

Family Experiences of Homelessness in Massachusetts

The Case for Family-Centered Care

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February 2017

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Homes for Families
with support from the Oak Foundation

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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, please see: <http://www.homesforfamilies.org/>

About the Authors

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, and helped launch The Bassuk Center on Homeless and Vulnerable Children and Youth. Dr. DeCandia is the founder and owner of Artemis Associates, LLC where she provides training and consultation to organizations to build trauma-informed and family centered services for children and families. She maintains a small clinical practice providing assessment of children birth-age 17, and is an Adjunct Faculty at Boston College.

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Executive Summary

“If the providers understand the family’s perspective on things, they are better able to help, are more sympathetic, and the family’s needs can be better met.”

- Homes for Families Consumer Advocacy Team (CAT) Member, 2017

The number of families experiencing homelessness in the United States has increased from one to 37 percent of the overall homeless population over the past 30 years;^{1,2} Massachusetts is among the top states in the country with the greatest increases in homelessness.³ Families are at the center of the issue of homelessness. As such, their experience and input must be central to the solution.

FCC has yet to truly take hold when addressing service delivery for family homelessness. What has been their lived experience of homelessness? What services are needed for families experiencing homelessness in Massachusetts? What do families say they need most? This study sought to answer these questions and complement the ongoing work of HFF in sharing the voice of parents with policy makers.

Over two decades ago, providers came together to form Homes for Families (HFF), as a means to increase the voices of families in advocacy efforts to end family homelessness in Massachusetts. HFF has a long history of engaging families in the development of policy recommendations and in influencing systems change. Before Family-Centered Care (FCC)⁴ was a recognized service model in most human service fields, HFF intentionally and actively placed the family voice at the center of its work, promoting *provider-policymaker-family* partnerships in advocacy and policy making.

5 Service Needs identified by Families

- 1) Consistent housing search and case management services.
- 2) Training for and access to jobs that pay livable wages.
- 3) Transportation.
- 4) Better access to mental health care, especially for new mothers to address signs of depression, as well as services to address domestic violence.
- 5) Services to support children’s health and well-being.

In 2015 and 2016, we asked 117 families experiencing homelessness in Greater Boston and western Massachusetts about their experiences with housing and support services. By listening to families, we identified places where families’ needs and the emergency shelter (EA) family homeless service system were aligned, as well as five critical gaps in service needs (See insert.) Family input to the future design of the emergency assistance (EA) system in

Over the last 20 years, Family-Centered Care (FCC) has taken hold in the medical community and is now recognized as a core component of working effectively with children and families.⁴ However,

Massachusetts is essential to improve the system’s overall effectiveness. With the goal of ending family homelessness by 2020,⁵ and Massachusetts’ efforts to end motel use to house families,⁶ the results of this study provide valuable insights about what service users need most to inform the system’s development.

Introduction

Structural issues are at the core of the experience of homelessness for Massachusetts families. As a group, homeless families experience deep poverty and work in low-wage jobs in a market that lacks affordable housing. Other factors that either contribute to, or are a consequence of, homelessness include intimate partner violence (IPV),⁷ unaddressed issues of traumatic stress and depression,^{8, 9, 10, 11} and challenges to parenting.¹² For children, half of whom are under age five,¹³ frequent moves, family separations, and exposure to IPV can result in child welfare involvement,¹⁴ developmental delays, mental health issues, and school problems.¹⁵

In most communities, emergency shelters, transitional housing, and permanent supportive housing are the typical housing options available to literally homeless families.¹⁶ In some states, such as Massachusetts, motels have been used to manage the overflow of families needing shelter. However, evidence demonstrating program effectiveness is severely lacking.¹⁷

For 30 years, the dominant paradigm used to meet the needs of homeless families has been one that is adult-focused, rather than family focused, and resource-based rather than needs-based. Within this paradigm, the integration of housing with essential support services has been minimized (except for those in the highest need category) to focus resources on housing needs.^{18, 19} A recent large scale study conducted by the Department of Housing and Urban Development (HUD) confirmed the consensus that housing vouchers are effective in helping families move from homelessness to more stable housing in the community, however, it did little to examine the alignment of families' complex needs with services.²⁰ Although the study highlighted the structural components of homelessness – the need for affordable housing and federal resources for

vouchers to move families out of homelessness – it failed to comprehensively address the complexity of families' experiences and service needs.

“We are better because we listen and learn from the people we serve.”

- Governor Charlie Baker
State of the Commonwealth Address,
January 24th, 2017

The continued growth of family homelessness over the decades²¹ suggests that the dominant paradigm has largely failed families. If we are to end family homelessness, we must know what works for which families. This necessarily entails robust structural supports for affordable housing and livable wages, as well as rigorously studying integrated delivery of housing and services²² in preventing homelessness and stabilization from the point of entry into shelter to housing in the community.²³ For any such studies, family-centered approaches are required.

Family centered approaches to service delivery are required to ensure effective, lasting solutions to family homelessness. Family Centered Care (known as FCC) puts the family's experiences, wishes, and needs at the center of the process, prioritizing parents as the decision makers for their children's care. A family-centered approach to service delivery must align families' needs, as voiced by the families themselves, with services. To do so, the consumer voice must take center stage in the design of research, practice, and policy initiatives.

Method

Rationale for Study Design: Participatory Research with Homeless Families

Community-based participatory research (CBPR) can identify targets for improving and reforming shelters and shelter-based services. Within CBPR, all stakeholders in the research process, particularly those whose “community” is being studied, hold valuable knowledge and contribute to both the decision-making and ownership of the research process.^{24,25} CBP researchers must collaboratively build knowledge and technical capacity with communities. Results of CBPR allows for policies to be developed that are rooted in the stakeholder’s lived experience and relevant expertise.

Participatory studies with low-income and homeless families have gained traction in recent years. These types of studies are designed to decrease power differentials between professional researchers and community stakeholders that are inherent to the research process. Most CBPR employs qualitative approaches to learn about families. Common qualitative techniques include photoblogging and photovoice;^{26,27,28,29} semi-structured interviews and focus groups;^{30,31,32} creative writing and performance art;^{33,34} and participatory mapping techniques.^{35,36} Goals of qualitative CBPR are to identify community and individual assets, develop understanding of how consumers perceive their families’ needs, and enable participants to give voice to their challenges and struggles. Consumer involvement in research at all stages of the research process is a central tenet; this ensures that consumers’ voices guide the process to ultimately effect meaningful change on policy and practice.

It is likely that similar projects have been conducted with homeless and vulnerable families that have not been published; though there are none we are aware of in Massachusetts that has inquired about such a breadth of issues. Most studies published in peer-reviewed journals reflect a non-representative subset of consumer-engaged assessment initiatives (e.g., data collection partnering with academic partners). Historically, most research involving participants relies on largely qualitative techniques in

understanding the experiences of families, and focuses on engaging families as research participants in the data collection phase rather than true partners.

These patterns illustrate the key gaps this study seeks to fill. Although qualitative techniques are useful in learning the context of the experience of family homelessness,³⁷ they lack the ability to reliably and parsimoniously measure family needs. Although it is certainly valuable to include the voices of families as research participants, involvement of people with lived experience in the entire spectrum of research activities – from designing the research questions and measurement tools to be used to disseminating results – will help ensure that findings generated are useful, trustworthy, and validly speak to people’s real needs and life experiences.^{38, 39} It is only by situating the family voice at the center of studies on family homelessness that consumer driven, family-centered approaches will ultimately take hold as an accepted evidence based, best practice in homeless services for families.

The Homes for Families CAT

The Consumer Advocacy Team (CAT) at HFF is comprised of a group of parents who have experienced homelessness and severe housing instability. They meet monthly and are partners in the work of the organization.

CAT members have participated in Leadership Development training and take active roles in advocating, impacting and influencing systems change for housing and economic justice. CAT members are dedicated to lessening the trauma and vulnerability for all families facing homelessness and housing instability.

Study Team & Approach

The Consumer Advocacy Team (CAT) was central to the development of our study’s methodology and the content of the survey itself. We developed our process for engaging individuals with lived experience in accordance with recommendations offered by others regarding community-based

data collection efforts integrating diverse stakeholder perspectives.^{40,41} Prior to engaging the CAT team in study design, we conducted three discussion-based workshops on the fundamental pillars of research. The study design, materials, procedures, and protocols were all approved by the Massachusetts Department of Housing and Community Development (DHCD).

Training #1: Research Fundamentals. In order to ensure CAT members' baseline level of awareness of their role in this study, we conducted a 2-hour workshop on the fundamentals of research. The workshop was centered on a case study to illustrate research principles as they operate in "real life." Participants were prompted to discuss their definitions of research, who traditionally conducts research versus who is capable of conducting research, examples of types of research and how data is interpreted, threats to validity and reliability, and how to avoid inaccuracies.

Training #2: Research Ethics. The second training focused on the ethical aspects of research, a crucial consideration in studies in which substantial power differences are involved. In small and large group discussions, participants discussed several case studies highlighting different ethical issues, largely based on the Belmont Report's basic ethical principles (beneficence, respect for persons, and justice).⁴² We facilitated participants' conversations to create a list of ethical guidelines to intentionally guide their approach to the study, via group consensus-building. This list focused specifically on what to consider in the conduct of shelter-based research, and included the importance of: ensuring surveys were kept confidential and anonymous; allowing participants the ability to withdraw at any point; recognition of trauma histories and the availability of resources to address triggers should they arise; attention to the needs and sensitivity of those with limited English language literacy; offering care for children during data collection; and ensuring research would be used to enable positive change for other families.

Training #3: Data Collection Basics. The final training focused on basic issues in quantitative and qualitative data collection. Case examples were used to illustrate key concepts and sample survey questions were used to demonstrate the

difference between well-designed and poorly-designed surveys. Participants practiced interviewing one another in pairs, using a pre-developed interview guide to learn about how to conduct a fluid and comfortable interview experience.

Following the trainings, the research and CAT teams determined that a group-based survey would be the best approach for the study. CAT members provided feedback on the first draft of the survey instrument, which had been largely developed by the HFF staff and intern team. Feedback was solicited from CAT members using a focus group-based cognitive interviewing approach. This involved having each CAT member first complete the survey in a group setting followed by three smaller groups facilitated by HFF staff. Participants addressed several issues to improve the survey including modifying questions that would be unclear to families, providing input on survey length, and discussing the order of questions. Discussions also focused on addressing and modifying items that might be difficult for families. Following the focus group discussions, HFF staff met to synthesize key themes raised by CAT members to incorporate into the next survey instrument. The CAT tested the administration of the final survey instrument and reviewed all consent forms. The survey was reviewed and approved by DHCD prior to initiating data collection.

