

“I Felt Better When I Moved Into My Own Place”: Needs and Experiences of Intimate Partner Violence Survivors in Rapid Rehousing

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Abstract

Accessing stable housing is a basic need for intimate partner violence (IPV) survivors, and rapid rehousing programs are a critical way to address homelessness. However, little is known about survivor experiences, needs, and outcomes in rapid rehousing services within IPV agencies. This study uses an exploratory approach to understand the needs and experiences of 31 survivors using vouchers facilitated by an IPV program in the U.S. Southwest. Thematic analysis of structured interviews resulted in four summary themes: getting to housing, managing multiple needs, accessing support, and facing barriers. Practice and evaluation implications are discussed.

Keywords

domestic violence, homelessness, mental health, safety

Introduction

Intimate partner violence (IPV) and housing instability are widespread and intertwined public health crises. In the United States, 1 in 3 women and 1 in 10 men experience IPV, including physical violence, sexual violence, and/or stalking, with low-income

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women of color at the highest risk (Smith et al., 2018) and transgender individuals are 2.2 times more likely to experience physical IPV than cisgender individuals (Peitzmeier et al., 2020). The mental and physical health impacts of IPV are widespread and range from mild health challenges to severe mental and physical illness, injury, and death (Black et al., 2011). IPV has economic impacts across the lifespan, resulting in lost earnings, career disruptions, and economic and housing instability (Chan et al., 2021). Economic consequences of IPV include housing disruptions, such as late mortgage and/or rent payments, multiple moves, and loss of housing (Pavao et al., 2007; Rollins et al., 2012). IPV is the main contributor to family homelessness, with 25% to 40% of women and families homeless as a result (Stringer, 2019). Further, homelessness and housing instability have been linked to poor mental health and increased substance use (Gilroy et al., 2016; Rivera et al., 2015). To address these dual crises, community-based IPV agencies offer emergency shelters, transitional units, and vouchers to support the differing housing needs of survivors (Clark et al., 2019). IPV agencies frequently partner with local homelessness services to provide rapid rehousing vouchers scattered across the community, which provide longer-term housing to survivors (Burt et al., 2016; Mbilinyi, 2015). Nationally, 43% of IPV programs offer housing programs that extend beyond shelter, including rapid rehousing (National Network to End Domestic Violence [NNEDV], 2021) and the Department of Housing and Urban Development (HUD) recently allocated nearly \$120 million specifically for rapid rehousing vouchers for IPV survivors (HUD, 2020). Despite the widespread use of rapid rehousing vouchers by IPV programs, there is a lack of research investigating the needs and services experiences of survivors using these programs. Further, evaluation of rapid rehousing outcomes in IPV programs is limited, and the impact of these services is largely unknown. To begin to address this significant knowledge gap, an exploratory mixed-methods approach was used to understand rapid rehousing services within IPV agencies, using a single-site program evaluation of 31 current and former residents using vouchers facilitated by a community-based interpersonal violence program. Thematic analysis was used to gain insight into rapid rehousing resident needs and experiences, contributing to the nascent literature on IPV program housing voucher impacts.

IPV and Housing Instability

Housing has been identified as the most requested service, and most frequently unmet need, of IPV survivors (NNEDV, 2021; Wood et al., 2019). People who experience IPV are more likely to experience *housing instability*, defined as an inability to maintain housing or lacking a fixed, regular, and adequate nighttime residence (Baker et al., 2009; National Alliance to End Homelessness [NAEH], 2012). In many cases, exiting a violent relationship may require a survivor to forgo their housing and risk homelessness (Baker et al., 2009). In recent studies of IPV survivors, almost all participants reported some amount of housing instability (Gilroy et al., 2016; Rollins et al., 2012). Survivors are more likely to experience disruptions in their housing due to abusive partner tactics of economic abuse that create housing barriers, such as credit

sabotage and debt accumulation (O'Campo et al., 2016). Violence survivors may be managing psychological and physical consequences of IPV that impact their ability to work and maintain the income needed to support stable housing (Adams et al., 2013). Those in multiple marginalized positions, face a wide range of system and structural barriers including landlord discrimination, a general lack of affordable housing, lack of income, poor credit, or criminal records (often a direct result of IPV experienced), and barriers navigating the social services system (Clough et al., 2014; Holliday et al., 2021).

A goal of IPV-focused agencies is to help survivors address housing instability (Jategaonkar & Ponic, 2007; Sullivan, 2018). IPV agencies typically offer one or more of three types of housing: emergency shelter, transitional housing, and vouchers such as rapid rehousing (Clark et al., 2019; Klein et al., 2021). Survivors use emergency shelters, which are time limited to 30 to 90 days, to address immediate homelessness and safety concerns (Sullivan & Virden, 2017). On their annual national survey, the NNEDV estimated that in one single day in 2020, IPV agencies provided emergency shelter to 19,000 survivors. Due to high demand, IPV shelters are often at their maximum occupancy leading to frequent service denial due to lack of space. NNEDV estimates in a single day, over 6,000 more requested either shelter or other housing but were unable to obtain it due to lack of space (NNEDV, 2021). While a shelter may provide immediate safety, the short-term nature, communal living with multiple families in active crisis, and heavy emphasis on rules limit program effectiveness to address long-term housing needs (Gregory et al., 2021), leading many IPV programs to offer longer-term housing solutions, such as transitional housing and voucher programs. Transitional housing is frequently offered via units onsite at the IPV agency, is time limited in nature, and often involves a move from one housing unit to another at the program end (Clark et al., 2019). Housing vouchers, such as rapid rehousing programs, are consistently used by IPV agencies to offer survivors a way to obtain a housing unit (often an apartment) in the community at the location of their choice, with the opportunity to transition in place in that location at the end of the assistance period.

