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Evidence Based Stabilization: A Solution to Reduce Family Homelessness in Massachusetts

Carmela J. DeCandia, Psy.D.

September 2017

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with support from the Oak Foundation

Acknowledgements

Evidence Based Stabilization: A Solution to Reduce Family Homelessness in Massachusetts was developed to share evidence-based solutions to reduce family homelessness in Massachusetts. Homes For Families wishes to thank the Oak Foundation for its ongoing support, and Dr. Carmela DeCandia for sharing her expertise to improve the lives of families experiencing homelessness in Massachusetts.

About Homes for Families

Homes for Families is a statewide advocacy organization committed to ending family homelessness through permanent and emergency solutions. We are a collaborative of families who have experienced homelessness, service providers and advocates. Together we educate, organize and advocate for improved public policies to address the root causes of family homelessness with holistic community-based solutions. For more information visit www.homesfofamilies.org.

About the Author

Carmela J. DeCandia, PsyD, is a licensed psychologist who has dedicated her career to advancing best practices and policies to support vulnerable children and families, and to improve the systems which serve them. For more than 25 years, she has worked with children and families struggling against a variety of life adversities, led direct service and national agencies including St. Mary's Women and Children's Center and The National Center on Family Homelessness. Currently, Dr. DeCandia is the owner and president of Artemis Associates, LLC where she provides training and consultation to organizations to build trauma-informed and family centered services for children and families, and helps agencies develop evidence based assessment protocols. She maintains a clinical practice in Watertown, MA where she provided clinical assessment and neurodevelopmental and psychological testing of children birth - age 17, and is an Adjunct Faculty at Boston College.

Suggested Citation

DeCandia, C.J. (2016). Evidence Based Stabilization: A Solution to Reduce Family Homelessness in MA. Homes for Families, Boston, MA. www.homesforfamilies.org

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EXECUTIVE SUMMARY

While the failure to properly address the issue of homelessness in our state has become a financial problem, it is first and foremost a human tragedy…the status quo is simply unacceptable"
Governor Charlie Baker, 2013

For three decades, states and communities across the country have seen the numbers of families experiencing homelessness steadily climb. Although declines are reported in some years and in some locales, overall the numbers have increased to levels not seen since the Great Depression.[1]

Massachusetts is one of five states that accounts for the 53 percent of the population of families experiencing homelessness[2]. As of 2016, 13,174 families with children experienced homelessness in the state; this represents a 7 percent increase in the family homeless population[3]. As the number of families without homes increases, so do collateral costs in the state's systems of emergency housing (e.g. motel use), health care, schooling, and child welfare. In response to resource-based policies and funding priorities, and inconsistent public awareness of and political will for the plight of vulnerable families, the pendulum swings from increased numbers to reductions, and back again.

The continued rise and seemingly intractable problem of family homelessness can be tied directly to how it has been conceptualized. For 30 years, family homelessness has been viewed primarily as a housing problem, instead of the result of a complex interaction of events and experiences that compound over time and cascade to the catastrophe of homelessness.[4] The dominant narrative has repeatedly led policy makers to endlessly reform the system in search of a magic bullet, without sufficient evidence of its effectiveness. Although some reduction in numbers occur as a few new partnerships are formed, inevitably the pendulum swings back as the numbers of families becoming homeless eventually rebounds.

Family homelessness is more complex than a housing problem. The vast majority of families experiencing homelessness are headed by single mothers caring for young children. They have limited income or opportunity in a job market that provides low wages and little support for single parents. Most mothers have experienced severe trauma from interpersonal violence that increases their isolation and compromises their ability to function as the sole breadwinner for their families. Mainstream supports are often unavailable or insufficient. Support from family and friends, something no family can live without, are often absent or limited. Under such extreme circumstances, parents can quickly become depleted. As a result, many children experiencing homelessness become anxious or depressed, demonstrate behavioral problems, and suffer ill health. Considering more than half of homeless children are between the ages of birth to five, this kind of instability directly impacts brain development and places their very futures at risk.

Effective solutions to reduce family homelessness address a myriad of structural, individual, and sociocultural influences. The complex interaction of factors must be recognized not just as part of the narrative of family homelessness, but as its core feature. Until family homelessness is viewed in this context, policies and system reforms aimed at reducing shelter usage will continue to miss the mark and ultimately fail.

The United States Interagency Council on Homelessness [USICH] set a goal of ending family homelessness by 2020.[5] To do so, housing and service models that approach the problem from an integrated, evidence based perspective are sorely needed. Although the evidence base is still developing,[6] three strategies form the bases of an effective response: *Prevention, Diversion, and Stabilization*.

A Three-Pronged Approach to End Family Homelessness

- ✓ **PREVENT** families from becoming homeless;
- ✓ **DIVERT** families from shelter to stabilize in their local communities;
- ✓ **STABILIZE** families from shelter through transition into the community.

To date, most states, including Massachusetts, have focused their efforts on two of these three strategies: prevention and diversion. *Prevention* targets families at risk for homelessness;[7] *Diversion* targets families entering shelter to help locate alternative, safe, community placements.[8] As a result of these targeted efforts, in the past year Massachusetts has seen a significant reduction in the number of families sheltered in hotels and motels,[9] a major achievement by shelter and housing providers, the Department of Housing & Community Development [DHCD] and the Baker Administration.

Prevention and diversion approaches are effective in *reducing* family homelessness, if routinely funded and supported. However, on their own, prevention and diversion will not succeed in *ending* family homelessness. Evidence-based stabilization for families who have entered shelter and are transitioning back to the community is also needed. However, stabilization as a practice has yet to be fully developed, implemented, standardized, or rigorously evaluated.

Key Features of Effective Stabilization

- ✓ Housing.
- ✓ Income Supports.
- ✓ Education & Jobs.
- ✓ Homeless and mainstream programs to address the needs of culturally diverse families, especially single mothers.
- ✓ Services within homeless and mainstream programs to target:
  - Domestic violence
  - Interpersonal trauma.
  - Clinical parental depression.
  - Children's developmental needs and behavioral health.

Evidence-based stabilization is the third leg of an integrated approach to reduce, and ultimately end, family homelessness. An effective approach to stabilization is grounded in the evidence of who homeless families are, what they need, and the best practices to meet those needs. A stabilization component to shelter contracts and the Massachusetts HomeBASE program—already in place to help homeless families—provides a solid foundation on which to build an evidence-based model for family stabilization. Using existing stabilization programs as a starting point, Massachusetts can interrupt the cycle and reduce the numbers of families needing shelter. This singular signature initiative can change Massachusetts' position from a state that leads the nation in the growth of family homelessness, to one that leads the nation to end it.

