are reduced over time, while permanent housing subsidies remain constant. Thus rapid re-housing may prove to be considerably less expensive over a longer timeframe. Additionally, rapid re-housing programs varied in size, scope, and services delivered across sites. This variance makes it challenging to draw conclusions across all rapid re-housings sites, as some programs may have had better outcomes due to unique program elements.

National Program 2: Rapid Re-Housing for Homeless Families Demonstration

Program Context & Population Served

Also in 2008, HUD implemented the Rapid Re-Housing for Homeless Families Demonstration (RRHD), which piloted rapid re-housing programs throughout 23 urban communities in the United States (Cunningham, Gillespie, & Anderson, 2015). RRHD enrolled 1,459 individuals in the program. Most of the demonstration communities (75%) were in high-poverty areas (Cunningham, Gillespie, & Anderson, 2015).

Funding & Outcomes

RRHD was funded by HUD and received supplemental funding from HPRP. The final RRHD evaluation report is not yet available, but findings have been published in various conferences and presentations from contractors hired to evaluate the program. The report is expected by the end of 2015 (Cunningham, Gillespie, & Anderson, 2015). Available RRHD findings showed high rates of permanent housing placement and low rates of return to the homeless system, with only 10% of participants requiring future emergency shelter or temporary housing support (Cunningham, Gillespie, & Anderson, 2015). RRHD reports did not specify whether permanent housing placement data included participants moving from rapid re-housing program residences into permanent residences, or whether participants lived permanently in rapid re-housing program residences. Across sites, the percentage of families returning to the homeless system varied, but was always significantly lower than those exiting emergency and temporary interventions. Employment rates increased for participants in RRHD from 34% employed at baseline to 45% one year later. At the Philadelphia RRHD site, evaluators found that every additional month of rapid re-housing services resulted in a $15 per month household income increase (Cunningham, Gillespie, & Anderson, 2015).

RRHD reports found that challenges for those in rapid re-housing remained high. Even families who remained housed reportedly struggled with food insecurity (70%), money for rent (57%), children's school and behavioral performance (14%), and deteriorating health outcomes (17%) (Cunningham, Gillespie, & Anderson, 2015). Additionally, while the return to homelessness was low for rapid re-housing program participants, there was still high residential instability, meaning that many participants remained in housing but moved residences. Only 25% of families remained in the same unit a year after the demonstration (Cunningham, Gillespie, & Anderson, 2015). Instability increased as parental age decreased and number of children increased, particularly among lower-income families. For families escaping DV, the finding that rapid re-housing does not address these significant challenges is an essential consideration.

Local Program 1: New York City

Program Context & Population Served

The Pathways to Housing organization was founded in 1992 and predates the term "rapid re-housing." However, many of the components of the programs carried out by the organization were in line with current rapid re-housing guidelines, and the program is considered a rapid re-housing prototype. An evaluation of the organization's program in New York City was carried out in 2000, and while the program is ongoing, the information reported here stems from that evaluation.

The majority of participants in the Pathways to Housing program were male and Black, with over half suffering from diagnosed schizophrenia and substance addiction. Specific aspects of the program included prioritization of recruited participants based on risk of victimization (elderly persons, women,

formerly incarcerated individuals with reduced service access), and efforts to allow participants to make choices about their housing. Program managers and employees recruited private landlords as partners to agree to lease apartments of varying capacity. After participants chose their preferred housing option, program staff assisted with navigating the lease and other components of renting. The program also provided health services including harm reduction substance abuse support, as well as vocational support; however, as the rapid re-housing model prescribes, housing eligibility was not predicated on engagement with those services. While there were minimum requirements for staff contact and money management training, failure to meet those requirements did not result in housing loss.

Funding & Outcomes

The Pathways to Housing nonprofit subsidized approximately 70% of the rental cost for each beneficiary, while further subsidies were procured through external government grants and Section 8 vouchers (Tsemberis & Eisenberg, 2000). An evaluation of the program found 88% housing retention over five years among the 241 person sample (of over 4000 program participants). Traditional linear residential treatment programs in New York City had only 47% housing retention during the same period (Tsemberis & Eisenberg, 2000). Though it was not a requirement, 65% of the Pathways to Housing sample participants sought psychiatric treatment voluntarily from service providers.

Implementation Challenges

Besides the innate logistical and funding challenges of implementing such a large-scale project, one challenge to Pathways to Housing was clinician opposition. When Pathways to Housing was implemented, there was no evidence of rapid re-housing's effectiveness, and most clinicians favored the traditional linear treatment model and the idea that only high-functioning residents were capable of sustained housing retention (Tsemberis & Eisenberg, 2000). Another challenge was low vacancy rates and rental availability. Because of low vacancy, participants were concentrated in areas with low economic viability, which reduced participant choice, safety, and employment options. Additionally, Pathways to Housing found a shortage of funding for subsidies (Tsemberis & Eisenberg, 2000).

Local Program 2: Burlington, Vermont

Program Context & Population Served

Though Pathways to Housing was successful in New York City's urban environment, there was little evidence that similar programs could be adapted successfully in rural areas with low population density, limited public transportation, expansive physical coverage area, limited workforce options, and limited housing availability (Stefancic, Henwood, Melton, Shin, Lawrence-Gomez, & Tsemberis, 2013). Pathways to Housing Vermont adapted the New York City model for Burlington, Vermont and the surrounding rural areas in 2009. The program served was 170 individuals, who were mostly white and returned from incarceration (Stefancic, et al., 2013). As with New York City's model, participants were recruited based on mental illness.

One unique aspect of implementation was personalized partnerships with landlords due to the lack of large property management companies. There were also two main adaptations to program implementation: (1) novel use of technology to mitigate expansive distances; and (2) team restructuring to create two groups of service providers: general coordinators for non-emergency, general support, and regional specialists for more specialized services such as employment support and psychiatric care.

The novel use of technology included provision of computers with teleconferencing capability to program staff and participants in order to carry out "video visits" with specialists and provide enhanced

responsiveness and crisis intervention (Stefancic et al., 2013). Team restructuring was meant to more effectively divide case work. The general support coordinators had a caseload ratio of 1:20, and carried out weekly site visits to ensure monitoring, in-person contact, and assistance with typical needs. The regional specialists interacted with households on an as-needed basis. This hybrid model of optional service provision "enabled consistent and responsive case management services, whereas accessibility of regional specialists ensured that consumers still had direct access to a wide spectrum of multidisciplinary services" (Stefancic et al., 2013, p. 3207).

Funding & Outcomes

The Pathways to Housing Vermont program received funding from various sources, including HUD and the Vermont Department of Correction, which likely accounts for the high number of participants entering from jail. As with the New York City model, Pathways to Housing Vermont measured retention outcomes and found 85% housing retention after three years, a comparable number to other rapid re-housing program outcomes (Stefancic et al., 2013). Evaluators also measured participants' self-reported days spent homeless in the past 30 days and found a significant decrease from baseline at 12-month follow up.

Implementation Challenges

While clinicians did not offer opposition to the Pathways to Housing Vermont program, other challenges were similar to those experienced in New York City, particularly shortages of housing subsidy funding and low vacancy rates (Stefancic et al, 2013). Another challenge was that, due to the small, close-knit populations in rural communities, landlords sometimes had personal relationships with tenants and previous negative experiences could delay re-housing or limit options if a landlord refused to rent to the participant. Additionally, the large geographic areas and travel time required for staff was an implementation challenge.

Local Program 3: King County, Washington

Program Context & Population Served

King County, Washington implemented the Washington State Domestic Violence Housing First program (DVHF) beginning in 2009, and focused specifically on DV survivors and their families. The program served individuals and families in urban, rural, and tribal communities. The program served 681 adults and 1000 children through 2014 (Mbilinyi, 2015). The majority of participants were low-income and had low levels of education. In addition, 35% were Native American, and another 22% were immigrants. One essential implementation component of DVHF was a tiered support services system similar to the system used by Pathways to Housing Vermont. During intake, households were assigned to one of the following support service tiers (Mbilinyi, 2015):

1) The "light touch" tier included one-time, minimal cost logistical support, such as one month's rent or installing locks on rental units;
2) The "medium touch" tier included services in the light touch tier as well as ongoing, higher-cost services such as legal assistance and counseling; and
3) The "high touch" tier included light and medium touch tier services as well as long-term assistance to secure housing, improve financial situation, and ensure safety.

Another important component of DVHF was provision of culturally relevant and aware services, such as prioritizing bilingual staff in place of translation services and awareness of gender dynamics on local Native American reservations (Mbilinyi, 2015).

Funding & Outcomes

The Bill and Melinda Gates Foundation provided major funding for the program, which was coordinated by the Washington Coalition Against Domestic Violence and involved multiple community-based agencies (Mbilinyi, 2015). DVHF used housing retention statistics and a variety of individual and children-focused qualitative interviews to gauge outcomes (Mbilinyi, 2015). The program found 96% housing retention over 18 months, and 84% of participants agreed that the program increased their safety and that of their children. During interviews, participants were most pleased with outcomes for their children, including physical safety, safety from unsafe neighborhoods, reduced stress, increased focus on education, and a sense of normalcy (Mbilinyi, 2015). The evaluation of DVHF found that the multi-tiered service groups and culturally relevant practices were crucial to the program's success (Mbilinyi, 2015). The three-tiered service system ensured resources were used efficiently, and both providers and participants reported that the culturally responsive services contributed to strong retention outcomes and positive program experiences.

Implementation Challenges

One particular challenge was that Native American DV survivors preferred to stay in reservation communities; however, this was not possible due to limited housing availability and proximity to abusers (Mbilinyi, 2015). This may also be a challenge in similar contexts such as immigrant or rural communities where DV survivors' cultural needs and identity depend on remaining in their current communities. DVHF attempted to mitigate this challenge for Native American DV survivors by ensuring that they could continue daily activities and non-DVHF services, such as health clinic appointments, on the reservation (Mbilinyi, 2015).

Recommendations & Implications for NCCADV

Below are the recommendations and implications synthesized from the five program studies analyzed.

- **Prioritize participant housing choice.** In multiple studies, participants who were given a choice in housing options (type, location) reported higher satisfaction and greater emotional well-being. These studies indicate that participants view housing choice as a symbol of independence and were less likely to return to their previous living conditions when they had freedom to choose (Tsemberis & Eisenberg, 2000). Rapid re-housing programs should offer as many different locations and types of housing as possible and support participants in making decisions about their preferred housing situation.
- **Consider incorporating technology to complement in-person services.** Rapid re-housing programs can use video conference calls to increase staff accessibility and participant support. This may require the use of in-home computers, tablets, or other devices that provide videoconferencing capability (Stefancic et al, 2013), and can be especially useful in rural settings.
- **Differentiate intensity of services.** Rapid re-housing programs should consider creating a tiered structure to ensure efficiency of service provision based on severity of participant need. Both the Pathways to Housing Vermont and DVHF programs differentiated services in ways that best met the needs of their participants and staff.
- **Ensure culturally-responsive services and providers.** Rapid re-housing programs should focus on meeting culturally specific needs of DV survivors by both hiring staff that share a similar cultural background to survivors and adapting services to be culturally aware. Bilingual staff is

especially important. To be culturally responsive, rapid re-housing programs can consult local community organizations and leaders (Mbilinyi, 2015).

- **Follow NAEH best practices**. The National Alliance to End Homelessness provides general guidelines for implementing rapid re-housing programs for all contexts. These best practices are included in Appendix B.

There is a lack of data about the impact of rapid re-housing on outcomes related to children in families with a homeless guardian, both in terms of services provided to children who have witnessed or experienced DV and in terms of housing instability. Both the Family Options Study and Rapid Re-Housing Demonstration reports hypothesize about the indirect, positive impacts of rapid re-housing as a mechanism for housing stability on children. However, given the significant health and well-being impacts of DV and homelessness on children, more research is needed to draw conclusions about the proximal and distal effects of rapid re-housing on children.

Conclusion

Rapid re-housing presents a promising strategy for alleviating homelessness for individuals and families who have experienced DV. Evaluations of previous rapid re-housing programs can inform the design and implementation of new and better solutions to homelessness, including for survivors of DV. While this literature review covers the national policies for rapid re-housing and evaluations of rapid re-housing programs throughout the United States, there is little information available about current rapid re-housing efforts in North Carolina. Based on research of the peer-evaluated and gray literature, rapid re-housing is being implemented in several North Carolina counties. However, process and impact evaluations are unavailable for these programs. More information on the North Carolina context is synthesized in the Summary of Current Rapid Re-housing Efforts in North Carolina (deliverable #2).

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Appendix A: Methods

In this literature review, we identified relevant research regarding homelessness, domestic violence, housing policies, and rapid re-housing programs by searching databases from the disciplines of social work, city and regional planning, sociology, gender studies, public health, and medicine. Our initial search included twelve databases. We found that the articles yielded by most of these databases were not relevant to our purposes, so narrowed our scope to include NCBI PubMed, PsychINFO, and Google Scholar. Any relevant articles that were originally found in other databases were also found in these three databases. We searched these databases for articles from 2000-2015. A complete list of databases searched appears in Appendix D. Ultimately, we expanded our criteria to include evaluation reports published by rapid re-housing programs, as well as gray literature and government and non-profit reports. We adjusted our search strategy to target the types of policies and programs most relevant to the local context in North Carolina.

In order to ensure that relevant studies were not missed, the search terms remained broad. Search terms included one option from each of the following categories, with a term from the third category as needed to narrow the search:

1) "Homelessness," "housing," "Housing First," "rapid re-housing," or "housing and urban development";
2) "Domestic violence," "inter-personal violence," "DV," or "IPV";
3) "Children," "families," "adolescents," or "child services."

While we purposefully included broad terms, this strategy yielded overly broad results. Therefore articles were excluded based on depth of term exploration and ability to triangulate conclusions from other included criteria (for example, many articles about homelessness do not specify domestic violence survivors; however, with appropriate domestic violence literature, we could synthesize findings).

Articles were eligible for case study inclusion based on: (1) demographic or geographic similarity to North Carolina context and (2) avoidance of redundancy as determined by different populations and contexts served.

To capture program reports, we researched the websites of rapid re-housing programs in the United States only. For gray literature, we completed a comprehensive search of Internet resources using the aforementioned search strings and included articles or websites if they were: (1) published by federal agencies and/or (2) published by national or state homelessness or domestic violence non-profit organizations.

Our search was limited by considerations for capacity (both in timeline and personnel), as well as by the purpose of the literature review. Given that the purpose of the literature review is for local use in North Carolina and that rapid re-housing is already the model of choice for NCCADV, we focused on sources most relevant to that context, which included approximately 37 articles.

Appendix B: National Alliance to End Homelessness Rapid Re-Housing Best Practices

Per the National Alliance to End Homeless: "The text in bold below is the accepted core components. *The non-bold text, a description of the components, is the opinion of the National Alliance to End Homelessness, alone, and has not been approved by the federal agencies."*

Category One: Housing Identification

Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness. On the most basic level, a rapid re-housing program helps individuals and families identify and secure housing. Programs do this by identifying available affordable rental units, and by recruiting landlords willing to rent to homeless families and individuals, including those who may have poor credit histories, past evictions, or other tenant qualification issues.

