Domestic Violence Housing First Demonstration Evaluation Project: Final Report of Findings through 24 Months

Executive Summary

Contract No:
HHSP233201600070C

September 2022

Prepared for:
Lisa Trivits, Ph.D.
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave., SW, Room 404E
Washington, DC 20201

Submitted by:
Judy Chen
Washington State Coalition Against Domestic Violence
1511 Third Avenue, Suite 433
Seattle, WA 98101

Cris M. Sullivan, Ph.D.
Michigan State University
Ecological-Community Psychology
316 Physics Rd.
E. Lansing, MI 48824

DOMESTIC VIOLENCE HOUSING FIRST DEMONSTRATION EVALUATION
EXECUTIVE SUMMARY

KEY FINDINGS: Unstably housed domestic violence survivors who received the Domestic Violence Housing First (DVHF) model – including housing-related advocacy and/or flexible financial assistance – reported a number of positive changes at 6-, 12-, 18- and 24-months after seeking services. Evidence indicates that the DVHF model is more effective than services as usual (SAU) in helping survivors achieve housing stability, safety, and improved mental health over twenty-four months. Survivors who received DVHF also reported higher prosocial behaviors from their children compared to parents who received SAU. Positive change in these domains happened quickly (within the first 6 months after seeking services) and persisted across 12, 18, and 24 months. The model does not appear to be more effective than SAU in increasing financial stability, increasing quality of life, or reducing substance misuse. It also showed no impact on children's school attendance, school performance, nor on their behavioral problems.

In addition to testing the primary study hypotheses, we conducted four exploratory analyses and present findings in this summary. First, advocates were able to accurately predict whether program participants would be more stably housed six months into the future, although the effect size was small. Second, the DVHF model worked similarly across people from various race and ethnicity groups, as well as both urban and rural geographic service areas. Third, for participants who had received DVHF, the extent to which they reported agencies engaging in trauma-informed practices was positively related to their housing stability and safety, and negatively related to their depression and alcohol misuse at both 6-months and 12-months follow-up. Fourth, COVID-19 did not appear to impact the effectiveness of the intervention across most outcomes.

Background

The objective of the Domestic Violence Housing First Demonstration Evaluation is to add to the knowledge base about housing and advocacy interventions for survivors of domestic violence and their children. Domestic violence (DV) is a leading cause of homelessness.[1] Little evidence exists about effective strategies to assist survivors as they work to avoid homelessness while freeing themselves and their children from the abuse of partners and ex-partners. This demonstration evaluation will significantly add to our knowledge base by examining the impact of housing-related advocacy and flexible funding on the lives of DV survivors and their children over time.

[1] Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate partner violence and housing instability. *American Journal of Preventive Medicine*, *32*, 143–146.

The demonstration evaluation was designed to rigorously examine the Domestic Violence Housing First model, which provides housing-related advocacy and flexible funding to help survivors achieve safe and stable housing. Over 400 people who survived DV and were homeless or unstably housed participated in a quasi-experimental, longitudinal evaluation study that followed them over two years after they sought services from one of five participating DV agencies. Careful attention was paid during recruitment efforts to ensure that all eligible survivors were invited to participate in the study. Those who agreed to participate were interviewed every six months over two years. In addition to conducting in-depth interviews with survivors, this multi-method, multi-source design involved collecting data from their service provider advocates and agency records.

The Domestic Violence Housing First Model

The three pillars of the Domestic Violence Housing First model that are designed to promote safety and housing stability are:

1. **Mobile housing-related advocacy:** A critical component of the model is that advocates focus on addressing needs identified by survivors rather than on needs pre-determined by the agencies. Advocates are also geographically mobile, meeting survivors where it is safe and convenient for them, and advocacy continues for as long as survivors need support.

2. **Flexible financial assistance:** Many survivors need not only advocacy to obtain safe and stable housing, but also temporary financial assistance to support themselves and their families. Funds are therefore targeted to support survivors so they can rebuild their lives, including covering childcare costs, transportation, school supplies, uniforms and permits required for employment, as well as time-limited and flexible rental assistance.

