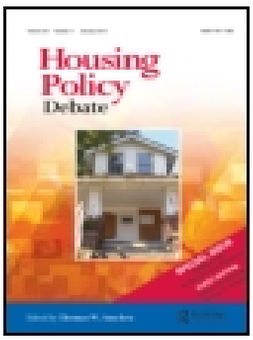

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No Easy Decisions: Developing an Evidence-Informed Process to Allocate Housing Choice Vouchers to Survivors of Intimate Partner Violence

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ABSTRACT

This article describes the development of an evidence-informed screening tool and process to allocate 25 Housing Choice Vouchers (HCVs) to homeless and unstably housed survivors of intimate partner violence (IPV) through an innovative pilot program called SASH (Survivors Achieving Stable Housing). Informed by empirical and community-defined evidence, the screening tool comprised two forms, a survivor self-referral form and a form completed by a domestic violence (DV) advocate on the survivor's behalf. Responses were scored such that higher scores indicated fewer barriers to the SASH definition of housing success (i.e., to lease up with and maintain an HCV). We received 92 applications, primarily from survivors living in DV shelters. Of those, 31 were excluded; the remaining 61 were randomized into either the voucher or the queue group. Survivors needed considerable advocacy from the SASH team to move through the public housing authority application process as well as financial assistance to lease up. Lessons learned during the SASH project have important implications for DV and housing practitioners, especially those involved in developing coordinated entry procedures. These lessons include the utility and feasibility of screening questions and tools, moral dilemmas of resource allocation, and challenges of working across siloed systems and policies.

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Allocation of scarce resources is a perpetual challenge for human service providers. In the homelessness field, resource allocation is particularly vexing. As others have noted, deciding how to target housing resources is a "moral, practical, and political act" (Glendening & Shinn, 2017, p. 10) that requires accountability to multiple stakeholders (e.g., clients, service providers, systems, and the greater good) with competing needs. In medicine, where scarce medical interventions can mean life or death, considerable attention has been given to the ethical principles that should guide resource allocation (Persad, Wertheimer, & Emanuel, 2009). According to Persad et al. (2009), a just allocation process depends on a multiprinciple framework that balances core but competing societal values: prioritizing the neediest, maximizing benefits for individuals and society, and treating people equally.

Balancing these values depends on the availability of evidence-informed assessment tools that are standardized in their application, yet tailored to the needs of specific groups within the homeless population (Levitt, 2015). For example, intimate partner violence (IPV) survivors who interface with homeless services require tailored assessment tools and procedures because of their unique safety needs (Botein & Hetling, 2016; Domestic Violence & Housing Technical Assistance Consortium

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[DVHTAC], 2017). At present, however, little has been documented regarding what might be included in a tailored assessment tool for survivors, or how the data that are collected might be used to inform resource allocation. This void is concerning, especially given federally mandated changes to the new coordinated entry (CE) process for continuums of care (CoCs). In the new CE process, the needs of IPV survivors must be addressed at every stage (e.g., access points, screening and assessment procedures, and referral options); however, CoCs have considerable autonomy as long as they follow the general requirements of the U.S. Department of Housing and Urban Development (HUD; DVHTAC, 2017). As a result, assessment and allocation practices vary across communities. For example, some communities have developed their own domestic violence (DV)-specific tools; others have added IPV screening questions to their main tool (National Network to End Domestic Violence [NNEDV], 2018).

Informed by the lack of attention in the literature regarding IPV-specific housing assessment, this article describes an evidence-informed screening tool and resource allocation procedure developed for an innovative pilot program called SASH (Survivors Achieving Stable Housing). As we will describe, the SASH team was tasked with allocating 25 Housing Choice Vouchers (HCVs) to homeless and unstably housed IPV survivors. The project was highly political in nature and involved many stakeholders with varying interests, both factors that influenced the content and format of the tool and process. Our purpose in writing this article is to offer guidance to practitioners—especially those developing CE processes—about questions to ask and factors to consider when assessing and prioritizing housing resources for IPV survivors. We also highlight the policy-related challenges we encountered along the way and offer recommendations for addressing them. In the next section, we provide an overview of the relationship between IPV and homelessness, followed by an in-depth review of the studies that informed the development of the SASH tool and allocation process.

Literature Review

IPV and Homelessness

IPV is a widespread and devastating problem in the United States. Estimates from the population-based National Intimate Partner and Sexual Violence Survey (NISVS) indicate that approximately 25.1% of women and 10.9% of men report experiencing at least one incident of contact sexual violence, physical violence, or stalking by an intimate partner that directly resulted in negative consequences such as being injured, feeling fearful, missing work or school, or needing medical or law enforcement assistance (Smith et al., 2017). Two other pervasive forms of IPV among men and women are psychological aggression and coercive control (Breiding, Chen, & Black, 2014). Among women in particular, economic abuse is common (e.g., denying access to financial accounts and credit cards, withholding or stealing money, ruining credit, and interfering with work; Adams, Sullivan, Bybee, & Greeson, 2008), as is social isolation (e.g., reducing social networks and cutting off emotional and tangible support; Davies & Lyon, 2014). Moreover, these forms often co-occur (Breiding et al., 2014) and can contribute to a range of immediate and long-term harms to survivors' physical (e.g., traumatic brain injury; Campbell et al., 2018), mental (e.g., depression; Devries, Mak, Bacchus, Child, & Falder, 2013), and economic (e.g., financial hardship; O'Connor & Nepomnyaschy, 2019) health.

Given the many forms and effects of IPV, it is not surprising that it can also increase the risk of housing instability and homelessness. Two studies have found that women who reported IPV were 3–5 times more likely to experience housing instability than their female counterparts (Montgomery et al., 2018; Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007). Regarding estimates for the overlap between IPV and homelessness, a recent report found that 40% of the more than 18,0000 families living in New York City's homeless shelters in 2018 were there because of IPV, and another 2,519 families had utilized IPV-specific emergency shelters (i.e., DV shelters; Stringer, 2019). Estimates from other studies are higher, indicating that approximately half to two thirds of female-headed families

in homeless shelters have experienced IPV victimization (Bassuk et al., 1996; Gubits, Shinn, Bell, Wood, & Dastrup, 2015).

As others have noted, the relationship between IPV and homelessness is complex (Baker, Billhardt, Warren, Rollins, & Glass, 2010; Botein & Hetling, 2016). The experience of IPV can cause survivors to flee their residences to protect themselves and their children, particularly when lethality risk is high (Botein & Hetling, 2016; Clark, Wood, & Sullivan, 2019). In addition, IPV can lead to eviction, especially when abusive partners intentionally sabotage survivors' housing (e.g., damaging the property, scaring other tenants, provoking police response; Baker et al., 2010; Desmond, 2016). Finally, the impact of IPV on the various health domains described previously can create formidable barriers to maintaining stable housing (Baker et al., 2010; Daoud et al., 2016). In all of these pathways, structural factors such as racism, sexism, and poverty play an enormous role; survivors with multiple oppressed identities are limited in what housing options are available to them and often trapped in a cycle where IPV begets homelessness and vice versa (Daoud et al., 2016; Goodman, Smyth, Borges, & Singer, 2009). For example, residents of DV shelters, who are often women of color with very low income (Galano, Hunter, Howell, Miller, & Graham-Bermann, 2013), report that they would have had no choice but to stay with their abusive partner or live on the streets if not for the DV shelter (Gezinski & Gonzalez-Pons, 2019; Lyon, Lane, & Menard, 2008).

Programs and Policies for Homeless IPV Survivors

As knowledge about homelessness has evolved, so too have practice and policy responses. For more than a decade, the homelessness field has placed increasing emphasis on targeted prevention strategies (e.g., provision of diversion funds) and low-barrier interventions that exit people out of the shelter system and into housing as quickly as possible, through models such as Housing First and Rapid Rehousing (Culhane, Metraux, & Byrne, 2011; Padgett, Henwood, & Tsemberis, 2016). These approaches, which focus on choice, self-determination, and flexibility, differ from the traditional CoC response—a model that moves people in stages from emergency shelter toward eventual permanent housing as they become more housing ready (Culhane et al., 2011; Padgett et al., 2016).