Evidence Based Stabilization:
A Solution to End Family Homelessness in Massachusetts

INTRODUCTION

Since it was first recognized as a growing social problem in the early 1980s,[10] the number of families experiencing homelessness has reached epidemic proportions. In 2016 the United States [U.S.] Department of Housing and Urban Development [HUD] reported 549,928 people were homeless on a given night in January, including 194,716 people in 61,265 families with children, representing 35 percent of the total homeless population[11]. Five states, including Massachusetts, accounted for more than half of homeless families in 2015 and 2016.[12], [13]

In Massachusetts, an estimated 28,683 children were homeless in 2010; by 2013 that number had grown to 31,516.[14] By the end of 2014, 4,900 families were living in shelters, transitional housing, and motels.[15] The Point-in-Time count from 2007-2015 indicates a 116 percent increase in the numbers of families experiencing homelessness in Massachusetts.[16] The most recent 2016 HUD Point-In Time count reported another 7 percent increase in family homelessness in Massachusetts. Health and safety issues (e.g. domestic violence, irregular housing, housing not meant for human habitation) are cited as the most common reasons for homelessness.[17]

To address the continued increase in family homelessness in Massachusetts, we must first understand the root causes. While family homelessness is certainly caused by a lack of housing and income, addressing these two factors alone will not solve the problem. A closer look at the characteristics of homeless families points the way to an effective solution.

Characteristics of Families Experiencing Homelessness: A Review of the Research

> *To effectively deliver housing and services to women, we must respect, embody, and value the diversity among women experiencing homelessness. We should be choosing policies that benefit women.*
> *USICH, 2016*

The profile of homeless families has remained consistent over the past 30 years. The individual risk factors of homeless families have been firmly established by a robust literature.[18] Although a heterogeneous group, the majority of families experiencing homelessness share three key features: single parenting for racially diverse mothers, high rates of traumatic stress and major depression, and developmental concerns for the children. As such, approaches to address families' needs cannot be simply copied from the work done with other homeless subgroups, but instead must be tailored to target the specific risk factors of families.

Families Headed by Single Mothers

Most homeless families are comprised of single mothers in their late twenties with young children, at least one of whom is under age six.[19] HUD's most recent Annual Homeless Assessment Report [AHAR] report to Congress[20] reported that 60 percent of homeless parents in shelter are women, and the HUD Family Options Study[21] reported that 78 percent of adults in sheltered families are women.

Racial minorities are disproportionately represented in the shelter system. For example, Census data indicate that African Americans make up 15 percent of the U.S. population,[22] but represent almost four times that many families in shelters (51 percent).[23] Similarly, 26 percent of families in shelter are Hispanic, though they represent only 17 percent of the general population.[24] Although single father and two parent households entering shelter increased after the foreclosure crisis,[25] the data overwhelmingly indicate that homelessness among families is primarily a problem of inequity that disproportionately affects low-income, racially diverse, single mothers.[26]

In Massachusetts, the gap between income and rental costs places an extraordinary burden on families, especially those headed by single mothers. These families live in extreme poverty and often struggle with limited education, low wages, and unemployment.[27] Accessing affordable child care is a significant hurdle to finding and maintaining employment.[28] As a result, single female headed families often face eviction.[29] To address these underlying gender and racial inequities, a recent federal summit recommended that policies and practices be tailored primarily to the strengths and needs of racially diverse women and children.[30]

> *"If incarceration had come to define the lives of men from impoverished black neighborhoods, eviction was shaping the lives of women.*
> *Poor black men were locked up.*
> *Poor black women were locked out."*
> *Matthew Desmond, 2016*

<u>High Rates of Interpersonal Trauma and Clinical Depression</u>

Homeless Families are resilient. In the face of overwhelming stress, parents routinely care for their children, work, and go to school. That said, we still cannot ignore or minimize their health and mental health needs.

Risk Profiles of Homeless Mothers

78%	Women in sheltered families (most in their late 20's)
4x	More likely to be African American
1.5x	More likely to be Latina
93%	Interpersonal trauma (assault)
91%	Childhood abuse
81%	Multiple traumas
60-70%	Domestic violence
45-85%	Clinical depression
36-56%	PTSD

Over 90 percent of homeless mothers have experienced interpersonal trauma in their lifetimes; most report repeated victimization in childhood and adulthood.[31] Domestic violence impacts between 60-70 percent of homeless families.[32] As a consequence, approximately two-thirds of homeless mothers suffer with clinical depression,[33] and rates of Post-Traumatic Stress Disorder [PTSD] are three to four times greater than the general population.[34] These life-altering experiences and clinical disorders are rarely assessed or addressed among homeless families;[35] most never receive treatment. In addition, although not captured by threshold-based assessment instruments, many more women struggle with subclinical post-trauma responses that exact a debilitating toll on parental functioning.

<u>Developmental Concerns for Children Experiencing Homelessness</u>

One in 30 children in the United States experiences homelessness each year, according to 2013 data.[36] This is an increase from one in 50 in 2006.[37] Race is again a factor. One study indicated that African American children under the age of five are 29 times more likely than White children to be in homeless shelters.[38]

Risk Profiles of Homeless Children

51%	Under age 6
83%	Exposure to violence by age 12
40%	School age mental health issues
25%	Witnessed family violence
25%	Preschool developmental delays
5x	Gastrointestinal problems
4x	Respiratory infections
2x	Ear infections

The impact of homelessness on child development is well established. Children in families living in unstable housing arrangements are 59 percent more likely to have been hospitalized and 52 percent more likely to be at risk for developmental delays compared to those in housing secure families.[39] More than one-third of children who are homeless have been involved in a child protection investigation.[40] Homeless children are also more likely to experience hunger, be separated from caregivers, witness violence, struggle in school, and experience a host of medical illnesses at greater rates than their housed counterparts.[41] Homelessness during infancy has been linked to later poor health outcomes.[42] This includes developmental delays in language and communication among preschoolers,[43] and mental health and learning difficulties for school age children.[44]

The Adverse Childhood Experiences (ACEs) study demonstrated a progression from early adversities to medical, social, emotional, and cognitive impairments in later life.[45] ACEs are more likely to be associated with poverty, unsafe communities, unstable home environments, and family separations. This type of early adversity, common among many children facing homelessness, can create toxic stress and negatively alter a child's brain development.[46] Despite exposure to significant early adversity, most homeless children rarely receive interventions known to prevent or ameliorate developmental concerns.

"Healthy development of young children in the early years of life literally provides a foundation for just about all of the challenging social problems that our society and other societies face."

Jack Shonkoff, M.D.
The Science of Early Childhood

Children are also resilient. Even for those experiencing adversity, when early interventions are provided to address developmental needs, children respond; problems can be ameliorated or prevented. Given the grave and long-lasting impact homelessness can have on children, policymakers should especially be concerned about responding to their needs. As most children experiencing homelessness are under the age of six, policies should be crafted to prevent and minimize the impact of early adversity on the child's developing brain. Not doing so is more than a missed opportunity; it fuels the intergenerational issues that often plague homeless families. In both human and economic terms, the cost of not addressing these known risks is immeasurable.