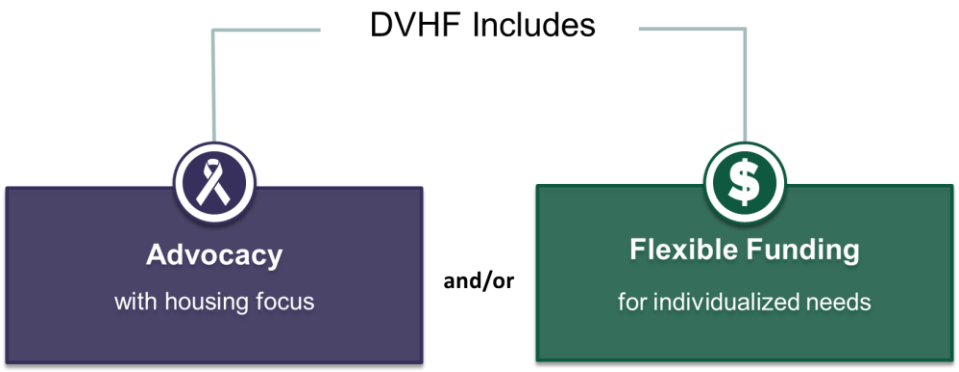
3. **Community engagement:** Advocates proactively engage people in the community who can help support the safety, stability, and well-being of survivors. Advocates engage with health care professionals, law enforcement and the legal systems, educators and school administrators, religious and spiritual leaders, and others.

The evaluation design allowed us to examine the first two pillars of the model: mobile housing-related advocacy and flexible funding (Figure 1).[2] While all of the participating agencies reported using the DVHF model, they acknowledged that due to limited resources (e.g., staff turnover, limited funds) it was often the case that survivors received "what was available at the time." Similar to programs around the country, they may or may not be able to meet all of survivors' needs. Systematically inviting all eligible survivors into the study

[2] Examining community engagement was beyond the scope of this evaluation as it is community context-specific and fluid, and all participating agencies reported engaging with their communities as a part of their work.

during the enrollment period enabled us to capture this natural variability in service delivery, enhancing the generalizability and ecological validity of the findings.

Figure 1. Two DVHF pillars examined in evaluation



Primary Research Questions and Exploratory Questions

Primary research questions

Primary research questions were tested using all five data collection time points across twenty-four months (baseline at study entry and every six months after that through 24-months). The primary research questions of the study are:

1) Did survivors who received the DVHF model in the first six months of the study show greater improvement on housing stability, financial stability, safety, mental health, and substance misuse compared with survivors who received "services as usual"?

2) Will children of survivors who received the DVHF model in the first six months of the study show more positive outcomes on school attendance and performance, prosocial behaviors, and problem behaviors, compared with children of survivors who received "services as usual"?

Exploratory research questions:

In addition to testing hypotheses that were informed by prior evidence and theory, we also examined four exploratory research questions:

1) Can advocates predict which survivors will be stably and safely housed over time?
2) Are there particular survivor characteristics that are associated with better intervention outcomes?
3) Are there particular agency characteristics that are associated with better outcomes?
4) Did COVID-19 impact the effectiveness of the DVHF intervention?

