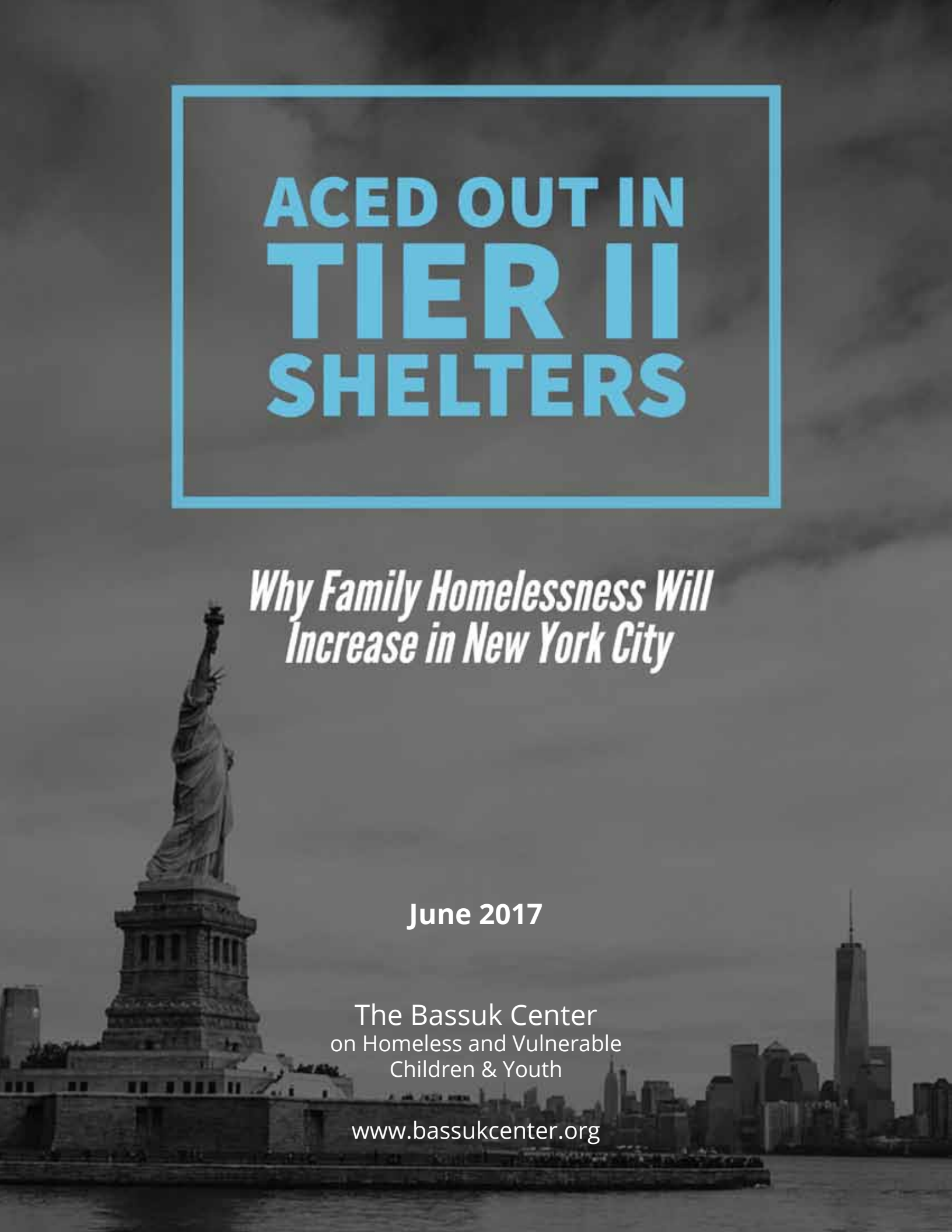

ACED OUT IN TIER II SHELTERS

Why Family Homelessness Will Increase in New York City

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The Bassuk Center
on Homeless and Vulnerable
Children & Youth

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Executive Summary

Seventy percent of people experiencing homelessness in New York City are now families according to data gathered by the City's Department of Homeless Services (DHS)—more than twice the percentage of families comprising the homeless population nationally. The DHS daily census shows more than 14,800 families and 22,160 children are residing in City shelters (June 6, 2017). In contrast to the national median length of shelter stay of four months for families, the average length in New York City is more than 400 days. New York City has become the family homelessness capital of America.