WHAT WORKS: NATIONAL EVIDENCE

Prevention and diversion assistance may include a combination of financial assistance, mediation, housing location, or other supports. When the intervention is aimed at helping families stay in their current housing, safety should be a primary consideration.
USICH, 2014

The story of "what works" emerges from three sources. First, there exists a remarkable consistency in the national data on population characteristics and risk profiles of homeless families. Second is the ever growing convergence of research from such varied disciplines as economics, child

development, and neuroscience identifying best practices to support vulnerable children and families. Third, anecdotal reports are increasingly being supported with qualitative and quantitative data capturing the voices of providers[47] and families.[48] For example, in Massachusetts, families from across the state met at the Homes for Families Annual Visioning Day event to share their perspectives on what families need. Families advocated for affordable housing, child care, living wages, community based supports, and "*to be treated with dignity and respect through trauma-informed, culturally competent, and inclusive practices.*"[49] Research and families suggest it is time for an evidence-based, three-pronged approach to family homelessness.

Effectiveness of Prevention and Diversion

Preventing families from becoming homelessness is a goal anyone combating this complex social problem desires. To do so, it is important to understand its causes and identify predictive factors specific to the population.[50] This has been a challenge for researchers due to the complexity of the issue.[51] The tendency to narrow and target approaches – focusing on one issue at a time – makes it easier to target resources. However, this specialized approach does not fully appreciate the interrelated structural and individual factors that conspire to lead to homelessness.[52]

Housing assistance plays a critical role in primary homelessness prevention.[53] When families are granted priority access to long-term housing subsidies, significant improvements are seen in housing stability and certain aspects of family functioning.[54] Stable housing is linked to better educational outcomes for children.[55] In addition, stable housing improves health outcomes for all family members while reducing costs to the healthcare system.[56]

Housing subsidies are the most effective means of preventing homelessness for poor families.[57] Additionally, effective prevention strategies include: increasing access to income supports (e.g. TANF), housing court mediation to preserve tenancies, and eviction prevention.[58] Data sharing, cross system collaboration, and appropriate resource allocation enables states and communities to target families in need.[59]

Diversion offers another housing response to individual instances of homelessness. Diversion targets families entering shelter to help locate alternative, safe, community housing placements.[60] In addition to identifying housing options, diversion programs may also connect families with services and financial assistance that will help them return to permanent housing without entering shelter. Diversion programs can decrease the number of families becoming homeless and reduce the demand for shelter placements.[61]

The initial outcomes of diversion programs suggest it is a worthwhile approach to explore for use with families applying for shelter. Early pilot projects reported diversion rates between 25-46 percent among those seeking shelter.[62] For example, a pilot program in Boston, MA diverted 42 percent of families seeking shelter. After 7 weeks, only 14 percent had returned to the shelter.[63] In Columbus, OH, a pilot program diverted one in four families seeking shelter, of which less than five percent returned to the shelter system.[64] More recently, a diversion project in New London County, CT diverted 80 percent of families seeking emergency shelter to alternative housing. Initial outcomes indicate that only one in six of those families later returned seeking shelter.[65] Current data in Massachusetts indicates that 20 percent of families were diverted from shelter in 2016[66].

Despite these reported successes, it is important to note that there is a lack of longitudinal evidence regarding the outcomes of families who have been diverted from shelter. As such, the practice must be approached cautiously and be accompanied by a comprehensive model that fully assesses issues of eligibility, the appropriateness of placement outcomes, whether needed services are accessed, and the family's functioning once diverted. To fully know whether diversion is effective in stabilizing families in housing and improving wellbeing, routine outcome monitoring needs to be embedded into the system to track families over time. This will require data sharing to be successful.

Stabilization

Stabilizing homeless families involves use of emergency shelter and the creation of rehousing plans combined with services to address educational, employment, and individual needs. However, what constitutes an effective stabilization program has not yet been carefully defined and studied.

The current focus on the need for affordable housing is perhaps the most critical component of an effective policy response to stabilization; families do indeed benefit from housing subsidies.[67] Although the dominant paradigm has created models that target resources to structural needs and system reforms,[68] it falls short in creating approaches that integrate services. In general, these models, though they are not without benefit, do not incorporate evidence for, or understanding of, trauma and its impact on women, parenting, and child development. That said, a review of the two models most commonly applied to families – Rapid Rehousing and Housing First – provides insight into what works, as well as into the gaps in current stabilization models for families.

Rapid Rehousing is the most common stabilization practice. Endorsed by the federal government, Rapid Rehousing was developed to quickly rehouse families and reduce shelter usage. Its goal is to create quick shelter exists (generally within 30 days or less) with minimal services. Rapid Rehousing helps reduce length of shelter stays and move families more quickly into housing,[69] but has yet to demonstrate significant improvement in housing stability or family well-being.[70]

Rapid Rehousing makes use of a stabilization model known as "progressive engagement."[71] This approach aims to provide minimal services to families upon exit from shelter, and to only increase services if they fail to show improvement. Fundamentally, progressive engagement forces families to "fail-up" to needed services. The practice is not in line with the science for addressing risk and protective factors of vulnerable families, and lacks a more complex frame that makes use of comprehensive assessment to guide the process.

Comprehensive assessment of a family's strengths and needs is essential to guide effective stabilization. Currently, there is a high degree of variability across providers in practices and models,[72] and most assessments are not standardized. As a result, assessment outcomes often miss significant areas of family need.[73] Federal policy requires that all Continuums of Care (CoCs) develop and implement a centralized or "coordinated assessment,"[74] but coordinated assessment of families experiencing homelessness is in its infancy. The *Family Service Prioritization Decision Assistance Tool* (F-SPDAT), and the abbreviated *Prescreen for Families*, are increasingly being adopted by communities. However, the evidence base on their effectiveness has yet to be established. A review of its components identified it as a good tool to identify basic housing needs, but weak in assessing specific risks relevant to homeless children and mothers.[75]

Housing First is an integrated approach to housing and services that makes use of Critical Time Intervention (CTI), an evidenced based, time limited, phased approach to stabilization. CTI was developed to integrate housing and services for chronically homelessness individuals with serious mental illness.[76] CTI is listed in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP) and is widely acknowledged to be a strong evidence-based model for addressing homelessness. Family Critical Time Intervention (FCTI) is an early adaptation of this model for families,[77] although it did not include comprehensive services for children. To date, CTI/FCTI's effectiveness for homeless families has not been well studied;[78] however, it provides a strong foundation on which to build an evidence-based stabilization program for homeless families.

Even with the provision of housing, stabilization post-shelter is challenging for some families. For example, the Services and Housing Interventions for Families in Transition (SHIFT) study found that severity of mothers' trauma symptoms predicted residential instability for homeless families 30 months after leaving shelters or housing programs.[79] Walsh et al (2014) examined barriers and facilitators of residential stability for homeless families and identified services that were needed to maintain residential stability.[80] These include: education and training to improve employment opportunities; mental health and substance abuse treatment, especially related to trauma; and access to child care and parenting supports. For most homeless families these types of supports are often difficult to obtain both within and outside of the homeless system. For example, mainstream behavioral health services are often unavailable or difficult to access. In addition, although "trauma-informed care" is being advanced as a cost-effective, organizational strategy for homeless programs,[81] the degree to which such services are implemented varies widely.[82]

The evidence is clear. Policies to house and stabilize homeless families must include a focus on factors that can compromise their ability to maintain stability. Along with housing support, education, employment, and services to address trauma and mental health treatment for mothers and developmental needs of children are necessary components of an effective response to stabilization.