Address potential barriers to landlord participation such as concern about the short term nature of rental assistance and tenant qualifications. Landlord participation and acceptance of the program is key to a program's ability to re-house households quickly—ideally within 30 days of program entry. Programs should address landlord concerns about possible tenants as well as concern around the short-term nature of financial assistance. Effective programs accomplish this by assuring support to landlords during the move-in process and by offering landlords a direct contact at the program in the event they have issues with a tenant placed by the program. When legally permitted, some programs also offer enhanced damage deposits, or create other financial mechanisms to alleviate landlords' concerns over the nature of the tenants or the subsidies.

Assist households to find and secure appropriate rental housing. Beyond landlord recruitment, programs must also match households to appropriate housing—housing for which they will be able to pay the rent after financial assistance ends; that is decent; and, especially in the case of survivors of domestic violence, that is safe. Effective programs accomplish this by recruiting many landlords to provide a variety of housing options in a variety of neighborhoods and by serving as a resource to households during the housing search, location, and application process. With regard to a household's ability to afford rent after the termination of financial assistance, programs should not assume this can be accurately assessed at the time of entry. Effective programs and jurisdictions have found that even households that had zero income at entry to a rapid re-housing program are able to maintain housing once program involvement ends.

Funding sources for rapid re-housing often require an inspection to ensure the decency and safety of a housing unit for which financial assistance will be provided. Rapid re-housing programs should work to facilitate and expedite the inspection process so as to minimize delays in a household moving into a unit. In the absence of an inspection requirement, programs should still ensure a unit's habitability and safety before moving in a household.

Category Two: Rent and Move-In Assistance

Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing. The amount and duration of financial assistance provided by a rapid re-housing program can vary, but at a minimum, programs should provide the

assistance necessary for households to move immediately out of homelessness and to stabilize in permanent housing. Programs can provide funds to assist with move-in costs, security deposits, rental payments, and utility assistance. In some instances, a first month's rent or security deposit is sufficient for a household to exit homelessness and data show that programs typically provide financial assistance for six months or less; but many funding streams allow assistance for up to 24 months if necessary.
Financial assistance in a rapid re-housing program can come in the form of a full subsidy, covering the full rent for a period of time, or a shallow subsidy, covering a portion of the rent. Some programs may start with a full subsidy and gradually step down the assistance a household receives. Programs interested in helping as many households as possible may employ a progressive engagement model in which programs provide minimal amounts of assistance to all households initially and then extend or intensify the assistance provided as-needed based on an ongoing assessment of household needs.

Category Three: Rapid re-housing case management and services

Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. Rapid re-housing programs play an important role in assisting the household with the selection of a permanent housing option that meets the household's unique needs. Ensuring a household is placed in a unit that meets its financial situation and lifestyle needs, such as school, work, family, and support networks, will increase the likelihood that households will remain stably housed once program assistance ends. Effective programs attempt to provide households with choices in housing and often adopt creative strategies, such as renting rooms or accessory units, co-tenancy, or shared housing, to increase the likelihood that households want to remain and can afford to remain in their unit of choice once financial assistance ends. Preliminary outcome data have shown that households, even when unemployed or underemployed at entry to a rapid re-housing program, still manage to stay housed after financial assistance ends. Strategies that providers use to mitigate a household's lack of employment include help accessing public benefits and creating shared living situations to minimize rent costs in addition to traditional services geared towards helping a household establish employment.

Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).Program-related case management and services are an essential component of rapid re-housing programs. These services must be guided by the unique needs and wants of individuals and families experiencing homelessness. One function of rapid re-housing case management is to immediately begin to address such issues as credit history, evictions, arrears, and legal issues that may prevent a household from being able to obtain a lease. Programs should still work to find housing for households with challenging histories because, in some cases, a program may be able to negotiate with a landlord to overlook an unfavorable credit or rental history. In other cases, a program can work to have some debts removed by paying arrearages or by working with creditors to remove items from credit history.

Help individuals and families negotiate manageable and appropriate lease agreements with landlords. One of the most important functions of rapid re-housing case management is to help households negotiate manageable lease agreements with landlords and to help households understand their rights and responsibilities as tenants. It is imperative that any lease agreement provides the tenant with the same rights and responsibilities as a typical community lease holder and that the financial terms of the lease are such that the household has a reasonable ability to assume rental costs once financial support ends. Effective programs also make themselves available to both tenants and landlords to resolve disputes and issues that may arise, as well as provide tenants with skills necessary to be a

good tenant and develop positive relations with the landlord. In instances when eviction is threatened, effective programs will help the household negotiate and relocate to another unit with another landlord without an eviction, if necessary.

Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing. Each household entering a rapid re-housing program faces unique barriers and challenges, and programs must be flexible enough to provide the services and assistance necessary. In some instances, a household may be able to easily stabilize in housing with limited, one-time assistance and have no need for services. In other instances, a household may need or request additional services, such as employment or job training services, in order to stabilize in housing. Successful programs have the capacity to appropriately assess a household's unique situation, and to provide the necessary services and resources, either internally or through a connection to community-based assistance. All participation in services should be voluntary and driven by the household.

Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided. While services are voluntary, it is appropriate and essential that program staff is able to monitor the progress of participants' housing stability and be available to assist in the resolution of any crises that threaten that stability. This could include employment issues, barriers to benefits, transportation challenges, and family conflict. A program's ability to intervene or assist a household after a family or individual has transitioned off financial assistance can be integral to ongoing housing stability and preventing a recurrence of homelessness.

Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. It is not necessary that all services provided to a household originate within the agency providing financial assistance. A successful rapid re-housing program has relationships with and linkages to other service providers, benefits counselors, employment agencies, and community-based services. Again, depending on unique needs and preferences, a household should have access to programs and services that will offer them the opportunity to achieve both short- and long-term well-being and stability. While a rapid re-housing program should provide opportunities for a household to access services they may want or need, a household's housing should never be contingent on participation in a service plan.

Ensure that services provided are client-directed, respectful of individuals' rights to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance. Regardless of the depth and breadth of case management and services available, all services provided must be client-directed, meaning they are respectful of individuals' rights to self-determination. Services and case management compliance should be voluntary, unless required by statute or regulation for the program's funding stream. Participation in additional services should never be a requirement for a household to receive rapid re-housing assistance.

Source: National Alliance to End Homelessness, 2014

Appendix C: Housing & Urban Development in North Carolina

North Carolina Organizations Receiving Continuum of Care and/or Emergency Solutions Grants Funding (November 2015)

- Asheville Housing Authority
- Asheville, NC
- Catawba County, NC
- Charlotte, NC
- Cumberland County, NC
- Durham Housing Authority
- Durham, NC
- Elizabeth City Housing Authority
- Fayetteville Metropolitan Housing Authority
- Graham Housing Authority
- Greensboro Housing Authority, NC
- Greensboro, NC
- Greenville Housing Authority, NC
- High Point, NC
- Mecklenburg County, NC
- NC-500 - Winston-Salem/Forsyth County CoC
- NC-501 - Asheville/Buncombe County CoC
- NC-502 - Durham City and County CoC
- NC-503 - North Carolina Balance of State CoC
- NC-504 - Greensboro, High Point CoC
- NC-505 - Charlotte/Mecklenburg County CoC
- NC-506 - Wilmington/Brunswick, New Hanover, Pender Counties CoC
- NC-507 - Raleigh/Wake County CoC
- NC-508 - Anson, Moore, Montgomery, Richmond Counties CoC
- NC-509 - Gastonia/Cleveland, Gaston, Lincoln Counties CoC
- NC-511 - Fayetteville/Cumberland County CoC
- NC-512 - Burlington/Alamance, Rockingham Counties CoC
- NC-513 - Chapel Hill/Orange County CoC
- NC-514 - Neuse-Tideland Regional CoC
- NC-515 - Greenville/Pitt County CoC
- NC-516 - Northwest North Carolina CoC
- NC-517 - Franklin/Granville/Warren/Vance CoC
- NC-518 - Rocky Mount/Nash, Edgecombe Counties CoC
- NC-519 - Randolph County CoC
- NC-522 - Southwest CoC
- NC-524 - Goldsboro/Duplin, Wayne, Duplin Counties CoC
- NC-525 - Johnston, Lee, Harnett Counties CoC

- NC-526 - Concord/Davidson County/Piedmont CoC
- New Reidsville Housing Authority
- North Carolina
- Orange County, NC
- Raleigh, NC
- Sanford Housing Authority, NC
- Wilmington Housing Authority, NC
- Winston-Salem Housing Authority
- Winston-Salem, NC

Source: United States Department of Housing and Urban Development, n.d.j

North Carolina Continuum of Care Programs (November 2015)

- Asheville/Buncombe County
- Chapel Hill/Orange County
- Charlotte/Mecklenberg County
- Durham City/Durham County
- Fayetteville/Cumberland County
- Gastonia/Cleveland/Gaston/Lincoln Counties
- Greensboro/High Point/Guilford County
- Northwest NC
- Raleigh/Wake County
- Wilmington/Brunswick/New Hanover/Pender Counties
- Winston-Salem/Forsyth County
- North Carolina Balance of State (all areas not covered by another CoC)

Source: North Carolina Coalition to End Homelessness, n.d.

Appendix D: Initial Search Databases

- Family and Society Studies World Wide
- GenderWatch
- Google Scholar
- Interuniversity Consoritum for Political and Social Research (ICPSR)
- JSTOR
- LexisNexis
- Psychiatry Online
- PsychInfo
- PubMed
- Social Sciences Citation Index
- Social Services Abstracts
- Women's Studies International

SPRING 2016

SUMMARY OF CURRENT RAPID RE-HOUSING EFFORTS IN NORTH CAROLINA

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE CAPSTONE

CLAIRE BRENNAN, ANNA DARDICK, MADELINE MORRISSEY & HILLARY MURPHY
University of North Carolina at Chapel Hill Gillings School of Global Public Health | Department of Health Behavior

DELIVERABLE 2

CONTRIBUTIONS	Anna Dardick and Hillary Murphy led the development of the screener tool, interview guide, and piloting process, as well as the planning, development, and writing of the report. They also managed communication and coordination with interview participants. Claire Brennan and Madeline Morrissey each participated in the piloting of one interview, and conducted and coded an additional interview each.
DELIVERABLE PURPOSE & AUDIENCE	The purpose of the Summary of Current Rapid Rehousing Efforts in North Carolina is to identify current policies and practices in North Carolina (NC) related to rapid re-housing, particularly related to domestic violence (DV) survivors and their children. The report includes stakeholders' perspectives on the critical components, assets, and challenges of rapid re-housing. In conjunction with the Literature Review, it is used as the foundation for Deliverable #3, the Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children and contributes to Deliverable #4, the Community Readiness Assessment Instrument. The intended audience is the North Carolina Coalition Against Domestic Violence (NCCADV).
STEPS	1. Completed IRB application. 2. Developed screener tool and interview guide for participants and piloted both. 3. Coordinated with housing intervention organizations in North Carolina to schedule and conduct semi-structured interviews. 4. Developed codebook based on interview guide questions and coded data using a coding matrix. 5. Analyzed findings for key themes to support development of the Summary of Current Rapid Rehousing Efforts in North Carolina. 6. Disseminated report to NCCADV.
RESULTS AND KEY FINDINGS	• Building mutually beneficial relationships with landlords is key to the success of rapid re-housing. • Availability of safe affordable housing is a major barrier. • Rapid re-housing, alone, is not the answer to homelessness; multiple simultaneous approaches are necessary. • Using county and federal funding is complex and is less flexible, and private funding is beneficial for rapid re-housing programs. • Data collection can be difficult due to loss to follow up and non-uniform use of data collection systems. • Coordination among rapid re-housing efforts in North Carolina would be beneficial. • Providing wrap around services such as mental health and counseling services and case management plays an important role in the success of clients. • DV survivors and children with trauma exposure are under-addressed in current rapid-re-housing efforts.
NEXT STEPS	The Summary of Current Rapid Rehousing Efforts in North Carolina will be used to inform deliverable #3, the Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children. It will also be used by NCCADV to gain a more in-depth understanding of the rapid re-housing efforts currently taking place in NC.

Table of Contents

Introduction

Several communities in North Carolina use rapid re-housing (RRH), a type of intervention following the Housing First approach, to combat homelessness. The Housing First approach centers on providing people experiencing or at risk of homelessness with housing as quickly as possible, without preconditions. RRH programs place individuals and families in permanent housing and provide temporary assistance to help households stabilize and become self-sufficient. RRH programs also include voluntary wrap-around services such as financial counseling and assistance finding employment, among others.

While rapid re-housing has been successfully implemented throughout the United States, there is a lack of information about what makes a program successful in North Carolina. There is also little evidence of best practices for implementing rapid re-housing programs that serve survivors of domestic violence (DV) and their children. The strategies communities use to identify and address domestic violence through program intake processes also vary, and there is limited consensus about which intake protocols have the best outcomes for families (North Carolina Coalition Against Domestic Violence [NCCADV], 2014).

The United States Department of Housing and Urban Development (HUD) estimates that there were 11,491 homeless individuals in North Carolina in 2014 (U.S. Department of Housing and Urban Development [HUD], 2014). Women survivors of domestic violence (DV) are disproportionately represented among homeless individuals, and in the 2014 North Carolina Point-in-Time count, victims of DV were one of the largest sub-populations of homeless persons identified (North Carolina Coalition to End Homelessness, 2014). These statistics emphasize the importance of targeting rapid re-housing programs in North Carolina towards DV survivors and their children.

Purpose

The purpose of this report is to gather information on current rapid re-housing policies and practices in North Carolina by gaining stakeholders' perspectives on critical components, assets, and challenges of rapid re-housing. This report presents the findings of surveys and in-depth interviews conducted with local organizations engaged in rapid re-housing efforts in North Carolina.

Methodology

Participants

Surveys were conducted with 16 representatives from continua of care (CoCs) from around North Carolina. CoCs are diverse bodies of stakeholders responsible for implementing housing interventions and dispersing HUD funding on the local level. Each representative was asked to fill out a survey about any rapid re-housing programs they operate. Fourteen CoC representatives currently engaged in RRH were asked to participate in in-depth interviews about their programs, and to provide names of others who could provide insight. In total, in-depth interviews were conducted with four CoC representatives and also with four RRH contractors. Rapid re-housing contractors are organizations using funding dispersed by a CoC to implement rapid re-housing programs.