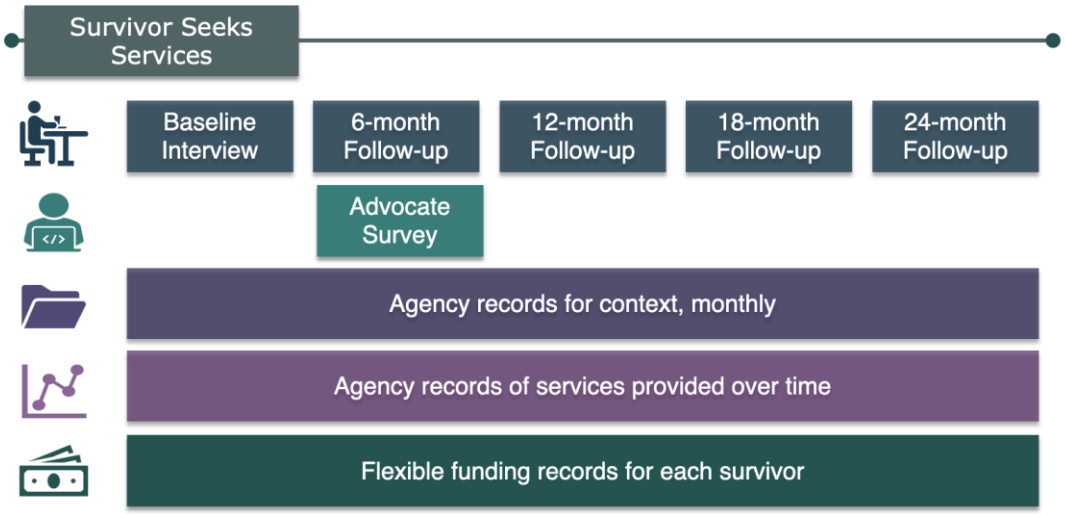
DVHF Programs and Study Methodology

Procedures

Five domestic violence agencies in the state of Washington participated in this longitudinal program evaluation – two in urban areas and three in rural areas. Each agency received a one-time award from the Bill & Melinda Gates Foundation (through the Washington State Coalition Against Domestic Violence) to offset project expenses. In addition, each agency received funding to provide survivors with flexible financial assistance. Over the four years, the rural programs each received a total of $112,500 for flexible funding and the urban programs each received a total of $105,000 for flexible funding.

To address the primary study research questions and the exploratory research questions, the evaluation involved collecting data from: (1) DV survivors, (2) their advocates, and (3) agency records (see Figure 2).

Figure 2. Evaluation data sources



Evaluation Data Sources

Survivor Interviews. Agency staff invited eligible participants to hear more about participating in this study. Eligibility criteria included (1) being a recent survivor of DV, (2) being homeless or at risk of becoming homeless, (3) having entered services within the prior three weeks, and (4) speaking English or Spanish, or agreeing to participate with the assistance of an interpreter. Agency staff made every effort to assure that the participant was approached about the study within 10 days of receiving services – a time frame chosen to ensure that participants were not approached about the research study when they were

in immediate crisis. Research staff then contacted eligible participants and obtained their informed consent to participate in the study.

Survivors were interviewed five times over 24 months, with interviews spaced six months apart (baseline when survivors first sought services, 6 months, 12 months, 18 months, and 24 months after first seeking services). Interviews included questions about abuse, financial instability, housing instability, social support, mental health, substance abuse, well-being, service needs, and services received (see Technical Report for more details on measures and methodology). Baseline interviews also captured basic demographic information as well as historical data regarding abuse and homelessness. Parents were asked questions about the behavioral problems and social-emotional skills of one of their children, who was chosen at random.

Initial interviews were conducted in person by a member of the evaluation team, in a private and safe location. Subsequent interviews were conducted either in person or by telephone, based on participant preference. Participants were paid $50 for each interview. The study was approved by Michigan State University's Institutional Review Board (IRB).

Advocate Surveys. During the 6-month interview, study participants were asked to provide the name of the primary advocate they worked with, if applicable, and that advocate was invited to complete a brief online survey about their work on behalf of that particular program participant. In addition to providing basic demographic and work background about themselves, advocates reported on the various housing barriers that the participant had faced, and what services they provided to stabilize the participant's housing status, safety, and well-being.

Agency Records. Agencies provided service start and end dates for participants in the study, and documented which services were provided to them over time. They also systematically tracked their use of flexible funding for each participant. Agencies documented critical contextual information about their agency resources each month, such as the average caseload of DVHF advocates and the availability of funds to provide flexible funding.

Determining Who Received the DVHF Model

Findings at six months are based on the 375 participants who completed both baseline and 6-month interviews (92 percent retention rate). As indicated in Table 1, there were 30 participants (8 percent) who reported receiving no services in the prior six months**.** There were a total of 124 participants (33 percent of the sample) who received Services as Usual (SAU). Services as Usual (SAU) included other DV services that did not involve flexible funding or housing-related advocacy. Of the 124 participants in the SAU group, 50 participants (13 percent) reported that they had not worked with an advocate, but reported they had received other services and for whom there was no record of their having received flexible funding. Services as usual can also include advocacy that is not

housing-focused, such as referrals, support groups, or counseling. So if someone said they worked with an advocate, but wanted and did not receive help with housing (and did not receive flexible funding), they were also placed in the SAU group. There were 74 people (20 percent) in this subcategory.