Likewise, DV programs have begun to prioritize prevention strategies (e.g., flexible funding programs) and interventions such as Housing First and Rapid Rehousing, either in addition to their residential services or as a replacement for them (Botein & Hetling, 2016; Mbilinyi, 2015; Rollins et al., 2012; Sullivan, Bomsta, & Hacskaylo, 2019; Sullivan & Olsen, 2016; Sullivan, Strom, & Fluegeman, 2017; Ward-Lasher, Messing, & Stein-Seroussi, 2017). According to Sullivan and Olsen (2016), several core tenets of Housing First align well with those of DV services (e.g., belief that housing is a human right; respectful and compassionate treatment), and others can be adapted to meet the unique needs of IPV survivors. For example, whereas traditional Housing First focuses on harm reduction (it was developed to assist chronically homeless individuals with co-occurring severe mental illness and substance abuse), DV Housing First prioritizes safety planning regarding IPV and threats to emotional safety that stem from IPV (e.g., avoiding neighborhoods that would put a survivor in contact with the abusive partner as well as those that might trigger traumatic memories).

The DV Housing First approach is guided by four tenets: mobile advocacy, flexible engagement, trauma-informed practice, and community engagement (Sullivan & Olsen, 2016). Specific practices, however, vary across programs. For example, some programs use a scattered-site model, which involves moving survivors as quickly as possible from shelter or other temporary arrangements (e.g., motel placement) to apartments in the community by providing time-limited financial rent subsidies, flexible funding for other housing costs, and voluntary supportive services (Botein & Hetling, 2016; Sullivan et al., 2017). Although not as common, others use a project-based model, which involves providing permanent supportive housing and voluntary supportive services for survivors who have been living in shelter or transitional housing programs. Although DV Housing First programs generally follow the low-barrier threshold of Housing First, they often assess need to determine

service fit and some have eligibility criteria (e.g., permanent housing programs might not accept those with a high level of danger; Botein & Hetling, 2016).

Although research on DV Housing First programs is only just emerging, the few existing evaluations indicate that these programs have had considerable success transitioning survivors from housing instability and homelessness to permanent housing (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013; Sullivan et al., 2017). Nevertheless, a minority of survivors struggle to find and maintain permanent housing, with the following factors appearing to play a role: enduring unemployment, substance abuse, ongoing IPV, criminal history, undocumented status, and landlord discrimination (i.e., refusing to rent to IPV survivors because they think they will cause trouble; Mbilinyi, 2015; Mbilinyi & Kreiter, 2013). Regardless of the model used, DV Housing First programs often rely on HCVs to help subsidize survivors' housing, either at entry or when the short-term program subsidy ends (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013; Sullivan et al., 2017).

The HCV Program

The HCV Program, also known as Section 8, is a federally funded housing assistance program for very low-income households that is operated by the U.S. Department of Housing and Urban Development (HUD) and distributed by local public housing authorities (PHAs; Gubits, Khadduri, & Turnham, 2009; HUD, 2019). Low income is defined as below 50% of the area median income (AMI), with at least 75% of vouchers earmarked for those below 30% AMI. The amount of the subsidy is based on household size and the income of all of the adults who will be living in the household, as long as they are not full-time students. In cases of IPV, the survivor would not need to report the abusive partner's income unless that person was planning to live in the unit.

The HCV Program has been shown to be one of the most effective strategies for reducing homelessness. The strongest support comes from The Family Options Study, a large-scale randomized control trial comparing housing interventions for shelter-using families, which found that families assigned to the permanent housing subsidies (primarily HCVs) experienced substantially better housing outcomes at the 18-month follow-up point compared with families in emergency shelter, transitional housing, and rapid rehousing programs (Gubits et al., 2015). In an earlier randomized control trial, families who received HCVs were substantially less likely to experience homelessness compared with families in the control group (Gubits et al., 2009). Findings from the Family Options Study also indicate that HCVs are a preferred intervention among homeless families: the percentage of families who agreed to move forward with the intervention they were offered was substantially higher among those in the subsidized housing group compared with those in the rapid rehousing and transitional housing groups (Gubits, Spellman, Dunton, Brown, & Wood, 2013).

Although transitional housing was least desirable in the Family Options Study (Gubits et al., 2015), a study specific to IPV survivors indicated that DV transitional housing was preferable to rapid rehousing (HCVs were not asked about) when survivors were in higher levels of danger (because they would not feel safe in independent housing) and had greater psychological and social needs (because they wanted on-site services; Clark et al., 2019). Length of subsidy also mattered: only 30% of survivors in that study reported that they would choose rapid rehousing if offered a 6-month subsidy, compared with 70% if offered a 2-year subsidy.

Challenges to Success with an HCV

Despite the HCV Program's general effectiveness, not all families are successful in their efforts to access and use an HCV (i.e., to lease up; Graves, 2016; Gubits et al., 2013). The primary challenge is the scarcity of vouchers in relation to demand. Limited supply means that some families wait several years before a voucher becomes available and others are barred altogether because the HCV Program list is closed to new applicants (National Low Income Housing Coalition [NLIHC], 2016). In addition, the HCV Program uses several other mechanisms to ration vouchers, including eligibility

criteria (e.g., citizenship status), lotteries (e.g., closing lists to randomize applicants), preferences, (e.g., displacement, IPV), and administrative processes such as mandatory paperwork and meetings (Moore, 2016).

In addition, successfully leasing up with an HCV is contingent upon the availability of scarce resources, such as housing units that are affordable and can pass the PHA inspection criteria (Graves, 2016; Gubits et al., 2009), and landlords who are willing to accept vouchers (Graves, 2016; Greenlee, 2014; Mbilinyi, 2015). Indeed, a recent report from the Urban Institute underscored the challenges of using a voucher, especially in cities with tight rental markets (Cunningham et al., 2018). Other common barriers to leasing up include poor credit, inability to afford the costs of leasing up such as rental application fees and security deposits, short housing search timeframes, and transportation constraints (Graves, 2016). In addition, location plays an important role in families' decision-making regarding voucher usage: some families give up the voucher because the available units are either in unsafe neighborhoods (Graves, 2016) or not close to their other basic needs such as public transportation, work, and social networks (Fisher, Mayberry, Shinn, & Khadduri, 2014). Finally, although families comprising citizens and noncitizens (i.e., mixed) are eligible for an HCV, they receive a smaller subsidy (i.e., prorated assistance) based on the number of eligible household members (U.S. Department of Housing and Urban Development, 2019); thus, they might not be able to use the voucher because they cannot afford their portion of the rent. Despite these challenges, a sizable proportion of families do lease up with HCVs. In the Family Options study, 71% of families in the subsidized housing group leased up with HCV, which they note is 10–20% higher than the number in prior studies (Gubits et al., 2013).

Finally, some households that have successfully leased up with a voucher eventually lose it. Using data from the Family Options Study, Glendening and Shinn (2017) examined housing outcomes for participants who had been assigned to subsidized housing with an HCV. They found the following factors were related to a subsequent return to shelter or a doubled-up situation: prior housing instability, poor health, multiple adults in the family, past felonies, separation from a child at shelter entrance, and not having worked in the previous 24 months (Glendening & Shinn, 2017). Additional factors associated with eviction and voucher termination include being unable to keep up with rent payments (Brisson & Covert, 2015; Smith et al., 2015), experiencing current severe IPV, being pregnant or having an infant at the time of voucher receipt (Rog & Gutman, 1997), and not complying with the program's administrative regulations (Gubits et al., 2009). Although these studies provide valuable insight on potential factors, research on this topic is generally scarce and provides little guidance for assessment and resource allocation. This lack of guidance was an influencing factor in the SASH team's decision to draw from multiple sources of evidence when developing its screening tool and allocation process.

Risk Factors for Housing Instability and Repeat Homelessness

Given the limited research on factors that affect success with an HCV, we also reviewed the research on factors associated with increased risk for repeat homelessness and housing instability among homeless families. As others have noted, however, the literature on this topic is limited and does not indicate what factors predict which housing intervention is best for whom (Levitt, 2015). Moreover, few studies on this topic focus specifically on IPV survivors.