Rapid Re-Housing Survey

The rapid re-housing survey was developed using Qualtrics survey software. The first question determined whether the CoC was currently engaged in rapid re-housing. Rapid re-housing was defined

as “A program or intervention targeting homeless individuals or families by providing support to secure permanent housing and short-to-medium-term subsidies to retain that housing. It does not offer permanent subsidies, but rather targets people who are likely to be able to sustain housing once subsidies end. Rapid re-housing also provides connections to community resources and social services that may help beneficiaries solve other life problems or achieve other life goals; however, there is no requirement that beneficiaries engage in these resources.” For CoCs currently engaged in rapid re-housing, subsequent questions were asked about program details, including funding sources, implementation challenges, and data collection. The full survey can be found in Appendix A. Surveys were completed between November 2015 and January 2016.

In-Depth Interviews

Two semi-structured interview guides were developed, one for CoCs and another for rapid re-housing contractors. Interview questions were open-ended and related to program details and critical components, assets, and challenges of implementing RRH. In-depth interviews were conducted between November 2015 and February 2016. Key informants were interviewed by phone and interviews lasted between 1 and 1.5 hours. The full interview guides can be found in Appendix B. Interviews were audio-recorded and analyzed using a data matrix based on interview guide question themes. Quotes were selected to illuminate key themes.

Findings

Rapid Re-Housing Surveys

The rapid re-housing surveys created a snapshot of funding sources and data collection methods currently in use by RRH programs across North Carolina.

Funding

Many CoC representatives reported using city or state Emergency Solutions Grant (ESG) funds from HUD for their rapid re-housing programs. The ESG program provides funding for outreach to homeless populations and to improve the quantity and quality of emergency shelters, assist in operating emergency shelters, and provide services to shelter residents. Additionally, it funds rapid re-housing projects for individuals and families to prevent them from becoming homeless (HUD, n.d.). While rapid re-housing is eligible to be funded through the ESG program, only individuals or families who lack a fixed, regular, and adequate nighttime residence, including those who reside in an emergency shelter, are eligible to receive rapid re-housing services through those funds (HUD, 2013). This means that individuals or families who are fleeing or attempting to flee DV are not eligible for rapid re-housing services using ESG funding unless they first enter the shelter system. Cities and states are required to match federal ESG funds and distribute the money to contracting organizations. There are also targeted funds based on national priorities – for example, the Veterans Administration provides funds for rapid-re-housing of homeless veterans. Apart from ESG funding, stakeholders reported receiving fund directly from CoCs.

Participants also mentioned private donations as sources of funding for rapid re-housing in North Carolina. With private donations, there is greater potential for reallocation of funds for needs identified by the individual program. The Salvation Army, which re-houses families who are living in hotels, has a private grant from United Way.

Data Collection

CoCs receiving funding from HUD for rapid re-housing reported collecting data on elements included in the North Carolina Homeless Management Information System (NC-HMIS). NC-HMIS is a statewide "centralized data collection tool to compile information, over time, on characteristics, service needs, and service utilization of individuals experiencing homelessness" (Durham Opening Doors, n.d.). It is Health Insurance Portability and Accountability Act (HIPAA) compliant. NC-HMIS allows for better coordination between rapid re-housing programs and assists in follow-up with participants. Programs that are not utilizing HUD funding do not participate in the NC-HMIS data collection and thus may experience barriers with participant follow-up and coordination with other CoCs.

In-Depth Interviews

An analysis of the in-depth interviews with CoC and RRH contractor representatives resulted in the identification of eight key themes:

1. Building mutually beneficial relationships with landlords is key to the success of rapid re-housing.
2. Availability of safe affordable housing is a major barrier to implementing rapid re-housing.
3. Rapid re-housing alone, is not the answer to homelessness; multiple simultaneous approaches are necessary.
4. County and federal funding is complex and less flexible than private funding; private funding is therefore beneficial for rapid re-housing programs.
5. Data collection can be difficult due to loss to follow-up and non-uniform use of the formalized HMIS data collection system.
6. Coordination among rapid re-housing efforts in North Carolina would be beneficial.
7. Wrap-around services such as mental health and counseling services, supportive employment services, and case management play an important role in the success of families participating in RRH.
8. DV survivors and their children are under-addressed in current rapid-re-housing efforts.

Each of these key themes are discussed in greater detail below.

Landlord Relationships

"Don't start rapid re-housing unless you have landlords that want to work with you and with your clients, because without that it isn't gonna work."
- Rapid re-housing contractor 1

The difficulty of building and maintaining relationships with landlords was a common theme, especially when stakeholders discussed challenges they face in implementing rapid re-housing programs face. Although building these relationships is key to having access to housing, it was often suggested that landlords were hesitant to work with rapid re-housing clients, as they assumed individuals in need of housing assistance would be less reliable tenants.

Ideas about how to navigate landlord concerns included hosting landlord recruitment and acknowledgement breakfasts, setting up a hotline for landlords to call with any client issues or

complaints, and most importantly, employing full-time staff, often called Housing Recruitment Specialists, to manage relationships and intervene and offer support to landlords if any complications arise. If program staff are able to manage tenant issues while rent is reliably paid, landlord relationships are much more likely to be successful. Landlords tend to know each other, so having one or two "champion" landlords can go a long way toward getting other landlords to commit to housing rapid re-housing clients. In addition, landlords often use specific systems for criminal and credit checks, and it may be helpful for RRH programs to purchase this software system in order to know what the landlord looks at when considering tenants.

"One landlord who manages 50% of units says he doesn't wanna partner with homeless shelters' rapid re-housing programs, because they don't have enough staff time to make sure people are successful in the unit – we will be burning bridges with landlords if we don't have the money for staffing to make sure people are going to be successful."

- Rapid re-housing contractor 4

The importance of differentiating between a client who is chronically homeless and one who has perhaps never been unsheltered but is fleeing DV was also discussed. In these cases, there is not a history of being unable to maintain residence, but rather a need for housing to avoid having to return to a potentially unsafe environment due to financial need. One stakeholder emphasized that because many clients fleeing DV do not have co-occurring barriers to housing or a history of being unable to maintain residence, landlords may feel more comfortable renting to them.

Affordable Housing

"We need more affordable housing units to be successful, because we can put everything in place, but if there is nowhere to put people, the problem will still be there."

- CoC representative 2

In exploring rapid re-housing across North Carolina, both rural and metropolitan areas reported experiencing a lack of safe, affordable housing. In 2015, a housing needs analysis of Buncombe, Henderson, Madison, and Transylvania counties in western North Carolina found that there was an apartment vacancy rate of 1%, signifying a serious housing shortage (Axtell, 2015). Finding affordable housing is especially difficult for larger families, since homes with more bedrooms often cost much more than families can afford. Affordable housing availability is a particularly difficult barrier to address, as building infrastructure is expensive, time intensive, and influenced by federal and state political desires (National Center for Policy Analysis, 2009).

"Affordable housing is so scarce that you take what you can get."
- CoC representative 3

Although it is critical for affordable housing to be accessible by public transportation in both rural and metropolitan settings, stakeholders in rural locations especially discussed this as a burden compounding the difficulty of finding affordable housing.

The issue of affordable housing emphasizes the importance of relationships with landlords, because when landlords are unwilling to work with rapid re-housing programs, it further reduces the availability of affordable housing.

Rapid Re-Housing and Diversified Housing Programs

"Ideal situation: emergency shelter, transitional housing, permanent [supportive] housing, and rapid re-housing, because one size does not fit all."
- Rapid re-housing contractor 4

One informant emphasized the need for multiple approaches to addressing homelessness, including providing emergency shelters, transitional housing, and permanent housing options. She explained that because rapid re-housing is considered a best practice for addressing homeless, some communities have begun to focus solely on rapid re-housing instead of continuing to fund multiple housing options. In these cases, individuals and families who are not eligible for rapid re-housing or have only temporary need may be left without housing options. A diversified housing program is ideal to ensure that there is a housing option that fits the needs of every individual and family facing homeless in North Carolina.

Funding

"With federal grants there is a little wiggle room, but you have to follow eligible expenses and procedures."
- CoC representative 1

The majority of rapid re-housing programs in North Carolina receive at least some federal or state funding. Federal funding programs mentioned by stakeholders included HUD programs such as Emergency Solutions Grants, Continua of Care, and Supportive Services for Veteran Families (SSVF). Each of these funding sources includes specific requirements for prioritized populations and eligible participants. These requirements can cause barriers to addressing homelessness if the populations most

in need of rapid re-housing do not fulfill the specific definition of homelessness stipulated by the funding source. Support from private funders gives programs flexibility to address needs specific to homeless individuals and families in their community. Interviewees reported that in North Carolina, that most rapid re-housing funding has gone to urban areas, so rural areas may struggle to implement best practices on a more limited budget and often with less expertise.

Data Collection

> *"DV agencies have access to the North Carolina DV database on a different platform than HMIS statewide, but the two platforms don't cross, so we manually take DV stuff and add it in and it doesn't always add up numbers-wise."*
> *- CoC representative 1*

Interviewees discussed how rapid re-housing programs in North Carolina using federal funding collect data use the NC-HMIS system, but programs not receiving federal funding are left out of this system, resulting in a lack of coordination. This means that follow-up with clients who move to an area served by a different CoC can be a barrier, and evaluating client outcomes can be difficult for programs not receiving federal funding and support for data collection. Stakeholders using NC-HMIS suggested that one barrier to adequately addressing the needs of DV survivors is that there are two separate platforms for rapid re-housing client data (NC-HMIS) and data for clients identified as DV survivors (North Carolina DV database).

Coordination

> *"The fact that the city and county were willing to combine funds with us was pretty significant because we all wanted the same things. We wanted to provide more housing, to reduce duplication of services where possible, and make paperwork consistent so people weren't spending more time on paperwork than necessary."*
> *- CoC representative 2*

Coordination among organizations is critical for rapid re-housing success. The broad spectrum of wrap-around services that should be offered necessitates collaborative partnership among many organizations. For optimal coordination, the primary rapid re-housing organization should understand what partner programs can and cannot do, how rapid re-housing can fit a need for their program, and any relevant terminology from partners' areas of expertise. Stakeholders recommended twice-monthly meetings between representatives of partner organizations and RRH case managers to make sure that each RRH family receives the services they need. A sense of collective responsibility and strong personal relationship building can also go a long way in maintaining effective partnerships. Stakeholders noted

that collaboration with DV agencies is variable. In some counties, the only shelter is the DV shelter so the programs work together, while in other areas DV agencies rarely send representatives to housing meetings and are reluctant to refer clients to rapid re-housing because of confidentiality and anonymity concerns.

Wrap-Around Services

"The key to rapid re-housing is the supportive services piece"
- Rapid re-housing contractor 4

Interviewed stakeholders emphasized that wrap-around services are a particularly important component of RRH programs. Case management is necessary to determine the needs of individuals and families, most commonly involving mental health services, substance abuse services, job training, transportation assistance, and children's advocacy. While these services should be made available, it should not be made mandatory that clients participating in rapid re-housing utilize them. To adequately address the needs of DV survivors engaged in rapid re-housing, developing a strong partnership with a DV service provider is crucial. This relationship can help ensure that services are appropriately tailored to these individuals and any children involved. Rapid re-housing organizations are also looking for guidance in maintaining anonymity and confidentiality for survivors of DV during the housing process. Interviewees suggested that services for DV survivors could include alarm system installation and, when possible, seeking female landlords.

"[Wrap-around services] could be counseling for children, therapeutic intervention, life skills and development. One [DV and rapid re-housing] agency does stuff on parenting because they have vulnerable parents."
- CoC representative 1

It is key that wrap-around services prioritize needs of children with trauma exposure. Interviewees agreed that homelessness itself can be very traumatic and put stress on the body and the brain, so even in cases that are not associated with DV, attention to trauma is critical. The Salvation Army of Wake County is the only organization that participated in this study that explicitly focuses on child trauma in North Carolina and its relationship to homelessness. The Salvation Army of Wake County recommends a child-centered model of case management with assessment through the Ages & Stages Questionnaire: Social-Emotional (ASQ: SE), Brigance, and Strengths and Difficulties Questionnaire, among others. They work within the Trauma-Informed Care model, which emphasizes compassionate care and understanding of the neurological components and effects of toxic stress. The Salvation Army also noted that children with trauma exposure may require wrap-around services such as intensive case

management, mental health treatment, tutoring, Head Start, Medicaid sign-up, speech pathology, tutoring, or even low-cost glasses.

Focus on DV Survivors and Their Children

> *"By definition, homelessness is traumatic. . . . It's traumatic loss for these kids."*
> *- Rapid re-housing contractor 3*

Many organizations and CoCs currently implementing rapid re-housing are not aware of the specific needs of DV survivors and their families, even though many of their RRH clients may fall into that category. Interviewees identified a deep need to train rapid re-housing specialists and even landlords on trauma and related skills, since they interact often with RRH households affected by trauma. Stakeholders recommended that training be completed twice-yearly. Currently, the Salvation Army of North Carolina provides trainings on child trauma, and additional trainings related to DV could help rapid re-housing program staff provide better assistance for RRH clients. According to stakeholders experienced in trauma trainings, the trainings should be both informational and skill-building and involve interactive components such as role-play scenarios. In the majority of sites in North Carolina, although DV survivors and their children make up a sizable portion of clients, there is no prioritization for rapid re-housing for this population. Topic-specific knowledge and wrap-around services would provide a needed addition to rapid re-housing programs statewide.

Conclusion

Surveys and in-depth interviews with key rapid re-housing stakeholders in North Carolina provide key insights into the implementation of rapid re-housing throughout the state. Strong relationships with partner organizations and landlords can ease families' transitions into permanent housing, as can trauma-informed care and wrap-around services. However, finding appropriate housing is also limited by the availability of affordable housing. Our findings identify a gap in services and training specifically around survivors of domestic violence and their children. There is also a critical need for coordination among existing rapid re-housing programs to maximize effectiveness for families, considering funding, data collection mechanisms, and implementation of wrap-around services tailored to trauma survivors.

Appendix A: Rapid Re-Housing Survey

1. Does your CoC engage in rapid re-housing? (if no, skip to Q7)
2. Approximately how many people per year does your rapid re-housing program serve?
3. How is your rapid re-housing program funded?
4. Which of the following elements does your rapid re-housing program contain? (check all that apply)
    a. Landlord outreach
    b. Financial assistance
    c. Case management
    d. Assessment of housing barriers
    e. Data management and evaluation
5. Do you do coordinated intake for your rapid re-housing program?
6. Do you believe your rapid re-housing program is successful at reducing the number of homeless people in your community? If yes, why?
7. Is there a domestic violence service provider represented on your CoC?

Appendix B: Interview Guides

Interview Guide for Continua of Care

Thank you for agreeing to participate in our interview. We will be using the information we collect from you today to help construct an environmental scan of rapid re-housing in North Carolina. Just a reminder that your participation is completely voluntary and you are welcome to decline to answer any questions you do not feel comfortable answering. The information we collect from this research will be kept private, and we will not be sharing information about you personally to anyone outside of the research team or partner organization, NCCADV. Do you consent to participating in this interview?

Research Question (RQ)1: What are the current rapid re-housing programs and their effects in North Carolina?