The two pillars of the DVHF model focused on in this study were flexible funding and mobile housing-related advocacy. Survivors could have received one or both pillars to be considered as having received at least some form of DVHF. Between study entry and the 6-month interview, there were 221 participants (59 percent) who received DVHF. Of these 221 participants, 39 people (10 percent) received flexible funding, but no housing-related advocacy, and 64 people (17 percent) received housing-related advocacy but no flexible funding. The remaining 118 participants in the DVHF group received both flexible funding and housing-related advocacy (32 percent).

Table 1. Services Received in the First Six Months; N=375

	Number	Percent
No Services	**30**	**8%**
Services as Usual	**124**	**33%**
No advocacy	*50*	*13.3%*
Advocacy but not housing-related	*74*	*19.7%*
DVHF	**221**	**59%**
Flexible funding, no housing-related advocacy	*39*	*10.4%*
Housing-related advocacy only	*64*	*17.1%*
Housing-related advocacy and flexible funding	*118*	*31.5%*
Total	**375**	**100%**

Analytic Approach for Primary Research Questions

The hypotheses for the primary research questions were tested across twenty-four months, comparing those who received the DVHF model with those who received SAU in the first six months of the study. Prior to hypothesis testing, logistic regressions examined baseline differences between survivors in the DVHF group and the SAU group that may have impacted who received DVHF versus SAU.[3] Statistically significant differences were found at baseline for 15 of the 72 variables examined suggesting that, generally, survivors in DVHF had fewer barriers and greater assets at baseline compared to those who received SAU. Linear regressions also identified covariates that were associated with study

[3] Inverse-probability-weighted (IPW) estimators based on these differences were then included in analyses as sampling weights to account for selection bias present in non-randomized intervention comparisons.

outcomes, and these were included in the models. Longitudinal mixed effect models examined change over 24 months.[4]

Description of Participants at Study Entry

Demographics. The final baseline sample consists of the 406 participants who completed an interview at study entry. Study participants were predominantly female (97 percent) and heterosexual (86 percent). Their ages ranged from 19 to 62 years old, with an average age of 34.5 years old.

Within the sample, 35 percent were non-Hispanic White, and 65 percent reported a minority racial/ethnic identity. Of the survivors who identified as Black, Indigenous, or Person of Color (BIPOC), 15 percent selected more than one race/ethnicity category, indicating multiracial or multi-ethnoracial identities. Racial/ethnic background (which total over 100 percent due to multiracial and multi-ethnic identities) included: Hispanic/Latinx (35 percent), Black (19 percent), US Indigenous (12 percent), Asian (4 percent), and/or Middle Eastern (1 percent).[5]

At baseline, 74 percent had children they were currently responsible for. The primary language for most survivors was English (80 percent). Immigrant survivors represented 18 percent of participants. Approximately one in six (17 percent) of all adult participants had been in foster care as children.

Education. The highest educational level attained by participants varied considerably: 29 percent had not completed high school, 22 percent had a high school diploma/GED, 36 percent had some vocational training or had attended college classes, and 13 percent had college degrees (either Associate's, Bachelor's or advanced degrees).

DV Victimization. Survivors had experienced a range of domestic violence in the prior six months, including emotional abuse (96 percent), physical abuse (93 percent), stalking (90 percent), economic abuse (89 percent), and sexual abuse (53 percent). A majority of parents (89 percent) reported perpetrators using their child(ren) against them in the last six months.

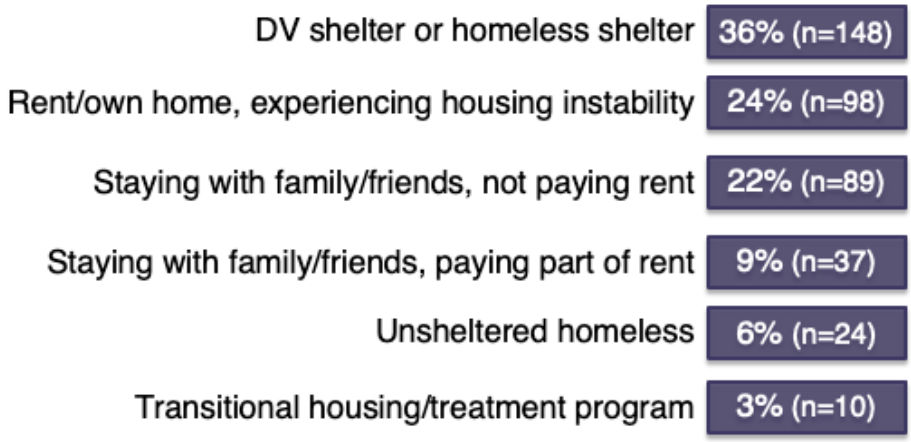
[4] Analyses accounted for the fact that survivors received services from different advocates who worked within different agencies (e.g., survivors were nested within advocate who were nested within agency). Models also controlled for the levels of each outcome at baseline and whether an interview timeframe occurred before or after COVID-19 began. Receipt of advocacy and/or funding across 12, 18, and 24 months were included as time-varying covariates.