Rapid Rehousing Programs

Rapid rehousing programs aim to place people in permanent housing as quickly as possible (NAEH, 2014) by operating on the assumption that addressing housing stability *first* allows people to then focus on longer-term goals such as economic stability and health needs. As rapid rehousing programs expanded, HUD began distributing resources through its Homeless Assistance Program (Burt et al., 2016; NAEH, 2014; Walton et al., 2018). IPV survivors receiving assistance from IPV agencies and other homeless providers are frequently served by rapid rehousing programs (Burt et al., 2016). Vouchers are most often distributed by communities' Continuum of Care through a coordinated assessment process focused on individuals' social, health, economic, and trauma experiences (McCauley et al., 2020). This screening process relies on tools such as the Vulnerability Index-Service Prioritization Decisions Assistance

Tool (VI-SPDAT), which often leads to a prioritization of those who have experienced IPV and other traumas (Thomas et al., 2020; Wilkey et al., 2019). When a voucher is available, programs provide material and economic support to overcome the initial financial burden of obtaining housing (e.g., providing first and last months' rent payments, deposits for utilities, and moving costs) and help to locate housing. Financial housing support is time limited, ranging typically from 3 to 24 months, sometimes with a step-down component so that participants take over full housing payments gradually (Cunningham et al., 2015). At the end of the program period, the goal is for participants to be able to stay in the housing they selected, taking over full responsibility for monthly payments. This way, the goal is to maintain the social connections and informal support networks developed within their immediate neighborhood or housing context as well as access to key amenities such as public transportation or children's schools (Holliday et al., 2021).

Several recent projects have assessed rapid rehousing in general homeless populations. Across three demonstration projects, which all included families experiencing homelessness and IPV, at least 70% of program participants were able to successfully engage with permanent housing by the end of their rapid rehousing period (Finkel et al., 2016; Focus Strategies, 2012; U.S. HUD, 2016). A study of voucher use in veteran families found that after 1 and 2 years post rapid rehousing vouchers, only 9.4% and 15.5%, respectively, experienced another episode of homelessness (Byrne et al., 2016). Further, data demonstrate that rapid rehousing participants were more likely to be in their own homes with a lease several months after random assignment (Gubits et al., 2016) and experience a modest increase in income 12 months post program (Finkel et al., 2016). Other studies have shown mixed results with stable housing outcomes in rapid rehousing, varying widely depending on community factors, such as housing affordability and availability, and program design (Keefe & Hahn, 2021; Walton et al., 2018).

IPV Agencies and Rapid Rehousing. Agencies focused on IPV typically partner with area homelessness coordinated entry efforts to provide rapid rehousing vouchers and services to their clients (Thomas et al., 2020). Programs may offer rapid rehousing vouchers to clients who have less intensive needs than those in transitional housing or shelter (Clark et al., 2019). IPV programs are unique to other rapid rehousing programs because of the supportive service model used focused on the needs of survivors. Aligned with a trauma-informed and empowerment-based approach, IPV case management (or advocacy) services strive to be survivor-driven, a model of services that are person-lead and focus on expressed needs rather than service provider expectation (Davies & Lyon, 2014; Goodman et al., 2016; Wood et al., 2020). In line with policy codified by the Family Violence Prevention Services Act, IPV housing programs operate with a voluntary service model, in which programs cannot make receiving housing contingent on attending any other ancillary service (Nnawulezi et al., 2018). In this model, survivors are viewed as the experts in their own situations, being given the choice to engage with each service based on their own assessment of their needs and desires (Nnawulezi et al., 2018; Wood et al., 2020). There is

emerging evidence that a voluntary service model for IPV survivors in rapid rehousing focused on advocacy, flexible engagement, trauma-informed practices, and community engagement can lead to greater wellbeing, safety, and quality of life (Nnawulezi et al., 2018; Sullivan & Olsen, 2016). Very few evaluations have been conducted of rapid rehousing programs operated by IPV programs, but initial evidence suggests these programs are successful in helping survivors retain their housing up to 18 to 24 months after program entrance, as well as enhance long-term economic security and safety (Mbilinyi, 2015; Sullivan et al., 2019).

Survivors routinely engage with IPV-focused agencies to use rapid rehousing vouchers to provide longer-term housing after violence, but their needs, experiences, and outcomes in these programs are largely unknown. To expand the knowledge base related to IPV survivors in rapid rehousing, including services provision, this study focuses on structured interviews with current and former IPV rapid rehousing residents in a large suburban area in a Southwest state in the United States. Given the nascent literature on IPV survivor outcomes in rapid rehousing, we used qualitative and quantitative approaches with people using housing vouchers facilitated by a single IPV agency. The research questions guiding this study were: (1) What are the needs of survivors in IPV agency-facilitated rapid rehousing? and (2) What are the service experiences of IPV survivors in rapid rehousing? Study aims were designed with the goal of gaining understanding to develop further evaluative approaches.