Interview Question (IQ)1: Does your community have a rapid re-housing program?

- Probe: Can you describe your community's rapid re-housing program?
- Probe: How is your RRH program funded?
- Probe: How flexible is your funding? (Can you reallocate resources?)
- Probe: What are your prioritized populations? How did you decide on these populations?
- Probe: How do you decide who qualifies for RRH? (Can you describe how that works?)

IQ2: How effective has RRH been for reducing homelessness in your community?

- Probe: What types of data do you collect to track whether or not RRH is working?

RQ2: What do stakeholders identify as critical components, assets, and challenges of rapid re-housing in North Carolina?

IQ3: What are the key components of your community's rapid re-housing program?

- Probe: What partnerships and stakeholders were necessary for implementation?
- Probe: Tell me how your intake process works.
- Probe: How did you develop relationships with landlords for your rapid re-housing program?
- Probe: How are your relationships with landlords?
- Probe: Do landlords benefit equally from the relationship?
- Probe: What are some lessons learned from working with landlords?
- Probe: Do you use contractors/agencies? If yes, what are important qualities/skills in the contractors/agencies that implement rapid re-housing?

IQ4: What wrap-around services are part of your program?

- Probe: Which services are utilized most often?
- Probe: Which services are utilized most often by DV survivors and their families?

IQ5: What had to be in place in your community before you could implement rapid re-housing?

- Probe: How do you decide which agencies to work with on rapid re-housing?
- Probe: What local policies were necessary?
- Probe: What infrastructure was necessary for the CoC? For the agency?
- Probe: What partnerships were necessary?
- Probe: What pitfalls did you encounter when trying to form those partnerships?
- Probe: What might you have done differently?

IQ6: What are some of the challenges you've experienced with implementing rapid re-housing?

Probe: Did you face any opposition to RRH in your community? From whom, and what was the nature of the opposition?

IQ7: If you could change one thing about your RRH program to make it more effective, what would that be?

Probe: What is some of the feedback you've received from individuals or families you've re-housed?

Probe: Is there anything that your clients have expressed need for that the CoC is unable to provide?

RQ3: What are current policies and practices in North Carolina related to homelessness among domestic violence survivors and children with trauma exposure?

IQ8: How does domestic violence relate to homelessness in your community?

Probe: What percent of clients are coming from domestic violence situations?

IQ9: In what ways does your CoC address homelessness among survivors of domestic violence?

IQ10: Tell me about the intake process for rapid re-housing.

Probe: When is that tool used?

Probe: Are survivors and/or families prioritized?

IQ11: In what ways does your program address needs of children with trauma exposure? (only agencies may know this)

IQ12: If funding were not an issue, what would you like to see your community do to better serve families who have experienced domestic violence?

IQ 13: Does your CoC have a relationship with a domestic violence service provider in the area?

Probe: Does you CoC help fund this provider?

Probe: Has that relationship been helpful? If so, how?

Probe: What could be improved?

IQ14: What is working well in your rapid re-housing program?

Probe: What advice would you give to other communities who are considering rapid re-housing?

Interview Guide for Contractors

Thank you for agreeing to participate in our interview. We will be using the information we collect from you today to help construct an environmental scan of rapid re-housing in North Carolina. Just a reminder that your participation is completely voluntary and you are welcome to decline to answer any questions you do not feel comfortable answering. The information we collect from this research will be kept private, and we will not be sharing information about you personally to anyone outside of the research team or partner organization, NCCADV. Do you consent to participating in this interview?

RQ1: What are the current rapid re-housing programs and their effects in NC?

IQ1: Please describe your rapid re-housing program.

Probe: How is your RRH program funded? Which CoC?

Probe: How flexible is your funding? (Can you reallocate resources?)

Probe: What are your prioritized populations? How did you decide on these populations?

Probe: How many rapid re-housing clients do you currently have?

Probe: How do you decide where clients are housed?

Probe: How do you decide who qualifies for RRH? (Can you describe how that works?)

Probe: Are you part of a coordinated intake process? If not, can you explain your intake process?

Probe: Walk me through the process of getting engaged with rapid re-housing. (Pretend that I am a client)

Probe: What other agencies/programs do you coordinate with? Specifically domestic violence service providers?

IQ2: How effective do you think your program has been in reducing homelessness in your community?

Probe: What types of data do you collect to track whether or not RRH is working?

Probe: What is your rate of retention in stable housing? How far into the future do you track participants?

RQ2: What do stakeholders identify as critical components, assets, and challenges of rapid re-housing in North Carolina?

IQ3: What are the key components of your rapid re-housing program?

Probe: What partnerships and stakeholders were necessary for implementation?

Probe: Is there sufficient housing to meet the needs of the program?

Probe: How did you develop relationships with landlords for your rapid re-housing program?

Probe: How are your relationships with landlords?

Probe: Do landlords benefit equally from the relationship?

Probe: What are some lessons learned from working with landlords?

IQ4: Does your program provide wrap-around services?

If yes,

Probe: How do you assess what services people need?

Probe: Which services are utilized most often?

Probe: Which services are utilized most often by survivors and their families?

If no,

Probe: Who do you refer clients to?

IQ5: Walk me through the steps to starting your rapid re-housing program.

Probe: How do you decide which agencies to work with on rapid re-housing? For coordinated intake? For wrap-around services?

Probe: What local policies were necessary?

Probe: What infrastructure was necessary for the CoC? For the agency?

Probe: What partnerships were necessary?

Probe: What pitfalls did you encounter when trying to form those partnerships?

Probe: What might you have done differently?

IQ6: What are some of the challenges you've experienced with your rapid re-housing program?

Probe: Did you face any opposition to RRH in your community? From whom, and what was the nature of the opposition?

IQ7: If you could change one thing about your RRH program to make it more effective, what would that be?

Probe: What is some of the feedback you've received from individuals or families you've re-housed?

Probe: Is there anything that your clients have expressed need for that your program is unable to provide?

RQ3: What are current policies and practices in North Carolina related to homelessness among domestic violence survivors and children with trauma exposure?

IQ8: Do you have clients that are domestic violence survivors?

Probe: What percent of clients are coming from domestic violence situations?

IQ9: In what ways does your program address homelessness among survivors of domestic violence differently than other clients?

IQ10: In what ways does your program address needs of children with trauma exposure? (Only agencies may know this)

IQ11: If funding were not an issue, what would you like to see your organization or community do to better serve families who have experienced domestic violence?

IQ 12: How is your relationship with your CoC?

Probe: How do you work together? Who sets priorities?

Probe: Has that relationship been helpful? If so, how?

IQ13: (If they have one) How is your relationship with your local domestic violence service provider?

IQ14: What is working well in your rapid re-housing program?

Probe: What advice would you give to other communities who are considering rapid re-housing?

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SPRING 2016

RECOMMENDATIONS FOR IMPLEMENTING RAPID RE-HOUSING FOR DOMESTIC VIOLENCE SURVIVORS AND THEIR CHILDREN

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE CAPSTONE

CLAIRE BRENNAN, ANNA DARDICK, MADELINE MORRISSEY & HILLARY MURPHY
University of North Carolina at Chapel Hill Gillings School of Global Public Health | Department of Health Behavior

DELIVERABLE 3

CONTRIBUTIONS	Claire Brennan, Anna Dardick, Madeline Morrissey, and Hillary Murphy synthesized findings from the literature review and environmental scan report to brainstorm recommendations. Claire Brennan and Madeline Morrissey developed an outline for the structure of the report, and Claire Brennan wrote the report. Madeline Morrissey wrote the one-pager that accompanies the report.
DELIVERABLE PURPOSE & AUDIENCE	The purpose of the Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children is to present findings from the literature review and Summary of Current Rapid Rehousing Efforts in North Carolina in the form of recommendations for organizations currently or considering implementing rapid re-housing interventions. The recommendations focus on strategies to take the unique needs of domestic violence (DV) survivors and their children into consideration in rapid re-housing programs. The intended audience is the North Carolina Coalition Against Domestic Violence (NCCADV) and organizations implementing rapid re-housing
STEPS	• Combined and analyzed findings from Literature Review and Environmental Scan Report to create recommendations. • Developed detailed report outline. • Wrote and piloted the report. • Wrote and piloted persuasive justification one-pager for community organizations. • Disseminated report and one-pager to NCCADV.
RESULTS AND KEY FINDINGS	1. Coordination among rapid re-housing service providers and cultural adaptation of existing rapid re-housing programs will allow for the most effective interventions for DV survivors and children with trauma exposure. 2. Availability of affordable housing stock and maintenance of strong relationships with landlords are two of the most urgent issues hindering the implementation of rapid re-housing programs. More effort needs to be put towards determining feasible, multi-level solutions to these problems.
NEXT STEPS	The Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children is for the ongoing use of NCCADV and their partner organizations. It will be used primarily to assist in refining existing rapid re-housing programs and to focus interventions on DV survivors and their children.

Table of Contents

Rationale

While rapid re-housing is an essential mechanism for addressing homelessness, it is also a potentially effective way to address the housing needs of domestic violence survivors and their children. Given that housing insecurity and the threat of homelessness may cause people to remain in violent or potentially violent situations, rapid re-housing programs may be an important way to combat both domestic violence and homelessness.

Domestic violence is a critical public health problem and the leading cause of homeless for women and children in the United States. An estimated one out of every five women living in the United States will experience domestic violence in her lifetime and domestic violence survivors are at greater risk of many negative health and social outcomes, including homelessness. Unstable or inadequate housing is associated with stress for survivors, their children, and their support systems. It is also associated with economic instability, food instability, and long-term poverty, and compounds the negative outcomes that result from domestic violence itself. When faced with homelessness as the alternative for leaving an abusive home, survivors may choose to remain in a violent situation. For children of survivors, ongoing exposure to domestic violence can increase the risk of emotional and behavioral problems, as well as increase the risk of becoming a perpetrator or victim of domestic violence later in life. Although there is limited literature on the impact of homelessness on children who have been exposed to domestic violence, there is an association between homelessness and negative behavioral, academic, and health outcomes for children. While homelessness in children is associated with poor mental and physical health and lower achievement in school, these outcomes have been found to decline over time when housing is stabilized.

Clearly, there are multi-generational implications for addressing domestic violence and homelessness together. Using rapid re-housing programs as the channel for this concurrent intervention may offer an essential way to ensure healthy outcomes for both domestic violence survivors and their children.

Using this Report

The *Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children* report operationalizes findings from both a formal literature review and an assessment of rapid re-housing programs in North Carolina. The recommendations here can be used by existing rapid re-housing programs to focus their programs and services on the needs of domestic violence survivors and their children. These recommendations are intended to build on existing rapid re-housing programs to reduce negative outcomes of trauma exposure related to domestic violence and increase housing stability among domestic violence survivors and their children.

Recommendations Overview

The following recommendations are meant to help organizations improve rapid re-housing programs and incorporate appropriate services for domestic violence survivors and their children. They are discussed in greater detail in *Recommendations for Implementing Rapid Re-Housing for Domestic Violence Survivors and their Children*.

- Provide culturally appropriate services.
- Prioritize participant housing preferences.
- Form strong relationships with landlords.
- Ensure availability of safe and affordable housing.
- Explore and form community partnerships.
- Link participants to existing social services.
- Differentiate intensity of services.
- Consider incorporating technology to complement face-to-face services.
- Collect and coordinate data on experiences of domestic violence and trauma.
- Diversify funding sources.
- Implement strategies to support children.
- Communicate among continua of care and rapid re-housing providers.

Introduction

Background

Domestic violence (DV) is a critical public health problem in the United States. An estimated one out of every five women living in the United States will experience DV in her lifetime (Centers for Disease Control and Prevention, 2008). DV survivors are at greater risk of other negative health and social outcomes, including housing instability (World Health Organization, 2012). DV is the leading cause of homelessness for women and children in the United States (Maqbool, Viveiros, & Ault, 2015; Baker, Billhardt, Warren, Rollins, & Glass, 2009), and among women with children experiencing homelessness, over 80% have also experienced DV (USICH, 2015).

Rapid re-housing (RRH) is one option for addressing DV-related homelessness (Cunningham, Gillespie, & Anderson, 2015). RRH is based on the Housing First model that emphasizes providing housing as quickly as possible to those in need, without other stipulations. It enables quick access to housing and services, and provides temporary financial assistance so that households gradually become self-sustaining and can remain in their housing units permanently. It also provides access to a variety of wrap-around services, which participants can choose to take advantage of if they wish.

Purpose

This report summarizes recommendations for rapid re-housing best practices, based on information from a review of published literature and organizational reports, and surveys and interviews conducted with organizations working on RRH in North Carolina (NC). This report is aimed at community organizations that are considering implementing RRH, or that are seeking to improve their RRH programs. There is a particular emphasis on recommendations to better incorporate procedures and services benefitting DV survivors and their children into RRH programs.

More details and examples of some of the recommendations can be found in the resources listed at the end of the report, under the "Additional Resources" heading.

Sources of Information

The recommendations included in this report stem from three sources. The first is a review of the literature on rapid re-housing as an intervention for homelessness and domestic violence. The literature review included peer-reviewed articles and published reports from organizations participating in rapid re-housing. It also included policies and recommendations for rapid re-housing from governmental and private stakeholders at the national and local levels.

The second source is a set of semi-structured interviews with people administering rapid re-housings programs throughout North Carolina. Interviews were conducted with representatives of continuum of care (CoC) organizations in North Carolina and with public and private agencies implementing rapid re-housing. An effort was made to interview people working in both rural and urban settings and with varied populations. The third source is data from a survey of North Carolina CoCs about the scope of rapid re-housing projects, funding sources, data collection, and incorporation of services for DV survivors, among other topics. Findings from the interviews and surveys are summarized in the document, *Summary of Current Rapid Re-Housing Efforts in North Carolina*.

Details about the methods used to complete both the literature review and the environmental scan report, as well as complete reference lists, can be found in the respective documents.

Recommendations

Provide culturally appropriate services. Rapid re-housing programs should consider the cultures, heritages, and needs of the populations they serve. RRH programs should hire staff with the same backgrounds as those they seek to serve, including non-native English speakers, immigrants, and Native Americans. In the case of programs aimed at DV survivors, having DV survivors on staff can help build a bridge between the program and the population and help ensure sensitivity to the issues survivors face. One example of culturally appropriate services for DV survivors in rapid re-housing was carried out in Washington State, where Native American DV survivors who lived in RRH sites outside of their reservations were able to return to the reservations for activities and services that were central to their identities.

Prioritize participant housing preferences. In multiple studies of rapid re-housing, participants who were given greater opportunity to express their preferences for housing (especially for the type and location of housing) reported higher satisfaction with rapid re-housing and greater emotional well-being. Participants viewed choice in housing as a sign of independence and were more likely to continue participating in rapid re-housing programs. Rapid re-housing programs should offer as many options for housing as possible and support participants in making decisions about their preferred housing situation. These RRH offerings can include giving participants an opportunity to voice their preferences prior to being re-housed and working with landlords to offer varied housing options.