Sampling and Recruitment

A total of 117 participants were recruited for the study between December 2015 and July 2016. We employed a non-probability purposeful sampling approach aiming to capture adequate representation among both shelter types (congregate shelters, partial congregate shelters, scattered-site shelters, co-shelters, and hotels/motels) and geographic regions (Greater Boston, Central Massachusetts, North Shore, South Shore, and Western Massachusetts). Final data was collected in Greater Boston and Western Massachusetts due to the size of the catchment areas and availability of family respondents. Once a time and date was set for the survey administration, shelter contacts disseminated information regarding the survey, the opportunity for families to participate, and the incentive involved for participating via standard communication channels used with residents.

Data Collection and Management Procedures

For each participating shelter, HFF staff partnered with shelter staff to determine an agreeable time and location to conduct the group-based survey. This included discussions, time to review the survey with a staff person, how to provide a safe option for respondents with limited English-reading proficiency or difficulty understanding questions, and/or other reasons not to complete the survey manually. We also reviewed the procedure and resources for staff and families to contact in the event of a potential triggering question or experience while taking the survey. Arrangements were made with HFF and shelter staff to ensure that childcare could be provided during the time of survey. Informed consent was obtained from participants prior to beginning the survey.

Surveys took approximately 30 minutes to complete and contained closed and open-ended questions concerning the family's background and experiences with the emergency shelter system in Massachusetts. HFF staff were available to answer and clarify any questions on the survey and to assist in completing the survey in the case of literacy or other barriers. Participants were given a \$20.00 stipend for their time and cooperation.

Survey Development

We began with 145 questions, which were reviewed and tested with the research team and the CAT. The final survey had a total of 43 questions found to be most pertinent to families'

needs and experiences with the shelter system in Massachusetts. The CAT identified items most needed to assess the alignment of families' needs and services; as a result, some items were either removed or modified. The final survey covered two main domains, each with multiple constructs that were identified by the study team, the CAT, and DHCD. The survey was translated into Spanish using the TRAPD (Translation, Review, Adjudicate, Pretest, and Document) Team Translation Model.⁴³ The final 43 survey items were written at an eighth-grade reading level as assessed by the SMOG text readability formula.⁴⁴ The SMOG formula is a widely used measure for assessing literacy requirements for health materials and surveys.

Data Analysis

All data were entered by trained HFF staff and consultants into a Microsoft Excel database. For quantitative questionnaire data, we used STATA software version 10 (College Station, TX) for data management and calculating both descriptive and inferential analyses. Statistical tests were used for determining differences between means (via t-tests) and distributions (via chi-square tests). For open-ended questionnaire data, a generalized inductive analytic approach⁴⁵ was used to organize raw data into a summary format. Missing responses were excluded when analyzing results for the specific question.

Results

Survey findings are reported according to the two core domains. Domain I covered elements of the family experience, and Domain II covered family perception of service need and delivery. Domain I included six constructs: (1) demographics and family structure, (2) housing and homelessness history, (3) education, employment, and income, (4) health and well-being (5) support systems, (6) civic engagement. Domain II included two constructs: (1) family service use and (2) satisfaction with services. Results from each section are reported below.

Domain I: Family Needs

This domain contains information about the characteristics of the families in our study, and about their experiences prior to and within the shelter system.

Demographics and Family Structure

Consistent with the literature on family homelessness, family respondents were predominantly female (79.3%). Almost 14% of our sample identified as LGBT. The average respondent age was slightly higher than the national average

(31.9 years), although most women were in the 25 to 35 age category (41.3%). The sample was ethnically diverse, with the most prevalent race/ethnicity being Latino/Hispanic (38.3%) – again, higher than the national average. This was followed respectively by White (27.3%) and Black (22.7%).

Our demographic data was consistent with the most recent data from DHCD in that the majority are female-headed households and most children were under age five (Table 1). Our sample differed only in that more of respondents identified as Hispanic, and more male parents were represented. Differences may be because our sample was drawn from Boston and western Massachusetts only versus statewide, and that families living in motels were overrepresented.

Table 1. Characteristics of current study to most recent DHCD demographics

Demographics	Current Study Sample	DHCD Caseload (as of 01/19/17) ⁴⁶
Female	79.3%	91.0%
Race/Ethnicity		
White	27.3%	49.0%
Black	22.7%	40.0%
Hispanic	48.3%	44.0%
Average Family Size	2.8	3.2
Age of Children		
0-5	40.8%	44.0%
6-12	33.9%	35.0%
13-18	25.3%	17.0%

Consistent with the literature on homeless families, the majority of survey respondents identified as single parents (53.5%); 35.9% were single, 29.9% were married, and 24.8% were in a relationship but not married. Slightly less than half of those in relationships resided in the same shelter as their partner (47.0%). Most partners were not incarcerated (91.5%) and neither respondents nor partners had previously served in the military (90.6%). Reasons cited by respondents for why they did not currently reside with their partner commonly included insufficient income, not being married, only recently becoming partners, and shelter restrictions.

Respondents also provided information regarding their children (both inside and outside of shelter).

Half of the sample had only one child (50.2%). The average child age was 6.7 years, and the greatest representation was among elementary school-age population (i.e., grades 1-8) (42.9%). However, it should be noted that nearly a quarter of respondents indicated their child’s educational status as “N/A,” which may mean that the child is not currently enrolled. Male and female children were equally represented (50.7% and 49.3%, respectively). Most children were their parents’ biological children (82.9%), but step-children and foster children were also present to lesser degrees (0.2% and 0.1%, respectively). Similar to their parents, children were commonly reported to be Latino/Hispanic (51.2%), White (34.1%), and Black (23.0%); over two-fifths of children were multiracial (41.0%).

“The father of my child lives with Aunt/Sister. Living in a women's shelter, he had to find somewhere to stay.”

- Family Study Participant 2016

About a quarter of respondents had additional children that weren’t presently with them while in shelter (24.8%). The reasons most often cited were: 1) that the child(ren) were not in their parent’s custody (26.7%); 2) the child(ren) were over age 21 (15.6%) or: 3) the child(ren) were staying with a family member or friend (8.9%).

Respondents noted that the child’s other parent was involved, largely by virtue of living in shelter with them (47.8%) with a smaller proportion involved but outside of shelter (5.4%). A fifth of respondents shared that the child’s other parent was not financially or otherwise involved in caring for the child (21.5%). Other than their child(ren) and their partner, respondents did not report other family members living with them in shelter.

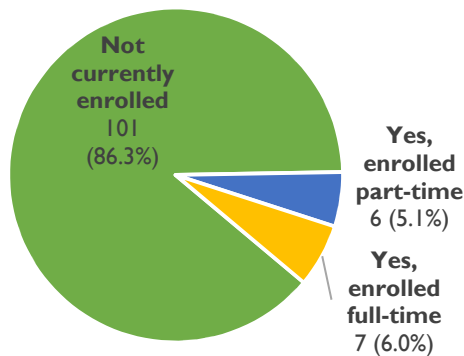
Education, Employment, & Income

Massachusetts families involved in the EA shelter system reported educational levels and employment history that was largely consistent with national trends, indicating most parents did

not possess advanced degrees. A quarter of our sample had a high school degree; 11% had a GED. Less than 1% possessed a Bachelor's degree and 3.5% had an Associate's degree.

More than four-fifths of respondents were unemployed at the time of the survey (82.05%) – this included both those who had never been employed (16.2%), as well as a large segment of individuals who had been employed previously (65.8%). Less than a fifth were currently employed; this included

Figure 1. Family respondents' current job-training program enrollment



seasonal/temporary, part-time, and full-time positions (17.1%). Despite the expressed need for employment and livable wages, enrollment in job training programs was extremely low. Most respondents (86.3%) were not enrolled in any type of job training program. Of those that were, half (6%) were enrolled on a part-time basis (Figure 1).

We also asked respondents which fields they currently or had previously worked in, as well as which fields they hoped to work for in the future (see Supplemental Table 1 in Appendix). Respondents had the most experience with education/childcare, domestic work, labor/agriculture, and sales/marketing, however these were not fields individuals wanted to pursue in the future. Technology, law enforcement/security and human services were reported as fields respondents would be interested in pursuing. Respondents reported they would like to “help others in recovery,” or “make sure other families have an easier time.” Most families reported that they simply wanted a job that worked for their families. One respondent commented that she would work

in “any field that brings money to the table.” Another stated that she would do “Anything. I’m having a hard time finding job that works with my children schedule.”

Family income was consistently reported to be well below what is needed to support a family in Massachusetts (Figure 2). Families reported an average monthly income of \$663.45. Nearly half of respondents were paid on an hourly basis (44.4%), earning less than the current statewide minimum wage (\$11/hour). A small number of families had salaried positions (17.1%). Most did not receive employee benefits that would support their families.

As expected, most families participated in a variety of state programs to help support their families. Transitional Aid for Families with Dependent Children (TAFDC) (47.9%) was used most often, followed by Supplemental Security Income (SSI) (19.7%). Traditional employment lagged far behind for families (16.2%) (Figure 3).

To support their families, most respondents accessed the Supplemental Nutrition Assistance Program (SNAP; i.e., food stamps) (85.5%) and received state sponsored health insurance (e.g., MassHealth 70.9%). Two thirds (38.5%) received support from the Supplemental Nutrition Program for Women, Infants, and Children (WIC) (38.5%). Only 3.4% reported not receiving any state benefits.

Housing and Homelessness History

Families surveyed reported both prior experiences with homelessness, or separation from their families prior to becoming homeless as an adult. Over 40 percent of families in the survey reported that they had temporarily stayed with friends or family or were in the care of someone other than their parents as a child. A quarter had either been in a homeless shelter or lived in subsidized housing as a child, and almost 10 percent had spent time in foster care. Most had not been involved with juvenile detention or inpatient mental health treatment; almost half the sample had no prior experiences of out-of-home placement (see Supplemental Table 2 in the Appendix).