Methods

Data were collected from a convenience sample of 31 current and former rapid rehousing recipients who were clients at an IPV agency serving a large suburban area adjacent to a major U.S. city in the Southwest. Data were collected as part of a two-year process and outcomes program evaluation of residential services, conducted from November 2018 to October 2020, for a large multiservice violence agency serving survivors of IPV and sexual assault. The evaluation team had extensive practice and evaluation experience in IPV community-based agencies. The evaluation scope, plan, research questions, and interview questions were developed collaboratively with staff from the IPV agency's housing and shelter services department. Feedback from survivor participants was requested after the first round of interviews which led to some modifications of the interview questions. The IPV agency's rapid rehousing voucher program provides rental assistance and voluntary supportive services (e.g., case management and mental health services) for survivors for an average of 12 months. A mixed-methods approach to data collection was employed to address the research questions. Current or former rapid rehousing program participants were eligible if they were (1) at least 18 years of age and (2) the head of their household. Rapid rehousing residents were recruited to participate in structured interviews, which included a mix of open-ended questions and previously validated scales, and which were conducted in person or via phone with members of the study team. Promotion and recruitment for the study were conducted in collaboration with the staff from the IPV agency staff, via posted printed fliers, promotional emails sent to clients, word of mouth, and

through a secure online referral survey completed by IPV agency staff after receiving consent from rapid rehousing clients. The study was reviewed by the Institutional Review Board of the first author's institution prior to data collection and was deemed to be a quality assurance project due to the use of a single site. The study team used informed consent procedures and forms, strict confidentiality standards, and participant distress protocols aligned with Institutional Review Board standards and best practices in IPV and sexual assault research. All interviewers had experience working with IPV and sexual assault survivors. Participants identified the safest method of contacting them during the study for use by the team.

Measures and Interview Questions

Data were collected in English and Spanish. Participants were asked both scaled and demographics questions with and without answer options, and open-ended prompts throughout the interview. Established measures and open-ended questions were used in the structured interview. Measures were used and modified from prior evaluations of IPV-related housing conducted by the study team and established in the literature.

Participant Demographics. Demographics included age, race, ethnicity, language, gender identity, children in the home, and employment/education status. Demographic questions had set answers the interviewer could choose from; however, the questions were asked without giving the answer choices, and write-in options were available.

Experiences of Violence/Abuse. Questions to understand how participants' experiences with violence had changed since starting the rapid rehousing program included "Since you started receiving (IPV agency housing) services, has the (physical abuse, sexual abuse, stalking), against you...?" with answer choices of "increased, decreased, no change, never experienced."

Depression. Symptomology was measured using the Patient Health Questionnaire-9, which has been validated in a wide range of populations and has preestablished cutoff scores for mild, moderate, and severe depression symptomology (Kroenke et al., 2001). This scale asks about the number of days the participant has experienced different depressive symptoms in the last two weeks (e.g., trouble concentrating or lack of energy) (Kroenke et al., 2001).

Posttraumatic Stress Disorder. Experiences of posttraumatic stress disorder (PTSD) symptoms were assessed using the brief PTSD inventory Primary Care PTSD Screen (Prins et al., 2015). It captures symptomology in the last month (e.g., nightmares about the events). Participants screened as likely having PTSD based on the conservative threshold of four reported symptoms established in the literature (Prins et al., 2015).

Perception of Case Manager. Participants were asked a series of questions about their primary caseworker that they worked with at the IPV agency while in a rapid rehousing program. Questions to assess the relationship with the case manager came from the Community Advocacy Project (Sullivan & Allen, n.d.). Participants were given a series of statements of “To what extent do you feel like your advocate/case manager: ‘Cared about you, supported you, and knew about community resources you might need’ with a four-point scale.” Participants were also asked a question about overall program satisfaction.

Open-Ended Question Prompts. Several open-ended questions throughout the protocol were asked to assess participant needs and experience in rapid rehousing. Questions included “What is the physical environment at your apartment like?”, “In your own words, what has staff at (IPV Agency) done for and with you to help you address any of these (mental health or physical health) issues?”, “What additional concerns do you have regarding your former/current partner who used violence and safety?”, and “What would have improved your interactions *with staff*?” Participants were also asked open-ended questions about needs met and unmet in rapid rehousing.

Data Analysis

Thematic analysis methods were used for qualitative interview data (Braun & Clarke, 2006). The thematic analysis involves a process of data familiarization, generation of initial codes, search and reviewing themes, defining and naming themes, and summary of results (Braun & Clarke, 2006). Data familiarization was used to develop themes around rapid rehousing residents’ needs and service experiences. Three members of the research team reviewed transcripts, notes, sound files, and quantitative measures, and then met to discuss themes, concepts, and codes for data analysis, which began the creation of a codebook. Data were then coded via Atlas.ti. Initial coding related to themes in the data and including “experiences in services,” “health and mental health,” and “housing.” Team members wrote memos and met regularly to discuss the coding process, resolve questions, and review discrepancies in the use of codes. Themes were developed by two team members in the second phase of coding, organizing codes into higher-level themes to understand rapid rehousing participant needs and experiences. Resultant themes were reviewed and finalized through verification across the data set and are summarized by research questions and topics below. Quantitative survey data were analyzed via descriptive statistics, including frequencies and measures of central tendency, to assess the frequency or severity of reported barriers and experiences.

Participants

All rapid rehousing participants identified as female. See Table 1 for demographic information. Participant data is provided below with study-assigned numbers. Demographic information, such as age, race/ethnicity, and language, is not included when describing individual quotes in order to maintain further confidentiality of participants.

Results

Structured interviews with 22 current and 9 former rapid rehousing residents were conducted in 2019 and 2020 from a single IPV agency. The rapid rehousing program provides IPV survivors with a housing voucher that was partially subsidized by the program depending on their income for an average of 12 months. Eligibility and access to rapid rehousing were jointly managed by the county IPV program and homelessness coalitions. Thematic analysis of interview data resulted in four major themes guiding rapid rehousing residents in IPV programs needs and experiences: the experience of getting to housing; managing resource, health, and safety needs while at rapid rehousing; accessing services to meet needs; and barriers that impeded goals.

Getting to Housing: “Getting Me out of a Situation That I Couldn’t get Myself out”

Nearly all participants lived in the agency’s IPV emergency shelter before entering rapid rehousing. In a shelter, participants navigated the complexities of communal living with families that had a range of trauma experiences. One participant described life in a shelter and the transition to rapid rehousing:

Table 1. Participant Demographics.