[5] The Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) classifies people who identify as Middle Eastern as White. However, the DVHF survey instrument was designed to capture additional information on race/ethnicity, which supported people identifying themselves in the way that made the most sense to them. People could choose one or multiple categories, including Middle Eastern.

Employment. Over half of the participants had been employed (58 percent) at some point in the six months prior to participating in the study, but only 35 percent were employed at study entry. Of the 46 percent of survivors who had lost or left their jobs in the prior six months, 70 percent reported it was due to the abuse they had experienced.

Housing Status at Baseline. At study entry, 42 percent of the participants were experiencing homelessness (36 percent living in a shelter, and 6 percent unsheltered homeless). The other 58 percent of participants were unstably housed: 24 percent were in homes they owned or were renting, but were at-risk of losing; 22 percent were staying with family and friends without paying rent, 9 percent were living with family and friends and paying part of the rent; and 3 percent were in transitional housing or a residential drug treatment program (see Figure 3).

Figure 3. Housing Status at Study Entry for Full Sample (n=406)



History of Homelessness. Most study participants (73 percent) had a prior history of homelessness. Of those who had experienced homelessness, the average cumulative amount of time spent homeless was just over two years. Thirty-three percent of those with a history of homelessness had experienced homelessness at least once before age 18. Most of the sample (87 percent) had stayed with family or friends at least once in order to avoid homelessness.

Services Needed. At baseline, most participants were looking for long-term help from the agency: 77 percent wanted the agencies to help them find a new, safe home, and 18 percent wanted to stay in or return to their current home (5 percent were unsure). Survivors noted many issues they hoped the agency could help with, with the most prevalent being housing (96 percent); financial help (92 percent); counseling (85 percent); social support (85 percent); and legal assistance (72 percent).

Findings

Flexible Funding Payments in the DVHF Group

A total of 811 payments were made to 169 participants who received financial assistance between intake into the agency and the 6-month time point[6]. There were sometimes multiple payments made at one time. For example, a survivor might have received $500 on one date to cover transportation, utility bills, and moving costs. These were counted as three payments. The total amount of funding received by each participant was as low as $11 and as high as $9,552, averaging $1,949 (median = $100).

Many payments went specifically for housing-related costs such as rental assistance (24 percent), move-in costs (7 percent), moving expenses (4 percent) and housing preparation (6 percent), such as application fees. The next two highest categories of funding after rental assistance were transportation costs (17 percent) and basic needs (17 percent), such as household furnishings, groceries and personal care items.

Retention of Study Participants Across Time

Retention across all study participants was high across all time points, from 92 percent at the 6-month follow-up to 89 percent at the 24-month follow-up (Table 2). Those participants retained in the study were similar to those who were not retained with regard to age, race, ethnicity, housing status at baseline, history of homelessness, abuse severity and number of children. There was only one statistically significant difference between those who were retained in the sample and those who were not retained. Those who were retained in the study were more likely at each time point to have received services in the previous six months compared to those not retained, based on examining agency records.

Table 2. Retention Rate Over Time

Interview	# Interviews Completed	Retention Rate
Baseline	406	**n/a**
6 Month	375/406	**92%**
12 Month	369/406	**91%**
18 Month	359/406	**88%**
24 Month	363/406	**89%**

[6] Agency records are based on the full sample of 406 participants and not just the 375 who were interviewed at 6-months

Findings Across Twenty-Four Months

Eleven statistically significant group differences were found, all favoring those who had received DVHF. The effect size for housing instability was medium; all other effect sizes were small. For each outcome below, there was a statistically significant difference between survivors in the DVHF and SAU groups, with more positive outcomes for survivors who received DVHF. There were no statistically significant time by intervention interaction effects, indicating that the differences were consistent between DVHF and SAU at each follow-up time point through 24 months.