As adults, 61.5% of respondents had entered the EA or another shelter system 1 or 2 times, and 12% had entered 3 or more times. About a quarter were able

Figure 2. Family respondents' most recent wage and benefits

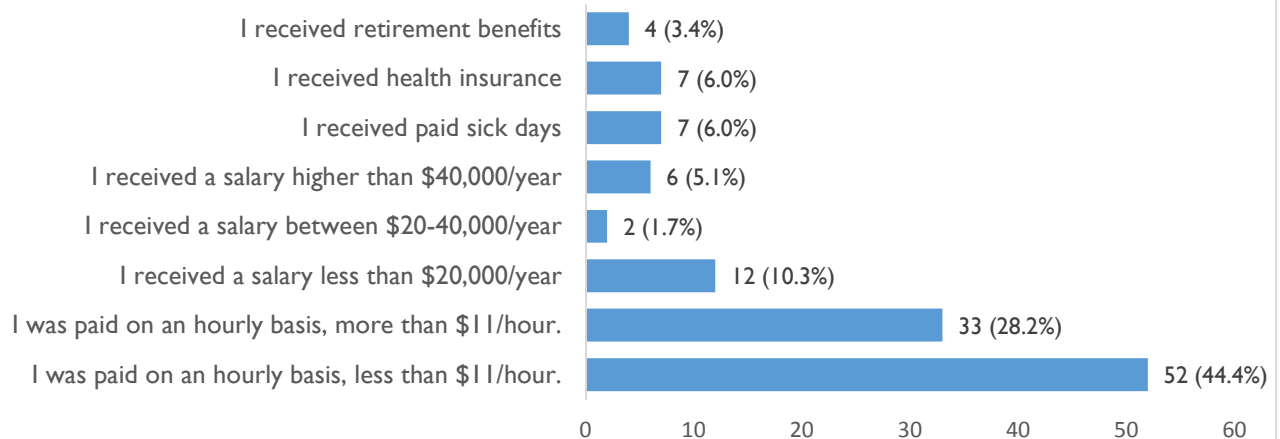
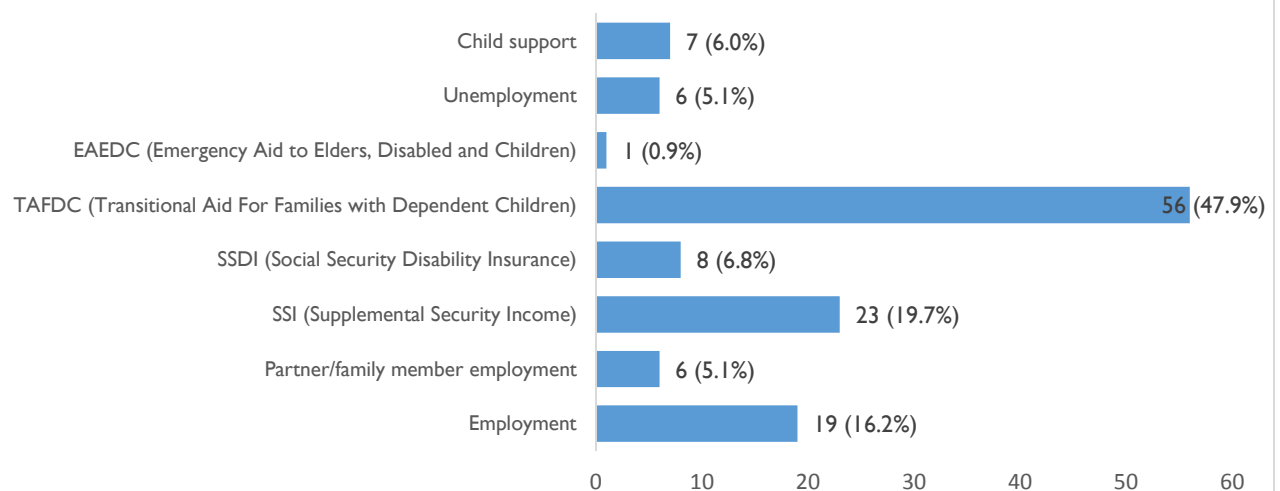


Figure 3. Family respondents' current sources of income



to leave shelter after receiving a short-term subsidy (26.1%). Only a small percentage who had previously been in shelter received permanent subsidies (7.3%). Almost two thirds of the sample had not received prevention or rapid re-housing assistance in the past five years (60.5%). Among those that did, HomeBASE (27.2%) and Rental Assistance for Families in Transition (RAFT) (5.3%) were the reported sources of prevention or rapid rehousing resources (Figure 4).

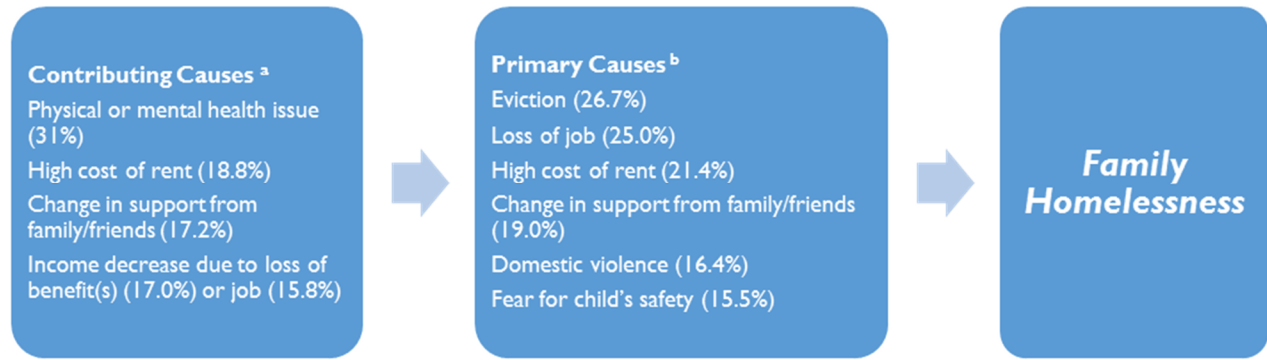
Respondents also provided information on the degree to which certain life experiences contributed to or were the precipitating factor leading to their current homelessness; the most frequent responses are depicted in Figure 5. Although income and housing needs are reported as the primary cause of entering the shelter system, families experience a

number of precipitating stressors that contribute to their eventual need for shelter. Of note, physical and mental health issues for respondents or their partners contributed to the eventual need for emergency shelter services for a third of respondents.

Consequences of homelessness were also reported; in many instances the consequence of homelessness was similar to the cause. For example, eviction and loss of income was represented as a primary cause and consequence of homelessness. Similarly, a loss of support from family and/or friends contributed to becoming homeless, and worsened as a consequence.

Family respondents also shared their perceptions of barriers to obtaining employment and housing. Top

Figure 5. Contributing and primary causes to family’s current experience of homelessness



^a Contributing causes refer to experiences in which respondents indicated was a precipitating factor influencing their becoming homelessness. ^b Primary causes refer to experiences in which respondents indicated it was one of the main reasons for their current state of homelessness.

employment barriers included a lack of childcare, not having education/job training, being pregnant, having gaps in employment, and having a physical disability.

Prominent housing barriers included having bad credit, having a large family, having a criminal record, lacking education/job training, and having gaps in employment. Barriers common to both consisted of lacking transportation, limited availability of jobs, lacking employment, having insufficient income, and having bad references (Table 2).

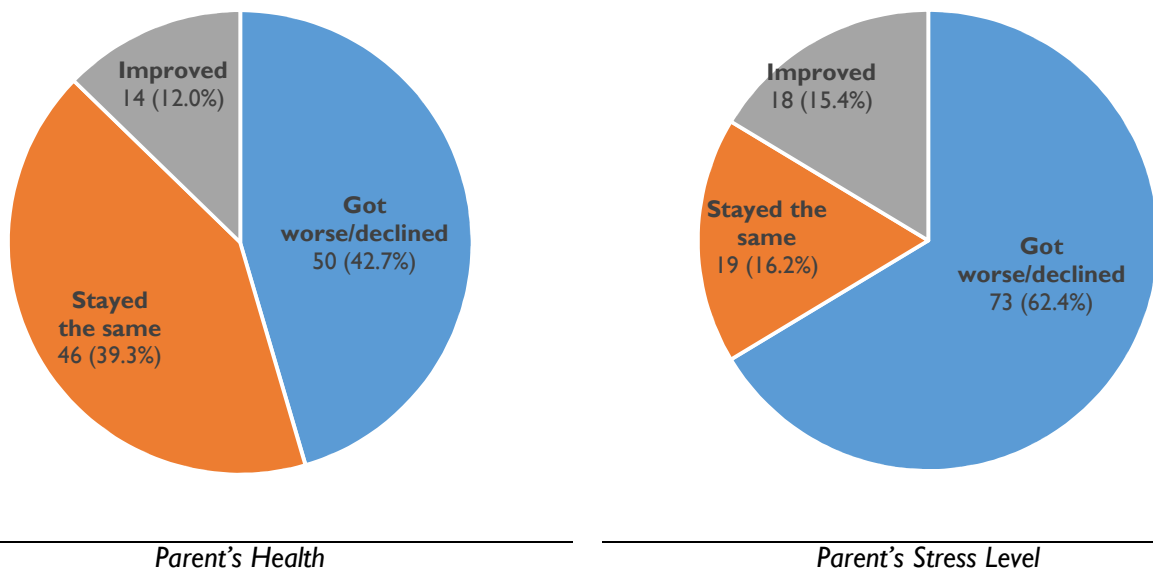
Health and Well-Being

Respondents also reported on a range of early

childhood life experiences (see Supplemental Table 3 in the Appendix). Half of respondents reported having grown up in a family with separated or divorced parents (50.4%); nearly half were raised by a single parent (44.4%). Nearly a third reported early experiences of domestic violence in the home (31.6%), or having grown up in a family where substance use (30.8%) or mental illness (30.8%) were present. Faith was an important component for a third of respondents; this portion reported being involved in a church group (33.3%) as a child.

In addition to asking about early life experiences, we asked family respondents about their perceived health and stress since entering shelter (Figure 6). Of note, more than 40% felt their health had

Figure 6. Family respondents’ reported health and stress level change since entering shelter



declined since entering shelter and over 60% reported that their stress level had worsened. A third or more respondents felt their health and stress had either stayed the same or improved.

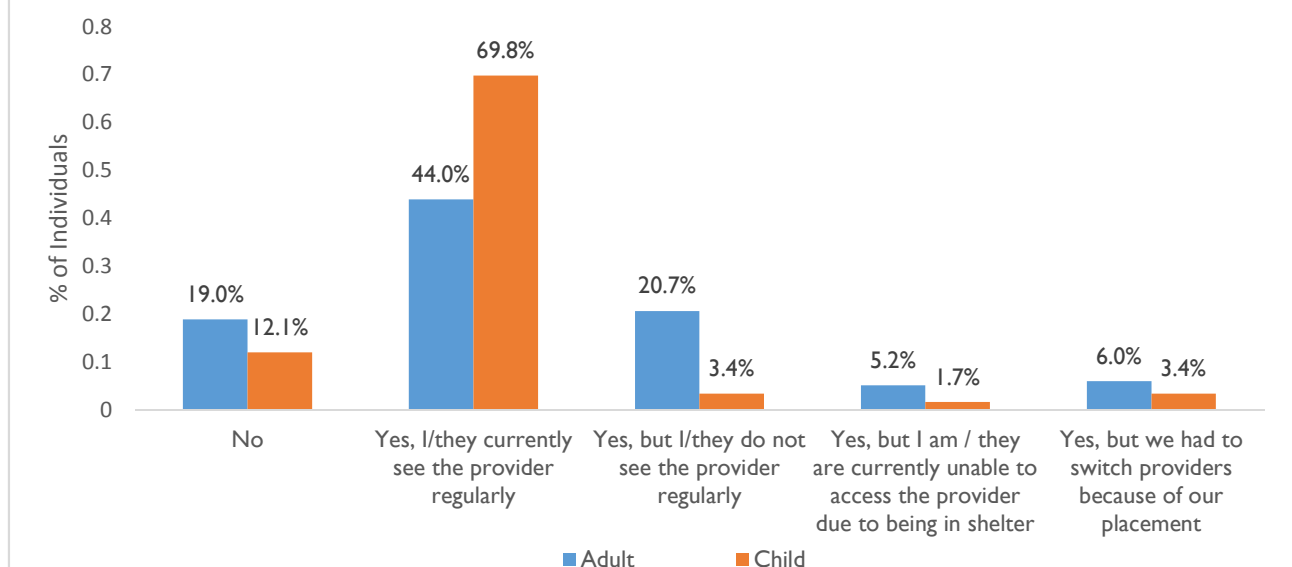
Additionally, respondents reported diagnoses for medical conditions for themselves or their children

(see Table 5 in Appendix). Of the conditions surveyed, the most common adult physical health conditions included overweight/obesity (18.8%) and asthma (14.5%); the most common childhood physical health diagnoses included low birth weight (16.2%) and asthma (13.7%).