APPLYING WHAT WORKS IN MASSACHUSETTS

> *"The governor's multifaceted approach demonstrates that this crisis must be addressed on several fronts in order to achieve real success and break the cycle of homelessness and poverty. A safe place to live is the foundation, but customized support services are also essential."*
> *Deborah Hughes, CEO Brookview House*
> *Boston Globe 5/26/2016*

Massachusetts has long led the nation in implementing best practices. Historically, the Massachusetts Interagency Council on Housing and Homelessness (ICHH) has worked to create policies and initiatives targeted to the needs of homeless individuals and families.[83] In 2014, Massachusetts was ranked 2nd in the nation for its state policy and planning efforts, and third in the nation overall for its handling of child homelessness.[84] Although families were not formally identified as a priority population by the ICHH from 2007-2014, key interagency initiatives with member agencies addressed families' needs. Some examples included use of HomeBASE and Flexible Funds for housing support, focusing on family unification, and cross training on early

education resources and screening for child care and homeless providers. The current ICHH, co-chaired by the Secretaries of Health and Human Services and Housing and Economic Development, provides a structure for collaboration across state agencies. Pending legislation requires state agencies to enter in a Memorandum of Understanding (MOU) to share data and develop protocols to prevent homelessness and have a more coordinated response to housing instability[85].

Prevention and diversion efforts represent two effective strategies that have been applied in Massachusetts. Through a variety of initiatives, the numbers of families in motels in Massachusetts has declined. Since taking office in January 2015, Governor Baker and the Department of Housing and Community Development (DHCD) sustained focus on prevention and diversion and improved system management practices leading to an impressive 97 percent reduction of families living in motels, a statewide diversion rate of 20 percent, and a 20 percent reduction in the total caseload in the Emergency Assistance (EA) system .[86] In addition, efforts to better integrate housing and healthcare systems are being explored. Research indicates that one cross-system prevention strategy worth pursuing is to make screening for housing status an integral part of health care. A recent study in Boston reported that screening of low-income mothers during well-child visits at community health centers, combined with referrals for housing and health care supports, helped prevent homelessness among at-risk families.[87]

Despite the progress being made, it is estimated that the percentage of families across Massachusetts with a severe housing burden (paying more than 50 percent of income on housing costs) increased 8.4 percent between 2013 and 2014[88] and that more and more families are still living on the edge of homeless. With the shelter contracts and Massachusetts HomeBASE program providing the structural basis of its stabilization model, all sheltered families are now eligible for 12 months of housing support of $8,000, up from the original amount of $4,000 per year.[89] Although still lower than the true need for most families to attain long-term residential stability, the program demonstrates the current administration's commitment to addressing the structural gap between low wages for poor families and single parents, and their housing costs.

Family Assessment and Stabilization: The Cutting Edge

The cutting edge of policy and practice in family homelessness lies in how we approach stabilization. Although providing a 12-month subsidy through HomeBASE is commendable considering the lack of federal resources available to combat homelessness, shallow subsides alone are not effective in reducing homelessness. Knowing that one-year subsidies can only go so far, it is especially critical that any amount of housing support be accompanied by an evidence-based stabilization model if family homelessness is to be permanently reduced.

Researchers support enhancing stabilization services in Massachusetts to support the transition from shelter to the community for families struggling with the combined effects of structural and individual risk factors.[90] Still needing to be developed, tested, and brought to scale, this third leg of an effective response represents the forefront of innovation in the homelessness field. Leadership, the courage to embrace a new paradigm, and bold action are needed if these innovative models are to be implemented and evaluated.

A New Paradigm

Housing and income are essential to end family homelessness. However, for too long the dominant paradigm for addressing family homelessness has stubbornly refused to acknowledge the role that

race, gender, and interpersonal violence have in perpetuating this national tragedy. In doing so, the need for housing support for the homeless population remains the focus, while individual risk factors specific to the subgroup of families are blurred. After 30 years, this paradigm has failed to permanently reduce the number of homeless families. Now, armed with 30 years of research about who families are and what they need, it is time to base policies on a new paradigm.

A more appropriate paradigm to address family homelessness falls within what is referred to as the population/ high-risk framework[91]. This model is focused on the combined effects that structural factors and sociocultural inequities have on life outcomes.[92] This framework "*draws attention to the need for direct intervention among those at most risk, and also for modifying the overall context… only the population/ high-risk approach focuses on identifying and targeting the causes of homelessness at multiple levels."*[93]

Although better suited to address the complexity of homelessness, the population/high risk paradigm is not without its challenges. Prevention resources are limited and cannot be spread across the entire population. Similarly, targeting scarce resources to only those at highest risk is a difficult task requiring assessment and screening tools to be highly sensitive to predictive factors – something not yet well developed in the homelessness field. The dangers are that the right interventions are not delivered to the right persons, and that many families are missed altogether.[94]

> *"It is likely that families will require both affordable housing and special services in order to prevent homelessness or remain stably housed"*
> *Apicello, 2010, pp.45.*

Despite these challenges, the hard reality is that policies and practices must address both population needs and individual risks. Providers have long been aware of the need to address housing and services simultaneously for families experiencing homelessness. Many have done so for years, but without a clear unifying model tested for its effectiveness. New models are being developed. One model that targets population needs for housing and income supports as well as subgroup individual risk factors is *BSAFE: Building Strengths and Advocating Family Empowerment.*[95] *BSAFE* provides a framework for the delivery of various evidence-based approaches (e.g., CTI, trauma-informed care) to stabilize homeless families from the point of shelter into the community. In line with the research, and consistent with the population/high risk paradigm, *BSAFE* targets both the structural and individual issues impacting homeless families. With HomeBASE and MRVP as rehousing tools, Massachusetts is well positioned to lead the nation in adopting a population/high risk approach to ending family homelessness.

Cost Savings Will Offset State Investments in Family Stabilization

Prevention, diversion, shelter, and stabilization all have a place in the fight to end family homelessness. Cost savings are noted when investments are made. The Bush and Obama administrations allocated an annual increase of 500 million dollars by 2008, and a one billion dollar increase in annual funds by 2014 to provide housing and services for chronically homeless individuals and homeless veterans, respectively. As a result, homelessness among both subgroups has declined by over 30 percent since 2007.[96]

In Massachusetts, use of evidence-based stabilization (Housing First) with chronically homeless individuals also led to cost savings across other systems of care. Costs for acute medical care, substance abuse treatment, health and incarceration all dropped by an estimated $11,000 per person over 6 months – a savings of more than 25 percent.[97]

The same cannot be said for family homelessness, where similar levels of investment have yet to be made. However, preliminary data indicate that significant cost savings are possible when targeted investments are made in prevention, diversion, and stabilization for families. In a 2016 presentation to the Massachusetts ICHH, Culhane reported cost savings in central Massachusetts using diversion, rehousing, and stabilization services versus shelter and stabilization for families.[98] Estimated savings were $77 per day per family, and $14,053 per family over six months. Culhane recommended that to improve system outcomes, strategies should include incorporating CTI into service delivery, and making funds flexibly available for prevention, diversion, shelter and stabilization.