Rapid rehousing residents	(N = 31)
Race/ethnicity	
African American/Black (non-Hispanic)	8
Hispanic/Latino	14
White/Anglo American	5
Other/multiracial	4
Age	
Range	27–62
Mean	40.61
Preferred language	
English	22
Spanish	9
Attending school	
Yes	8
No	23
Employment status	
Employed	10
Not employed looking for work, work irregularly, waiting for work permission	10
Not employed not looking, disabled, caring for loved one at home	11
Children: do you have children?	
Yes	27
No	4

...it (shelter) was really loud. It was a lotta families. Even if you had your own room because you had—I think it was four people to a room. If you had your family in the room because me and my children had our own room because it was enough people for that. It was super loud in the hallways. You can hear moms or kids or whatever. You could hear that all the time or staff screaming or whatever, and here you don't hear—you hear people outside or the lawn mowing or whatever. It doesn't feel like—it's a calming feeling instead of—I don't know. I felt trapped. I can't explain it to you. I don't even know how to explain it. (P28)

Other participants described a shelter as “a culture shock,” and “horribly” run with “poorly trained” staff. Some participants viewed shelter as a positive experience, linking them with resources and providing safety from abusive partners. One participant spoke of shelter, “it was the sanctuary I needed at the time.” For the vast majority of participants, exiting the shelter for permanent housing was the primary goal.

Housing barriers kept participants from being able to exit the shelter. The most common housing barriers for study participants were credit history challenges, not having the money to afford rent or a deposit, employment, and transportation. The agency offered rapid rehousing vouchers to qualifying¹ participants to address housing instability and expedite shelter exit. Wait times for rapid rehousing units varied greatly among participants based on the agency availability, with an average shelter stay between two weeks and three months before getting a rapid rehousing unit. One participant who moved quickly from the shelter to a rapid rehousing unit noted more time in the shelter might have been helpful to her getting resources and information.

I was fully expecting to stay a minimum of three months (at shelter), and then they had this emergency money come in that they had left over, so I only ended up staying two and a half weeks, which I think was maybe detrimental to me. I might have been better off had I stayed a little longer. (P2)

When a voucher is available, participants were able to look for housing in a location of their choice, but a unit was not always available in a preferred area. For several participants, this meant relocating to parts of the county or even the state where they could be away from their abusive partner, but also without their support networks, and living in neighborhoods that had high rates of community violence. Hurdles in finding a unit often meant that participants had to compromise on quality and/or location. Housing quality in the rapid rehousing unit varied based on availability, location, and housing barriers from the participants. One participant stated her apartment location was “very low-income” and another shared that the “apartment was smelling really bad and in bad shape and not healthy for my babies.” Condition complaints about units included bugs and rodents, lack of working appliances, and poor upkeep.

The IPV agency helped participants overcome housing barriers to get a unit in rapid rehousing, such as paying back debt, civil legal help to address evictions and lease violations, and to persuading property owners to rent to their clients. A participant explained:

Well, I had the broken lease from tryin' to escape him when we went to the hotel or whatever. The apartment community, they didn't uphold the laws to lettin' me out of my lease. They gave me a lot of trouble. They (IPV agency) put up an extra security deposit in order to help me get moved into the apartments that we live in now. (P5)

Another participant shared how the agency brokered its reputation to help clients “they (IPV agency) do partner with a lot of apartments that will pardon you, forgiveness, so to speak, because of the fact that you were a client at (IPV agency).” Another expressed that because of her previous eviction, she was happy to get a unit at all, regardless of condition.

I'm satisfied, but I don't mess with nobody. Whatever they do, they do. I'm satisfied, but I don't—my situations and all the stuff I've been through, I don't communicate with people. I mean, if I see you, I'll speak to you, but I don't just hang out. I don't do all that. Yeah, because when you have an eviction on your background, it's a lot of—you can't get into a lot of places. That's the only place that I can get into. P12

Despite condition issues, virtually all participants noted personal and environmental improvements when they moved from shelter into their rapid rehousing unit. One participant noted, “Now that we have our own space-it is a lot calmer.” Another participant shared,

Then coming here (Rapid Re-housing apartment) was like a breath of fresh air, like, “Thank God we don't have to—” I would tell my daughter, “Do you hear that? It's so quiet.” You don't have to hear all that noise of the kids screaming or crying or parents screaming at their kids or whatever. I guess it was a breath of fresh—it's just that I know what it's like to have a better place because we had a better place. This was a stepping stone for me, and I was grateful to have it. It's just that I'm ready for my new life. (P18)

For almost all participants, moving from communal shelter conditions to their own apartment had immediate positive impacts on their lives. Participants indicated advocacy and support provided by the IPV agency were impactful in assisting with financial barriers and other challenges to accessing housing.

Managing Multiple Needs in Rapid Rehousing: “I Still Get Scared All the Time”

When moving into rapid rehousing, participants had pressing and intertwined health, safety, and economic needs that were priorities. The interrelated nature meant that participants had difficulties untangling connected needs to take direct actions. Safety and health needs created financial barriers, which worsened health and safety concerns. For one participant, her chronic medical condition made it difficult to obtain higher-wage work.

They diagnosed me as chronic pain. I can't stand. I can't stand long at all. The home healthcare jobs I get, the people can go to the restroom on their own. I clean up, wash

dishes, and I sit down. I wash their clothes, I sit down and fold them. That's the kind of jobs I've been getting. (P12)

Many survivors moved into rapid rehousing apartments without needed material items and with past debt. For participants, addressing furniture and utility needs were both economic and health issues. One resident described the health impacts of a lack of household items, such as a bed.