Form strong relationships with landlords. The recruitment and maintenance of strong relationships with landlords are necessary for offering rapid re-housing program participants housing options. They are also important because without access to private properties in which to place participants, RRH programs are unable to provide quick access to housing. Landlords are often hesitant to participate in rapid re-housing programs because of fears about late or missed rent and other issues. Possible methods of recruiting and retaining landlords include conducting landlord recruitment and acknowledgement events, such as the landlord breakfasts carried out in Wake County, North Carolina, and setting up a hotline for landlords to call about concerns or problems with their rapid re-housing tenants. Programs should ensure that there are staff specifically dedicated to recruiting landlords, serving as points of contact, and intervening in disputes between landlords and participants. It may be helpful for a RRH program to have one or two "champion" landlords who are willing to attest to the reliability of the program and participants, and help recruit other landlords. It may also be useful to consider what background and criminal checks landlords run prior to accepting tenants so that the program is familiar with the information landlords are using. For RRH programs focusing on DV survivors, it is important for program staff to work with landlords to ensure awareness and sensitivity about safety and other DV-related issues.

Ensure availability of safe and affordable housing. Prior to implementing a program for DV survivors, there should be extensive research on the availability of housing with appropriate security measures to protect DV survivors and their families from abusers. RRH programs throughout North Carolina reported insufficient affordable housing stock in their communities. One way to mitigate this lack of affordable housing is to maintain the best possible relationships with landlords in the area. If there is insufficient housing stock, long-term efforts to increase the supply will be necessary. Various approaches, advocacy efforts, and partnerships with policy-level organizations should be leveraged to increase affordable housing stock over time.

Explore and form community partnerships. Partnering with other community organizations and resources enables rapid re-housing programs to provide the greatest variety of social services to their participants and avoid duplication of efforts. Traditional rapid re-housing partners include organizations such as therapeutic and financial counseling services. For programs to provide rapid re-housing to DV survivors, strong partnerships with other DV survivor-supporting organizations are necessary. Programs can also explore non-traditional partners, such as construction companies that can modify available housing to better serve the target population, or security services that can provide greater physical safety for DV survivors.

Link participants to existing social services. The availability of wrap-around services is an integral part of rapid re-housing programs. RRH programs should provide services such as mental health, substance abuse, and financial counseling to participants for as long as possible. Programs should ensure that participants are connected to available community- and local government-provided resources prior to the end of rapid re-housing assistance. While participation in these services is voluntary, programs should link participants with specific points of contact within organizations that may be beneficial in the future, as many participants in RRH programs may need services for an extended period of time. For DV survivors, links to DV support services and organizations should be made as quickly as possible. Children in families that have experienced DV should be linked to trauma support services immediately following intake. Additional services for DV survivors could include alarm system installation, un-listing home addresses and address confidentiality programs, provision of a new phone number, and, if possible and desired, housing of survivors in homes owned by female landlords.

Differentiate intensity of services. Rapid re-housing programs should consider creating organizational structures that allow for the greatest possible efficiency in delivering services to their participants. The Washington State program that focused on DV survivors created a tiered system, where participants with the least need were given lighter staff support in order to free up time and resources for participants with the greatest need. This system reflected the diversity of the program's DV survivor population in terms of need, which ranged from only needing new locks on doors and one month's rent all the way to requiring long-term financial assistance, intensive counseling, and other services. Some counties in North Carolina are also funneling RRH participants into various levels of service to maximize efficiency while still providing participants with needed assistance and services.

Consider incorporating technology to complement face-to-face services. Rapid re-housing programs may choose to use video conference calls to increase staff accessibility and participant support, in rural settings and areas with limited public transit as well as in cities. This requires the use of computers, tablets, or other devices that provide videoconferencing capability, which should be provided for in-home use by participants if at all possible. Easily accessible public locations that offer technology and privacy, such as community centers or libraries with private rooms, could potentially be used as well. This may be particularly relevant for DV survivors and their children, when access to counseling and other wrap-around services is critical.

Collect and coordinate data on experiences of domestic violence and trauma. Current guidelines for the Homeless Management Information System (HMIS) used by providers receiving funding from the US

Department of Housing and Urban Development (HUD) require homelessness services providers to ask heads of household and other adults if they have experienced DV during intake, but do not allow for more detailed information to be collected. Due to privacy concerns and the need for more detailed intake data, DV service providers often use comparable data collection systems, such as EPIC. More complete information about children's experiences is required in order to offer appropriate services to families and children with histories of trauma, and heads of household should be asked to provide such information voluntarily. Data about DV and trauma often gets lost if a family moves between geographic areas, so all efforts should be made to share data among programs, including those carried out by organizations that do not maintain HMIS systems (such as many DV service providers). This data can also be useful in evaluating RRH programs. When appropriate, both qualitative and quantitative data should be collected at intervals throughout a family's participation in a RRH program, while maintaining privacy as a top priority.

Diversify funding sources. While federal, state, and local governments are the most common sources of funding for rapid re-housing programs, efforts should be made to obtain private funding as well. Private funding often allows programs to be more creative in their activities and to diversify the services they can provide, as well as increase the number of families they can serve. Though private funding sources often do not require the same data collection as HUD and other governmental funders, data collection should be comparable for all funding sources in order to provide the best possible snapshot of families served, services provided, and outcomes achieved.

Implement strategies to support children. Homelessness itself is a traumatic experience for children, and for children from families that have experienced DV, trauma is likely much greater. Use of the Trauma-Informed Care Model, which emphasizes compassionate care and understanding of trauma's effects on the brain, is one model for providing children in rapid re-housing programs with needed care and support. Assessment of children entering RRH programs and awareness of their needs should be an integral part of any rapid re-housing program that serves families. Appropriate assessment tools include the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) and the Strengths and Difficulties Questionnaire, either of which could be included in the intake process. Children who have been exposed to trauma, such as those in families that have experienced DV and/or homelessness, may require additional wrap-around services, including intensive case management, mental health treatment, tutoring, Head Start enrollment, Medicaid sign-up assistance, speech pathology, and even glasses and primary medical care. Training of program staff and landlords on the needs of children of DV survivors may also be necessary.

Communicate among CoCs and rapid re-housing providers. Coordination among CoCs and rapid re-housing providers in larger geographic areas is recommended for a number of reasons. Families experiencing homelessness often move in and out of homelessness services catchment areas, and information about families and their histories should be shared among providers (when not in breach of confidentiality requirements) in order to provide the best services possible. Landlords may own properties in various counties or locations, and sharing information about which landlords are willing to lease to RRH families could help provide much-needed housing options. Additionally, sharing both successes and failures among providers will help improve all RRH programs. Frequent communication with DV service agencies is also important so that best practices from both RRH and DV programs can be shared and incorporated into available services.

Conclusion

Domestic violence and homelessness are inextricably related. Rapid re-housing is one option for helping families move out of homelessness, and can be effective for families that have experienced DV and trauma. The recommendations above offer guidance on ways to improve RRH for all individuals and families, with particular focus on the integration of DV- and trauma-related practices. When unsure about the best ways to serve DV survivors and their children, it is crucial to communicate with others serving the same population. Knowledge about the environment, context, and populations being served can help providers adapt previous interventions to make them as effective as possible.

For more information about the recommendations in this report, or for access to the literature review and *Summary of Current Rapid Re-Housing Efforts in North Carolina*, please reach out to the North Carolina Coalition Against Domestic Violence.

Additional Resources

See: *Mbilinyi, L. (2015). The Washington State Domestic Violence Housing First Program Cohort 2 Agencies Final Evaluation Report: September 2011 – September 2014. Retrieved on 4 November, 2015, from http://wscadv.org/wp-content/uploads/2015/05/DVHF_FinalEvaluation.pdf* for information on and examples of providing culturally appropriate services, differentiating intensity of services, and implementing strategies to support children.

See: *Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric services (Washington, D.C.), 4, 487–493* for information and examples of prioritizing participant housing preferences.

See: *Stefancic, A., Henwood, B. F., Melton, H., Shin, S.-M., Lawrence-Gomez, R., & Tsemberis, S. (2013). Implementing Housing First in rural areas: Pathways Vermont. American Journal of Public Health, 103, S206-S209* for information on and examples of differentiating intensity of services and incorporating technology to complement face-to-face services

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SPRING 2016

COMMUNITY READINESS ASSESSMENT INSTRUMENT

NORTH CAROLINA COALITION AGAINST DOMESTIC VIOLENCE CAPSTONE

CLAIRE BRENNAN, ANNA DARDICK, MADELINE MORRISSEY & HILLARY MURPHY
University of North Carolina at Chapel Hill Gillings School of Global Public Health | Department of Health Behavior

DELIVERABLE 4

CONTRIBUTIONS	Anna Dardick and Hillary Murphy adapted the assessment tool developed by the Tri-Ethnic Center for use by the North Carolina Coalition Against Domestic Violence (NCCADV).
DELIVERABLE PURPOSE & AUDIENCE	The purpose of the Community Readiness Assessment Instrument is to support organizations in assessing the readiness of their community to address the needs of domestic violence (DV) survivors and children with trauma exposure experiencing homelessness. The instrument will be used in communities already engaged in rapid rehousing and will support grant-writing efforts of organizations engaged in or collaborating with rapid rehousing. The audience consists of organizations interested in assessing the readiness of their community to address the needs of DV survivors and children with trauma exposure experiencing homelessness.
STEPS	1. Researched commonly used community readiness assessment instruments. 2. Applied findings from the literature review and environmental scan to adapt the Tri-Ethnic Center's Community Readiness Assessment to rapid re-housing and DV. 3. Piloted instrument with community partner in Watauga county 4. Disseminated instrument to the North Carolina Coalition Against Domestic Violence (NCCADV) to distribute to organizations engaged in rapid re-housing in NC.
RESULTS AND KEY FINDINGS	• Communities engaged in rapid re-housing in North Carolina (NC) will have an instrument to help evaluate their readiness to address the needs of DV survivors and children with trauma exposure. • The instrument will help identify areas where organizations can collaborate and communities can improve efforts to address needs of DV survivors and children with trauma exposure.
NEXT STEPS	NCCADV can disseminate this instrument to organizations through a request for applications. Then, resulting readiness scores will be used to determine next steps to better address the needs of DV survivors and children engaged in the community's rapid re-housing program. The interviews involved also serve as a way to compile community information supporting the integration of trauma-informed care in rapid rehousing.

Community Readiness Assessment Instrument

Trauma-Informed Rapid Re-Housing of Domestic Violence Survivors and Children with Trauma Exposure

SUMMARY

The aim of the Community Readiness Assessment Instrument is to help organizations evaluate how ready their community is to implement a rapid re-housing program with capacity to competently serve domestic violence survivors and children who have experienced trauma. It is adapted from the Tri-Ethnic Center Community Readiness tool and rooted in nine Stages of Readiness that can assist in tailoring interventions and acceptability efforts to the community. As part of this assessment, at least four interviews are conducted with key stakeholders. Then, each dimension is assessed based on anchored rating statements. The resulting community readiness score can be used to determine effective next steps.

Table of Contents

Acknowledgement

This Community Readiness Assessment Tool draws heavily from "Community Readiness for Community Change" handbook from the Tri-Ethnic Center for Prevention Research at Colorado State University. Key components, interview questions, anchored rating statements, and recommendations have been adapted; rating procedure, definition of community readiness, Stages of Readiness, and Community Readiness Model have been taken directly from the Tri-Ethnic Center's handbook.

Tri-Ethnic Center for Prevention Research. (2015). Community Readiness for Community Change. Retrieved April 19, 2016, from http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf.

Introduction

Domestic violence (DV) is a critical public health problem. An estimated one out of every five women living in the United States will experience domestic violence in her lifetime. Domestic violence survivors are at greater risk of many negative health and social outcomes, including homelessness (World Health Organization, 2012; Maqbool, Viveiros, & Ault, 2015). There were 11,448 homeless individuals in North Carolina in 2014 (North Carolina Coalition to End Homelessness [NCCEH], 2014). Of these individuals, domestic violence survivors were one of the largest sub-populations.

For programs engaged in rapid re-housing, it is critical to address the needs of clients who have experienced domestic violence or been exposed to trauma. The purpose of the following tool is to assess your community's ability to effectively serve rapid re-housing clients with these needs. Results will help your program identify ways to make your program more trauma-informed.

Terms and Assumptions

Relevant definitions include:

Domestic violence	"A pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone." (The United States Department of Justice [DOJ], 2015)
Rapid re-housing	A program or intervention targeting homeless individuals or families by providing support to secure permanent housing and short-to-medium-term subsidies to retain that housing. It does not offer permanent subsidies, but rather targets people who are likely to be able to sustain housing once subsidies end. Rapid re-housing also provides connections to community resources and social services that may help beneficiaries solve other life problems or achieve other life goals; however, there is no requirement that beneficiaries engage in these resources.
Trauma	"An emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea." (American Psychological Association, 2016)
Trauma-informed	"A program, organization, or system that is trauma-informed: 1. *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and

	4. Seeks to actively resist *re-traumatization*." (Substance Abuse and Mental Health Services Administration, 2015)

When we discuss children, we make the assumption that children engaged in rapid re-housing will have experienced trauma from being homeless, and often also from experiences such as primary or secondary exposure to DV.

What is community readiness?

Important note: this instrument defines "community" as "the organization or network of organizations that are responsible for rapid re-housing or domestic violence services."

Community readiness is the degree to which a community is willing and prepared to take action on an issue. Here, we are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services (Tri-Ethnic Center, 2015). An assessment of community readiness measures the attitudes, efforts, knowledge, and resources of community members and leadership. This tool will evaluate the community's readiness to address an issue (in this case, trauma-informed rapid re-housing specific to domestic violence survivors and their children) on key dimensions. This particular tool identifies those key dimensions as:

- Community Knowledge of Efforts,
- Leadership,
- Community Climate,
- Community Knowledge of Issue, and
- Resources.

Assessing community readiness in this way can be beneficial for identifying next steps tailored to the community's particular Stage of Readiness as well as forging the relationships that will be essential in moving forward to address the issue.

The Community Readiness Model can help a community move forward and be more successful in its efforts to change in a variety of ways, including:

- Measuring a community's readiness levels on several dimensions that will help diagnose where you need to put your initial efforts;
- Helping identify your community's weaknesses and strengths, and the obstacles you are likely to meet as you move forward;
- Pointing to appropriate actions that match your community's readiness levels;
- Working within your community's culture to come up with actions that are right for your community; and
- Aiding in securing funding, cooperating with other organizations, working with leadership, and more (Tri-Ethnic Center, 2015).

Although the Community Readiness Model is a well-researched and highly-valued approach to initiate community change, it is not:

- A method for determining whether an issue is actually occurring in the community;
- A tool that tells exactly what to do to increase your readiness levels; or
- A prevention program.