Research has demonstrated that several household composition factors affect housing instability and homelessness. First, younger mothers (age 18–24) are at increased risk for housing instability (Adams et al., 2018), homelessness (Phinney, Danziger, Pollack, & Seefeldt, 2007), repeat use of homeless shelters (Metraux & Culhane, 1999; Wong, Culhane, & Kuhn, 1997), and return to homelessness after involvement in a Rapid Rehousing program (Finkel, Henry, Matthews, & Spellman, 2016). One study, however, found that older household heads (ages 45–61) were more likely to experience homelessness after involvement in a Rapid Rehousing program than were their younger counterparts (ages 18–29; Byrne, Treglia, Culhane, Kuhn, & Kane, 2015). Second, larger family size is

associated with return to homelessness (Bassuk, Perloff, & Dawson, 2001; Finkel et al., 2016), multiple homeless shelter stays (Metraux & Culhane, 1999; Wong et al., 1997), and difficulty finding permanent housing (Rocha, Johnson, McChesney, & Butterfield, 1996). Third, having young children increases the risk of repeat homeless shelter stays (Metraux & Culhane, 1999; Wong et al., 1997) and differentiates homeless mothers from low-income housed mothers (Bassuk et al., 1997, 1996). Finally, recent or current pregnancy increases risk of repeat homeless shelter stays (Metraux & Culhane, 1999; Wong et al., 1997) and eviction (Rog & Gutman, 1997).

Regarding socioeconomic status, a lower level of education differentiates homeless mothers from low-income housed mothers (Bassuk et al., 1997, 1996) and is associated with eviction (Phinney et al., 2007). Lower income is associated with housing instability among IPV survivors (Adams et al., 2018) and a return to homelessness after involvement in a Rapid Rehousing program (Finkel et al., 2016), and it differentiates homeless mothers from low-income housed mothers (Bassuk et al., 1996). Conversely, receipt of government assistance is protective against homelessness (Glendening & Shinn, 2017). As discussed previously, low income and unemployment are associated with HCV Program termination and eviction (Brisson & Covert, 2015; Glendening & Shinn, 2017; Smith et al., 2015) and repeat homelessness among recipients of DV Housing First (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013).

Several health domain factors are also important. First, a history of drug use is associated with eviction from public housing (Phinney et al., 2007), and alcohol and drug abuse differentiates homeless mothers from low-income housed mothers (Bassuk et al., 1997, 2001, 1996). Finally, chemical dependency was reported as a barrier to accessing and maintaining housing in DV Housing First programs (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013). Second, prior housing instability is associated with shelter use and multiple episodes of homelessness (Galano et al., 2013; Metraux & Culhane, 1999; Wong et al., 1997), and homelessness after involvement in a Rapid Rehousing program (Byrne et al., 2015) and the HCV Program (Glendening & Shinn, 2017).

Finally, although the role of IPV has been discussed, several specific associations are worth noting. Experiencing IPV once housed after homelessness is a primary predictor of return to shelter (Bassuk et al., 2001). In addition, IPV is associated with return to homelessness after involvement in a Rapid Rehousing program (Finkel et al., 2016), a lower likelihood of receiving subsidized housing (Shinn et al., 1998), eviction (Phinney et al., 2007), and repeat use of homeless shelters (Metraux & Culhane, 1999; Wong et al., 1997), and is a barrier to staying housed among recipients of DV Housing First (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013).

Screening and Assessment Tools

The increased understanding that people who are homeless are not a monolithic group, combined with a perpetual scarcity of housing resources, has led to the adoption of triaging households as standard practice (Fritsch, Hiler, Mueller, Wu, & Wustmann, 2017). Effective triage depends on assessment tools that can accurately assess the type and acuity of need to match households with the most appropriate housing resource and case management services. As mentioned previously, CoCs can choose which assessment tool to adopt, resulting in the development of a variety of different tools across the country (Fritsch et al., 2017). Fritsch et al. (2017) compared eight of the more well-known tools and found both similarities and differences. For example, all but one (the Arizona Self-Sufficiency Matrix) aim to prioritize who receives services; however, only five of those aim to predict fit (i.e., risk of repeat homelessness). Moreover, the majority of tools were developed to assess homeless individuals. Only two have been adapted to also assess families and youths: the Houston Coordinated Access Housing Assessment and Prioritization Tool and the Vulnerability Index–Service Prioritization Decision Assistance Tool (VI-SPDAT). Only one of the tools (the Comprehensive Assessment Tool from the National Alliance to End Homelessness) refers to DV specifically (Fritsch et al., 2017).

The VI-SPDAT is one of the most commonly used assessment tools (Brown, Cummings, Lyons, Carrión, & Watson, 2018; Fritsch et al., 2017). According to its developers, the ideal use of the VI-SPDAT

is as a screening tool to determine service need, followed by the full SPDAT (for either families or individuals) for deeper assessment (Community Solutions, & OrgCode Consulting, Inc., 2015a). This delineation dovetails with DeCandia's (2015) assertion that, although the terms *screening* and *assessment* are used interchangeably in the housing and homelessness field, they actually reflect different processes. Screening provides a "snapshot of a person at a point in time"; assessment is a process that occurs over a period of time and results in more nuanced information (DeCandia, 2015, p. 7). The VI-SPDAT for families covers five domains: risks, socialization, daily functions, wellness, and family unit—with the latter not included in the VI-SPDAT for individuals. The scoring is the same: lower scores receive no housing intervention, middle scores are referred to Rapid Rehousing, and higher scores are referred to Permanent Supportive Housing or Housing First (Community Solutions, & OrgCode Consulting, Inc., 2015b).

Despite its popularity, the VI-SPDAT is not without challenges. Only one study, to our knowledge, has examined the reliability and validity of the VI-SPDAT, specifically the version for individuals (Brown et al., 2018). The authors found that the tool had low interrater and test–retest scores, indicating poor reliability. Regarding validity, the overall tool and the individual domains were a poor measure of vulnerability (the intended construct) and only neared significance as a predictor of service reentry. The only factor that was predictive was the type of housing service provided (Brown et al., 2018). This finding supports earlier assertions from housing experts that existing screening and assessment tools (including the VI-SPDAT) are limited in their ability to effectively target resources because there is not a strong evidence base for predicting who will be successful in which type of housing intervention (Levitt, 2015).

Finally, additional context for the VI-SPDAT's reliability and validity challenges comes from a recent qualitative study with CoC coordinators (Fritsch et al., 2017). They described how honest disclosure was a challenge without rapport, but that rapport affected rater objectivity, and that there were often discrepancies between score and need—especially for families, whose risks are weighted differently from those of individuals. Some even argued that the tool punishes people for being resilient. Finally, some questions were confusing, particularly the questions about DV, which affected disclosure. These questions ask about lifetime exposure to "emotional, physical, sexual or psychological abuse" and then follow up with the impact that this "abuse and trauma" has had on daily functioning and homelessness (Community Solutions, & OrgCode Consulting, Inc., 2015b).

Summary and Aims

As the literature review has demonstrated, various system- and individual-level factors result in the need for assessment and triage when working with people experiencing housing instability and homelessness. However, deciding who should receive which resource is complicated. A primary barrier is that research has yet to determine the factors that are the strongest predictors of housing success (i.e., staying housed over the long term), especially for IPV survivors, who often have unique challenges that must be considered. Moreover, although there is considerable evidence that HCVs result in housing stability for the majority of households that receive them, they are not a guarantee for everyone; more research is needed on the factors that hinder using and maintaining an HCV. As a result, current tools to assess fit are limited in their utility and sensitivity to the needs of IPV survivors. Guided by this research and practice context, the SASH team set out to develop an evidence-informed screening tool and allocation process that would facilitate the successful use and maintenance of an HCV among homeless and unstably housed IPV survivors receiving DV services. In describing the tool and allocation process, the aims of this article are to (a) increase the limited knowledge base regarding what questions to ask and factors to consider when assessing and prioritizing HCVs for IPV survivors, and (b) provide recommendations for addressing the policy-related challenges that emerged for the practitioners and survivors involved in the SASH project.