Table 2. Family respondents' reported barriers to housing and employment

Barrier	Employment Barrier		Housing Barrier		Barrier to Both	
	N	%	N	%	N	%
Lack of transportation	26	22.22%	12	10.26%	29	24.79%
Lack of childcare	24	20.51%	8	6.84%	13	11.11%
Limited education or job training	20	17.09%	9	7.69%	5	4.27%
Lack of employment	12	10.26%	34	29.06%	20	17.09%
Pregnancy	12	10.26%	7	5.98%	2	1.71%
Gaps in employment	11	9.40%	8	6.84%	10	8.55%
Lack of jobs	10	8.55%	17	14.53%	23	19.66%
Physical handicap	9	7.69%	5	4.27%	4	3.42%
Limited English proficiency	9	7.69%	4	3.42%	7	5.98%
Chronic medical issues	8	6.84%	7	5.98%	8	6.84%
Large family size (< 5 family members)	7	6.03%	22	18.97%	5	4.31%
CORI (criminal record)	7	6.03%	9	7.76%	9	7.76%
Mental health	7	6.03%	7	6.03%	11	9.48%
Insufficient Income	6	5.13%	48	41.03%	19	16.24%
Bad credit	5	4.31%	40	34.48%	12	10.34%
Immigration status	3	2.56%	9	7.69%	3	2.56%
Substance use	3	2.59%	5	4.31%	6	5.17%
Literacy challenges	3	2.56%	4	3.42%	2	1.71%
Bad references	2	1.74%	16	13.91%	13	11.30%
None	0	0.00%	2	1.71%	5	4.27%
Other	0	0.00%	1	0.85%	1	0.85%

Figure 7. Family respondents' primary care provider access for children and adults



With respect to family’s healthcare experience, we asked about families’ access to primary care and the use of various medical services. Just over 40% of respondents had a primary care provider for themselves, and almost 70% reported that their child(ren) had a provider whom they saw regularly. Twenty percent of respondents either did not have a provider, or did not see them regularly; these numbers were much lower for their children. A small group reported that they had a provider but were unable to access them due to their shelter placement (Figure 7). More than half of adults had visited an emergency room at least once in the past year (54.7%); almost a third had accessed an ambulance (30.8%), and a smaller group needed inpatient hospitalization (18.8%). The same pattern held for children – most had been to an emergency room (47.4%), while fewer used an ambulance (14.5%) or had been hospitalized (16.2%) (Figure 8).

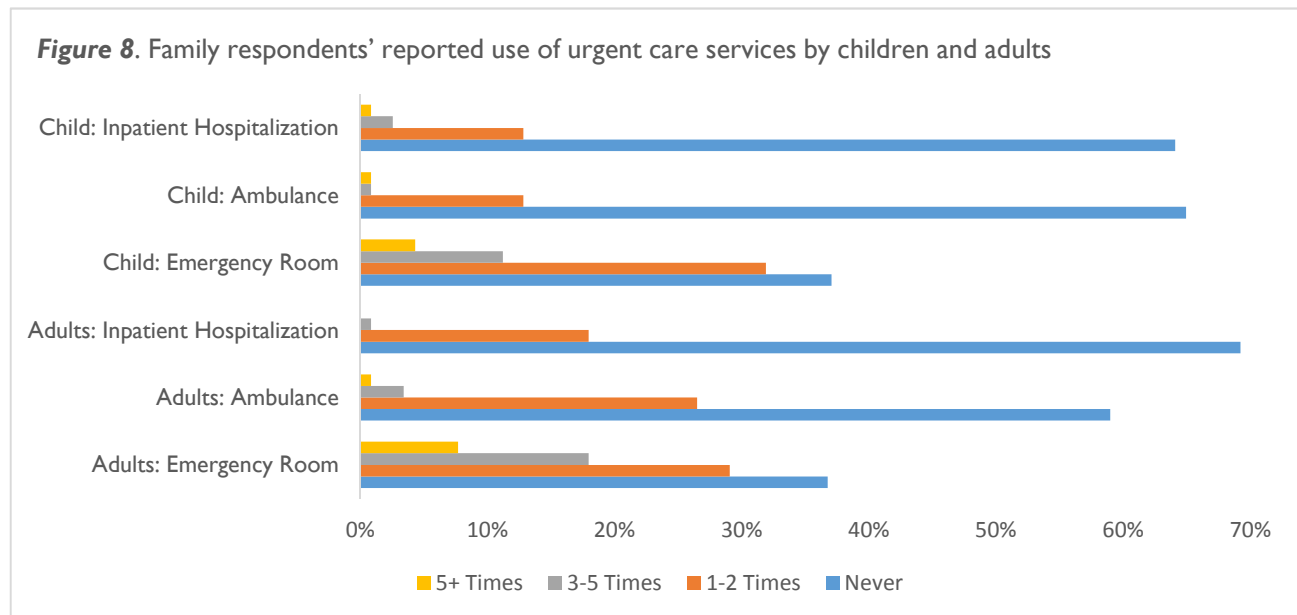
Pregnancy was uncommon in our study sample (five parents, or 4.6%). Among those who were pregnant, four reported receiving the prenatal care they desired (80.0%) and two had a birth plan (40.0%). Only one reported access to childbirth and postpartum information (20.0%); none had received the childbirth education/information that they wanted while in shelter.

As parents, more than a quarter (27.8%) reported having an infant child (i.e., <1 year old). Of this group, 50% reported that they felt healthy, while 40% felt bothered by depression and almost a

quarter reported having new health concerns (23.3%). Access to needed support services varied. Less than half of the group (40.0%) felt they had the support needed to care for their baby, or had access to information on post-partum care that they wanted (30.0%). Of mothers who reported their preference was to breastfeed (20.0%), only a small percentage felt they were unable to at the level they wanted (3.0%).

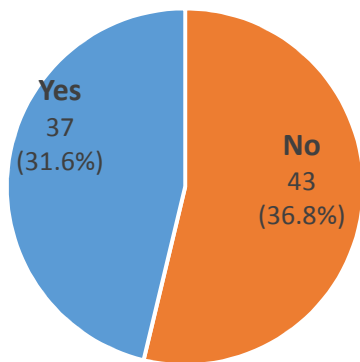
Half of our sample had a child between the ages of one and five years (54.7%). Three-quarters of these parents shared that their child’s health stayed about the same since entering shelter (71.9%), and half noted their behavior stayed constant (50.0%). However, more than a third of parents shared that their child’s behavior worsened (37.5%), and a quarter felt their child’s health had declined (25.0%).

The majority of our sample (62.4%) reported having a school-age child. Although over half reported that their child(ren)’s health stayed about the same (53.4%); almost a quarter (23.3%) noted a decline in child health. Similar patterns were seen across social skills, academic performance, and concentration; most reported no declines and even some improvement, while about a quarter reported concerns or declines in each area (Figure 10). Almost a third of school-age children had been diagnosed with a behavioral or developmental disorder (Figure 9; also see Supplemental Table 4 in the Appendix).



School-age child parents were also asked whether their child had an Individualized Education (IEP/504) Plan; nearly a third indicated that they did (32.5%). A fifth of parents reported that they had to change their child’s school during their shelter placement – 33.3% changed schools once, and 45.8% changed schools two or more times. A third of parents of school-age children indicated that at least one of their children had missed a significant amount of school (5 days or more). Of these, 73% shared that this was due to lacking transportation. Nearly a third of these parents mentioned illness (29.7%) and enrollment challenges (27.0%) as the main cause of absence.

Figure 9. Family respondent child(ren) diagnosed with behavioral or developmental disorder



Support Systems

We asked respondents to share the social support they receive in life, specifically by the source (family, partner/spouse, friends, and the broader community) and type of support (financial, emotional, or instrumental (e.g., favors, rides) (see Supplemental Table 5 in the Appendix). We sorted these concepts thematically, into broad categories (see Supplemental Table 6 in the Appendix). Frequently cited themes included feelings of isolation or lacking support, as well as the disjoint between shelter location placement and the location of their support system.

Conversely, several also noted having a positive support system (from their partner and/or family), as well as the importance of their faith. Across

sources and types, more than a third of respondents reported never receiving social support (36.0%). Support received from one’s spouse or partner seemed to be the most helpful across types, with an

“My support system is great mentally but financially and ride wise, which is what I need. It's very slim.”