Only reason why it's even mattering now is because I have been sleepin'— I had a mattress. It was on the floor, but it was okay 'cause it's a small space in here anyway, but when I recently messed my leg up, I had been swellin' a lot because I wasn't able to elevate it. I called them to see if they could help me with that bed because they already was supposed to deliver me one anyway, and I kinda got a promise that they would look into it, and nobody's even just gotten back with me yet. I contacted people at the thrift shop and at the (IPV agency), and it's like they just lettin' me be without that, it's not like I'm just a regular client that's just wantin' a bed. I really need it for medical purposes. (P14)

Getting and keeping employment—especially in the face of safety concerns from IPV—created additional stress for participants for whom getting a job was the solution to the prevention of homelessness after the program concluded.

I just remembered one: finding a job. That was so hard. That was so hard, and they kept stressing, “You need to get a job. You need to get a job,” but that was really hard for me. They just kept saying, “Just get any job.” I'm like, “They have to want to hire you, hello. I'll go on interviews.” Because I hadn't worked in so long and because I had gaps on my resume, they were hesitant to hire me. Maybe they thought, maybe she just doesn't want to listen. None of that was my issue. It was because I hadn't worked in so long so those were some of my issues. That was it: the job thing and them telling me, stressing me, “You need to get a job. You need to get a job.” We got it. We got it, but people have to hire you. Those were hard for me when I was there. Maybe that'll help. (P18)

COVID-19 created further issues getting and keeping a job, with participants noting they had lost employment or had their hours reduced in the first months of the pandemic.

Mental Health Needs: “Anxiety is off the Charts”

Health, including mental health needs, was significant for this sample. Participants were struggling with chronic pain, diabetes, cancer, high blood pressure, depression, anxiety, and PTSD. Over 53% of participants screened positive for moderate to severe depression, while 66% screened as having likely PTSD on validated scales used for the study. Most participants lacked access to health and mental health care to help them address chronic health conditions. One participant noted “I have chronic back pain, which I haven't had addressed. Then also I have numbing in my

left foot on my toes, and I haven't had that addressed either." Another shared "My health need is I wish I could get some kind of help so I could go to the doctor regular and get these three teeth pulled out of my mouth before I go crazy." Mental health needs also prevented participants from meeting other goals.

I go through depression at times, of course. Depends on what's going on. I've been through all kind of depressions, mood swings at times because of—I don't know. Flashbacks cause that. The normal aspect of it—not the point where it's debilitating or—sometimes it can be that way. That's why I stopped working, remember? (P13)

Another participant described how symptoms from a concussion created obstacles to addressing other needs.

I suffered a concussion from the assault at the beginning of the year, but I'm—everything I had—everything that happened after the concussion has subsided, all those symptoms that I had. I couldn't really focus. The light was sensitive and different things. It's kind of gone away. At the beginnin', like I say, it gave me a lot of trouble. I couldn't focus to read at all. One or two, three pages I read here, I wasn't able to get through the first page and the light sensitivity, headaches, and stuff like that. Like I said, it's died off a lot. (P5)

Mental and physical health concerns were substantial for rapid rehousing participants and many faced isolation living in rapid rehousing and a lack of mental health resources to address these concerns.

Safety Needs. "I Still Get Scared All the Time"

For the majority of participants, physical violence (76.7%) and sexual (63.3%) abuse decreased after moving into rapid rehousing. Stalking decreases were more limited, with 46.7% indicating a decrease. Many participants experienced ongoing safety concerns from the abusive partner, including stalking and threats.

He doesn't have a car, as far as I know, and he's only been out a short period, too. Before that, he was in jail. He did seven months because of the terroristic threat. He called my children's phone and told them that he was gonna shoot me in the head in front of them. (P13)

A participant shared "Oh, he did some dirty stuff on social media a month or two ago and how they access to phones, I have no clue, but it was some pretty bad stuff on social media." Another said, "Now that the divorce is almost final, he started texting and calling me again." Stalking behaviors and fear of potential actions from abusive partners meant that several participants had to change their jobs, routines, or contact information to increase their safety. One participant explained:

He still tries to call. I need to change my phone number, but I got so many things in the fire right now using my phone number that to change it right this second would kinda screw

me. I need about another week, and then I can change my phone number, and then I won't have to worry about it. (P2)

Employment was impacted by stalking experiences, as one participant noted. "I stopped going, and I lost the job because I had to—it was either—it was hard between keeping an eye on my children, staying sane—it just changed. Everything shifted, so I just stopped going." Even for participants without current active stalking, the fear that the abusive partner will harm them or their children loomed large, increasing anxieties. One participant shared, "right now I don't (have safety concerns) but I still get scared all the time he is a really crazy person." Another participant explained, "He drinks a lot and one of these days he's going to snap and come try to talk to me." Participants and their children experienced increased anxiety from the threat of potential encounters.

I tried hard not to think about it, but it's really hard when I'm out and about. Even with the kids, they have a lot of anxieties over it, too, because, since it happened, I had a protective order, but we've seen him in random public places and stuff. It's kind of hard for us not to look over our shoulder and be tense. I don't know. I don't know if he knows where we live at or not. Presumably he doesn't, but it's always a chance 'cause, like I say, we see him in random places. (P5)

Despite experiencing major decreases in abuse and violence, continued stalking, harassment, and fears of future violence to them or their children continued to negatively impact their ability to hold employment and freely move around their community.