The SASH Project

Background and Description

SASH (Survivors Achieving Stable Housing) is located in a large city in the Southwestern United States. Consistent with national trends, both the city and the state where it is located have been experiencing an extreme shortage of affordable housing (NLIHC, 2018). As a result, it has become increasingly difficult for low-income IPV survivors to find independent housing, leaving them unable to exit abusive residences or emergency shelters. In 2017, the city council responded to this crisis by earmarking 25 HCVs for IPV survivors, which were in addition to the regular allotment of vouchers that are made available on a first-come, first-served basis as part of the city's HCV Program.

The city council's expectation was that the 25 vouchers would be distributed using an evidence-informed screening tool and process that would precede (not replace) the standard PHA application process, be standardized and replicated with future applicants, and use criteria that would promote success for voucher recipients (see the next section for the SASH definition of success). The State DV Coalition, which contracted with the city to oversee the process, created an academic–community partnership consisting of itself, the city's PHA, and researchers from two universities. The researchers, who are the first three authors of this article, were chosen because of their extensive expertise in the topic and their track record of authentic, participatory collaboration with DV programs. The fourth author is a practitioner who worked as a high-level administrator at the DV coalition at the time of the project. As part of the contract, the coalition was given a small amount of funding to partially cover staff and researcher time, but that was all.

The research team worked closely with the DV coalition throughout the project; however, they were ultimately responsible for developing the tool, overseeing the allocation process, and evaluating the project's process and outcomes. As mentioned, this article documents the first two tasks; the findings from the evaluation will be reported elsewhere. The research team was also responsible for providing case management to survivors in the SASH project. This service was not a requirement of the city council, but rather a voluntary undertaking informed by the research on DV Housing First, particularly best practices for facilitating housing success. Because of limited resources, we relied on master of social work (MSW) interns (n = 3), who were affiliated with the second author's institution and supervised by the third author, an MSW-level practitioner and PhD student. The interns assisted survivors with completing the SASH application, and—if selected—the HCV application process and housing search. Part of the housing search help included connecting survivors with flexible funding sources to pay for a variety of housing-related costs (e.g., security deposits, rental applications, moving trucks). The flexible funding resources came from an Allstate grant (awarded to the coalition), the city PHA, and individual DV programs. Because of their status as interns, they were restricted to 3 days of work per week over a period of 9 months. As a result, we could only provide temporary, light-touch case management (Mbilinyi, 2015)—not the kind of intensive support that is often necessary in Housing First models with high-need populations. For more information about the case management component, see (Messing et al., forthcoming).

Developing the Tool

The in-depth review of the literature (described previously) was helpful in determining that we would develop our own tool and call it a screening tool (vs. an assessment tool) because we could only collect information at one point in time. The review also highlighted several factors that we should assess because they present barriers to housing stability (e.g., housing instability history). In addition, the recommendations from the Levitt report (2015) were also helpful, namely that screening and assessment tools should be tailored to reflect the needs of a population; reflect provider capacity, available resources, local context, and political climate; account for the additive nature of risk factors; and take practitioner wisdom into account. Eliciting practitioner wisdom felt especially important given the lack of research on housing success among IPV survivors. Thus, we sought

guidance on best practices from DV practitioners, both nationally and locally. This involved speaking with directors at DV Housing First programs across the country and staff at an array of DV programs in the community where SASH was located.

DV Housing First Programs

We had informal conversations with six director-level staff at six DV Housing First programs across the United States—chosen because they represent the few such programs that have been in operation for a few years. The goal was to learn how they determine who receives which housing service and the common barriers to housing success for their clients. The following insights emerged from these conversations. First, only one of the programs used a standardized tool to determine resource allocation. The tool, which they created and which is not public, focuses primarily on history of housing instability, barriers to housing stability, and housing preferences. Two programs assess location fit by asking about survivors' commitment to remain in a particular geographic area and ties to that area. This emphasis complements research on the important role that location plays in the housing decisions of homeless families (Fisher et al., 2014).

Second, several directors expressed a desire for a tool that would help them better determine who would be successful in which housing option. There was a general consensus, however, that it is difficult to predict housing success, especially among survivors in crisis. Third, they reported several common factors that lead survivors to struggle in their DV Housing First programs: the survivor returns to the abusive partner or becomes involved in a new abusive relationship, the ex-partner resumes their sabotage efforts, substance abuse, not having steady income from employment or public assistance, immigration status, high debt, bad credit, and prior evictions. Directors noted that these barriers are not insurmountable; however, they affect available housing options, especially when compounded.

Finally, all of the directors agreed that families facing multiple barriers need intensive support to succeed and that programs must be able to provide that level of support to families for at least 1 year. An essential component of that support is providing flexible funding to help survivors pay for the large and small financial barriers that keep them from staying housed. As one director stressed, self-sufficiency varies according to survivor. In one DV Housing First program, families are categorized as light touch, medium touch, or high touch, based on their level of need and situational factors (Mbilinyi, 2015; Mbilinyi & Kreiter, 2013). Given these situations, directors said that programs are often in a difficult bind of balancing need with success.

These conversations informed the development of the SASH tool and process in three ways. First, the SASH tool includes questions on the factors that directors described as common barriers for survivors. Second, the scoring system focuses on the number of barriers rather than any one barrier. Finally, the emphasis on the need for intensive, sustained assistance for high-touch families informed the design of the allocation process (described in a subsequent section).

Local DV Practitioner Community

It was especially important to gather the expertise of the local DV practitioner community given their deep understanding of survivors' needs, generally and because of local policies and systems. In addition, buy-in was essential, as our hope was that the DV practitioners would help advertise SASH and assist survivors with the application process. In May 2017, as the project was beginning, the DV coalition convened an in-person stakeholder meeting with the research team, representatives from the local PHA, and staff from eight local DV programs. DV staff included front-line practitioners (known in the field as DV advocates) and administrators.

This meeting informed several aspects of the tool and the overall process. First, we decided together that success in the SASH program would include one of two outcomes: (a) using the voucher until the survivor no longer needed it, which would allow the voucher to go back into rotation; or (b) using the voucher indefinitely—possibly forever—which would require following PHA requirements to avoid voucher loss or eviction. Even though research on the HCV Program suggests that the second outcome is more likely than the first, it was politically important that at

least some survivors exit successfully (as opposed to losing a voucher for eviction or noncompliance) so that the program would be a benefit to more than the initial 25 recipients.

Second, practitioners did not want us to use the VI-SPDAT. They were emphatic that it did not adequately capture survivors' needs and barriers; instead, they received scores that did not reflect the gravity of their situation and were directed to interventions that did not match their need. Third, we decided that the screening tool would incorporate input from DV practitioners. This decision emerged while we were discussing the literature on risk factors for repeat homelessness. DV practitioners expressed concern that some of the risk factors were too narrow to base eligibility on and that a fuller picture was needed. Age was a primary example: although practitioners agreed that survivors age 18–24 often have more difficulty maintaining independent housing than their older peers, they stressed that an individual's level of maturity was often more important than age. Fourth, practitioners wanted a question that asked whether the abusive partner would live in the unit with the survivor (and, thus, be on the lease); practitioners were concerned that living with an abusive partner would cause problems and ultimately compromise survivors' ability to maintain the voucher.

Fifth, because our screening process was intended to precede the PHA application process, we developed strategies for how our screening tool would support, but not encroach upon, the PHA. For example, although we were encouraged to include a question about whether the applicant was willing to live in the city limits for at least 1 year (an HCV Program requirement), it was decided that our screening tool would not include any questions related to PHA-specific eligibility criteria (e.g., legal system involvement); instead, those would be assessed by the PHA. Also, we were clear with survivors who applied for a voucher through the SASH project that they were not restricted in any way from also applying for an HVC through the regular PHA process. Finally, we agreed that for DV staff to effectively assist survivors with the process, the state coalition would host a webinar in which the SASH team and the city PHA explained the steps and requirements to the DV staff.