- Family Study Participant 2016

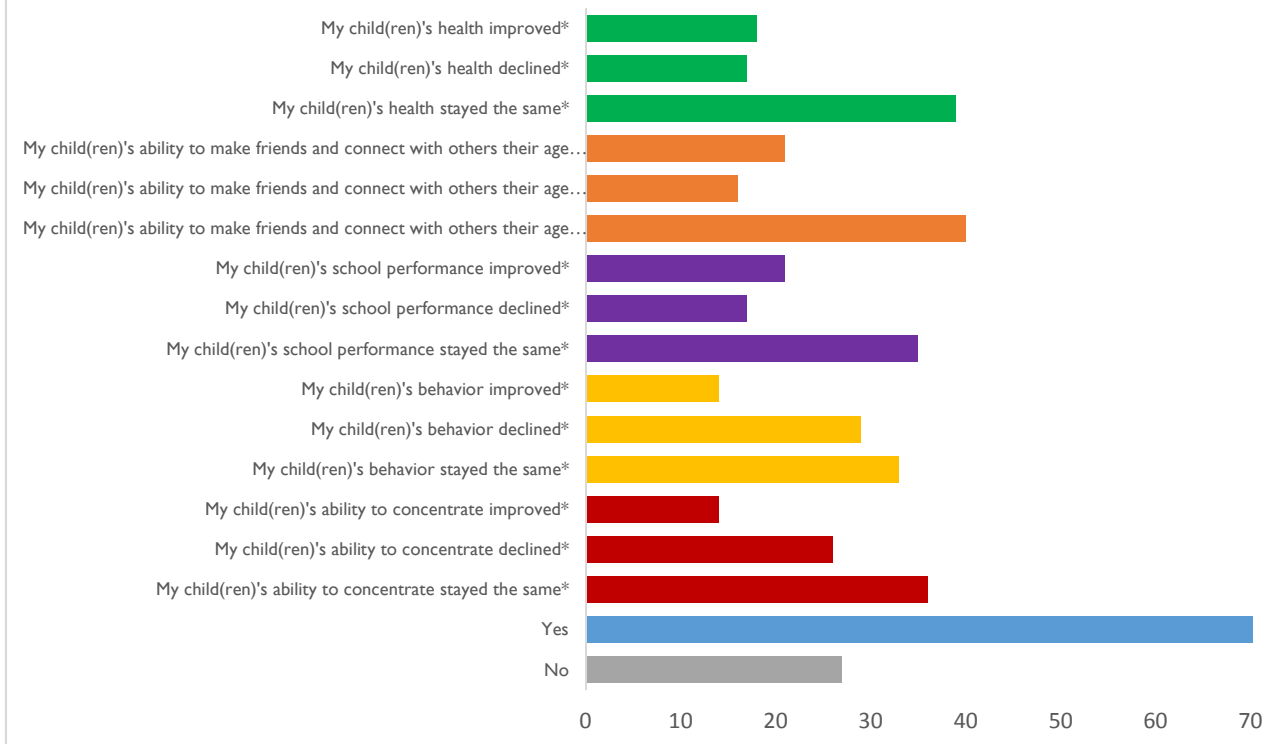
average of 54.4% of respondents reporting they receive some degree of social support from this source and a third reporting that they have that support all of the time (31.9%). This was in contrast to support received from one’s community, with an average of only 27.4% reporting community social support and only a small portion reporting that they have that support all of the time (2.6%).

When examining social support by type, emotional support tended to be the most commonly available form for families (an average of 16.0% reported having this all of the time), with financial and instrumental support less common (10.3% and 10.9% reported having this all of the time, respectively). This pattern held across support sources; regardless of the source, emotional support was more available to respondents than that of financial or instrumental support. Open-ended feedback underscored the lack of this tangible and actionable form of support, captured well by one respondent: *“My family and I are alone here and that makes it real difficult.”*

“I have no family, no support... it makes it so much harder not having anyone that normally may have helped.”

- Family Study Participant 2016

Figure 10. Family respondents' possession of school-age children, and changes observed in children



Civic Engagement

The final domain we asked families about regarded their participation in voting, connecting with elected officials, and sharing their experiences living as a homeless family (see Supplemental Table 7 in the Appendix). Nearly two-thirds of family respondents were registered to vote (63.3%), of those registered 36.8% generally vote in elections. These data rival estimates of nationwide voter registration (64.6%) and voter turnout (41.9%).⁴⁷ Most respondents had never contacted an elected official before to address their concerns (73.5%); more than half indicated an interest in using their own experience to inform better policies around shelters, housing, and other services for low-income families (54.7%).

Domain II: Services

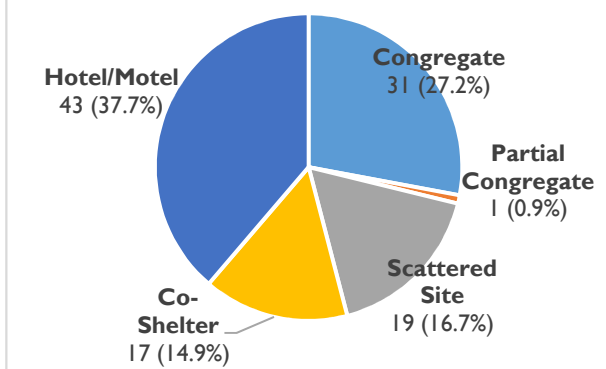
We asked about families' experiences and satisfaction with housing and support services in Massachusetts.

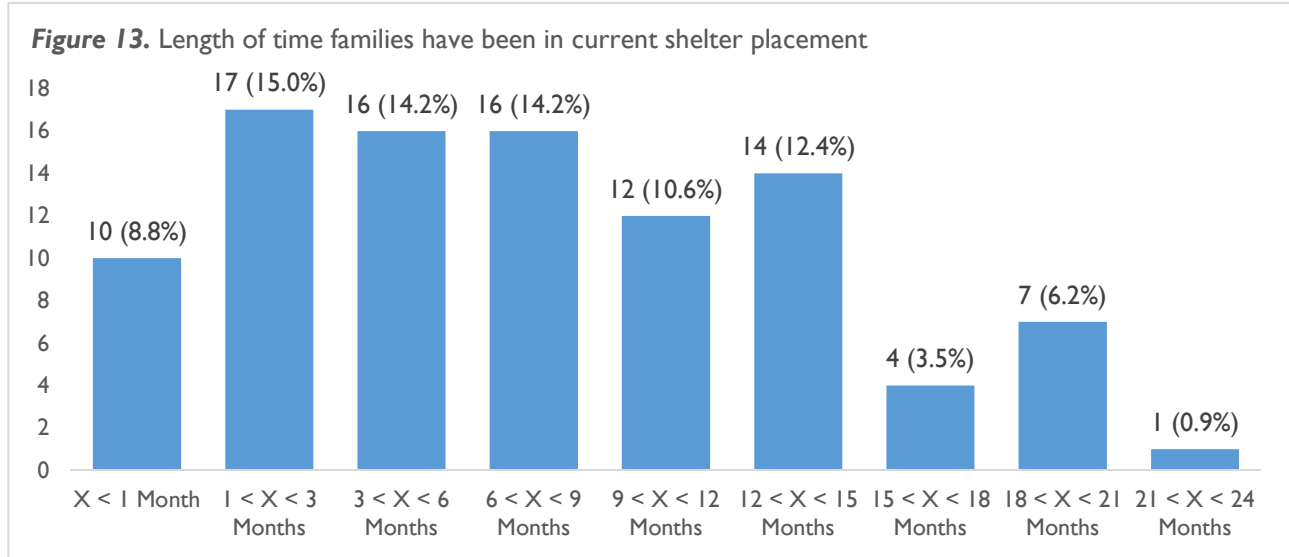
Family Service Use

More than half of our survey respondents had

entered the shelter system in 2015 (52.6%), with the most having entered in the last quarter of 2015. Very few had entered prior to 2014, and less than a fifth had entered in 2016 (15.8%). Families' current shelter placement reflected the range of approaches currently being employed by the state (Figure 11). In our sample, hotels/motels were most frequently represented (37.7%), followed by congregate care shelter settings (27.2%) and co-shelter arrangements

Figure 11. Families' current shelter placement





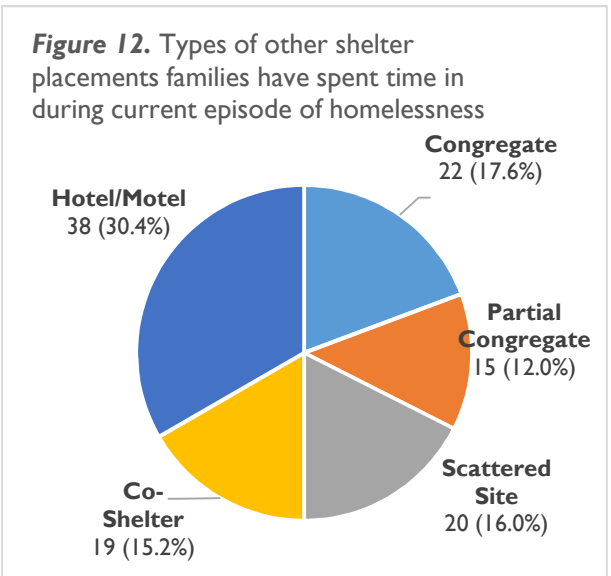
and scattered-site housing (14.9% and 16.7%, respectively). Only one respondent was from a partial congregate location (0.9%).

We also asked respondents about transfers to different placement types (Figure 12). Nearly a third had spent time in a hotel/motel (30.4%) as well as other shelter types. While those who had been transferred to congregate shelters, partial congregates, scattered sites, and co-shelters had been there an average of 0.45 months (~14 days); those transferred to hotels/motels had been there an average of 2.26 months (~68 days).

We asked participants how long they had resided in their current shelter placement. At the time they completed the survey, the average length of time was 7.3 months. Families reported having been in their placement from less than a month to two years. More than half of families had spent less than a year in shelter (62.8%), while nearly a quarter had been in their current shelter between one and two years (23.0%) (Figure 13).

We asked respondents about their experiences within shelter placement (Figure 14). At least half of respondents indicated that when they applied for shelter, they felt treated fairly (53%) and with respect (58%). The majority of individuals shared positive experiences regarding their perception of shelter: 57% reported feeling safe in their shelter location, 61% felt they know who to contact if they need help, 58% were aware of the services available in shelter, and 57% felt that the rules and expectations at their placement make sense.

With the intention of understanding salient family needs, we also looked specifically at individuals who strongly disagreed with any of the statements. Hotel/motel residents reported strong disagreement significantly more than respondents in other shelter types with respect to understanding rules/expectations; knowing who to contact if help is needed; and perceiving that their families' needs were being met (all $p < 0.05$). Respondents in full congregate shelters reported more strong disagreement regarding perception of shelter staff supporting awareness of community resources ($p = 0.072$), and that they were treated fairly when applying to shelter ($p = 0.061$); these differences were only marginally significantly different.



When we examined these experiences by program type, we found that there were a few significant differences in level of agreement for certain shelter circumstances compared to the average (via the Mann Whitney *U* test). Hotel/motel residents less frequently asserted that the rules/expectations made sense (52.2%, $p=0.019$), whereas scattered-site residents more commonly indicated that they knew who to contact if they needed help (94.4%, $p=0.008$). Hotel/motel residents indicated these less often than the average (50.0%, $p=0.041$). Full congregate residents were the least likely to share that they knew what services were available to them (51.7%, $p=0.032$), as well as that shelter staff helped them become aware of community resources (43.3%, $p=0.009$). Hotel/motel residents also had lower rates of reporting staff support in learning about local resources (41.3%, $p=0.012$), perception that their family's needs were being met (26.7%, $p=0.033$), and perception that they felt safe in shelter (50.0%, $p=0.049$) compared to other participants. Co-shelter residents had significantly higher rates of reporting being treated with respect when applying (76.5%, $p=0.011$). Finally, hotel/motel residents (82.4%, $p=0.013$) and co-shelter residents (56.5%, $p=0.025$) more commonly reported being treated fairly when applying for shelter.