Accessing Supportive Services: "Beyond the Call of Duty to Help Me"

To address needs while in the program, housing voucher participants engaged in several services through the IPV agency, including case management, mental health services, transportation assistance, legal advocacy, and career services. Case management was the main way for rapid rehousing participants engaged in agency services. Twenty-seven or 90% of participants had used case management services while in rapid rehousing. Most participants had a positive experience with case management, sharing "both case managers have been awesome," "I don't know where I would be without her," and "she always go beyond the call of duty to help me." As one survivor shared, her case manager "She listened to me. She felt my pain." Satisfaction ratings for case managers among participants were high, with an average score of 3.59 (out of 4) for perceptions of caring; 3.76 for support, and 3.45 for knowing about community resources. Participants particularly valued case managers that were available, non-judgmental, and welcoming:

When I went there, ...<name> didn't judge me. She held me in her arms, held my baby and looked at me and said "you will make it through." She didn't ask whether I was Hispanic or Muslim. She saved me. (P24)

Access to the case manager was particularly important to participants. “Whenever I reached out, (case worker) is always there—I always get a returned call & whenever they could do, they did it.” A participant expanded on the importance of availability:

I see her at least twice a month, and she is awesome. She sits and she’ll talk to me for a hour or two, just to make sure everything’s all right, if there’s something on my mind. It’s a hour at least, I’ve had her sit and talk to me. At least five hours a month. (P13)

Case managers and survivors in the rapid rehousing context, especially in the midst of COVID-19, relied on digital means to stay connected, “we text each other quite often.” Virtual connections help to build rapport and meet survivor needs “She texts and she calls and she makes sure everything’s just—she’s awesome.” Case managers anticipating needs while in rapid rehousing, and preemptively reaching out to clients to address them was impactful to participants feeling valued. One survivor shared “My case worker has brought by things for me which has been so helpful; many of the services on the list, I haven’t asked about.” A participant expanded on this.

I can say that working with my case worker she always lets me know about the services going on at that time & that they are available to me. And also asks what services I need regarding my health and mental state. (P9)

Several participants explained that their case managers are dedicated to their work and their clients’ needs, going “above and beyond.”

(Case manager) is very sweet and I can tell she is going to be very successful. She is very compassionate. Working with her has been great, she’s been awesome. For me, she’s been great. I told her I was going to end up on the street, and I remember her saying “I will never let that happen”. When she told me she was putting me in apartment, I was overjoyed. (P21)

Along with case management, participants used other agency services, especially counseling. Several participants noted they were able to get help with safety planning from the agency, which increased stability. A participant discussed how safety planning gave her new skills to cope:

Safety, first and foremost. They gave me an outlet to express myself as far as being able to talk to the staff. I can’t remember the program, what it’s called, but they just basically give you—it’s like a little therapy session. I don’t know. That helped a lot to talk about the issues and just more resources. They have been like an outlet for everything here. (P5)

Counseling services were also impactful for rapid rehousing participants. A participant shared, “I am doing counseling for mindfulness here at (agency) and it helps me focus and recenter.” For one participant, the therapeutic emotional support helped her move beyond some of the trauma she had experienced.

The counselling because they helped me a lot to move on from the crisis that I was in, emotionally. And the support with helping me to find somewhere to live because I was in danger where I was. (P15)

Overall, participants felt positive about the services offered by the agency and that they helped address needs, but the most useful part of the program was the housing, as one participant noted, “they are helping me with housing, that is what has helped me the most.” Participants explained the stability that even a temporary housing voucher gave to them.

I think the housing assistance was the most helpful just ‘cause it gives me—it was that immediate—I don’t have family or friends to count on, so just having somewhere to stay without having to put my family in a shelter setting. Then just giving me that full year of the rental assistance to help me get back on my feet. It wasn’t just the rental assistance, they were just like, “Okay. Do you need any type of furniture? Do y’all need clothes?” I mean, ‘cause I had lost everything. They made it very easy just to get me back on my feet. (P20)

An important indicator of service satisfaction is the extent to which service recipients might reuse the service if they need it again. For these rapid rehousing participants, the likelihood to use services again if they needed them was 1.55 on a scale of 1 (very likely) to 5 (very unlikely), indicating high levels of repeated use if needed.

Facing Barriers to Meeting Needs: “I Fell Through the Cracks”

While service satisfaction was generally high, participants noted significant barriers based on their needs. Each participant was asked to share the needs both met and unmet by the agency. The most frequently referenced met needs were housing, counseling, safety planning, and resources. The most often referenced unmet needs were permanent housing, job support/training, transportation, and medical aid. Legal advocacy was referenced frequently as both met and unmet. Because rapid rehousing residents are not physically located in the same place as case managers, as they may have been in a shelter, the transition from the hands-on approach to the shelter was difficult for some participants. Changes in how to access case management services in the rapid rehousing context caused delays, as one participant described “My first month and half, I fell through the cracks & didn’t know there was a procedure – but I was then re-assigned.” Another shared, “Once I get outside of the shelter, I’m out of sight, out of mind.” Staffing turnover created more problems for participants in getting their needs met. Several survivors shared that staffing changes created a delay in not only resource provision, but also trust building.

She is nice but I don’t really know her. 3 case workers in the past year: One was really mean; one was really great. I don’t see the new one much I don’t really know her. I think more like the one who took an interest in me & what was happening to me. (P8)

Other factors created problems with connecting with staff at the IPV agency, including age “She was so young, and I didn’t feel comfortable”; mental health “with my depression and everything, I just couldn’t get out of bed to go, so I missed the appointment.”; difficulties asking for help “you feel so broken inside that you don’t know how to ask for help”; and a perceived lack of individual reach outs from staff.

The place is great, but the staff needs to be concerned about what each woman is going through. Need to be more open-minded and ask questions of the women and not wait for them to ask. Lots of the staff are passionate about what they do, but certain people are not. (P22)

This lack of connection and support can be isolating for rapid rehousing residents, as one shared:

I know they’re doing the best they can. There’s just so many gaps there. I wouldn’t even know how to say they need to fix these gaps, but there’s things that are missing that are needed. I just don’t know the specifics, but when we’re going through that horrifying time in our lives, we need all the support we can get and every service possible that we can get and as many people involved that we can get. (P18)

A few participants noted unmet needs related to legal services, with one sharing “They said to google legal aid for help.” Participants expressed the need for additional support related to jobs, and during the pandemic, childcare, and schooling.