The SASH Screening Tool

The final screening tool consisted of two forms. The first was a self-referral form that took survivors approximately 30–45 minutes to complete. Survivors were given the option of completing the self-referral on their own or they could receive help from someone at the DV program where they received services or from one of the MSW student interns on the SASH team. The second was a referral form that was filled out by a DV advocate (i.e., front-line practitioner) working at the DV program where the survivor was seeking services. Typically, the advocate who was working most closely with the survivor was the one who filled it out, but that was not a requirement. The advocate form was intended to complement the survivor self-referral form by providing additional insight into the survivor's potential for success in the SASH project. It took approximately 15 minutes to complete. Both forms were required for the survivor to be considered for a voucher and were designed to be completed electronically through Qualtrics, a web-based survey system that can be accessed from a computer, tablet, or smart phone.

Survivor Self-Referral

This form included eight domains: demographics, socioeconomic status, housing situation and instability, family characteristics, social support and ties to geographic community, IPV-related factors, behavioral health, and service needs. Next, we describe the questions in each domain and which were included in the scoring system (see Table 1 for the wording and response options of questions that were scored). As a reminder, these questions reflect factors that emerged as important from our review of the literature and discussions with DV practitioners.

Demographics. This section contained seven questions that asked about the survivor's name, referring agency, gender, racial ethnicity, date of birth, and country of origin, and citizenship status.

The last three were scored such that being 18–24 years old and not being a citizen were considered barriers to success according to the SASH definition.

Socioeconomic Status. This section consisted of 17 questions (10 main and seven follow-up) that asked about the survivor's monthly income amount, income source, ability to pay $50 for rent per month (the HCV Program requires that households pay at least $50 a month for rent), recent work history, job training program involvement, credit history, education level, and school status. Questions were scored such that having very little to no income, not having $50 per month for rent, having poor credit history and debt, and having less than a high school degree were considered barriers to SASH-defined success. To contextualize survivors' responses about income, we also asked them to describe any physical or mental health barriers to employment.

Family Characteristics. This section consisted of nine questions (two main and seven follow-up) that asked about pregnancy status and children. If survivors answered yes to having children, they were asked about number and ages, and system involvement. Questions were scored such that being pregnant, having more than three children, and having young children were seen as barriers. Although the following was not scored, we asked if housing was the last step in getting custody from child welfare; this was to refer survivors to a special city program for parents in that situation (a PHA request).

IPV-Related Factors. This section consisted of 37 questions. The first four asked about relationship status with the abusive partner, when the abuse occurred, presence of a protection order, number of children in common with the abusive partner, child custody status, and access to custody paperwork. Questions were scored such that recent IPV, children in common, and being married (but not separated) were scored as barriers. Difficulty obtaining custody paperwork was also scored as a barrier; the HCV Program requires applicants to provide a variety of documents, including some related to custody. The next set of questions were the 20-item Danger Assessment Scale (Campbell, Sharps, & Glass 2001), which contains the response options of Yes = 1 or No = 0, and asks about lethality risk factors such as the abusive partner's use of nonfatal strangulation, homicide threats, jealousy and coercive control, and violence during pregnancy, as well as recent separation attempts. Because some items are weighted differently, the total possible score is 37 points, broken into four categories: variable danger, increased danger, severe danger, and extreme danger. We calculated the number of endorsed items and considered higher scores to be a barrier to SASH-defined success.

Finally, we assessed the level of safety-related empowerment using the 13-item Measure of Victim Empowerment Related to Safety, which was developed for IPV survivors (Goodman et al., 2014). Response options are on a 5-point Likert scale for a possible total of 65 points. Higher scores indicate higher levels of safety-related empowerment, defined as the internal tools needed for safety, external resources to support safety, and trade-offs involved with seeking safety. We calculated the total score and considered lower scores to be a barrier to SASH-defined success.

Housing Situation and Instability. This section consisted of 22 questions (19 main and three follow-up). The first set asked about the type of current residence, how long they had lived there, their status on other housing wait lists, willingness to live in the city for at least 1 year, whether it would be safe for them to live in the city for at least 1 year, willingness to live apart from the abusive partner for at least 1 year, neighborhood preferences, and ability to search for housing with only light support. Questions were scored such that the following were considered barriers: not wanting or being able to live in the city for 1 year, wanting to live with an abusive partner, and needing substantial housing search support.

The next set of questions assessed history of housing instability using the Housing Instability Index (Rollins et al., 2012). This measure was developed specifically for a DV Housing First program and consists of 10 questions about the following events within the past 6 months: number of moves,

living somewhere the person "did not want to live," difficulty paying for housing, borrowing money to pay for housing, being served an eviction notice, having trouble getting housing, how long they could continue to stay in current housing, and ability to pay for housing this month. We did not include the last question because it would not be applicable to survivors living in shelters. We calculated the number of endorsed items; higher scores were considered to be a barrier to SASH-defined success.

Social Support and Ties to Geographic Community. This section consisted of four questions. The first three were adapted from the 12-item Social Support Scale (Block, 2000), which was developed for IPV survivors. These questions asked whether the survivor had someone in their life (not the abusive partner) who they can talk to, borrow money from in an emergency, and depend on if in danger. We calculated the number of endorsed items; lower scores were considered to be a barrier. The last question asked the number of contacts the person had within 10 miles of the city that they felt safe to talk to and/or rely on for help, with *none* being scored as a barrier to success.

Behavioral Health. This section consisted of 12 questions that asked about mental health and substance use. Two questions asked whether the survivor had ever received treatment for mental health concerns, and the number of times they had been hospitalized for those concerns. Having been hospitalized more than once was scored as a barrier. Five alcohol use questions were asked, one on frequency of use adapted from the The Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001); the other four items, from the CAGE Drug Use Screening Tool (Ewing, 1984), focused on severity. We used the same questions to assess drug use, but changed "drinking" to "drug use." Survivors who responded *never* to the first question on frequency were not asked the questions on severity. Responses indicating higher frequency and severity were scored as barriers to success.

Service Needs. This section consisted of 35 questions, adapted from a study on IPV survivors' service experiences and needs (Lyon et al., 2008). These questions were not included in the scoring system, but rather were intended to inform the case management component of SASH, specifically an understanding of survivors' level of need and extent of current formal support. The first question asked survivors to select the five most pressing needs for themselves from a list of 24 areas (e.g., housing, employment, financial help, government benefits, safety, immigration-related issues). The next set of questions asked survivors to select which of the areas they were currently getting help with (e.g., Someone is helping me with transportation—yes/no), which included all 24 of the areas. Survivors were asked to do the same for needs related to their children—that is, to select the three most pressing of nine areas (e.g., child counseling, childcare, custody) and indicate which they were getting help with.

Advocate Referral

This form began with a brief introduction about the SASH project, the purpose of the form, and a description of the SASH definition of success. The form consisted of five Likert-scale questions about the survivor's level of maturity, readiness, employability (if applicable), and likelihood of maintaining the housing voucher (see Table 1 for questions and response options). In addition, each quantitative question was followed by at least one qualitative question asking advocates to elaborate on their rating. At the request of the city PHA, the open-ended responses were collected for research purposes only and were not used in the selection process.

The quantitative questions did not define the concepts of interest; thus, advocates responded based on their own internal definitions. However, for three of the concepts (maturity, employability, and readiness), the follow-up qualitative questions listed a few examples that might have influenced advocates' definitions. For maturity, the qualitative follow-up question asked, "Please explain the rating you assigned for maturity, and if possible, give examples to highlight the rating (e.g., when the client used good coping skills, managed a crisis, worked well with others)." For employability, the qualitative

follow-up question included the following examples: "starting a business, creative forms of income based on client skills, current jobs, untaxed income, teamwork, and work ethic." Finally, the qualitative follow-up question for readiness included the following clarifying questions for respondents: "What makes you think this person is ready for a program like this one? What are their strengths?" We developed these examples based on feedback from the stakeholder meeting.