- Housing instability[7]
- DV – physical abuse[8]
- DV – emotional abuse
- DV – stalking
- Economic abuse
- Use of the children as an abuse tactic
- Depression
- Anxiety
- PTSD
- Children's prosocial behaviors (e.g., being kind to others)

For each outcome below, there were no statistically significant effects found, meaning there were no statistically significant differences between participants in the DVHF group and participants in the SAU group.

- Inability to make ends meet (e.g., having enough money to pay living expenses)
- Financial strain (e.g., how often people anticipate going without necessities)
- Financial difficulties (e.g., difficulty paying for different bills)
- DV – sexual abuse
- Quality of life
- Alcohol misuse
- Drug misuse
- Children's problem behaviors
- Children's school attendance
- Children's school performance

[7] A 7-item Housing Instability Scale (HIS) was created for this study by modifying the 10-item Housing Instability Index (Rollins et al., 2012). The scale demonstrates strong concurrent and predictive validity, and shows evidence of scalar equivalence over time and across both the English and Spanish versions.
[8] The Composite Abuse Scale includes four subscales of domestic abuse: physical, emotional, sexual, and stalking. Significant differences in favor of those receiving DVHF were found for the entire scale and all subscales other than sexual abuse.

Exploratory Research Questions

Exploratory Question #1: Can Advocates Predict Housing Stability?

The first exploratory question, *Can advocates predict which survivors will be stably and safely housed over time?* was explored in response to advocates mentioning to the research team that they sometimes feel required to choose which participants would best benefit from different housing-related resources. For example, they may have a limited number of permanent housing vouchers to give out, and advocates feel pressured to know in advance who might best "succeed" from this assistance.

During their 6-month interviews, survivors were asked to name the primary advocate they had worked with during the past six months, if they had worked with someone. Of the 375 survivors who completed a 6-month interview, 233 identified a specific advocate they had worked with during the previous 6 months. With survivors' permission, the advocates were then invited to complete a brief online survey about their work with that participant. Out of the initial 180 surveys (77 percent of the original 233) completed by 45 different advocates, six were removed because survivor data was missing for the corresponding timepoints. Analyses were based on the remaining 174 advocate surveys matched with 174 survivor interviews. Analyses accounted for clustering by advocate.

Depending on when the advocate completed their survey, predicting the survivor's housing stability "in six months" may have aligned with the survivor's 12-month interview or may have aligned more closely with their 18-month interview. We examined the date of each advocate survey and calculated the time point six months later to determine whether the date was closer to the 12-month or 18- month follow-up interview of the survivors. We used 12-month interview data for 133 participants (76 percent) and 18-month interview data for 41 participants (24 percent).

Results indicated that advocates can predict program participants' housing stability six months later, but the effect size was small. Their ability to accurately predict housing stability was not related to how connected the survivor felt to them, nor with how satisfied survivors were with the amount of time and effort expended by them.

Exploratory Question #2: Does the DVHF Model Work Better for Some Survivors than for Others?

After examining the impact of the DVHF model across time for the entire sample, we conducted a number of subgroup analyses to see if the model worked better for some survivors than for others. Specifically, we replicated the longitudinal analyses across 24 months but added the following moderators in separate models to look for differences between:

1) Latinx survivors and non-Latinx survivors, and

2) BIPOC survivors[9] and White survivors[10]

Findings did not change for the models comparing Latinx with non-Latinx survivors. Most results were also the same when comparing BIPOC survivors to White survivors. The two exceptions were there that, for BIPOC survivors, those who received DVHF reported lower PTSD over time than did those in SAU. For White survivors, those who received DVHF reported less physical abuse over time compared to those who received SAU. There were no differences between those who received DVHF and those who received SAU. In sum, findings suggest that DVHF works similarly for survivors across race and Latinx ethnicity.

Exploratory Question #3: Are There Agency Characteristics that are Associated with Better Outcomes?

Two exploratory questions related to agency characteristics were examined: 1) whether the DVHF model worked similarly in the three rural and two urban agencies, and 2) whether DVHF survivors' outcomes were impacted by the extent to which they perceived agency services to be trauma-informed.