Stages of Readiness

The Community Readiness Model defines 9 Stages of Readiness:

- No awareness,
- Denial/resistance,
- Vague awareness,
- Preplanning,
- Preparation,
- Initiation,
- Stabilization,
- Expansion/Confirmation, and
- Community Ownership.

Readiness of an organization can move forward **or** backward.

The Tri-Ethnic Center (2015) offers brief explanations of each stage:

Stage 1: No Awareness

- The community has no knowledge about local efforts addressing the issue.
- Leadership believes that the issue is not really much of a concern.
- The community believes that the issue is not a concern.
- Community members have no knowledge about the issue.
- There are no resources available for dealing with the issue.

Stage 2: Denial/Resistance

- Leadership and community members believe that the issue is not a concern in their community or they think it cannot or should not be addressed.
- Community members have misconceptions or incorrect knowledge about current efforts.
- Only a few community members have knowledge about the issue, and there may be many misconceptions among community members about the issue.
- Community members and/or leaders do not support using available resources to address the issue.
- Representative quote: “We can’t (or shouldn’t) do anything about it!”

Stage 3: Vague Awareness

- A few community members have at least heard about local efforts, but know little about them.
- Leadership and community members believe that the issue may be a concern in the community. They show no immediate motivation to act.
- Community members have only vague knowledge about the issue (e.g. they have some awareness that the issue can be problem and why it may occur).
- There are limited resources identified that could be used for further efforts to address the issue.
- Representative quote: “Something should probably be done, but what? Maybe someone else will work on this.”

Stage 4: Preplanning

- Some community members have at least heard about local efforts, but know little about them.

- Leadership and community members acknowledge that the issue is a concern in the community and that something has to be done to address it.
- Community members have limited knowledge about the issue.
- There are limited resources that could be used for further efforts to address the issue.
- Representative quote: “This is important. What can we do?”

Stage 5: Preparation

- Most community members have at least heard about local efforts.
- Leadership is actively supportive of continuing or improving current efforts or in developing new efforts
- The attitude in the community is, we are concerned about this and we want to do something about it.
- Community members have basic knowledge about causes, consequences, signs, and symptoms.
- There are some resources identified that could be used for further efforts to address the issue; community members or leaders are actively working to secure these resources.
- Representative quote: “I will meet with our funder tomorrow.”

Stage 6: Initiation

- Most community members have at least basic knowledge of local efforts.
- Leadership plays a key role in planning, developing and/or implementing new, modified, or increased efforts.
- The attitude in the community is, this is our responsibility, and some community members are involved in addressing the issue.
- Community members have basic knowledge about the issue and are aware that the issue occurs locally.
- Resources have been obtained and/or allocated to support further efforts to address the issue.
- Representative quote: “This is our responsibility; we are now beginning to do something to address this issue.”

Stage 7: Stabilization

- Most community members have more than basic knowledge of local efforts, including names and purposes of specific efforts, target audiences, and other specific information.
- Leadership is actively involved in ensuring or improving the long-term viability of the efforts to address the issue.
- The attitude in the community is, we have taken responsibility. There is ongoing community involvement in addressing the issue.
- Community members have more than basic knowledge about the issue.
- A considerable part of allocated resources for efforts are from sources that are expected to provide continuous support.
- Representative quote: “We have taken responsibility.”

Stage 8: Confirmation/Expansion

- Most community members have considerable knowledge of local efforts, including the level of program effectiveness.
- Leadership plays a key role in expanding and improving efforts.
- The majority of the community strongly supports efforts or the need for efforts.
- Participation level is high.
- Community members have more than basic knowledge about the issue and have significant knowledge about local prevalence and local consequences.
- A considerable part of allocated resources are expected to provide continuous support.
- Community members are looking into additional support to implement new efforts.
- Representative quote: “How well are our current programs working and how can we make them better?”

Stage 9: High Level of Community Ownership

- Most community members have considerable and detailed knowledge of local efforts.
- Leadership is continually reviewing evaluation results of the efforts and is modifying financial support accordingly.
- Most major segments of the community are highly supportive and actively involved.
- Community members have detailed knowledge about the issue and have significant knowledge about local prevalence and local consequences.
- Diversified resources and funds are secured, and efforts are expected to be ongoing.
- Representative quote: “These efforts are an important part of the fabric of our community.”

To move ahead, readiness on all dimensions must be at about same level. If one dimension is lower than all the rest, then efforts should focus on that particular dimension until it equals the others.

Key Components

The key components of this model are:

- A set of survey questions consisting of open-ended questions about the community’s attitudes, knowledge, beliefs, etc. about rapid re-housing and domestic violence;
- A small number of interviews of key respondents using this survey;
- Scoring of the completed interviews using scales provided for each dimension of community readiness;
- Calculation of readiness scores on five dimensions using the interview scores; and
- Use of these final readiness scores to develop a plan for action (Tri-Ethnic Center, 2015).

Essential Steps

The essential steps for the proper use of this assessment tool are:

1. Select and train interviewer.
2. Select and train 2 scorers.
3. Select 4-10 stakeholders.
4. Conduct interviews.
5. Score interviews.

Suggested Stakeholders

As part of this Readiness Assessment, you will conduct several **30-60 minute interviews** with professionals from a variety of fields. Suggested stakeholders include:

- Continuum of Care (CoC) representatives,
- Local domestic violence service providers,
- Contractors currently engaged in rapid re-housing, and
- Social services administrators, including but not limited to case workers, administrators of tutoring programs, or representatives from relevant wrap-around service providers.

We recommend conducting at least 4 interviews, and ideally 6-12.

Interviews

Each interview should take 30-60 minutes. Questions are broken down into sections, each of which addresses one of the dimensions of readiness. A sixth section, which is not a part of the Tri-Ethnic Center's tool, has been included and consists of stakeholder-specific questions that will help you in the implementation phase of your efforts.

Helpful Tips from the Tri-Ethnic Center (2015)

- Interviews should be done over the phone, rather than in person.
- Ask permission to record interviews. Make sure your equipment is charged and working properly.
- Set up an appointment beforehand and give the respondent some information about the project.
- Do not send the readiness questions to the respondent beforehand.
- Interviewers should be familiar with the rating scales and understand the scoring process. This will help the interviewer know when to re-phrase questions or ask for more information.
- During the interview, the interviewer should never give their own opinion or rephrase the respondent's answer to validate their understanding.
- The interviewer should keep the respondent on track and make sure the question is actually answered.
- Interviewers should practice with another person prior to their first interview.
- **Once an interview is conducted, it should be transcribed word-for-word including pauses and laughter.**

Interview Guides

Continuum of Care Representative Interview Guide

Introduction

Hello, my name is _____ from (your organization or affiliation).

Thank you so much for agreeing to be interviewed for this project. We are contacting key people to ask about how the needs of domestic violence survivors and their children are addressed by the rapid re-housing programs your CoC serves. The entire process, including individual names, will be kept confidential.

For the following questions, please answer keeping in mind your perspective of what community members believe and not what you personally believe. We are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

Stakeholder-specific questions

Note: These are NOT INCLUDED in the readiness calculations, and therefore are not numbered.

a. Describe the structure of your CoC.
b. What, if any, are the relationships between the rapid re-housing programs your CoC serves and domestic violence service providers in the area? Please explain.
c. Is there a network of trauma-informed therapeutic services the rapid re-housing program your CoC serves could refer children to?
d. How, if at all, do the programs your CoC serves take participant housing preference into consideration?
e. Do the rapid re-housing programs have intake procedures specifically to address the needs of children with trauma exposure? Please explain.
f. On a scale of 1 to 10, with 1 being "not concerned at all" and 10 being "extremely concerned," how concerned are the rapid re-housing program administrators with developing positive relationships with landlords? Explain your rating.
g. Do the rapid re-housing programs your CoC serves have established relationships with landlords? Please describe how these were developed.
h. Do you know if any rapid re-housing best practices are being evaluated through your CoC?
i. Are evaluation results being used to make changes in the rapid re-housing program?

Dimension A. Community knowledge of efforts

1. On a scale from 1-10, how much of a concern is domestic violence to members of your CoC, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
2. On a scale from 1-10, how much of a concern is child trauma to members of your CoC, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
3. Are there efforts in your CoC or the rapid re-housing projects you serve to specifically address domestic violence survivors or children with trauma exposure? [Probe using the term "wrap-around services," if necessary. *If "no," SKIP to #13.*]
   Can you briefly describe each of these?
4. How long have each of these efforts been going on? [Probe for each program/activity.]
5. Who, demographically, do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?

6. To what extent do rapid re-housing clients who have experienced domestic violence and children with trauma exposure utilize these efforts? How do you know?
7. What are the strengths of these efforts?
8. What are the limitations of these efforts?
9. About how many members of your CoC are aware of each of the following aspects of the efforts: none, a few, some, many, or most?
    - Have heard of efforts?
    - Can name efforts?
    - Know the purpose of the efforts?
    - Know who the efforts are for?
    - Know how the efforts work (e.g., activities or how they're implemented)?
    - Know the effectiveness of the efforts?
10. Thinking back to your answers, why do you think members of your CoC have this amount of knowledge?
11. Are there misconceptions or incorrect information among members of your CoC about the current efforts? If yes, please describe.
12. What planning for additional services for rapid re-housing clients who have experienced domestic violence and children with trauma exposure is going on in the CoC?
    Only ask if the answer to #3 was "No" or unsure:
13. Is anyone in the CoC trying to get something started to address the specific needs of domestic violence survivors and/or children with trauma exposure?

Dimension B. Leadership

I'm going to ask you how the leadership in your CoC perceives domestic violence and child trauma. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the CoC and/or who lead the CoC in helping it achieve its goals related to rapid-re-housing.

14. Using a scale from 1-10, how much of a concern is domestic violence or child trauma to the leadership of the CoC, with 1 being "not a concern at all" and 10 being "a very great concern"? Can you tell me why you say it's a [insert numerical rating]?
15. How much of a priority is addressing domestic violence or child trauma to leadership? Can you explain why you say this?
16. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many leaders…
    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?

17. Do you think the CoC leaders support additional efforts to address the needs of rapid re-housing clients who have experienced domestic violence and children? Please explain.

Dimension C. Community Climate

As a reminder, we are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

18. How much of a priority is addressing the issue to community members? Can you explain your answer?
19. I'm going to read a list of ways that community members might show their support or lack of support for efforts to address domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most community members would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
20. About how many community members would support expanding efforts in the community to address this issue? Would you say none, a few, some, many or most? How might they show this support?
21. What are the primary obstacles in the community to adding more supportive wrap-around services for rapid re-housing clients who have experienced domestic violence and children?

Dimension D. Community Knowledge of Issue

22. On a scale of 1 to 10, where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about trauma-informed services for domestic violence survivors and children? Why do you say it's a [insert numerical score]?
23. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to trauma-informed services for domestic violence survivors and children? [After each item, have them answer. Prompt as needed with "nothing, a little, some or a lot."]
    - Trauma, in general
    - The signs and symptoms of trauma
    - The causes of trauma
    - The consequences of trauma
    - Tow many domestic violence survivors and children are homeless in your area
    - That can be done to prevent or treat trauma
    - The effects of domestic violence-related trauma on work, school, and health

If the answer to #3 was "Yes," go to #24. If the answer to #3 was "No" or unsure, SKIP to #25.

Dimension E. Resources

24. *Only ask if the answer to #3 was "Yes":* How are current efforts to address domestic violence and trauma among rapid re-housing clients funded? Is this funding likely to continue into the future?

25. I'm now going to read you a list of resources that could be used to address trauma-informed care in your CoC. For each of these, please indicate whether that resource is available in your community.
    - Best practices guide
    - Trauma training workshops
    - Financial donations from organizations, businesses, or private donors
    - Grant funding
    - Experts
    - Child-focused counseling services
    - Domestic violence-focused counseling services
    - Space for workshops
    - Staff capacity
26. Would CoC staff and leadership support using these resources to address domestic violence and child trauma? Please explain.
27. On a scale of 1 to 5, where 1 is no effort and 5 is great effort, how much effort are CoC staff and/or leadership putting into doing each of the following things to increase the resources going toward addressing domestic violence and child trauma in your community?
    - Reaching out to the North Carolina Coalition Against Domestic Violence to procure best practices guidance?
    - Providing a best practices guide to rapid re-housing programs?
    - Soliciting donations from businesses or other organizations to fund current or expanded community efforts to address domestic violence and/or child trauma?
    - Writing grant proposals to obtain funding to address trauma?
    - Forging partnerships with local experts on child trauma, domestic violence, and/or trauma-informed care?
    - Forging partnerships with local organizations that address child trauma, domestic violence, and/or trauma-informed care?
    - Designating staff time to address issues of trauma and domestic violence?
28. Are you aware of any proposals or action plans that have been submitted for funding to address homeless domestic violence survivors and/or children? If "Yes," please explain.

Conclusion

Thank you so much for assisting us with our Readiness Assessment!
Is there anything else you would like to add? Do you have any questions for us?

Domestic Violence Service Provider Interview Guide

Introduction

Hello, my name is _____ from (your organization or affiliation).

Thank you so much for agreeing to be interviewed for this project. We are contacting key people to ask about how the needs of homeless domestic violence survivors and their children are addressed. The entire process, including individual names, will be kept confidential.

For the following questions, please answer keeping in mind your perspective of what community members believe and not what you personally believe. We are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

Stakeholder-specific questions

Note: These are NOT INCLUDED in the readiness calculations, and therefore are not numbered.

a. Please describe the structure of your organization.
b. Please describe your role in serving domestic violence survivors.
c. Please describe your role in serving children with trauma exposure.
d. What, if any, are the relationships between your organization and the rapid re-housing programs in your area? Please explain.
e. Is there a network of trauma-informed therapeutic services to which you refer children?

Dimension A. Community knowledge of efforts

1. On a scale from 1-10, how much of a concern is homelessness to members of your organization, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
2. On a scale from 1-10, how much of a concern is child trauma to your organization, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
3. Are there efforts in your organization that specifically addresses homeless domestic violence survivors or children with trauma exposure? [*If "No," SKIP to #14.*]
   Can you briefly describe each of these?
4. How long have each of these efforts been going on? [Probe for each program/activity.]
5. Who, demographically, do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?
6. To what extent do domestic violence survivors and children with trauma exposure utilize these efforts? How do you know?
7. What are the strengths of these efforts?
8. What are the limitations of these efforts?
9. About how many members of your organization are aware of each of the following aspects of the efforts: none, a few, some, many, or most?
   - Have heard of efforts?
   - Can name efforts?
   - Know the purpose of the efforts?
   - Know who the efforts are for?
   - Know how the efforts work (e.g. activities or how they're implemented)?
   - Know the effectiveness of the efforts?

10. Thinking back to your answers, why do you think members of your organization have this amount of knowledge?
11. Are there misconceptions or incorrect information among members of your organization about the current efforts? If yes, what are they?
12. What planning for additional services for homeless domestic violence survivors and children with trauma exposure is going on in your organization?
13. Are there any current efforts to improve your organization's ability to offer culturally competent services?