Application, Scoring, and Selection Process

In August 2017, the DV coalition advertised a 7-day window for survivors and advocates to submit referrals; we received a total of 92 complete referrals from 11 programs. Nearly half (n = 43) came from one DV program—not surprising given that it is the largest DV program in the city, with approximately 30 transitional living units and 100 emergency shelter beds. We reviewed data from all 92 referrals to get a full picture of each survivor and to identify any problematic questions. First, we eliminated the question "When did the abuse occur?" because responses indicated that some survivors thought it was asking when the abuse *started*. Thus, some survivors with ongoing abuse were being categorized as no longer experiencing IPV. Second, we removed several questions that had no variability: alcohol and drug use (all reported *never*), living apart from their abusive partner (all reported *yes*), and living in the city for at least 1 year (all reported *yes*). Finally, among survivors who had at least one child in common with their abusive partner (n = 50), the vast majority (78.0%) did not have formal custody arrangements, which meant that only 11 were asked about access to custody paperwork (only one of whom reported that access would be a challenge).

After reviewing all of the referrals, we applied the following evidence-informed selection process. First, we excluded anyone who reported that it would be unsafe for them to reside within the city limits or whose advocate reported that they were "not at all" or only "a little" likely to succeed in the HCV Program; this resulted in the exclusion of 11 referrals. We then applied the scoring system to the remaining 81 referrals. As detailed in Table 1, the scoring system involved assigning a point value to the questions that assessed for 28 barriers to success (three of which were dropped because of response patterns). Each referral could be assigned a total of 39 points, with a higher number of points indicating greater likelihood of success. The purpose of the scoring system was to determine each referral's *cumulative* barriers to success to ensure that survivors would not be excluded based on the presence of any *one* barrier.

Scores for the 81 referrals ranged from 13 to 32 (M = 21.9, SD = 4.2), indicating that each survivor faced at least a few of the identified barriers (see Table 2 for scores by group). We then applied the SASH definition of success to the distribution of scores and excluded the bottom quartile of applicants (n = 20), whose scores ranged from 13 to 18 points (M = 16.5, SD = 1.6). Although this was a difficult decision, the low scores indicated that applicants faced a substantial number of barriers to using and maintaining a voucher, and that they would be better served in DV residential programs, where they could receive intensive, on-site assistance to help them transition from homelessness to long-term housing (Clark et al., 2019; Sullivan, Bomsta & Hacskaylo, 2019). As discussed previously, the SASH team was only able to offer temporary, light-touch case management (Mbilinyi, 2015). In addition, maintaining a larger queue was deemed unmanageable because of the importance of maintaining contact with all potential applicants and because of SASH's limited resources. We also did not want to impart false hope, and it seemed unlikely that we would need more than 61 survivors to distribute 25 HCVs; we did not want people to be waiting for an HCV when the likelihood of obtaining one seemed very low.

The remaining 61 referrals were placed into a random numerical order by a third party. Randomization seemed to be the fairest approach and important for evaluation purposes; the use of a third party was a mandate from the institutional review board. The first 25 referrals on the randomized list were assigned to the *voucher* group; the other 36 were assigned to the *queue* group. Table 2 details the applicants' characteristics according to group (voucher, queue, and bottom quartile), with an emphasis on factors scored as barriers. The average age of the 81 total applicants

Table 1. Survivors Achieving Safe Housing screening tool questions and scoring.

	Survivor self-referral form
Survivor's age	1. What is your date of birth? • Scoring of age: 18–24 = 0, 25+ = 1
Survivor's citizenship status	1. Are you a citizen of the United States? • Scoring: Citizen by birth or naturalization = 1, Noncitizen = 0
Income amount and source	1. Roughly, what is your monthly income according to the source of income? (Please fill out for all that apply) • Full-time employment, Part time employment, Temporary employment, TANF, Alimony, Child support, SSI, SSDI, Pension, Unemployment, Other, I don't have any income • Scoring of income type: Full-time employment = 3, Part-time employment/SSI/SSDI/Pension = 2, Any other type = 1, no income = 0 • Scoring of income amount: $1,801 or more = 3; $1,171–$1,800 = 2; $536–$1,170 = 1 $535 or less = 0 2. Are there any physical or mental health barriers preventing you from working full or part time? • Scoring: No = 1, Yes = 0 • (If yes), Please explain. _____ • Not scored; used to understand type and severity of barriers 3. Can you pay at least $50 per month toward rent? • Scoring: Yes = 1, No = 0
Credit history and debt	1. Do you consider yourself to have good credit history? • Scoring: Yes = 1, No = 0 2. Do you have any debt? • Scoring: No = 1, Yes = 0 • (If yes) What is the source of that debt? (e.g., student loans, credit cards) and the amount owed: _____ • Not scored; used to understand type and severity of debt
Education	1. What is the highest level of education you have completed? • Scoring: College graduate (associate degree or higher) = 2, High school graduate or some college = 1, Less than high school degree = 0
Family characteristics	1. How many children do you have within the following age groups? Ages 0–1, 1–5, 6–12, 13–17, 18 or older • Scoring for total number of children: 0–3 = 1, 4 or more = 0 • Scoring for child age: • Any children age 0–1: No = 1, Yes = 0 • Any children age 2–5: No = 1, Yes = 0 2. Are you currently pregnant? • Scoring: No = 1, Yes = 0
IPV-related factors	Involvement with abusive partner 1. How long ago did the abuse occur? Ongoing, Within the past 3 months, 3–6 months ago, 6–12 months ago, 1–5 years ago, 5+ years ago • Scoring: We intended to score but ultimately did not; responses indicated that many applicants misunderstood the question. 2. What is your current marital status with your abusive partner? • Scoring: Single/divorced = 2, Separated = 1, Married = 0 3. How many of your children age 0–17 are in common with your abusive partner? • Scoring: None = 1, At least one = 0 4. If you have you established child custody, do you have a copy of the custody paperwork? • Scoring: Yes = 1, No, but I can get it easily = 1, No, and it would be difficult to obtain a copy = 0 Lethality risk Measured with the 20-item Danger Assessment (Campbell et al., 2001). Danger Assessment scores span 0–37 and are broken into four categories: variable danger, increased danger, severe danger, extreme danger. • Scoring: Fewer than 8 = 3, 8–13 = 2, 14–17 = 1, 18+ = 0 Safety-related empowerment Measured with the 13-item Measure of Victim Empowerment Related to Safety (Goodman et al., 2014). Scores range from 13 to65; higher scores indicate higher levels of safety-related empowerment. • Scoring: 42–65 = 3, 21–41 = 2, 0–20 = 1

(*Continued*)

Table 1. (Continued).

	Survivor self-referral form
Housing situation and instability	1. Are you willing to stay in [City] for at least 1 year? ● Scoring: Answering yes was an eligibility requirement. All applicants said yes. 2. Are there any neighborhoods in the city that are NOT safe for you and/or your children? (Please be specific) _____ ● Scoring: No safe neighborhoods in the city = ineligible for SASH 3. Are you willing to live apart from the person who has been abusive to you for at least 1 year? (Yes, No) ● Scoring: Answering yes was an eligibility requirement. All applicants said yes. 4. Are you able to search for housing independently or with little support? ● Scoring: Yes = 1, No/unsure = 0 ● (If yes) Please explain the factors that will support your housing search. _____ ● Not scored but used to better understand facilitators. ● (If no) Please explain the factors that might get in the way of your housing search. _____ ● Scoring: Not scored but used to better understand barriers. Items taken from the 10-item Housing Instability Index (Rollins et al., 2012) In the last 6 months… 1. How many times have you moved? _____ (0–2 times = 1, 3 or more = 0) ____ [Response options for questions 2–9: Yes = 1 and No = 0] 2. Have you had to live somewhere that you did not want to live? 3. Have you had difficulty (or were unable to) pay for your housing? 4. Have you had to borrow money or ask friends/family/others for money to pay your rent/mortgage payment? 5. Have you had trouble with a landlord? 6. Has your landlord threatened to evict you? 7. Have you been served an eviction notice? 8. Have you had trouble getting housing? 9. Do you expect you will be able to stay in your current housing for the next 6 months? ● Scoring: 0–3 = 2, 4–7 = 2, 8–9 = 0
Ties to geographic community and network	1. How many of the people in your life who you consider safe to talk to or rely on for help live within 10 miles of the city? ● Scoring: 1 or more = 1, 0 = 0
Social and tangible support	Items taken from the 12-item Social Support Scale (Block et al., 2000) [Response options: Agree = 1 and Disagree = 0] 1. There is someone I can talk to openly about anything. 2. Someone I know will help me if I am in danger. 3. I have someone to borrow money from in an emergency. ● Scoring: 3 = 2, 2 or 1 = 1, 0 = 0
Behavioral health	Mental health 1. How many times in the past year have you been hospitalized for mental health concerns? __ Scoring: 0–1 = 1, 1+ = 0 Alcohol use Questions included one on frequency of use from the AUDIT (Babor et al., 2001) and four from the CAGE Alcohol Use Screening Tool (Ewing, 1984). ● Scoring: We intended to score but ultimately did not because no one reported high-risk alcohol use. Drug use Questions included one on frequency of use adapted from the AUDIT (Babor et al., 2001) and four from the CAGE Drug Use Screening Tool (Ewing, 1984) ● Scoring: We intended to score but ultimately did not because no one reported drug use.