Cost saving models indicate that investing in housing and services targeted to the specific needs of homeless subgroups saves money and improves lives. Continued prevention and diversion efforts, coupled with a robust, evidence-based response to stabilize homeless families from shelter into the community will be lower than what is now spent on keeping families in emergency shelters for prolonged periods of time. The data indicate that, as has been shown with other subgroups, doing so will reduce public spending across systems; for families it is expected that the biggest savings will be seen in health care services and child welfare involvement. Additionally, parents who join the state's workforce will be better able to support their households, and become greater contributors to the state's economy.

CONCLUSION

"The challenge for policymakers is to make use of these data to steer policy and practice in line with the emerging evidence base."
DeCandia, 2015

Over the past 30 years, we have learned a great deal about what works and what is needed to end family homelessness. We know who homeless families are; we know about their strengths; and we know about the risk factors in their lives. We know that support for housing works. We know prevention works. We know that some families, with careful assessment, can be diverted from shelter to alternative, safe housing. We also know that most families will require services, ongoing support, and access to opportunities to move from shelter to long-term stability.

After decades of changing policies and cycles of reform, the solution lies in the evidence. New paradigms point to simultaneously addressing population-level structural factors and individual risk factors. With 2020 a mere three years away, to reduce the numbers of families experiencing homelessness in Massachusetts, evidence-based practices must be intensified, brought to scale, and where absent, developed and rigorously evaluated.

In the case of family homelessness, effective policies and practices must target three things: 1) prevention and diversion for those in emergent need; 2) structural factors that affect the homeless population as a whole (e.g. affordable housing, and access to child care, income supports and jobs/careers), and; 3) stabilization programs and services to address known subgroup individual risk factors (e.g. trauma, domestic violence, trauma, child development).

Massachusetts has already developed a good base for delivering prevention, diversion, and stabilization services; efforts should continue in that direction, and wherever possible, be strengthened. How we build stabilization models, in line with the evidence, to meet the needs of families remains the critical question and gap to be filled, in practice as well as in policy. CTI models adapted for families show great promise, as outlined in the newly developed framework, *BSAFE*. Massachusetts is now in a position to pilot the first evidence-based stabilization model adapted for families, and lead the way forward in a cutting-edge response to ending family homelessness.

If prevention and diversion efforts continue at the current pace, with continued support from the Commonwealth, the numbers of families in motels in Massachusetts will reach zero. Stabilizing families as they leave shelter, so they do not return, will also likely lead to significant reductions in the homeless population. As history has demonstrated, not doing so will inevitably lead to the pendulum swinging back to increased numbers. Evidence from multiple fields indicates the time is right to create a statewide, evidence-based, approach to stabilization and put an end to family homelessness.

ENDNOTES

[1] Bassuk E.L., DeCandia, C.J., Beach, C.A., & Berman, F. (2014a). *America's youngest outcasts: A report card on child homelessness.* The National Center on Family Homelessness at American Institutes for Research. Waltham, MA. Retrieved from www.homelesschildrenamerica.org. Burt, M. (1992). Over the edge: The growth of homelessness in the 1980s. NewYork: Russell Sage Foundation. Schon, D. A., & Rein, M. (1994). Homelessness in Massachusetts. In *Frame reflection: Toward the resolution of intractable policy controversies.* New York, NY: Basic Books, A Division of HarperCollins Publishers, inc. ., pp. 129-161.

[2] U.S. Department of Housing and Urban Development (HUD). (2016). The 2016 point-in-time estimates of homelessness. The 2016 Annual Homeless Assessment Report to Congress, Vol.1. Washington, DC: Author.

[3] U.S. Department of Housing and Urban Development (HUD). (2016). The 2016 point-in-time estimates of homelessness. The 2016 Annual Homeless Assessment Report to Congress, Vol.1. Washington, DC: Author.

[3] Bassuk et al., 2014a.

[4] Apicello, J. (2010). A paradigm shift in housing and homeless services: applying the population and high-risk framework to preventing homelessness. *Open Health Services and Policy Journal*, *3*, 41-52.

[5] U.S. Interagency Council on Homelessness (USICH). (2010). Opening doors: Federal strategic plan to prevent and end homelessness. Washington, D.C.:Author. U.S. Interagency Council on Homelessness (USICH). (2014). Family Connection: Build Connections to End Family Homelessness. Washington, D.C.: Author. https://www.usich.gov/tools-for-action/family-connection. U.S. Interagency Council on Homelessness (USICH). (2015a). Opening doors: Federal strategic plan to prevent and end homelessness, update 2015. Washington, D.C.: Author. U.S. Interagency Council on Homelessness (USICH). (2015b). Summary of changes to opening doors, as amended June 2015. Washington, D.C.: Author. Retrieved from: http://usich.gov/resources/uploads/asset_library/Summary_ Changes_2015_OD_Amendment.pdf.

[6] Bassuk, E. L., DeCandia, C. J., Tsertsvadze, A., & Richard, M. K. (2014b). The effectiveness of housing interventions and housing and service interventions on ending family homelessness: A systematic review. *American Journal of Orthopsychiatry*, 84(5), 457–474. U.S. Department of Housing and Urban Development [HUD] (2015b). Family Options Study: Short-Term Impacts of Housing and Services Interventions for Homeless Families. Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

[7] Burt, M. R. (2005). Strategies for preventing homelessness. U.S. Department of Housing and Urban Development, Office of Policy Research and development. The Urban Institute, Washington, D.C. Culhane, D.P. & Byrne, T. (2010). Ending Family Homelessness in Massachusetts: A New Approach for the Emergency Assistance Program. http://repository.upenn.edu/spp_papers/144. Culhane, D. P., Metraux, S., Park, J. M., Schretzman, M., & Valente, J. (2007). Testing a typology of family homelessness based on patterns of public shelter utilization in four US jurisdictions: Implications for policy and program planning. *Housing Policy Debate*, *18*(1), 1-28. National Alliance to End Homelessness[NAEH] & U.S. Department of Housing and Urban Development (HUD). (2015a). Assessment tools for allocating homelessness assistance: State of the evidence. Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Policy and Research.

[8] National Alliance to End Homelessness [NAEH] (2015b). Progressive Engagement Stability Conversation Guide. Available at: http://www.endhomelessness.org/library/entry/progressive-engagement-stability-conversation-guide

[9] DHCD entry data report 07/08/16. Department of Housing and Community Development[DHCD] Emergency Assistance [EA] Monthly Report, Statewide Summary (May 2016). Retrieved 07/25/16 from http://www.mass.gov/hed/docs/dhcd/hs/ea/eamonthlyreport.pdf..

[10] Schon & Rein,1994.

[11] U.S. Department of Housing and Urban Development (HUD). (2016). The 2016 point-in-time estimates of homelessness. The 2016 Annual Homeless Assessment Report to Congress, Vol.1. Washington, DC: Author.

[12] U.S. Department of Housing and Urban Development (HUD). (2015a). The 2015 point-in-time estimates of homelessness. The 2014 Annual Homeless Assessment Report to Congress, Vol.1. Washington, DC: Author.