Only ask if the answer to #3 was "No" or unsure:

14. Is anyone in your organization trying to get something started to address the specific needs of homeless domestic violence survivors and children with trauma exposure?

Dimension B. Leadership

I'm going to ask you how the leadership at your organization perceives homelessness and child trauma. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in your organization and/or who lead your organization in helping it achieve its goals related to homelessness or trauma. [If this person is one of the leaders, they should answer for themselves accordingly.]

15. Using a scale from 1-10, how much of a priority is homelessness among domestic violence survivors and their children to the leadership of your organization, with 1 being "not a priority at all" and 10 being "a very high priority"? Can you tell me why you say it's a [insert numerical rating]?
16. Using a scale from 1-10, how willing is your organization director to partner with organizations that address homelessness, with 1 being "not willing all" and 10 being "very willing"? Can you tell me why you say it's a [insert numerical rating]?
17. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address homelessness and child trauma. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many leaders…

    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
18. Do you think the organizational leaders support additional efforts to address the needs of rapid re-housing clients who have experienced domestic violence and children? Please explain.

Dimension C. Community Climate

As a reminder, we are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

19. How much of a priority is addressing this issue to community members? Can you explain your answer?

20. I'm going to read a list of ways that community members might show their support or lack of support for efforts to address domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most community members would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?

21. About how many community members would support expanding efforts in the community to address this issue? Would you say none, a few, some, many or most? How might they show this support?
22. What are the primary obstacles in the community to adding more supportive wrap-around services for rapid re-housing clients who have experienced domestic violence and children?

Dimension D. Community Knowledge of Issue

23. On a scale of 1 to 10, where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about homelessness among domestic violence survivors and their children? Why do you say it's a [insert numerical score]?
24. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to trauma-informed services for domestic violence survivors and their children? [After each item, have them answer. Prompt as needed with "nothing, a little, some or a lot."]
    - Trauma, in general
    - The signs and symptoms of trauma
    - The causes of trauma
    - The consequences of trauma
    - What can be done to prevent or treat trauma
    - How many domestic violence survivors and children are homeless in your area
    - The relationship between domestic violence and homelessness

If the answer to #3 was "Yes," go to #25. If the answer to #3 was "No" or unsure, SKIP to #26.

Dimension E. Resources

25. *Only ask if the answer to #3 was "Yes":* How are current efforts to address homelessness among domestic violence survivors and children with trauma exposure funded? Is this funding likely to continue into the future?
26. I'm now going to read you a list of resources that could be used to address this issue in your organization. For each of these, please indicate whether that resource is available in your community.

- Best practices guide?
- Trauma training workshops?

- Organizations that have rapid re-housing programs?
- Financial donations from organizations, businesses, or private donors?
- Grant funding?
- Experts?
- Child-focused counseling services?
- Homelessness counseling services?
- Space for workshops?
- Staff capacity?

29. Would organizational staff and leadership support using these resources to address homelessness among domestic violence survivors and children with trauma exposure? Please explain.
30. On a scale of 1 to 5, where 1 is no effort and 5 is great effort, how much effort are organizational staff and/or leadership putting into doing each of the following things to increase the resources going toward addressing homelessness among domestic violence survivors and children with trauma exposure in your community?

- Reaching out to the North Carolina Coalition Against Domestic Violence to procure best practices guidance?
- Providing a best practices guide to rapid re-housing programs?
- Soliciting donations from businesses or other organizations to fund current or expanded community efforts to address domestic violence and/or child trauma?
- Writing grant proposals to obtain funding to address trauma?
- Forging partnerships with local experts on child trauma, domestic violence, and/or trauma-informed care?
- Forging partnerships with local organizations that address child trauma, domestic violence, and/or trauma-informed care?
- Designating staff time to address issues of trauma and domestic violence?

31. Are you aware of any proposals or action plans that have been submitted for funding to address homeless domestic violence survivors and their children? If yes, please explain.

Conclusion

Thank you so much for assisting us with our Readiness Assessment!
Is there anything else you would like to add? Do you have any questions for us?

Rapid Re-housing Contractor Interview Guide

Introduction

Hello, my name is _____ from (your organization or affiliation).

Thank you so much for agreeing to be interviewed for this project. We are contacting key people to ask about how the needs of domestic violence survivors and their children are addressed by rapid re-housing programs. The entire process, including individual names, will be kept confidential.

For the following questions, please answer keeping in mind your perspective of what community members believe and not what you personally believe. We are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

Stakeholder-specific questions

Note: These are NOT INCLUDED in the readiness calculations, and therefore are not numbered.

a. Describe the structure of your organization.
b. What, if any, are the relationships between your rapid re-housing program and domestic violence service providers in the area? Please explain.
c. Is there a network of trauma-informed therapeutic services your rapid re-housing program could refer children to?
d. How, if at all, does your program take participant housing preference into consideration?
e. Does your rapid re-housing program have intake procedures specifically to address the needs of children with trauma exposure? Please explain.
f. On a scale of 1 to 10, with 1 being "not concerned at all" and 10 being "extremely concerned," how concerned are your rapid re-housing program administrators with developing positive relationships with landlords? Explain your rating.
g. Does the rapid re-housing program have established relationships with landlords? Please describe how these were developed.
h. Do you know if any rapid re-housing best practices are being evaluated through your program?
i. Are evaluation results being used to make changes in the rapid re-housing program?

Dimension A. Community knowledge of efforts

1. On a scale from 1-10, how much of a concern is domestic violence to your program staff, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
2. On a scale from 1-10, how much of a concern is child trauma to your program staff, with 1 being "not a concern at all" and 10 being "a very great concern"? [Scorer note: Community Climate]
   Can you tell me why you think it's at that level?
3. Are there efforts in your rapid re-housing program that specifically address domestic violence survivors or children with trauma exposure? [Probe using the term "wrap-around services, if necessary. *If "no," SKIP to #13*]
   Can you briefly describe each of these?
4. How long have each of these efforts been going on? [Probe for each program/activity.]
5. Who, demographically, do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?
6. To what extent do rapid re-housing clients who have experienced domestic violence and children with trauma exposure utilize these efforts? How do you know?
7. What are the strengths of these efforts?
8. What are the limitations of these efforts?

9. About how many of your program staff are aware of each of the following aspects of the efforts: none, a few, some, many, or most?
    - Have heard of efforts?
    - Can name efforts?
    - Know the purpose of the efforts?
    - Know who the efforts are for?
    - Know how the efforts work (e.g. activities or how they're implemented)?
    - Know the effectiveness of the efforts?
10. Thinking back to your answers, why do you think your program staff have this amount of knowledge?
11. Are there misconceptions or incorrect information among your program staff about the current efforts? If yes, what are these?
12. What planning for additional services for rapid re-housing clients who have experienced domestic violence and children with trauma exposure is going on in your organization?
    Only ask if the answer to #3 was "No" or unsure:
13. Is anyone in your organization trying to get something started to address the specific needs of domestic violence survivors and children with trauma exposure?

Dimension B. Leadership

I'm going to ask you how the leadership in your organization perceives domestic violence and child trauma. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in your organization and/or who lead your organization in helping it achieve its goals related to rapid-re-housing.

14. Using a scale from 1-10, how much of a concern is domestic violence or child trauma to the leadership of your organization, with 1 being "not a concern at all" and 10 being "a very great concern"? Can you tell me why you say it's a [insert numerical rating]?
15. How much of a priority is addressing domestic violence or child trauma to leadership? Can you explain why you say this?
16. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many leaders…
    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
17. Do you think your leaders support additional efforts to address the needs of rapid re-housing clients who have experienced domestic violence and children? Please explain.

Dimension C. Community Climate

As a reminder, we are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

18. How much of a priority is addressing this issue to community members? Can you explain your answer?
19. I'm going to read a list of ways that community members might show their support or lack of support for efforts to address domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most community members would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving, or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing, or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
20. About how many community members would support expanding efforts in the community to address this issue? Would you say none, a few, some, many or most? How might they show this support?
21. What are the primary obstacles in the community to adding more supportive wrap-around services for rapid re-housing clients who have experienced domestic violence and children?

Dimension D. Community Knowledge of Issue

22. On a scale of 1 to 10, where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about trauma-informed services for domestic violence survivors and children? Why do you say it's a [insert numerical score]?
23. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to trauma-informed services for domestic violence survivors and children? [After each item, have them answer. Prompt as needed with "nothing, a little, some or a lot."]
    - Trauma, in general
    - The signs and symptoms of trauma
    - The causes of trauma
    - The consequences of trauma
    - Tow many domestic violence survivors and children are homeless in your area
    - What can be done to prevent or treat trauma
    - The effects of domestic violence-related trauma on work, school, and health

If the answer to #3 was "Yes," go to #24. If the answer to #3 was "No" or unsure, SKIP to #25.

Dimension E. Resources

24. *Only ask if the answer to #3 was "Yes":* How are current efforts to address domestic violence and trauma among rapid re-housing clients funded? Is this funding likely to continue into the future?
25. I'm now going to read you a list of resources that could be used to address trauma-informed care in your rapid re-housing program. For each of these, please indicate whether that resource is available in your community?

- Best practices guide?
- Trauma training workshops?
- Financial donations from organizations, businesses, or private donors?
- Grant funding?
- Experts?
- Child-focused counseling services?
- Domestic violence-focused counseling services?
- Space for workshops?
- Staff capacity?

26. Would organizational staff and leadership support using these resources to address domestic violence and child trauma? Please explain.
27. On a scale of 1 to 5, where 1 is no effort and 5 is great effort, how much effort are organizational staff and/or leadership putting into doing each of the following things to increase the resources going toward addressing domestic violence and child trauma in your community?

- Reaching out to North Carolina Coalition Against Domestic Violence to procure best practices guide
- Providing a best practices guide to rapid re-housing programs
- Soliciting donations from businesses or other organizations to fund current or expanded community efforts to address domestic violence and/or child trauma
- Writing grant proposals to obtain funding to address trauma
- Forging partnerships with local experts on child trauma, domestic violence, and/or trauma-informed care
- Forging partnerships with local organizations that address child trauma, domestic violence, and/or trauma-informed care
- Designating staff time to address issues of trauma and domestic violence

28. Are you aware of any proposals or action plans that have been submitted for funding to address homeless domestic violence survivors and children? [If "Yes," please explain.]

Conclusion

Thank you so much for assisting us with our Readiness Assessment!
Is there anything else you would like to add? Do you have any questions for us?

Social Services Administrator Interview Guide

Introduction

Hello, my name is _____ from (your organization or affiliation).

Thank you so much for agreeing to be interviewed for this project. We are contacting key people to ask about how the needs of homeless domestic violence survivors and their children are addressed. The entire process, including individual names, will be kept confidential.

For the following questions, please answer keeping in mind your perspective of what community members believe and not what you personally believe. We are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

Stakeholder-specific questions

Note: These are NOT INCLUDED readiness calculations, and therefore not numbered.

a. Please describe the structure of your organization.
b. Please describe your role in serving homeless domestic violence survivors.
c. Please describe your role in serving homeless children with trauma exposure.
d. What, if any, are the relationships between your organization and the rapid re-housing programs in your area? Please explain.
e. What, if any, are the relationships between your organization and domestic violence service providers in your area? Please explain.
f. What policies does your organization have around responding to crisis?

Dimension A. Community knowledge of efforts

1. On a scale from 1-10, how much of a concern is homelessness to members of your organization, with 1 being "not a concern at all" and 10 being "a very great concern"? (Scorer note: Community Climate)
   Can you tell me why you think it's at that level?
2. On a scale from 1-10, how much of a concern is child trauma to members of your organization, with 1 being "not a concern at all" and 10 being "a very great concern"? (Scorer note: Community Climate)
   Can you tell me why you think it's at that level?
3. Are there efforts in your organization that specifically addresses homeless domestic violence survivors or children with trauma exposure? [*If "No" SKIP to #14*]
   Can you briefly describe each of these?
4. How long have each of these efforts been going on? [Probe for each program/activity.]
5. Who, demographically, do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?
6. To what extent do homeless domestic violence survivors and children with trauma exposure utilize these efforts? How do you know?
7. What are the strengths of these efforts?
8. What are the limitations of these efforts?
9. About how many members of your organization are aware of each of the following aspects of the efforts - none, a few, some, many, or most?
   - Have heard of efforts?
   - Can name efforts?
   - Know the purpose of the efforts?
   - Know who the efforts are for?

- Know how the efforts work (e.g. activities or how they're implemented)?
- Know the effectiveness of the efforts?

10. Thinking back to your answers, why do you think members of your organization have this amount of knowledge?
11. Are there misconceptions or incorrect information among members of your organization about the current efforts? If yes: What are these?
12. What planning for additional services homeless domestic violence survivors and children with trauma exposure is going on in your organization?
13. Are there any current efforts to improve your organization's ability to offer culturally competent services?

    Only ask if the answer to #3 was "No" or unsure:
14. Is anyone in your organization trying to get something started to address the specific needs of homeless domestic violence survivors and children with trauma exposure?

Dimension B. Leadership

I'm going to ask you how the leadership at your organization perceives homelessness and child trauma. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in your organization and/or who lead your organization in helping it achieve its goals related to homelessness or trauma. [If this person is one of the leaders, they should answer for themselves accordingly.]

15. Using a scale from 1-10, how much of a priority is homelessness among domestic violence survivors and their children to the leadership of your organization, with 1 being "not a priority at all" and 10 being "a very high priority"? Can you tell me why you say it's a [insert numerical rating]?
16. Using a scale from 1-10, how willing is your organization director to partner with organizations that address homelessness, with 1 being "not willing all" and 10 being "very willing"? Can you tell me why you say it's a [insert numerical rating]?
17. How about organizations that address domestic violence?
18. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address homelessness and child trauma. Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many leaders…
    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
19. Do you think the organizational leaders support additional efforts to address the needs of rapid re-housing clients who have experienced domestic violence and children? Please explain.

Dimension C. Community Climate

As a reminder, we are defining community as the organization or network of organizations that are responsible for rapid re-housing or domestic violence services.

20. How much of a priority is addressing this issue to community members? Can you explain your answer?
21. I'm going to read a list of ways that community members might show their support or lack of support for efforts to address homelessness related to domestic violence and child trauma. Can you please tell me whether none, a few, some, many or most community members would or do show support in this way? Also, feel free to explain your responses as we move through the list.

    How many community members…

    - At least passively support efforts without necessarily being active in that support?
    - Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?
    - Support allocating resources to fund community efforts?
    - Play a key role as a leader or driving force in planning, developing or implementing efforts? [Prompt: How do they do that?]
    - Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?
22. About how many community members would support expanding efforts in the community to address this issue? Would you say none, a few, some, many or most? How might they show this support?
23. What are the primary obstacles in the community to adding more supportive wrap-around services for homeless individuals who have experienced domestic violence and their children?