Despite feeling treated well within the shelter, critical gaps were identified. A little over a third of respondents reported that their families' needs were not being met (35%), and almost half of families (46%) reported that they did not get information about available community resources. Twenty-two and 28% respectively reported not being treated with respect or not being treated fairly when applying to shelter. These areas reflect dimensions of quality of service delivery and person/family-centered care and represent areas for improvement.

In addition to general shelter experiences, we asked specifically about two services critical to helping homeless families achieve stability – housing search assistance and general case management (Figure 14). Three-quarters of respondents indicated that they received housing search assistance (76.3%) or general case management services (77.2%). However, a quarter indicated they did not receive these services at all.

When we examined housing search and case management services by program type (via the Mann Whitney *U* and Kruskal Wallis tests), residents in full congregate shelters more commonly reported that they received housing search assistance (88.5%, $p=0.031$), compared to the average. Motel/hotel residents reported that they had received case management services significantly less frequently (78.0%, $p=0.014$) than the rest of the study respondents.

Among those who did receive housing search and case management support, the frequency varied. Roughly half of respondents reported receiving these services once a week or more (51% for housing search, 46% for case management). A sizeable group only received housing search or case management less than once a week, or never (41% housing and 44% case management respectively). The results indicate a lack of consistency in how housing and case management services are designed and delivered.

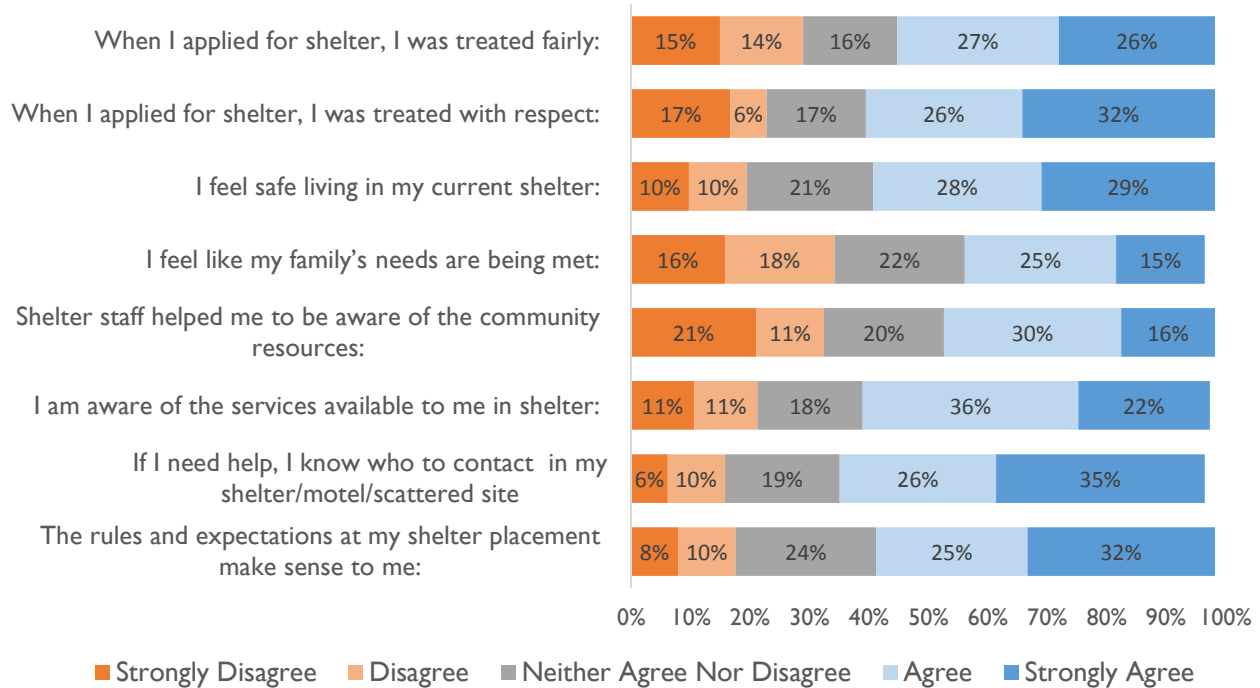
Satisfaction with Services

Finally, respondents were asked about whether the services received were sufficient to meet their family's comprehensive needs, in the domains of health needs (substance use, domestic violence, mental health, healthcare); basic needs (housing search, healthy food, financial services, child care, child space, services for their child); social needs (language support non-English speakers [ESOL], case management, parent support, legal services); and professional/financial needs (job search, adult education). For services not currently received, respondents were asked whether pertinent services would be useful to the family while in shelter.

“I do believe that it would be helpful to have more one to one to set up what is going to happen when we leave shelter and not wait for us to move and our lease to be up and have to return back to shelter.”

- Family Study Participant, 2016

Figure 14. Families' degree of agreement on various characteristics of their current shelter placement



For services that respondents currently receive, financial assistance (19.9%), job search services (18.9%), case management services (19.8%), and transportation (16.6%) were among the most frequently reported as insufficiently being met during their time in shelter. This was relatively consistent with those who expressed which services were not currently being met, and would be helpful to their family.

On the right, quotes from family respondents capture the range of experiences, from grateful and satisfied to expressing a need for resources, support, and services.

Transportation (32.3%), case management services (29.2%), housing search services (27.3%) were cited as the most frequently desired services. ESOL services were also represented prominently, with 26.3% of individuals noting that it would be valued, but is not currently available to them. Adult education, legal services, parent support, mental health and domestic violence services, job search, and services for children were all each expressed by more than 20% of respondents as being needed but

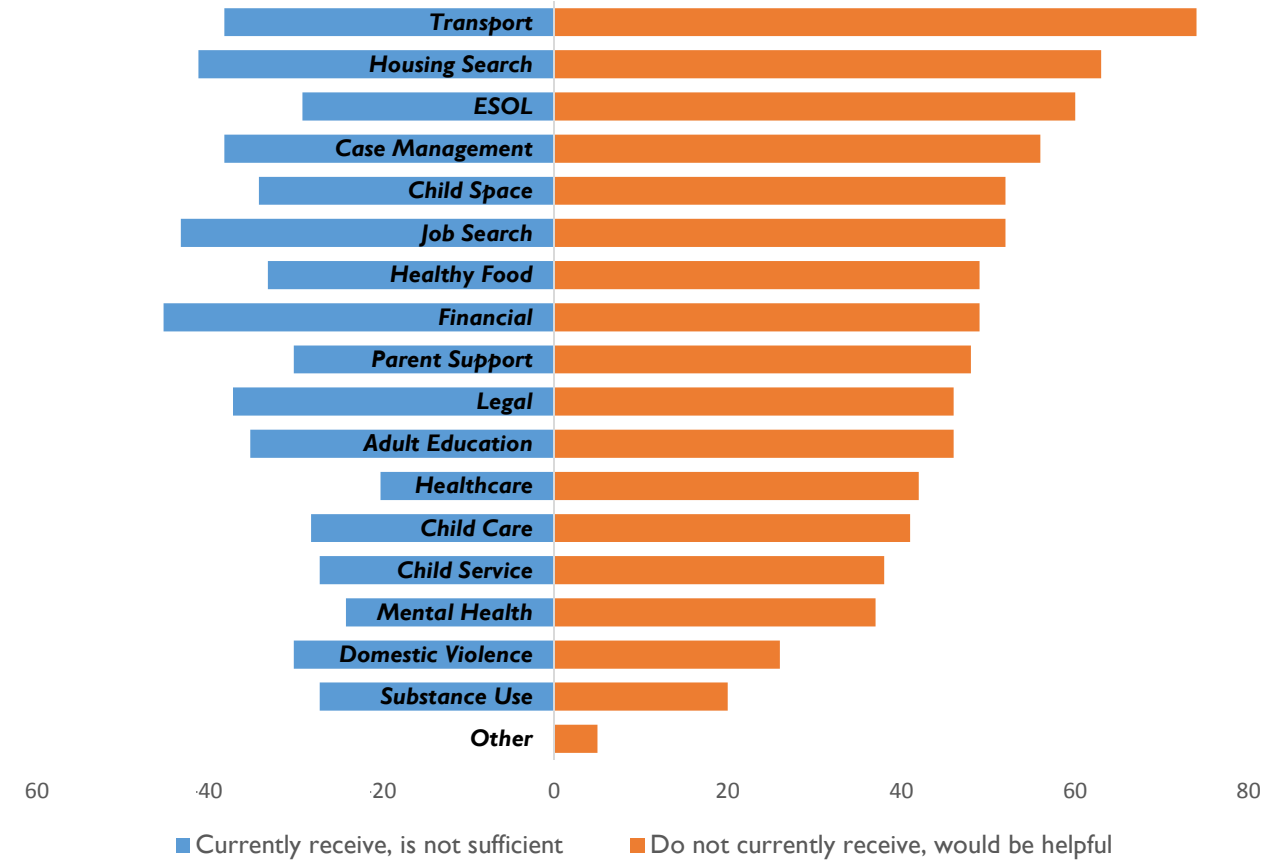
not sufficiently met (Figure 15).

“I feel my current shelter has been extremely helpful and the workers have done above and beyond helped me regarding some significant and/or serious issues and I am very grateful for that.”

“I would like for the shelters to do more parenting and life skills groups and budgeting groups.”

“I have been given the bare minimum when it comes to resources in the shelter. I have asked where food banks and agencies that can help are only to be told to find out myself. I cannot believe how little is done to help families get resources in the community.”

Figure 15. Families' perception of sufficiency of services received, and level of need for services not received



Discussion

Family-Centered Care (FCC) is guided by a service philosophy that places the family’s needs, wishes, and experiences at the center of how providers practice. FCC policies necessarily support this person-centered orientation to multiple generations in a family. Although considered a best practice in the medical community, family-centered approaches are not yet a routine best practice when addressing family homelessness. This study sought to fill this gap by asking families experiencing homelessness in Massachusetts about their experiences with being homeless, as well as their experience with the emergency shelter system. The results highlight areas of strength, and five areas for improvement, which are based on what the consumers of the system - the families themselves - say is needed.

Our study surveyed a convenience sample of 117 families experiencing homelessness from programs in Greater Boston and Western Massachusetts. The programs and families enrolled in the study by choice; as such, little is known about residents of programs not participating in the study, nor about homeless families not currently connected to the shelter system (e.g., doubled-up). We had a very low attrition rate, which is uncommon in research with homeless populations. Only two participants did not complete/opted out of finishing survey (one was triggered by the survey questions, and the other needed to care for her child). Families expressed a strong degree of gratitude expressed for giving them the opportunity to share their experience. Families clearly wanted to share their experiences in hopes of improving the service

system for themselves and other families.