[13] U.S. Department of Housing and Urban Development (HUD). (2016). The 2016 point-in-time estimates of homelessness. The 2016 Annual Homeless Assessment Report to Congress, Vol.1. Washington, DC: Author.

[14] Bassuk et al., 2014a.

[15] On Solid Ground Coalition (2015). *On Solid Ground: Building Opportunity, Preventing Homelessness*. Citizens Housing and Planning Association. Boston, MA.

[16] HUD, 2015a; Weinreb, L., Rog, D., & Greer, A. (2016). Intersection between homelessness and healthcare in Greater Boston: Curent status, challenges, and prospects for improvement. Fina Report. Oak Foundation. London, England.

[17] Department of Housing and Community Development [DHCD] Emergency Assistance [EA] shelter report December (2014). Retrieved 2/27/15 from http://www.mass.gov/hed/housing/stabilization/emergency-assistance.html.
[18] Bassuk, E. L., Weinreb, L., John, C. B., Browne, A., Salomon, A., & Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. Journal of the American Medical Association, 276(8), 640-646. Bassuk, E. L., Buckner, J. C., Weinreb, L. F., Browne, A., Bassuk, S. S., Dawson, R., & Perloff, J. N. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health*, 87(2): 241-48. Bassuk, E. L. & Beardslee, W. (2014). Depression in homeless mothers: Addressing an unrecognized public health issue. *American Journal of Orthopsychiatry*, 84(1), 73–81. Bassuk, DeCandia, Beach, & Berman, 2014a; Bassuk, DeCandia, Tsertsvadze, Richards, 2014b; Bassuk, E. L., Richard, M., & Tsertsvadze, A. (2015). The prevalence of mental illness in homeless children: A systematic review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry*. Feb;54(2):86-96. Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). The national intimate partner and sexual violence survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.Browne, A., & Bassuk, S. S. (1997). Intimate violence in the lives of homeless and housed women: Prevalence and patterns in an ethnically diverse sample. American Journal of Orthopsychiatry, 67(2), 261–278. Buckner, J. C. (2008). Understanding the impact of homelessness on children: Challenges and future directions. *American Behavioral Scientist, 51* (6), 721-736. Buckner, J. C., Beardslee, W. R., & Bassuk, E. L. (2004). Exposure to violence and low income children's mental health: Direct, moderated, and mediated relations. American Journal of Orthopsychiatry, 74, 413-423.Burt, M., & Aron, L. Y. (2000). *America's homeless II: Populations and services*. Washington, DC: The Urban Institute. Guarino, K., & Bassuk, E. (2010). Working with families experiencing homelessness: Understanding trauma and its impact. Zero to Three, 30(3),11-20. Haskett, M., Armstrong, J.M. & Tisdale, J. (2015). Developmental Status and Social–Emotional Functioning of Young Children Experiencing Homelessness. *Early Childhood Education Journal*, doi 10.1007/s10643-015-0691-8. Hayes, M., Zonneville, M., & Bassuk, E. (2013). *The SHIFT Study final report: Service and housing interventions for families in transition*. The National Center on Family Homelessness; Newton, MA. Herbers, J. E., Cutuli, J. J., Lafavor, T. L., Vrieze, D., & Leibel, C. (2011). Direct and indirect effects of parenting on the academic functioning of young homeless children. *Early Education and Development*, 22(1),77–104. Herbers, J. E., Cutuli, J. J., Monn, A. R., Narayan, A. J., & Masten, A.S. (2014). Trauma, adversity, and parent-child relationships among young children experiencing homelessness. *Journal of Abnormal Child Psychology*. doi: 10.1007/s10802-014-9868-7. Hicks-Coolick, A., Burnside-Eaton, P., & Peters, A. (2003). Homeless children: Needs and services. *Child & Youth Care Forum*, *32*, 197–210. HUD 2015b; Lindsey, E. W. (1998). The impact of homelessness and shelter life on family relationships. *Family Relations*, 47, 243–252. Masten, A. S., Cutuli, J. J., Herbers, J. E., Hinz, E., Obradović, J., & Wenzel, A. J. (2014). Academic risk and resilience in the context of homelessness. Child Development Perspectives, 8(4), 201-206. Masten, A., Militois, D., Grahma-Berman, S., Ramirez, M., & Neeman, J. (1993). Children in homeless families: Risks to mental health and development. *Journal of Consulting and Clinical Psychology*, 61, 335-343. National Network to End Domestic Violence. (2007). Domestic violence counts: A 24-hour census of domestic violence shelters and services across the United States. Washington, D.C.: Author. Perlman, S.M., & Fantuzzo, J. (2010). Timing and influence of early experiences of child maltreatment and homelessness on children's educational well-being. Children and Youth Services Review, 32(6), 874-883. Rog, D. J. & Buckner, J. C. (2007). Toward understanding homelessness: The 2007 National Symposium on Homelessness Research. In D. Dennis, G. Locke, & J. Khadduri (Eds.). Cambridge, MA: Abt. Associates. Samuels, J., Shinn, M., & Buckner, J.C. (2010). Homeless Children: Update on Research, Policy, Programs, and Opportunities. Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. Washington, D.C. Weinreb, L. F., Buckner, J. C., Williams, V., & Nicholson, J. (2006). A comparison of the health and mental health status of homeless mothers in Worcester, Mass:1993 and 2003. American Journal of Public Health, 96(8), 1444-1448.
[19] HUD, 2015a; Bassuk, DeCandia, Beach & Berman, 2014a.
[20] HUD, 2015a
[21] HUD, 2015b
[22] U.S. Census Bureau (2015). Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: April 1, 2010 to July 1, 2015. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
[23] HUD, 2015a.
[24] U.S. Census Bureau, 2015; HUD, 2015a.
[25] Currie, J. & Tekin, E. (2011). Is the Foreclosure Crisis Making Us Sick?.National Bureau of Economic Research Working Paper Series. Number 17310. Isaacs, J.B. (2012). The Ongoing Impact of Foreclosures on Children. Brookings Institute and First Focus. Washington, D.C. Kushel, M.B., Gupta, R., Gee, L., Haas, J.S. (2006). Housing Instability and

Food Insecurity as Barriers to Health Care among Low-Income Americans. Journal of General Internal Medicine 21(1), pp. 71–77.

[26] Burt, M., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (Urban Institute) (1999). *Homelessness: Programs and the people they serve: Findings of the National Survey of Homeless Assistance Providers and Clients*: Technical report prepared for Interagency Council on the Homeless. Washington, D.C.: The Council. U.S. Department of Housing and Urban Development (HUD). (2011). The 2011 Annual Homeless Assessment Report (AHAR) to Congress. Washington, D.C.: Author. HUD, 2015a. HUD, 2015b. Bassuk, DeCandia, Beach & Berman, 2014a.

[27] On Solid Ground Coalition, 2015; Wood, R. G., & Paulsell, D. (2000). *Employment Retention for TANF Recipients: Lessons from GAPS. Issue Brief*, no. 1. Mathematica Policy Research, Inc., Princeton, N.J. Available at http://www.mathematica-mpr.com/PDFs/WTWIsBr1GAPS.pdf; Hayes et al., 2013.