Rapid Rehousing is Not Considered Permanent Housing: “I Don’t Think I’ll Be Able to Pay for an Apartment”

Ultimately, the most pressing barrier for participants was permanent housing. As one participant said, “they helped me from being homeless for a year.” Survivors interviewed for this study did not generally view rapid rehousing as permanent housing, but a temporary program that would result in another housing change. One participant shared that her main goal was to “get permanent place for me and the baby.” The time pressure created significant anxiety for participants.

I am afraid right now, I’m afraid because the period will expire and I don’t have the means to pay— fend for myself. That’s my fear now and that’s what causing anxiety for me, all of that, because I’m not working now, that’s making me anxious. (P16)

Participants expressed concern that they would not be able to afford the apartments on their own.

I don’t think I’ll be able to pay for an apartment, so what I need right now is to find out more information about housing, but as I said, permanent. That’s what is worrying me right now because I only have until (month) in the program with them. (P15)

Several participants noted that they wanted longer-term assistance from the IPV program. “I wanted to be in a permanent housing program but they haven’t been able to help me with that.” They expressed that a year to a year and a half of subsidized rapid rehousing housing was not enough time to overcome the many financial, safety, and health concerns they faced. Participants overwhelmingly indicated that more time in housing was needed to address complex needs and barriers.

Discussion

Despite federal funding and robust use by IPV agencies, there has been limited scholarship on the experiences and needs of IPV survivors using program-facilitated rapid rehousing vouchers. The lack of research necessitates an exploratory approach, where mixed methods are appropriate to increase understanding and build evidence for future evaluative efforts. Using data from 31 female-identified survivors who currently and formerly lived in rapid rehousing units serviced by a local IPV agency, needs and experiences were explored with the goal of shaping program policy and forming future impact evaluation strategies. Four summary themes shaped experiences in IPV rapid rehousing: getting to housing, managing multiple needs, accessing support, and facing barriers.

Residents overwhelmingly indicated that the rapid rehousing program was helpful in addressing immediate threats created by homelessness and violence, and stabilizing their families. Supportive services from the IPV agency addressed many resources, mental health, and safety needs. Agency staff were instrumental in helping meet goals, and address needs. While not generally viewed as permanent housing, rapid rehousing offered by IPV programs offered a calmer and more secure longer-term alternative to emergency shelter for healing from trauma.

Rapid rehousing vouchers can play an important role in a continuum of services for survivors, addressing longer-term barriers which contribute to risk for subsequent IPV. By extending the voluntary and survivor-driven service model to this portion of the service continuum, IPV service providers can continue to maximize the effect of services for survivors and their families. There is emerging best practice guidance for rapid rehousing programs serving survivors of IPV that shows the need for these programs to have flexible, survivor-centered mobile advocacy, financial resources, long-term rental assistance, and building of community connections and support to bring greater stability to survivors’ lives (Billhardt, 2018; Mbilinyi, 2015; Sullivan et al., 2019). Several inflection points for this service model were identified by participants in this study. The challenges inherent in entrance into and exit from rapid rehousing services for survivors were clear—these are moments of significant change which require increased advocate attention and support. Agencies could consider these points in a survivors rapid rehousing journey as likely to be especially intensive and seek where possible to balance advocate workloads to ensure they have the time and emotional bandwidth to ramp up services at these key points.

Participants also highlighted that many experienced continuing economic challenges throughout their rapid rehousing journey, created by structural barriers as

well as ongoing stalking or violence. Enhancing flexibility in a survivors' length of stay and building routes to employ flexible funding through agency resources and expanded federal supports could further extend a survivor-centered approach within rapid rehousing services. Interviews indicated that survivors sometimes found accessing advocate support challenging, as they were not colocated in the same physical space as might be the case in an emergency shelter or onsite transitional housing program. Emerging evidence highlights the role of information communication technology in bridging this gap, particularly as a quick "how is it going?" text-based check in seemed like a viable route for this communication for many participants in this study (Voth Schrag et al., 2021). Ongoing work should explore the potential for virtual services, along with mobile advocacy (Sullivan & Olsen, 2016) to be paired with rapid rehousing models to maximize services efficacy. A critical component of a trauma-informed approach to services is addressing structural, systemic, and oppression-based barriers for survivors in the community. Similar themes have been echoed in a recent study focused on IPV survivors using rapid rehousing vouchers which documented the barriers of structural racism faced by survivors, including discriminatory housing practices and racial housing segregation, and gender discrimination in obtaining housing (Holliday et al., 2021). These interviews highlight the ongoing need for agencies providing rapid rehousing services to participate in education related to housing policies that landlords should be abiding by related to survivors of IPV.

Implications

Continued experiences of direct and technology-based stalking were detailed by survivors in this study. Intimate partner stalking is associated with negative consequences for survivors including housing instability, employment issues, and disruptions to daily routines (Baum et al., 2009; Logan & Walker, 2019). In addition, intimate partner stalking can have negative short- and long-term health impacts for survivors such as anxiety, insomnia, elevated distress and fear, and depression (Bailey & Morris, 2018; Edwards & Gidycz, 2014; Logan & Walker, 2019). Safe housing can immediately mitigate many forms of IPV, however, stalking—both technology-based and traditional—will occur despite the location of the survivor. Housing interventions addressing IPV must also be able to implement ongoing safety assessments and planning to address stalking that may be currently ongoing or that may occur at a later point in time. Safety planning must include attention to all potential forms of intimate partner stalking. Historically, stalking has been underreported, difficult to identify by advocates and the criminal justice system, and challenging to address (Backes et al., 2020; Logan, 2010). Advocates receive limited training in safety planning (Logan & Walker, 2019) and thus may not be well-versed in how to incorporate aspects of stalking into safety planning. Advocates must work collaboratively with survivors to identify any ongoing and potential stalking and technology abuses so that appropriate safety plans can be implemented.