We replicated the longitudinal analyses across 24 months but added agency location (urban or rural) as a moderator in order to see if findings changed based on whether services were delivered by urban or rural agencies. Almost all findings for the comparison of rural and urban agencies mirrored the analyses for the entire sample. The only group difference that emerged was that survivors who received DVHF from an urban agency reported lower quality of life at six months compared to their counterparts from a rural agency. Given that no other results from any analyses (whether examining the entire study sample or various subgroups) supported that DVHF impacts quality of life, and that this difference only appeared at six months, it is possible that this finding was due to chance. In summary, the DVHF model appeared to work similarly well regardless of whether the agency was in an urban or rural area. However, further studies are needed since the analyses involved only two urban and three rural agencies in one state.

We also examined whether survivors' outcomes at 6-months and 12-months were impacted by the extent to which agency services overall were perceived by survivors to be trauma-informed at 6-months. These data were collected through survivor interviews using the validated Trauma-Informed Practices Scale (TIPS; Goodman et al., 2016[11]). TIPS asks participants to give their overall impression of agency staff (on a scale from 'not at all true' to 'very true') with items such as "I had the opportunity to learn how abuse and other difficulties affect peoples' mental health" and "Staff were supportive when I was feeling

[9] Including any participant who reported being a race other than White (e.g., Black, U.S. Indigenous, Asian, Middle Eastern) and/or who identified as Latinx.
[10] Included only participants who reported being non-Latinx and White
[11] Goodman, L.A., Sullivan, C.M., Serrata, J., Perilla, J., Wilson, J.M., Fauci, J.E., & DiGiovanni, C.D. (2016). Development and validation of the Trauma Informed Practice Scales. *Journal of Community Psychology*, *44*(6), 747-764.

stressed out or overwhelmed." Within the sample of survivors who received DVHF services, survivors' report of agencies' trauma-informed practice was found to be significantly related to nine outcomes across six and twelve months. All findings indicated that survivors in the DVHF group who perceived services to be more trauma-informed had better outcomes than survivors in the DVHF group who perceived services to be less trauma-informed.

In summary, among survivors who received DVHF, the agencies' use of trauma-informed practices (based on survivor report) was related to a number of positive outcomes at 6-months: increased housing stability, decreased physical violence, decreased emotional abuse, decreased stalking, decreased economic abuse, decreased psychopathology (depression, anxiety, PTSD), and increased quality of life. Trauma-informed practices had both a direct and indirect impact on depression, anxiety, and PTSD at 12-months. Other significant impacts at 12-months – housing stability, decreased domestic violence, abuse subscales of emotional abuse and stalking, and quality of life – were all mediated through positive change first occurring at 6-months. Parents reported better school attendance for their children at 6-months but lower prosocial behaviors at 12-months, and it is unclear how these outcomes may relate to the agency's use of trauma-informed practices.

There was no relationship between trauma-informed practices and financial stability, use of children as an abuse tactic, anxiety, PTSD, drug misuse, quality of life, children's school performance, or children's behavioral problems.

Exploratory Question #4: Did COVID-19 Impact the Effectiveness of the DVHF Model?

Given that the COVID-19 pandemic began midway through data collection, we examined whether the pandemic impacted those who received DVHF differently compared to those who received SAU. All participants had completed their baseline and 6-month interviews before COVID-19 was declared a pandemic (using March 15, 2020, as the start date when stay-at-home orders began), and one-third of the sample had completed all five interviews across the 24 months. For the remainder of the sample, 21 percent completed their 12-month interview after the pandemic began, 42 percent completed their 18-month interview after the pandemic, and 67 percent completed the 24-month interview after the pandemic began.

Participants were asked, during each interview, about events occurring since their prior interview. For those interviewed before March 15, 2020, COVID-19 stay-at-home orders had not yet started. Those interviewed six months later (after September 15, 2020) would have been reflecting entirely on months impacted by the pandemic. For those interviewed between these dates, however, the time period for which they were reporting would contain one to five "pre-pandemic" months and one to five "post-pandemic" months. For example, someone who completed their 12-month interview on March 31, 2020, would be reflecting back on five and a half "pre-pandemic" months and only two weeks "post start of pandemic." A participant completing their 12-month interview on July 31, 2020, would be

reflecting back on six weeks "pre-pandemic" and four and a half months after the start of the pandemic. If length of time since the start of the pandemic is important to account for, we cannot consider these two individuals to have had a similar "dosage" of the pandemic. Therefore, for these analyses, data were restructured to account for the number of months before and after the onset of the COVID-19 pandemic. For variables that had six-month recall periods, data were restructured to 6-month intervals before and after the onset of the pandemic. For outcomes with more immediate recall periods, the data were restructured to 3-month intervals after the COVID-19 pandemic. By examining 3-month intervals after the onset of the pandemic, we were able to observe more specific effects of the pandemic as time progressed.