(*Continued*)

Table 1. (Continued).

	Survivor self-referral form Advocate referral form
Perception of survivor's maturity, housing readiness, employability and success	Response options: None = 1, A little = 2, Average = 3, Above average = 4, Excellent = 5 1. How likely is it that your client will be able to succeed in the HCV Program (i.e., stay housed with the voucher)? 2. Please rate your client's level of maturity. 3. Please rate your client's readiness for living on their own with a housing voucher. 4. Please rate your client's level of employability. ● Scoring: 20 = 3, 18–19 = 2, 16–17 = 1, 15 or fewer = 0

Note. SASH = Survivors Achieving Safe Housing. DV = domestic violence. HCV = Housing Choice Voucher. Higher scores indicate greater likelihood of success. TANF = Temporary Assistance to Needy Families. SSI = Supplemental Security Income. SSDI = Social Security Disability.

Table 2. Survivors Achieving Safe Housing applicant characteristics, by group.

	Voucher (n = 25)	Queue (n = 36)	Bottom quartile (n = 20)	Total (n = 81)
SASH score (mean, *SD*)	23.0 (3.2)	24.1 (3.2)	16.5 (1.6)	21.9 (4.2)
Age (mean, *SD*)	37.9 (10.2)	36.4 (9.4)	32.4 (9.4)	35.9 (9.7)
U.S. citizen (vs. no), %	64.0	77.8	85.0	70.37
Race/ethnicity, %				
Hispanic/Latinx	40.0	33.3	45.0	38.3
African American/Black	24.0	19.4	15.0	19.8
White	24.0	22.2	25.0	23.5
Asian/Native American/multiracial	12.0	25.9	15.0	18.5
Female (vs. male), %	96.0	100.0	100.0	98.8
Level of education, %				
Less than high school degree	28.0	22.2	40.0	28.4
High school graduate/GED	32.0	13.9	15.0	19.8
Some college/associate degree/graduate	40	63.8	45.0	51.8
Monthly income (mean, *SD*)	587.5 (558.4)	721.1 (739.2)	134.3 (232.5)	535.0 (634.0)
Can pay $50 per month for rent (vs. no), %	100.0	97.2	75.0	92.6
Health barriers to work (vs. no), %[a]	28.0	5.6	30.0	18.5
Has debt (vs. no), %	56.0	50.0	70.0	56.8
Pregnant (vs. no), %	8.0	5.6	15.0	8.6
Total number of children (mean, *SD*)	2.3 (1.4)	2.9 (1.8)	3.4 (2.3)	2.7 (1.9)
Has children < 18 (vs. no), %	72.0	83.3	90.0	81.5
Child with abusive partner, %	(n = 18)	(n = 31)	(n = 18)	(n = 67)
At least one (vs. none)	66.7	74.2	83.4	74.6
Danger assessment score (mean, *SD*)[b]	19.5 (9.2)	18.9 (6.3)	17.7 (6.2)	18.8 (7.2)
Safety-related empowerment (mean, *SD*)[c]	51.9 (7.9)	51.8 (7.1)	50.1 (9.2)	51.5 (7.9)
Current living situation, %				
Domestic violence shelter	88.0	77.8	100.0	86.4
Other	12.0	22.3	0.0	12.3
Housing instability index (mean, *SD*)[d]	4.4 (2.0)	3.8 (1.9)	5.5 (2.3)	4.4 (2.1)
Need housing search support, %				
Yes	56.0	69.5	65.0	64.2
No/unsure	44.0	30.5	35.0	35.8
Social support score (mean, *SD*)[e]	1.4 (0.58)	1.6 (0.60)	1.7 (1.1)	2.2 (0.9)
Safe supports within 10 miles of the city (mean, *SD*)[a]	0.96 (0.84)	2.2 (2.2)	1.3 (1.4)	1.6 (1.8)

Note. SD = standard deviation.
[a]Voucher and queue groups differed significantly at p <.05.
[b]Scores range from 0 to 37; higher scores indicate an increased level of lethality risk.
[c]Scores range from 0 to 65; higher scores indicate an increased level of safety-related empowerment.
[d]Within the past 6 months, only items 1–9 (of 10) are included; higher scores indicate increased housing instability.
[e]Only 3 (of 12) items are included; higher scores indicate increased social support.

was 35.9 (*SD* = 9.7) and the majority were women (98.0%) of color: Latina (38.3%), Black (19.8%) and other (Native American, Asian, or biracial; 18.5%). Socioeconomic status was generally low and

almost all were living in a DV shelter at the time of the application. Overall, the group of applicants was considerably marginalized and faced multiple sources of structural oppression.

The voucher and queue groups appeared to be similar across the majority of barriers, which is not surprising given the use of random assignment. We conducted chi-squared and *t*-tests to test for statistical differences, and two variables were found to be significant. Compared with the queue, a larger percentage of the voucher group reported health barriers to work (X^2 [1, n = 61] = 5.9, p =.02) and fewer safe supports within a 10-mile radius of the city (t[59] = − 2.7, p = .01). As described in the next section, we had to draw heavily from the queue because many survivors in the voucher group either did not pursue a voucher or did not successfully lease up. It is possible that the high percentage of health barriers and fewer nearby supports played a role. Finally, by the very nature of the scoring system, those in the bottom quartile had more vulnerabilities than the other two groups did. For example, they had far fewer financial resources, larger family sizes, and higher levels of housing instability.

Allocation and Leasing Up

The MSW interns contacted all referrals and their designated advocate to inform them that they had been placed on the voucher list, placed in the queue, or excluded—and to discuss next steps. Interns provided survivors placed on the voucher list with the PHA HCV application and a list of all documents that would need to be submitted with the application. The client and their DV advocate then met with the intern to review the application and get help with completing it if needed. The interns submitted the completed applications and all supporting documents to the PHA on the clients' behalf. Because the city PHA designated this a Special Project, a representative from the Housing Department met with the interns to review each application.

As of September 2019 (when oversight of SASH was transferred to the DV coalition), 21 survivors had completed the application process (submitted an application, attended a briefing, and searched for housing with an HCV) and successfully leased up with a voucher. Of those, 13 were from the original voucher group and eight were moved up from the queue. Of the 11 survivors from the original voucher group who did not successfully lease up, six did not start the application process because of the following complications: could not be located (n = 1), became unresponsive (n = 2), decided against living within the city limits (n = 1), was housed through another program (n = 1), and was worried about an expired work visa (n = 1). The other five completed the application process but did not lease up: one was not eligible per PHA eligibility criteria, two could not afford the proration rate they were given that was based on their immigration status, and two were given a voucher but could not find suitable housing before the voucher expired.

Of the 21 survivors who leased up, two were evicted and subsequently lost the voucher, and one phased out of the program because of an increase in income. Two voucher holders decided to take their voucher to a different city after reaching the 1-year mark. An additional two survivors have received the voucher and are in the housing search process, and two applications are pending with the PHA. Overall, 22 survivors were moved from the queue to the voucher list; 14 survivors were unreachable, had already found alternative housing, or no longer wanted to apply for the HCV.