The demographics of the study participants are largely consistent with those of the overall homeless family population with minor exceptions: our sample overrepresented the experience of families in motels and a higher percentage of respondents identified as Hispanic. It is unknown if these differences are statistically significant, but they may suggest that some of the needs expressed are especially relevant to these two groups. Further research on potential differences between families' experiences, needs, and satisfaction with services, based on contextual factors such as race, ethnicity, and program type, is needed to fully understand this question.

Despite these caveats, the results are considered a valid representation of the views of homeless families. Although the experiences voiced by the families regarding service needs and use are primarily relevant to families in these two geographic regions, we believe their experiences likely reflect the experiences of families with similar needs in other regions of the state.

We employed a purposeful sampling study design. Purposeful sampling is justified when investigations are exploratory, populations being surveyed are hard-to-reach, and/or limited budget and time impedes investing in the resources needed to achieve representative sample sizes. Resource and time limitations, combined with the myriad challenges and concerns with collecting data from this multiply-marginalized population^{48,49} precluded use of a more robust study design (e.g., multistage cluster sample). However, our approach enabled us to comprehensively examine the family homelessness experience in a manner that had not been done previously in Massachusetts.

Limitations

Three main issues limit our study. First, we included all data for questions that respondents provided answers for; we have no way of knowing the reason why respondents did not provide an answer for certain questions. On many items, no items were skipped, while on others, as much as 21% of respondents chose to skip the question. This could have been due to confusion in interpreting the questions, potential discomfort related to answering certain questions, or other unknown reasons. While this presents a challenge in

interpreting the study findings, the CAT advised us how critical it was to not mandate responses.

Relatedly, we acknowledge that the readability of our survey, as measured by the SMOG score, may be high compared to the national literacy average. This may have impeded comprehension of survey items. We pared down the readability level from an initial score of 19.0 to an 8th grade reading level, meeting the preferences of all stakeholders involved. The SMOG grade lacks validity in Spanish so was not applied to that version.

Finally, the open-ended data must be interpreted with caution. These questions were not asked in a structured interview format; respondents were not able to elaborate upon points raised in open-ended text boxes, nor were we able to clarify meaning. It is likely that the experiences noted in these fields have greater depth in contextual meaning and would warrant a more intensive qualitative data collection effort (e.g., interviews, focus group discussions) to develop a more comprehensive picture of family needs.

Alignment of Family Needs with Service Delivery

Families experiencing homelessness in Massachusetts have a variety of needs; income supports, jobs that pay livable wages and offer family-friendly benefits, and affordable housing rank highest among them. Families in Massachusetts are not unlike families experiencing homelessness across the country. The results of this study indicate that structural deficits between income and housing are the most common immediate precursor to becoming homeless. This is not new information. However, what is surprising is that despite the need to address income and housing support, most survey respondents reported that this need was not well addressed. For example, the majority of survey respondents were unemployed, not involved in a job training or education program, had made very low wages, and had not received housing assistance in the past five years. Families' responses indicate a significant misalignment between experience/need and service delivery and an area in need of strengthening.

Massachusetts has a robust provider network and a state system that has tried to be responsive to all in need of shelter while managing scarce resources. Despite the inherent challenges, more than half of

families reported feeling safe and treated respectfully in their current shelter placements. While this is a strength, there remains much area for improvement, as a third of families did not report similar experiences. One of the strongest areas of service delivery was seen in access to primary medical care. Likely as a result of Massachusetts' provision of state health services and of the Affordable Care Act, most adults and nearly all children had a primary care provider – most of whom reported they saw regularly.

This high level of access to and satisfaction with access to primary care services was not replicated in other areas. At least 20% of families reported that their needs were not being met, and a quarter reported that the services they did receive were insufficient. Surprisingly, housing search and case management, two staples of service delivery, were not consistently delivered to approximately 40% of families.

The results of this study also raise concerns about the long-term residential stability of families under the current system, and about the parents' health status. More than a quarter of our sample of currently homeless families had received HomeBASE or RAFT in the past five years, yet they had not stabilized and were currently in shelter. Although the state does provide prevention or short-term rapid rehousing resources, most families had not accessed these resources. For those families who had, it was not enough to secure long-term residential stability.

The impact on parents' health was also striking. Most parents reported that their health had declined and that their stress level had worsened since entering shelter; the same was reported for approximately a quarter of children. Half of school age children were reported to have been diagnosed with a behavioral health condition. It is unclear how many of these children were receiving services, though it is likely that need does not match service use based off previous literature.⁵⁰

Consistent with the literature, we identified gaps in services in the following areas: transportation support, adult education, job skills training, and mental health and domestic violence services.⁵¹ Among families in our study, health and mental health issues, experiences of domestic violence, and a loss of support systems were cited as the main

contributing factors to the experience of homelessness for families. Of the mothers with infant children, 40% reported feeling bothered by feelings of depression and in need of services.

5 SERVICE NEEDS AS IDENTIFIED BY FAMILIES

- ✓ Consistent housing search and case management services.
- ✓ Training for and access to jobs that pay livable wages.
- ✓ Transportation Support.
- ✓ Better access to services and supports including domestic violence services and mental health care, especially for new mothers to address signs of postpartum depression.
- ✓ Assessment and services to support children's health and well-being.

Services for children were not directly expressed as a need by study respondents. However, one quarter of parents reported that their children's health has declined and/or their behavior had worsened following entrance to shelter. This is consistent with earlier literature that indicates the adverse impact of homelessness on children.⁵² This fact alone demands that assessment of children's development and children's services be a routine part of shelter services, as echoed by others.⁵³

Overall, the results of this study indicate that there are places where Massachusetts is doing well to align services with families' needs and experiences, and there are areas in need of improvement. Access to affordable medical care under MassHealth and the Affordable Care Act has clearly benefited homeless families.

Despite these strengths, this study also identified a number of inconsistencies and gaps in service

delivery across program types. Not surprisingly, hotel/motel residents reported the lowest satisfaction with services. Most congregate shelter residents reported they were not aware of the services available to them. In contrast, nearly all scattered site residents reported they knew who to contact for help, which is likely a function of how the program is designed. These differences highlight how each type of program can improve services for the families they serve. Perhaps most importantly, across all program types, a third to one-half of families did not feel their needs were being met or that they were aware of/had access to local resources, respectively. Together, the results of this study indicate five service needs, as identified by families, that are considered essential components of an effective emergency response system for homeless families (see insert.).

The Case for Family-Centered Care

To best meet the needs of families experiencing homelessness, an approach is needed that is consumer driven and responsive to consumers' needs, experiences, and wishes. Three best practice paradigms have evolved over several decades to address the needs of historically underserved populations with complex service needs. They include: 1) Family-Centered Care (FCC),⁵⁴ 2) Person-Centered Care (PCC), and; 3) Two Generation Models.⁵⁵ In addition to their focus on the centrality of consumer voice and choice, all three require providers to interact with consumers within the context of their cultural beliefs, behaviors, and values.⁵⁶ As racial minorities are over-represented in homeless populations,⁵⁷ culturally competent practice and policies are especially critical to ensure quality services and effective outcomes.⁵⁸

Family-centered approaches to service delivery actively place families at the center of the process. After World War II, consumers (e.g., parents) started voicing concerns and advocating for more family friendly approaches. Over time, parents impacted the design of health service delivery to better align with their own and their children's needs. To support consumer efforts, the Institute of Family Centered Care was launched in 1992 and has since disseminated papers, advocating for policies and practices that support families.

5 Features of FCC

(HRSA, 2004)

1. Provider spends enough time with the family
2. Provider listens carefully to the parents.
3. Provider makes the parent feel like a partner in their child's care.
4. Provider is sensitive to the family's values and customs.
5. Provider provides the specific information that the parent requests and needs.

FCC recognizes that the adults in the family are parents first, and as such they are the ultimate decision makers for their children.^{59,60} Spurred by the health community's awareness of the detrimental impact of separating children from their families, after a 20-year evolution, FCC has become a cornerstone of pediatric practice.⁶¹ Although FCC is widely accepted philosophically in health care settings, its implementation remains uneven as systems struggle to become more flexible and inclusive of families in the face of strict regulations. From 2000-2002, a large national survey conducted on over 370,000 families assessed the prevalence of special health care needs among children in all 50 states and the District of Columbia. Results across race, gender, and income levels indicate that almost 20% of families reported that they did not get what they needed from their providers.

Family-centered care is merely a nascent concept in the homelessness system. Although some experts have recommended the approach,⁶² an effective system that is ecologically and developmentally grounded in the needs of the family members

“Family-Centered Care is a way of caring for children and their families which ensures that care is planned around the whole family.”

- Shields et al. 2006, pp.1318

“Support a two-generation approach to meet the needs of both parents and their young children experiencing homelessness by developing and strengthening partnerships across housing and early childhood programs and systems to obtain and sustain housing, achieve stability, ensure positive early experiences, and promote well-being for the whole family.”

- Joint Policy Statement by HHS, HUD, DOE, 10/31/16, pp.3

experiencing homelessness has yet to be implemented. The U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA) defined five criteria of FCC for families⁶³ (see insert). Providers across the housing and homeless systems require training to shift, develop, or evolve their models to better align with FCC.

Person-Centered Care (PCC) is designed to meet the needs of individual. Most often found in the delivery of medical services, PCC delivers services to the user that are holistic, individualized, respectful, and empowering.⁶⁴ The Institute of Medicine (IOM) identified 10 core fealties of PCC (see insert).⁶⁵ Consistent with FCC, within this framework, the individual service user is the expert of his or her own needs, providers bring clinical or content expertise and together they develop service delivery plans customized to the person’s needs.

Central to PCC is the importance of the provider–service user relationship and understanding the whole context of a person’s life. The person is not a passive recipient of services delivered by a provider who holds all the authority, but an active partner. Inherent to a person-centered approach is a focus on meeting the person’s expressed needs. PCC requires that comprehensive assessments are completed to direct what services and supports are best suited to the person.

10 Core Features of PCC

(IOM, 2006)

1. Continuous healing relationships.
2. Customization based on the needs and values of service users.
3. Service users as the source of control.
4. Shared knowledge.
5. Evidence-based decision making.
6. Safety.
7. Transparency.
8. Anticipation of needs.
9. Decrease in waste.
10. Cooperation among providers.

In PCC and FCC, the consumer is central to the decision-making process. In FCC, caregivers are viewed as the child’s primary source of support; children are not separated from families, but instead parents are supported and integrally involved in their child’s care. Research indicates that FCC and PCC can lead to improved patient satisfaction and outcomes.