Participants indicated several met and unmet physical and mental health needs while in rapid rehousing. Counseling services, when used and available, were

impactful for survivors. Several mental health interventions have been demonstrated to be effective for complex trauma survivors, with the International Society for Traumatic Stress Studies highlighting Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Prolonged Exposure, and Cognitive Processing Therapy as equally effective at reducing and resolving trauma (Forbes et al., 2020). Each of these interventions has an expectation of current safety and some level of stability as a prerequisite for engaging in treatment. As such, they may not be appropriate for those living in an emergency shelter but could begin to be useful in a rapid rehousing environment. Educating case managers about effective options and prerequisites for treatment could enhance the linking of survivors who may be a good match for trauma treatment with effective trauma services. Further, several participants indicate intensive physical health needs, in many cases from IPV injuries. Rapid rehousing programs facilitated by IPV programs should include connection to free health services; assistance applying for medical insurance, and collaborations to access needed medical supplies.

Research Implications

This study further underscores the urgent need for multisite, multistate longitudinal research with diverse populations of survivors on the impact of rapid rehousing offered through IPV agencies. Aligned with other IPV program outcomes (e.g., Sullivan, 2018) future research on rapid rehousing with IPV survivors should include assessment of safety from future violence, including stalking; changes in housing barriers, economic stability, and health and mental health; and resource and referral use. For participants with children, evaluative approaches should include a focus on both parenting and child outcomes. Housing barriers and neighborhood quality should be considered in evaluation designs (Holliday et al., 2021). IPV agency service use, including fidelity to an engaged survivor-driven voluntary service model, are critical covariates to examining program impacts. Further, the eligibility and screening process for rapid rehousing merits study and refinement, especially considering the complications with long emergency shelter stays. There is growing evidence that this screening process, typically using the VI-SPDAT, is not working as intended and is increasing racial housing disparities and creating more barriers (Brown et al., 2018; Nnawulezi & Young, 2021; NNEDV, 2020; Wilkey et al., 2019). An alternative screening tool to the VI-SPDAT, called the Survivors Achieving Stable Housing screening tool is being utilized and tested to ameliorate some of the barriers faced by survivors of IPV accessing housing vouchers (Thomas et al., 2020). Further refinement and testing of both program screening and outcomes are needed.

Limitations

A number of limitations should be considered when evaluating the findings of this study. First, data were collected from a single IPV program offering rapid rehousing which operates in a single large metropolitan region in U.S. Southwest. Agency,

local, and state contexts all shape the resources, expectations, and needs of survivors and IPV program staff. Future work would benefit from looking across sites and geographic regions to identify effective program models as well as understand survivor experiences. The study also includes a small sample of current and former participants, who have different recall timeframes based on their point in the rapid rehousing experience at study entry. While 31 participants allow for rich qualitative data, quantitative analysis was limited to descriptive statistics highlighting frequencies and experiences. Future work with larger samples will benefit from the ability to look across dynamics and overtime. Finally, data collection was interrupted by the onset of COVID-19 in Spring 2020, so data collection strategies and timeframes were shifted from the beginning of the study to the end to allow for socially distanced, safe data collection.

Conclusion

Safe, affordable, and accessible housing is a central concern and basic need for survivors of IPV and their families. Housing stability can be a gateway to a host of other positive outcomes or a contributing factor in continued violence and abuse. Spurred by federal support and the ability to provide support to survivors living in locations of their own preference, rapid rehousing programs have become a critical component of community-based IPV survivor services, despite limited research. To further the knowledge base, this study sought to capture the experiences, needs, and barriers to rapid rehousing residents, in order to inform program planning and enhance future evaluative efforts. Survivors consistently affirmed the importance of the rapid rehousing program model in crisis stabilization and providing a foundation for future efforts, and provided important feedback on strategies for enhancing programmatic practice and ultimately enhancing survivor outcomes. By enhancing access and communication between advocates and rapid rehousing dwelling survivors, while also prioritizing addressing the structural barriers that create challenges for accessing and maintaining housing, IPV agencies can continue to build out this important service model.

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Note

1. Eligibility was established at the county level in accordance with local housing authority guidelines.

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Maggie McGiffert is a senior research associate and sociologist at the Center on Violence Prevention at The University of Texas Medical Branch. She has worked on the intersecting issues of housing, homelessness, and IPV for over 20 years, directing services, policy initiatives, research, and evaluations. She has been the project director on evaluations of shelter, rapid rehousing and permanent housing programs, and statewide needs assessments for survivors of

IPV, children exposed to IPV, and older survivors, all focused on sharing the voices of survivors to impact policy, practice, and systemic barriers faced by survivors.

Joshua Brown, LCSW, BCN, serves as the Chief Programs Officer for an agency that serves survivors of intimate partner violence. In this role, he oversees numerous programs which include mental health services, permanent supportive housing and rapid rehousing, emergency shelter, children's services, life skills, and case management. He got his start in the intimate partner violence field developing an innovative neurofeedback program. Joshua has a background in psychology, is a Licensed Clinical Social Worker, and is board certified in neurofeedback.

Bethany Backes is an assistant professor in the Violence Against Women Faculty Cluster Initiative at the University of Central Florida and holds a joint appointment in the Department of Criminal Justice and School of Social Work. Her areas of scholarship broadly encompass research and evaluation on violence against women and crime victimization including formal and informal help-seeking trajectories, secondary and tertiary violence prevention strategies, and criminal justice and community-based interventions related to interpersonal violence.