The only significant group differences were on depression and children's prosocial behavior. Among those who were interviewed in the immediate months after COVID-19 stay-at-home orders, survivors who received DHVF and those who received SAU had similar rates of depression. However, among those who were interviewed 4-6 months after the onset of COVID-19, survivors who had received DVHF had significantly lower depression than survivors who had received SAU. This finding suggests that access to DVHF services may have lessened the pandemic's initial impact on depression for DVHF survivors.

We also found that in timepoints prior to the COVID-19 pandemic, survivors who had received DVHF reported significantly higher prosocial behavior in their children. After the onset of the pandemic there were no longer significant differences between DVHF and SAU. This finding suggests that the COVID-19 pandemic negatively impacted children's prosocial behaviors in both groups.

Summary and Implications

Primary Research Questions

This report presents the impacts of the DVHF model on domestic violence survivors and their children over twenty-four months. Longitudinal evidence from this demonstration evaluation indicates that the DVHF model is more effective than SAU in helping DV survivors obtain and maintain safe and stable housing over time. Given that the primary goal of DVHF is to assist survivors in stabilizing their housing, this is a very promising finding.

There were a number of other small but positive changes that emerged as a result of having received DVHF services. Survivors who received DVHF also reported lower abuse across the twenty-four-month follow-up compared to those receiving SAU. In addition, the DVHF model also appears to improve DV survivors' mental health. Specifically, those who received DVHF reported greater decreases in depression, anxiety and PTSD compared to those receiving SAU. This is significant, given evidence linking domestic violence with

mental health symptomatology.[12,13] Interventions that can increase housing stability and safety, while decreasing mental health problems, will be of special interest to community-based programs.

Improvements in housing stability, safety and mental health happened quickly (within the first 6 months after seeking services) and persisted across 12, 18, and 24 months. The positive outcomes for survivors did not, however, correlate with children's increased school attendance or school performance. There were also no significant differences in children's problem behaviors, although parents who had received DVHF reported greater prosocial behaviors from their children compared to survivors who had received SAU. The reasons for this are not clear, as the expectation was that positive changes in parental safety and housing stability would result in these additional positive changes for the children. Further research is needed, with larger and more diverse samples that follow families for an even longer period of time, to better examine these complex relationships.

Exploratory Research Questions

Advocates were able to accurately predict whether program participants would be more stably housed six months into the future, although the effect size was small. This may reflect the tenuous situations that many survivors were continuing to live in, as prior research has shown that people living in poverty or experiencing significant material hardships are often one crisis away from housing instability.

The DVHF model worked similarly across race, ethnicity, and urban and rural geographic service areas. The DVHF model may have been more effective, however, when it was perceived by survivors to be offered within agencies providing trauma-informed services.

COVID-19 did not appear to impact the effectiveness of the intervention across most outcomes. Access to DVHF may have lessened the pandemic's initial impact on depression for DVHF survivors, but over time this difference disappeared.

Taken together, the findings from this demonstration evaluation suggest that the DVHF model is effective in helping survivors achieve long-term safety, housing stability and mental health. Results, however, need to be considered in light of limitations. Both practical and ethical considerations led us to choose a quasi-experimental design over a randomized control trial, so study participants were not randomized into the DVHF or SAU groups. We took steps to ensure the accuracy of grouping participants by services received and we

[12] Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: a systematic review and meta-analysis. *Social Science & Medicine, 75*(6), 959-975.
[13] Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., et al. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *Journal of the American Medical Association, 306*(5), 513–521.

controlled for pre-existing group differences. However, there may be unidentified relationships that contributed to which services participants may have received or that may have accounted for outcomes achieved.

Further, while the study was racially and ethnically diverse, few participants were Indigenous or of Asian or Middle Eastern descent. Replication studies with even more diverse samples, across different geographic regions, and that employ a variety of methodologies, will help create a more comprehensive understanding of how this model works, for whom, and under what conditions.