[28] Loya, R.; Liberman, R.J.; Albeda, R.; & Babcock, E. (2008). Fits & Starts: The difficult path for working single parents. Crittenden Women's Union and The Center for Social Policy. Boston, MA.

[29] On Solid Ground, 2015; Desmond, M. (2016). Evicted: Poverty and Profit in the American City. New York: Crown. Abby- Lambertz, K. (2016). How The Eviction Epidemic Is Trapping Black Women In Poverty. Huffington Post 03/17/16. Retrieved from: http://www.huffingtonpost.com/entry/eviction-matthew-desmond-book_us_56e996e3e4b065e2e3d82403.

[30] White House (2016). United State of Women Summit: The Movement. http://www.theunitedstateofwomen.org.

[31] Bassuk et al., 1996; Weinreb et al., 2006; Hayes at al., 2013.

[32] Bassuk et al., 1996; Hayes et al., 2013; U.S. Conference of Mayors. (2008). A status report on hunger and homelessness in America's cities: 2008. Washington, DC: Author. Black et al., 2011; National Network to End Domestic Violence, 2007.

[33] Bassuk & Beardslee, 2014; Weinreb et al.,2006.

[34] Bassuk et al., 1996; Hayes et al., 2013; HUD, 2015b.

[35] DeCandia, C. J., Bassuk, E.L. & Richards, M. Assessment of Families Experiencing Homelessness: Analysis of Current Practice. *Advances in Child and Family Policy and Practice*, Springer Publishing. *In press.*

[36] Bassuk, DeCandia, Beach & Berman, 2014a.

[37] National Center on Family Homelessness (2009). America's Youngest Outcasts: A Report Card on Child Homelessness. Needham, MA.

[38] Culhane, D. P., & Metraux, S. (1999). Assessing relative risk for homeless shelter usage in New York City and Philadelphia. *Population Research and Policy Review, 18* (3), 219–236. Olivet, J. (2015). Homelessness, Racism and Social Justice Huffington Post 10/16/2015. Retrieved from: http://www.huffingtonpost.com/jeff-olivet/homelessness-racism-and-s_b_8312898.html.

[39] On Solid Ground, 2015; Weiss, I., Ettinger de Cuba, S.,, Sandel, M.,, Schiffmiller, A.,, Cook, J.,, Pasquariello, J., Coleman, S.,, and Frank, D. A. (2012). Safe, Stable Homes Mean Healthier Children and Families for Massachusetts. Children's HealthWatch. Retrieved from: http://www.childrenshealthwatch.org/wp-content/uploads/MAhousing_brief_Oct2012.pdf.

[40] Guarino & Bassuk, 2010.

[41] Buckner, J. C., Beardslee, W. R., & Bassuk, E. L. (2004). Exposure to violence and low income children's mental health: Direct, moderated, and mediated relations. American Journal of Orthopsychiatry, 74, 413-423. U.S. Department of Housing and Urban Development (HUD). (2009). The 2008 annual homeless assessment report to Congress. Washington, DC: Author. Masten et al., 1993; Masten et al., 2014; Perlman, S., Cowan, B., Gerwirtz, A., Haskett, M., & Stokes, L. (2012). Promoting positive parenting in the context of homelessness. American Journal of Orthopsychiatry, 82(3), 402. Perlman & Fantuzzo, 2010; Rog & Buckner, 2007; Samuels, Shinn, & Buckner, 2010; Shinn, M. B., Weitzman, B. C. (1996). Homeless Families are Different. In Baumohl J. (Ed.). Homelessness in America . Phoenix, Arizona: Oryx Press.

[42] Fantuzzo, J., LeBoeuf, W., Brumley, B., & Perlman, S. (2013). A population-based inquiry of homeless episode characteristics and early educational well-being. Children and Youth Services Review, 35, 966-972. doi:http://dx.doi.org/10.1016/j.childyouth.2013.02.016. Haber, M. G., & Toro, P. A. (2004). Homelessness among families, children, and adolescents: An ecological–developmental perspective. Clinical Child and Family Psychology Review, 7(3), 123-164. Park, J. M., Fertig, A. R., & Metraux, S. (2011). Changes in maternal health and health behaviors as a function of homelessness. Social Service Review, 85, 565-585. doi: http://dx.doi.org/10.1086/663636

[43] Haskett, Armstrong & Tisdale, 2015.

[44] Bassuk, Richard, & Tsertsvadze, 2015.

[45] Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: Implications for healthcare. In R. Lanius, E. Vermetten, and C. Pain (Eds.),

The impact of early life trauma on health and disease: The hidden epidemic, 77-87. Cambridge University Press. Felitti, V. J., Anda, R. F., Nordenberg, D., Wiliamson, D. F., Spitz, A.M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of deaths in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258.

[46] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition. http://www.developingchild.harvard.edu. Shonkoff, J. P. (2010). Building a new biodevelopmental framework to guide future early childhood policy. *Child Development*, 81, 357-367. Shonkoff, J. P., Garner, A. S., & The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129, 232–246. van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*, 389–399.

[47] Bassuk, E. L., DeCandia, C. J., Richard, M. (2015). *Services Matter: How to End Family Homelessness in America.* The Bassuk Center on Homeless and Vulnerable Children & Youth. Needham, MA.

[48] Homes for Families (2015). 2015 Visioning Day Recommendations. Homes For Families. Boston, MA. Author. Thomas, K. A., So, M. (2016). Lost in limbo: An exploratory study of the homeless mothers' experiences and needs at emergency assistance hotels. Families in Society: The Journal of Contemporary Social Services, 97(2), 120–131.

[49] Homes for Families, 2015.

[50] Burt, 2005.

[51] Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R., Jimenez, L., Duchon, L., James, S., & Krantz, D. H. (1998). Predictors of homelessness among families in New York City: From shelter request to housing stability. American Journal of Public Health, 88, 1651-1657.

[52] Smyth, K.F., Goodman, L. A., & Glenn, C. (2006). The Full-Frame Approach: A new response to marginalized women left behind by specialized services. *American Journal of Orthopsychiatry*, 76 (4), 489-502.

[53] Culhane & Byrne, 2010.

[54] HUD, 2015b.

[55] Doran, K. M., Misa, E. J., & Shah, N. R. (2013). Housing as health care – New York's boundary-crossing experiment. The New England Journal of Medicine, 369, 2374-2377. Molnar, J. M., Rath, W. R., & Klein, T. P. (1990), Constantly compromised: The impact of homelessness on Children. Journal of Social Issues, 46, 109–124. HUD 2015b.