Despite their evolution over the past two decades, to date, both family-centered and person-centered approaches are mostly found in the medical community, notably primary care and pediatric practice.⁶⁶ These approaches have not yet been implemented at a systemic level across programs, though they are strongly recommended as best practices to address family homeless.⁶⁷

Two-generation approaches represent a third model that is most similar to FCC.⁶⁸ This model offers services to help children while simultaneously working with parents and is mostly discussed in relation to families working with very young children. A two-generation approach is a

BEST PRACTICES FOR TWO GENERATIONS

- ✓ Early Childhood Education
- ✓ Adult Education
- ✓ Economic Support
- ✓ Physical Health Services for Parents and Children
- ✓ Mental Health Services for Parents and Children
- ✓ Building Families Social Capital and Natural Support Networks

recommended best practice when working with families in poverty. It makes use of a holistic case management process to assess for underlying issues impacting family functioning and the needs of each member of the family.⁶⁹ The goals of a two-generation approach are to enhance and strengthen parenting skills, build economic self-sufficiency, and address health or mental health needs⁷⁰. Two-generation models have been recommended for use with homeless families due to the high percentage of families with children under the age of five. Recent data indicate that newborns or infants in the first year of life are most likely to experience homelessness, followed by children between age one to five.⁷¹ Considering the known impact of early adversity on children’s development,⁷² this warrants an immediate response from policymakers and providers and a prioritization of two generation, family-centered approaches to addressing family homelessness.

Implications for Research, Policy, and Practice

Family-centered approaches, similar to two-generation models and PCC, have begun to enter human service systems (e.g., child welfare),⁷³ but so far, have had little impact on how homeless services are delivered. Although some shelters work in

holistic and family oriented ways,⁷⁴ as a system, the delivery of services for homeless families remains embedded in more traditional, adult focused models where service delivery is highly variable. To date, there remains no established evidence-based service model for families experiencing homelessness.⁷⁵ While federal policy suggests the use of two generation family models,^{76,77} resources to do so are limited at best and largely favor rapid rehousing over effective family based stabilization.⁷⁸

Efforts to support families at the state and federal levels include use of prevention and diversion to reduce the numbers of families entering shelter or being placed in motels,^{79,80} and screening for housing status within primary health care settings.⁸¹ In 2016, the federal government released a joint policy statement by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Department of Education (DOE) endorsing a two-generation approach to addressing family homelessness.⁸² The report offers specific recommendations to improve cross system collaboration, and highlights the core components of two-generation approaches that apply to working with families with young children experiencing homelessness (see insert).⁸³

The system serving homeless families has not yet adopted these models. Although the state’s efforts and federal policy statement represent major steps forward in shifting the system from an adult focused to family-centered one, to implement the approach effectively, resources and support for providers will be required.

It remains incumbent on policymakers to ensure the system developed meets the needs of families experiencing homelessness. To do so, we must listen to the voice of families, understand their experiences, and work to meet the complex needs – both structural and service-related – so that parents and their children can permanently move beyond the experience of being without a home.

Conclusion

The results of this study indicate that families need to be put at the center of research, practice, and policy to ensure alignment of services with their needs and experiences. As expected, we found that parents’ experiences of poverty, lack of affordable

housing, and unemployment are the main precipitants of homelessness. Although satisfaction was reported by many Massachusetts families, the results of this study indicate the system is hampered by inconsistent case management services and housing assistance, a lack of access to job training programs, gaps in transportation support, and a need for health, mental health, and domestic violence services. Moreover, there were significant differences in how families perceived their shelter experiences and the services received by shelter program model. Race, ethnicity, and the

type of program a family is assigned to appear to be contributing factors that warrant further investigation. Declines in parental health and increasing stress for parents should raise red flags for all policymakers about concern the impact of homelessness on the children. The voices of the families from this study clearly indicate what families need to move out of homelessness. It is now up to the policymakers and providers to listen and evolve the system in a manner that is most responsive to families' needs. 🏠

“No one understands how important a service is better than those in need to that service. Consumers – of anything – are the experts. We know why it succeeds, we know why it fails. Capturing data in raw moments in shelter brings another level of complexity to the feelings of folks experiencing homelessness. We are not just numbers. Providers need to see the whole picture.”

- Homes for Families Consumer Advocacy Team (CAT) Member, 2017

Appendix

Supplemental Table 1. Family respondents' current/previous employment vs. employment desired (including examples)

	Current/Previous Fields of Employment	Desired Fields of Employment
Primary	<ul style="list-style-type: none"> Medical/Healthcare (Medical Assistant, CNA, PCA, Home Health Aide, Nursing Assistant) Education/Childcare (Teacher, Caregiver, Daycare, Early Childhood Educator) Domestic Work (Housekeeping, Custodian, Cleaner) Food/Restaurants (Fast Food, Waitress) Labor/Agriculture (Grounds Crew, Carpenter, Farmer, Construction) Manufacturing (Warehouse Stocking, Factory) Administrative (Office Work, Secretary) Sales/Marketing (Sales Associate, Cashier, Telemarketer) Retail/Customer Service (Retail Associate) 	<ul style="list-style-type: none"> Medical/Healthcare (Medical Assistant, CNA, PCA, Home Health Aide, Nurse/NP) Food/Restaurants (Cook, Restaurant) Manufacturing (Factory, Warehouse) Administrative (Secretary, Receptionist) Retail/Customer Service (Customer Service, Retail) Human Services (Social Work, Elderly Care) Open to anything
Secondary	<ul style="list-style-type: none"> Technology (Electronics, Telecommunications) Salon/Beauty Human Services (Case Manager, Residential Counselor) Security/Law Enforcement (Corrections Officer, Security Guard) Managerial (Supervisor, Management) Other (Driver, Recruiter, Accounting) 	<ul style="list-style-type: none"> Education/Childcare (Daycare, Childcare) Domestic Work (Housekeeping, Cleaning) Sales/Marketing (Cashier) Security/Law Enforcement (Security Officer) Technology (Network Administration) Other (Airport, Driver, Environmental Services)

Supplemental Table 2. Family respondents' experiences in various living situations

Living Situation Experience	N	%
In the care of a family member other than a parent as a child	24	20.5
Temporarily stayed with friends or family as a child	26	22.2
In the care of foster parents	11	9.4
Residential treatment facility as a child	5	4.3
Residential treatment facility as an adult	5	4.3
Juvenile detention center	5	4.3
Jail or prison	7	6.0
Homeless shelter as a child	15	12.8
Raised in public/subsidized housing	15	12.8
Doesn't know	3	2.6
None	49	41.9
With family	2	1.7
Other	2	1.7
Total	117	100.0

Supplemental Table 3. Family respondents' reported life experiences

Life Experiences	N	%
I was raised by a single parent	52	44.44%
I witnessed domestic violence at home	37	31.62%
I moved from another country	22	18.80%
There was substance abuse in my family	36	30.77%
One of my family members was incarcerated	24	20.51%
My parents were separated or divorced	59	50.43%
There was mental illness in my family	36	30.77%
Someone in my family had serious health problems	31	26.50%
I served in the military	3	2.56%
I was involved in after school activities	35	29.91%
I was involved in church or faith group	39	33.33%
Total	117	100.00%

Supplemental Table 4. Family respondents' reported diagnosed conditions among children and adults

Health Condition	Adults		Children		Both		Total
	N	%	N	%	N	%	N
Low birth weight (less than 5 lbs 8oz)	1	0.85%	19	16.24%	2	1.71%	117
Diabetes	10	8.55%	3	2.56%	1	0.85%	117
Asthma	17	14.53%	16	13.68%	15	12.82%	117
Overweight/ Obese	22	18.80%	4	3.42%	7	5.98%	117
Heart Disease	3	2.56%	1	0.85%	0	0.00%	117
Cancer	4	3.42%	0	0.00%	0	0.00%	117
Chronic Obstructive Pulmonary Disease (COPD)	1	0.85%	0	0.00%	0	0.00%	117
None	0	0.00%	1	0.85%	25	21.37%	117

Supplemental Table 5. Respondents' report of sources of social support

	Never		Some of the time		Most of the time		All of the time	
	N	%	N	%	N	%	N	%
<i>Family</i>								
Instrumental	48	41.03%	35	29.91%	8	6.84%	9	7.69%
Financial	51	43.59%	38	32.48%	9	7.69%	5	4.27%
Emotional	43	36.75%	31	26.50%	14	11.97%	20	17.09%
<i>Spouse/Partner</i>								
Instrumental	26	22.22%	14	11.97%	12	10.26%	36	30.77%
Financial	26	22.22%	16	13.68%	14	11.97%	35	29.91%
Emotional	29	24.79%	8	6.84%	15	12.82%	41	35.04%
<i>Friends</i>								
Instrumental	42	35.90%	41	35.04%	7	5.98%	4	3.42%
Financial	53	45.30%	31	26.50%	4	3.42%	5	4.27%
Emotional	35	29.91%	45	38.46%	11	9.40%	10	8.55%
<i>Community</i>								
Instrumental	54	46.15%	20	17.09%	4	3.42%	2	1.71%
Financial	50	42.74%	27	23.08%	4	3.42%	3	2.56%
Emotional	49	41.88%	24	20.51%	8	6.84%	4	3.42%

Supplemental Table 6. Family respondent comments on their support system, by thematic category

Theme	Illustrative Quotes
Emotional support present, but instrumental/financial support is lacking	<ul style="list-style-type: none"> • My support system is great mentally but financially and ride wise, which is what I need, it's very slim. • I need transportation for my kids from shelter to daycare and vice versa.
Feelings of isolation/lack of support	• I have no support. Nobody who would be there for me and my children.
	• I am all alone.
	• Lack of support!!!
	• Very private - I don't have support.
Support from shelter staff	• My family and I are alone here and that makes it real difficult.
	• Being at shelter, ya tend to grow a bond with certain staff for support, it's still not a [good] place.
Positive support system	• My partner is very supportive. My whole family lives out of state.
	• I mainly depend on my wife since my operation ([craniotomy])
	• I have a really good support system, they help when they can and they are there for me.
	• My mother is the only one who helps me with my son which has autism.
Church/faith provides support	• Church provide a more supportive front.
	• The Father, the Son, and the Holy Spirit
	• I am so glad for my church family!
Mismatch between support and geography	• Location of the shelter situated in Western Mass. and my support system is in Eastern Mass. Where I was sent from.
	• At one time I lived near my family, they helped some, but now I have far away so can only rely on a very few [amount] of friends.
	• When placed here in shelter it's more than an hour away so I have no family, no support in this area so it makes it so much harder not having anyone that [normally] may have helped.
	• Everything is too far and I'm also not from here.

Supplemental Table 7. Characteristics of family respondents' civic engagement

	N	%
Registered to Vote	113	24.8
No	29	63.3
Yes	74	4.3
Not Eligible	5	4.3
Don't Know	5	
Votes in Elections (if registered)	101	
No	39	33.3
Yes	43	36.8
Sometimes	19	16.2
Contacted an elected official to resolve issues	108	73.5
No	86	12.0
Yes	14	6.8
Not Sure	8	
Interest in sharing personal narrative to policymakers	108	18.8
No	22	54.7
Yes	64	18.8
Not Sure	22	

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