Dimension D. Community Knowledge of Issue

24. On a scale of 1 to 10 where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about homelessness among domestic violence survivors and their children? Why do you say it's a [insert numerical score]?
25. Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to trauma-informed services for domestic violence survivors and their children? [After each item, have them answer. Prompt as needed with "nothing, a little, some or a lot."]
    - Trauma, in general
    - The signs and symptoms of trauma
    - The causes of trauma
    - The consequences of trauma
    - What can be done to prevent or treat trauma
    - How many domestic violence survivors and children are homeless in your area
    - The relationship between domestic violence and homelessness

If the answer to #3 was "Yes," go to #26. If the answer to #3 was "No" or unsure, SKIP to #27.

Dimension E. Resources

26. *Only ask if the answer to #3 was "Yes":* How are current efforts to address homelessness among domestic violence survivors and children with trauma exposure funded? Is this funding likely to continue into the future?
27. I'm now going to read you a list of resources that could be used to address this issue in your organization. For each of these, please indicate whether that resource is available in your community.

- Trauma training workshops?
- Organizations that have rapid re-housing programs?
- Financial donations from organizations, businesses, or private donors?
- Grant funding?
- Experts?
- Child-focused counseling services?
- Homelessness counseling services?
- Space for workshops?
- Staff capacity?

28. Would organizational staff and leadership support using these resources to address homelessness among domestic violence survivors and children with trauma exposure? Please explain.
29. On a scale of 1 to 5, where 1 is no effort and 5 is great effort, how much effort are organizational staff and/or leadership putting into doing each of the following things to increase the resources going toward addressing homelessness among domestic violence survivors and children with trauma exposure in your community?

- Providing a best practices guide to rapid re-housing programs?
- Soliciting donations from businesses or other organizations to fund current or expanded community efforts to address domestic violence and/or child trauma?
- Writing grant proposals to obtain funding to address trauma?
- Forging partnerships with local experts on child trauma, domestic violence, and/or trauma-informed care?
- Forging partnerships with local organizations that address child trauma, domestic violence, and/or trauma-informed care?
- Designating staff time to address issues of trauma and domestic violence?

30. Are you aware of any proposals or action plans that have been submitted for funding to address homeless domestic violence survivors and their children? If yes, please explain.

Conclusion

Thank you so much for assisting us with our Readiness Assessment!
Is there anything else you would like to add? Do you have any questions for us?

Scoring

Scoring is judged per interview, per dimension, using "anchored rating statements" for each Stage of Readiness. For each dimension, first examine the recipient's answers and compare them to the Stage 1 statement. Stage 1, "No Awareness," represents the lowest level of readiness and serves as the baseline against which to measure participant responses. If the information in the response for the dimension being scored meets or exceeds the statement, move to the next anchored rating statement. Continue until a statement is not met. In that case, the "score" of that dimension is the numerical value of the last stage fully met. However, **the score does not have to be a whole number**, so if you determine the dimension to exceed a certain stage, you can use a number with a decimal point. For example, if the interview shows that the community has exceeded Stage 4, but has some elements of Stage 5 for a particular dimension, then you may assign a value of 4.5. It is ideal for two people to score, then meet to reach consensus on those scores.

Process Tips from the Tri-Ethnic Center (2015)

- Have 5 different colors of highlighters. Designate one color for each dimension. For example, Community Knowledge of Efforts (CKE) might be assigned the yellow highlighter, Leadership might be assigned pink, and so on. Have the other scorer use the same color scheme, as it will make the joint scoring process easier.
- There are five rating scales that you will use to score, one for each dimension.
- Have a blank scoring sheet (see sample table on next page) available to keep track of your scores and the final consensus scores.
- Read through an interview in its entirety before scoring any of the dimensions. This will give you a general familiarity with the interview.
- Starting with Community Knowledge of Efforts (CKE), read the CKE rating scale to familiarize yourself with key concepts pertaining to this dimension.
- Then read through the entire interview and, using your highlighter for this dimension, highlight statements that refer to aspects of this dimension.
- Next, using the highlighted statements, start with the first statement on the anchored rating scale and ask yourself if the community exceeds that statement. If they do, proceed to the next statement and ask whether they exceed that statement.
- Continue this until you cannot move on to the next statement in the rating scale, that is, the community has not reached that stage yet. The readiness level for CKE is then at the prior stage. In order to receive a score at a certain stage, the entire statement must be true.
- Continue to the next dimension until all dimensions are scored for that interview.
- Score the rest of the interviews in the same fashion and fill out the table as you go.

Scoring Worksheet

After assessing all dimension ratings for each interview, average each row (see table below) to find the average score per dimension (Tri-Ethnic Center, 2015).

Interviews	#1	#2	#3	#4	#5	#6	TOTAL
Dimension A	_____	_____	_____	_____	_____	_____	_____
Dimension B	_____	_____	_____	_____	_____	_____	_____
Dimension C	_____	_____	_____	_____	_____	_____	_____
Dimension D	_____	_____	_____	_____	_____	_____	_____
Dimension E	_____	_____	_____	_____	_____	_____	_____

DIMENSIONAL READINESS: Then, use the combined score TOTAL in the table above and divide by the number of interviews conducted. Add the calculated scores together and enter it under total.

Stage Score

TOTAL Dimension A ____ ÷ # of interviews ____ = ____

TOTAL Dimension B ____ ÷ # of interviews ____ = ____

TOTAL Dimension C ____ ÷ # of interviews ____ = ____

TOTAL Dimension D ____ ÷ # of interviews ____ = ____

TOTAL Dimension E ____ ÷ # of interviews ____ = ____

CALCULATED TOTAL SUM: ____

If one of the dimensions is markedly different than the others, focus on that dimension first instead of using a generalized community readiness technique.

OVERALL STAGE OF READINESS: Take the TOTAL calculated score and divide by 6 (the number of dimensions). Use the list of stages below to match the result with a Stage of Readiness. Round down instead of up. By averaging across dimensions the scorers account for variation in readiness by dimension.

TOTAL Calculated Score ____ ÷ 6 = 

The boxed number, rounded down, can be used with the "Tailored Recommendations for Stages of Readiness" section. Find the stage that corresponds with that number for related recommendations.

Anchored Rating Statements for Scoring Each Dimension

The statements below are used to score each dimension, as described above (Tri-Ethnic Center, 2015).

Community Knowledge of Efforts

Level	Description
1	Community members have no knowledge about local efforts addressing the issue.
2	Only a few community members have any knowledge about local efforts addressing the issue. Community members may have misconceptions or incorrect knowledge about local efforts (e.g., their purpose or who they are for).
3	At least some community members have heard of local efforts, but little else.
4	At least some community members have heard of local efforts and are familiar with the purpose of the efforts.
5	At least some community members have heard of local efforts, are familiar with the purpose of the efforts, who the efforts are for, and how the efforts work.
6	Many community members have heard of local efforts and are familiar with the purpose of the effort. At least some community members know who the efforts are for and how the efforts work.
7	Many community members have heard of local efforts, are familiar with the purpose of the effort, who the efforts are for, and how the efforts work. At least a few community members know the effectiveness of local efforts.
8	Most community members have heard of local efforts and are familiar with the purpose of the effort. Many community members know who the efforts are for and how the efforts work. Some community members know the effectiveness of local efforts.
9	Most community members have extensive knowledge about local efforts, knowing the purpose, who the efforts are for and how the efforts work. Many community members know the effectiveness of the local efforts.

Leadership

Level	Description
1	Leadership believes that the issue is not a concern.
2	Leadership believes that the issue may be a concern in this community, but doesn't think it can or should be addressed.
3	At least some of the leadership believes that the issue may be a concern in this community. It may not be seen as a priority. They show no immediate motivation to act.
4	At least some of the leadership believes that the issue is a concern in the community and that some type of effort is needed to address it. Although some may be at least passively supportive of current efforts, only a few may be participating in developing, improving, or implementing efforts.

5 At least some of the leadership is participating in developing, improving, or implementing efforts, possibly being a member of a group that is working toward these efforts or being supportive of allocating resources to these efforts.

6 At least some of the leadership plays a key role in participating in current efforts and in developing, improving, and/or implementing efforts, possibly in leading groups or speaking out publicly in favor of the efforts, and/or as other types of driving forces.

7 At least some of the leadership plays a key role in ensuring or improving the long-term viability of the efforts to address the issue, for example by allocating long-term funding.

8 At least some of the leadership plays a key role in expanding and improving efforts, through evaluating and modifying efforts, seeking new resources, and/or helping develop and implement new efforts.

9 At least some of the leadership is continually reviewing evaluation results of the efforts and is modifying financial support accordingly.

Community Climate

Level Description

1 Community members believe that the issue is not a concern.

2 Community members believe that the issue may be a concern in this community, but don't think it can or should be addressed.

3 Some community members believe that the issue may be a concern in the community, but it is not seen as a priority. They show no motivation to act.

4 Some community members believe that the issue is a concern in the community and that some type of effort is needed to address it. Although some may be at least passively supportive of efforts, only a few may be participating in developing, improving, or implementing efforts.

5 At least some community members are participating in developing, improving, or implementing efforts, possibly attending group meetings that are working toward these efforts.

6 At least some community members play a key role in developing, improving, and/or implementing efforts, possibly being members of groups or speaking out publicly in favor of efforts, and/or as other types of driving forces.

7 At least some community members play a key role in ensuring or improving the long-term viability of efforts (e.g., supporting a tax increase). The attitude in the community is, we have taken responsibility.

8 The majority of the community strongly supports efforts or the need for efforts. Participation level is high. The attitude of the community is, we need to continue our efforts and make sure what we are doing is effective.

9 The majority of the community is highly supportive of efforts to address the issue. Community members demand accountability.

Community Knowledge of Issue

Level	Description
1	Community members have no knowledge about the issue.
2	Only a few community members have any knowledge about the issue. Among many community members, there are misconceptions about the issue, (e.g., how and where it occurs, why it needs addressing, whether it occurs locally).
3	At least some community members have heard of the issue, but little else. Among some community members, there may be misconceptions about the issue. Community members may be somewhat aware that the issue occurs locally.
4	At least some community members know a little about causes, consequences, signs, and symptoms. At least some community members are aware that the issue occurs locally.
5	At least some community members know some about causes, consequences, signs, and symptoms. At least some community members are aware that the issue occurs locally.
6	At least some community members know some about causes, consequences, signs, and symptoms. At least some community members have some knowledge about how much it occurs locally and its effect on the community.
7	At least some community members know a lot about causes, consequences, signs, and symptoms. At least some community members have some knowledge about how much it occurs locally and its effect on the community.
8	Most community members know a lot about causes, consequences, signs, and symptoms. At least some community members have a lot of knowledge about how much it occurs locally, its effect on the community, and how to address it locally.
9	Most community members have detailed knowledge about the issue, knowing detailed information about causes, consequences, signs, and symptoms. Most community members have detailed knowledge about how much it occurs locally, its effect on the community, and how to address it locally.

Resources

Level	Description
1	There are no resources available for (further) efforts.
2	There are very limited resources (such as one community room) available that could be used for further efforts. There is no action to allocate these resources to the issue. Funding for any current efforts is not stable or continuing.
3	There are some resources (such as a community room, volunteers, local professionals, or grant funding or other financial sources) that could be used for further efforts. There is little or no action to allocate these resources to the issue.

4 There are some resources identified that could be used for further efforts. Some community members or leaders have looked into or are looking into using these resources to address the issue.

5 There are some resources identified that could be used for further efforts to address the issue. Some community members or leaders are actively working to secure these resources, for example, they may be soliciting donations, writing grant proposals, or seeking volunteers.

6 New resources have been obtained and/or allocated to support further efforts to address the issue.

7 A considerable part of allocated resources for efforts are from sources that are expected to provide stable or continuing support.

8 A considerable part of allocated resources for efforts are from sources that are expected to provide continuous support. Community members are looking into additional support to implement new efforts.

9 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for new efforts.

Tailored Recommendations for Stages of Readiness

After you calculate your community's readiness using the above scoring technique, locate the corresponding Stage of Readiness below to find recommendations for next steps. Strategies included under each stage of awareness will help identify ways to increase your community's readiness to address the needs of homeless domestic violence survivors and their children.

Stage 1: No Awareness

- Here, your goal is to raise awareness that the issue exists.
- Identify service provider organizations that work within the domestic violence, social services, and housing spheres.
- Make one-on-one contact with community and system leaders.
- Visit existing and established small groups to inform them of the issue.
- Make one-on-one phone calls to potential supporters and champions.
- Place items in the media that explain or call attention to the issue.

Stage 2: Denial/Resistance

- To address this level, you have to raise awareness that the problem or issue exists in this community.
- Continue one-on-one visits with organizational leadership and encourage those you've talked with to assist.
- Discuss descriptive local incidents related to the issue.
- Approach and engage local partner organizations to assist in the effort.
- Place your own items in the media about the issue's local effects.
- Present information to local related community groups.

Stage 3: Vague Awareness

- Now that people recognize the problem, they have to be aware that the community can do something about it.
- Get on the agendas and present information at local community events and to potential partner organizations.
- Publish newspaper editorials and articles with general information and local implications.

Stage 4: Preplanning

- At this level, people are ready to start thinking about how to address the issue.
- Review existing efforts (programs, activities, etc.) to and their outcomes.
- Increase media exposure through radio and television public service announcements.

Stage 5: Preparation

- Here, the goal is information-gathering to lay the groundwork for planning community strategies to deal with the issue.
- Plan how to evaluate the success of your efforts and collect baseline data.
- Determine which organizations will be involved and designate points of contact for each.

Stage 6: Initiation

- As a more serious effort gets under way, organizations will need more technical assistance.
- Conduct in-service trainings for partner agencies.
- Attend inter-organizational meetings to provide updates on progress of efforts.
- Conduct client interviews to identify service gaps, improve existing services, and identify key places to post information.
- Attempt to identify additional funding resources.
- Begin evaluating efforts.

Stage 7: Stabilization

- Now that efforts and programs are in place, it's necessary to stabilize them so as to maintain the overall effort.
- Plan outreach to maintain support and publicize successful outcomes.
- Conduct training for additional partner organizations
- Conduct quarterly meetings to review progress and modify strategies based on evaluation findings and best practices.

Stage 8: Confirmation/Expansion

- Once services are stabilized, the task is to expand and enhance them.
- Formalize the networking with qualified service agreements. Prepare a community risk assessment profile.
- Publish a localized program services directory.
- Initiate policy change through support of local officials.
- Conduct media outreach on specific data trends related to the issue.
- Utilize evaluation data to modify efforts.

Stage 9: High Level of Community Ownership

- Once the community reaches the highest level, the trick is to maintain the momentum and continue growth.
- Maintain organizational relationships.
- Diversify funding resources.
- Continue more advanced training.
- Continue reassessment of issue and progress made.
- Utilize external evaluation and use feedback for program modification.
- Track outcome data for use with future grant requests.
- Continue progress reports.

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