[56] Center for Outcomes Research and Evaluation. (2013). Integrating housing and health: A health focused evaluation of the apartments at Bud Clark. Portland, OR: Providence Health Services.. Retrieved from . http://shnny.org/images/uploads/Oregon-SH-Report.pdf

[57] Bassuk et al., 2014b; Burt, 2005; Early, D.W. (2004) The determinants of homelessness and the targeting of housing assistance. Journal of Urban Economics 55: 195-214. HUD, 2015b. Shinn. M., Baumohl. J., & Hopper K. (2001). The prevention of homelessness revisited. Anal Social Issues Public Policy, 1: 95-127. Wood, M., Turnham, J., & Mills, G. (2008). Housing affordability and family well-being: Results from the Housing Voucher Evaluation. *Housing Policy Debate*, *19*, 367-412.

[58] Abt Associates (2006). Effects of housing vouchers on welfare families. Washington, DC: US Department of Housing and Urban Development. Burt, 2005; Mansur. E. T., Quigley, J.M., Raphael, S. et al. (2002). Examining policies to reduce homelessness using a general equilibrium model of the housing market. Journal of Urban Economics; 52: 316-40. Shinn, Baumohl, & Hopper, 2001; HUD 2015b.

[59] Burt, 2005.

[60] NAEH, 2015b.

[61] National Alliance to End Homelessness [NAEH] (2011a). Closing the Front Door: Creating a Successful Diversion Program for Homeless Families Available at: http://www.endhomelessness.org/library/entry/closing-the-front-door-creating-a-successful-diversion-program-for-homeless.

[62] NAEH, 2011a. National Alliance to End Homelessness [NAEH] (2011b). Using Diversion to Reduce Homelessness. Available at: http://www.endhomelessness.org/page/-/files/2208_file_OF_DiversionBrochure_FINAL_2_.pdf

[63] One Family, Inc (2008). The Dudley Diversion Pilot Project. One Family, Inc: Boston, MA NAEH, 2011b.

[64] NAEH, 2011a.

[65] Connecticut Coalition to End Homelessness (2015). Shelter Diversion for Homeless Families: New London County, CT. Connecticut Coalition to End Homelessness: Hartford, CT.

[66] EA Legislative Report 08/08/2017 Department of Housing and Community Development (DHCD), Quarter 4 SFY2017, retrieved from http://www.mass.gov/hed/docs/dhcd/hs/ea/fy17q4eareport.pdf

[67] HUD, 2015.

[68] Culhane & Byrne, 2010; Culhane et al., 2007.

[69] NAEH & HUD, 2015.
[70] HUD, 2015b.
[71] Gale, K. (2013). Progressive Engagement: How less can truly be more. Presentation at the National Conference to End Youth and Family Homelessness. Seattle, WA, February 21, 2013. Available at: http://b.3cdn.net/naeh/08f16eb23840899a44_rlm6btwbg.pdf. NAEH, 2015.
[72] DeCandia, et al., in press.
[73] DeCandia et al., in press.
[74] U.S. Department of Housing and Community Development (2013). CoC's Coordinated Assessment System Prezi Retrieved from https://www.hudexchange.info/resources/documents/CoCs-Coordinated-Assessment-System-Prezi-Slides.pdf.
[75] DeCandia, C.J. (2015). *Assessment of Homeless Families: A Guide for practitioners and policy makers.* Boston, MA: Homes for Families, Inc.
[76] Herman, D., Conover, S., Felix, A., Nakagawa, A. & Mills, D. (2007). Critical Time Intervention: An empirically supported model for preventing homelessness in high risk groups. Journal of Primary Prevention, 28, 295-312.
[77] Samuels J. (2010). Strengthening at risk and homeless young mothers and children. Young family critical time intervention (CTI): Successful transitions from homelessness to stability. National Center on Family Homelessness; Needham, MA.
[78] Shinn, M., Samuels, J., Fischer, S.N., Thompkins, A., & Fowler, P.J. (2015). Longitudinal impact of a Family Critical Time Intervention on children in high-risk families experiencing homelessness: A randomized trial. *American Journal of Community Psychology*, *56*(3-4), 205-216.
[79] Hayes et al., 2013.
[80] Walsh, C., Bell, M., Jackson, N., Graham, J., Sajid, S., & Milaney, K. (2015) Permanent Supportive Housing for Families with Multiple Needs. Calgary Homeless Foundation: Calgary, Canada.
[81] Bassuk, E.L., Volk, K., Olivet J. (2010). A Framework for Developing Supports and Services for Families Experiencing Homelessness. *Open Health Services and Policy Journal*, *3*, *34-40. 2010*.
Substance Abuse and Mental Health Services Administration (SAMHSA) (2014).
Trauma informed care in behavioral health services: A treatment protocol (TIP)
SERIES 57. HHS (SMA) 14-4816. Rockville, MD: Author.; USICH, 2014.
[82] DeCandia, C.J. & Guarino, K.G. (2015). Trauma-informed care: An Ecological Response. Journal of Child Care and Youth Work, 25, 7-32. Hopper, E.K., Bassuk, E.L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless service settings. *The Open Health Services and Policy Journal*, *3*, 80–100.
[83] Massachusetts Interagency Council on Housing and Homelessness [ICHH] (2007-2014): Overview of Efforts to End Homelessness in the Commonwealth. Boston, MA. Author.
[84] Bassuk, DeCandia, Beach & Berman, 2014a.
[85] Lannan, Katie (8/22/17): Bill eyes streamlining homelessness prevention efforts, Sentinel Enterprise available at (http://www.sentinelandenterprise.com/breakingnews/ci_31240572/bill-eyes-streamlining-homelessness-prevention-efforts
[86] DHCD, 2016. DHCD entry data report 07/08/16. Department of Housing and Community Development[DHCD] Emergency Assistance [EA] Monthly Report, Statewide Summary (May 2016). Retrieved 07/25/16 from http://www.mass.gov/hed/docs/dhcd/hs/ea/eamonthlyreport.pdf
[87] Garg, A., Toy, S., Tripodis, Y., Silverstein, M., Freeman, E. (2015). Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics* 135(2). e296-e304. Weinreb, Rog & Greer, 2016.
[88] Weinreb, Rog & Greer, 2016.
[89] Massachusetts Kids Count (2016). MassBudget's Children's Budget Updated January, 2016. Retrieved from: http://children.massbudget.org/homebase.
[90] Weinreb, Rog, & Greer, 2016.
[91] Apicello, J. (2010). A paradigm shift in housing and homeless services: applying the population and high-risk framework to preventing homelessness. *Open Health Services and Policy Journal*, *3*, 41-52.
[92] Apicello, 2010.
[93] Apicello 2010, pp. 44-45.
[94] Apicello, 2010.
[95] Bassuk, E. L., Olivet, J. & DeCandia, C.J. (n.d.). BSAFE: Building Strengths and Advocating Family Empowerment: An Intervention to End Family Homelessness. Implementation Guide. The Bassuk Center on Vulnerable and Homeless Children and youth and The Center for Social Innovation. Needham, MA.
[96] Culhane, D. (2016). Ending Homelessness: What's Working and Emerging Trends. Presentation to the Massachusetts Interagency council on Housing and Homelessness. Boston, MA.

[97] Culhane, 2016; Massachusetts Housing and Shelter Alliance [MHSA], 2015. Home & Healthy for Good: Permanent Supportive Housing: A Solution-Driven Model Progress Report. Boston, MA.
[98] Culhane, 2016.