Next Steps and Lessons Learned

The SASH project provided a unique opportunity to think creatively about how best to allocate a scarce housing resource to homeless and unstably housed IPV survivors. Despite being deeply rooted in both empirical and "community-defined" evidence (Martinez, Callejas, & Hernandez, 2010, p. 11), the project was fraught with a variety of challenges. Although these challenges were frustrating, they provide valuable lessons for practice and policy.

The Utility and Feasibility of the Screening Tool

The implementation of the screening tool highlighted growth areas. First, we included questions about alcohol and drug use because the prior research (Bassuk et al., 1996; Mbilinyi, 2015; Mbilinyi & Kreiter, 2013; Phinney et al., 2007) and DV practitioners we spoke with identified substance abuse as a barrier to housing success. These questions were not helpful, however, because not one survivor reported use of either substance. It is possible that this was true for this particular group of survivors, especially given that some DV shelters screen out people who use such substances (Nnawulezi, Godsay, Sullivan, Marcus, & Hacskaylo, 2018). However, it is also possible that at least some survivors were hesitant to answer honestly out of fear that they would not be eligible for a voucher or would face repercussions from the DV program where they were receiving services. According to the CoC coordinators in the Fritsch et al. (2017) study, building rapport is an important aspect of facilitating honest disclosure during the screening and assessment process. In this case, however, survivors were encouraged to fill out their part of the form either on their own or with their DV advocate. In the case of the latter, the preexisting rapport and relationship might have actually been a barrier to honesty, rather than a facilitator. Additional thinking is needed on whether to even assess for alcohol and drug use among this population, and if so, how to do so effectively and sensitively.

Second, the tool was long and took time to complete. One way to increase feasibility and utility would be to use a shorter version of the 20-item Danger Assessment (DA), such as the DA-5 (Messing, Campbell, & Snider, 2017). Using the DA-5 would reduce client burden, make it easier to score, and open up its use to practitioners outside the DV community (practitioners must be trained to use the 20-item DA, but not to use the DA-5). When the SASH researchers met with the local DV community to report on the screening tool and process, we suggested that they use the DA-5 going forward. They preferred, however, to become certified to use the full 20-item DA and to engage in risk-informed safety planning (Messing, 2019). Although it is feasible for DV programs to engage in these activities, the CoCs in charge of CE often do not have the resources or person power to engage in such specialized screening and intervention (Kofman & Marcus, 2018). It is important for DV programs that collaborate with CoCs on CE to understand these limitations when suggesting which IPV-related screening tools to adopt.

Third, the use of the DV advocate form presents challenges and possible ethical dilemmas that should be considered. As a reminder, this form was requested by the DV community and served as an additional data point in determining survivor housing success. The idea was that DV advocates gain valuable insight into survivors' needs and capabilities through their work with them, and that this information might not be conveyed through self-reporting of more objective variables such as age and income. However, this approach creates a situation in which DV advocates have considerable gatekeeping power, especially given that their referral form was a required part of the screening application. Thus, if a survivor did not have an advocate willing to complete the form on their behalf, they would not be eligible for SASH. In addition, the questions we used elicited inherently subjective responses. It is possible that advocates varied in how they defined the concepts of interest, such that the same survivor would have been scored differently by different advocates. It is also possible that advocates were influenced by their own unconscious prejudices and biases, for example giving difficult survivors lower scores, regardless of whether that has any bearing on their success with an HCV. In hindsight, some of these problems might have been mitigated by operationalizing concepts more clearly. Additional thought is needed on whether the form should be required for eligibility.

Finally, it is important to note that we did not gather survivor input when developing the SASH tool. We relied instead on research evidence, contextual evidence, and experiential evidence from practitioners (Puddy & Wilkins, 2011). Although some of the researchers and practitioners involved in the SASH project are IPV survivors, that should not be a substitute for gathering feedback from survivors who are currently experiencing housing instability and system involvement. Going forward, efforts to improve the SASH screening tool and process should include experiential evidence from

marginalized survivors, especially regarding how to handle some of the challenges just described (e.g., whether to include questions on substance use and require the advocate form).

The Moral Dilemma of Allocation

We strove to follow the ethical principles of resource distribution by balancing need and success for those who applied to SASH (Persad et al., 2009), while also considering the importance of success for the city, the DV programs, and future clients. In addition, we were operating in a context of limited financial and staff resources. Thus, we developed an allocation process that prioritized applicants with fewer barriers to success (where success is defined as getting an HCV, finding housing with it, and maintaining it). Even with this approach, the applicants in the voucher and queue groups were quite disadvantaged and needed considerable financial assistance to lease up. Through flexible funding provided by the DV coalition, survivors received financial assistance to cover security deposits, initial rent payments, utilities, houseware needs, and application fees. It is likely that at least some of these survivors would not have been able to lease up without this assistance. As others have noted, an HCV is not necessarily a guaranteed path to housing stability without additional support (Gubits et al., 2013). In addition, we were unable to contact some people in the queue when it was time to move them into the voucher group—despite having multiple ways to contact not only them, but also a safe personal contact and their advocate. Essentially, the wait list created unexpected challenges to balancing need and success and begs the question of whether an alternative system is needed.

Despite the challenges that the voucher and queue groups faced, the reality is that we excluded a particularly vulnerable group of survivors in need of some type of stable housing, which was by no means an easy decision. Balancing need and success might be fair, but that does not mean it feels right. In the homelessness field, there has been a concerted effort to prioritize the neediest, meaning those who are chronically homeless and at highest risk for death, and triage them into permanent supportive housing programs (Brown et al., 2018). However, the majority of IPV survivors do not fit these criteria, nor would those services be a good fit. DV-specific permanent supportive housing programs are a much more promising option for survivors with complex needs; however, only a few exist in the United States (Botein & Hetling, 2016). Likewise, DV-specific, 2-year transitional housing programs are becoming increasingly scarce as a result of pressure from HUD to substantially reduce survivors' stay lengths and shift toward more of a rapid-rehousing approach (Berman, 2016). Ultimately, until research can better predict who will succeed in which housing option, or what factors will ensure that everyone succeeds with an HCV, there is a need for housing options that can provide sustained, intensive support to survivors facing multiple barriers.

The Challenge of Siloed Systems and Policies

Because SASH involved collaboration from stakeholders in both the DV community and the homelessness community, the project underscored how these two systems are still relatively siloed from one another. A primary challenge we encountered was insufficient understanding of the Violence Against Women Act (VAWA) among housing staff. For example, when we first started to connect survivors to the PHA, they were told that they needed to do one of the following to prove that their abusive partner would not live in the unit with them: provide a letter from their abusive partner acknowledging the separation, apply for formal separation, or get a restraining order. In addition to posing safety risks, these requirements violated protections outlined in VAWA. Several members of the SASH team had to get involved to ensure that the PHA would accept a VAWA self-certification form from survivors instead. A recent needs assessment on barriers to coordination between DV and housing service providers found that both sides needed more education and training to widen their expertise about the intersection of IPV and homelessness (Kofman & Marcus, 2017).

Another challenge involved conflicting policies. One survivor was in the process of applying for a U-Visa, a VAWA provision that provides a pathway for undocumented survivors to become citizens. Although she had the money needed for the prorated rent, she could not disclose her income to the PHA because she was working without a legal work status and that could have jeopardized her U-Visa status. Ultimately she decided to withdraw her HCV application. Several other survivors who were undocumented also turned down the HCV because they could not afford the proration rate. Essentially, because of discriminatory policies and practices, the HCV Program does not appear to be a realistic housing option for undocumented IPV survivors whose children are U.S. citizens.

Conclusion

The SASH project was conducted with vulnerable IPV survivors who faced multiple barriers to success, including danger from an abusive partner. In the context of limited resources, the local community (city council, DV advocates, PHA, researchers) came together to provide HCVs to a small subset of families. We developed a screening tool and allocation process that were evidence-based, considered context and program requirements, and were acceptable to community stakeholders. The lessons learned along the way point to the need for additional research, provider education and training, and programs that can serve IPV survivors with complex needs.

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No potential conflict of interest was reported by the authors.

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