Affordable housing is the essential foundation for solving family homelessness in New York City. This report does not address strategies for increasing the stock of affordable housing but instead acknowledges this basic problem. We focus on the need to transform the Tier II shelters designated specifically for families that are sited throughout the City, mainly in Brooklyn, Bronx and Manhattan. According to research about the exposure of children to maltreatment and household dysfunction, and the consequent impact of traumatic stress on children, it is clear that services matter while families are in shelter—ideally, with early intervention beginning at birth. Given the extent of family homelessness in the City, the lack of affordable housing, the large size and design of the shelters, and the nature of shelter staffing, this report clearly documents that Tier II shelters are harming children.

Advances in public health document how Adverse Childhood Experiences (ACEs) can accumulate in young lives and affect the stress response, creating long-lasting changes in their brains and bodies. If these changes are ignored, children will develop some of the leading causes of adult morbidity and early mortality. High numbers of ACEs are related to impairments that double and quadruple rates of diabetes, heart disease, cancer, COPD—some of the leading causes of death in adults. ACEs are also directly connected to increased alcohol and drug use, and homelessness. Many children experiencing homelessness have multiple ACEs, but this remains unaddressed in Tier II shelters, and the effects are likely compounded by the extreme and unrelenting stress of shelter life.

This report describes how Tier II shelters are not conducive to implementing necessary services that can mitigate and even reverse the negative impact that ACEs have on children and families. We urge policymakers to pay special attention to the problems in the current

size, design, and structure of the shelters that must be addressed to assure that families can stabilize in permanent housing in the community and not return to homelessness, and the children will be able to grow up to be productive, participating citizens. Without acknowledging these problems and making urgent changes, the numbers of homeless families in the City will continue to increase:

- The massive scale and culture of Tier II shelters precludes the possibility of building collaborative, trusting relationships between providers and clients.
- Very long shelters stays with few services have harmful impacts on the development of children's brains, negatively affect their physical and mental health in the near term and throughout their lives, and increase the likelihood they will experience homelessness as adults.
- In shelters, mothers are most commonly parenting two children and have high rates of serious depression and co-occurring disorders such as PTSD that are not acknowledged or treated while in shelter.
- Centralized Prevention Assistance and Temporary Housing (PATH) intake assessment and local shelter intakes focus primarily on eligibility, rules, and control and are not helping families.
- Shelter staff are overburdened, do not receive the comprehensive ongoing training they need to support children and families, and spend most of their time on documentation and paperwork instead of helping families.
- A primary focus on shelter safety creates prison-like environments that isolate families and overshadows the effective delivery of essential supports and services.

The Mayor's plan to address family homelessness (*Turning the Tide on Homelessness in New York City,* 2017) aggressively doubles down on the current Tier II family shelter system, suggesting that City planners and policymakers do not understand the drivers of family homelessness or possible solutions. While the plan contains some constructive elements, it proposes to create many more large family shelters. The numbers of people experiencing homelessness has already become a city within a city, approaching the size of Niagara Falls, Troy, or White Plains. Under the Mayor's plan, the tide will not be turned but will instead become a flood that engulfs the City.

An effective alternative starts with transforming Tier II shelters from large scale custodial warehouses dominated by security, compliance, and documentation to become small-scale relational environments in which service providers and family members can develop relationships—the linchpin of service delivery and the route to ending family homelessness. In this report, we provide a blueprint for how the shelters must be transformed. We also discuss six essential services required for families to stabilize in housing after they leave shelter. These services are implemented in shelters and follow families when they return to the community using time-limited Family Critical Time Intervention:

1. Comprehensively assess all family members
2. Provide parents with education and employment opportunities
3. Provide organizational trauma-informed care
4. Address health needs of parents and children
5. Provide parenting supports in shelters
6. Optimize the shelter workforce

Our purpose in writing this report is to urge New York City policymakers to understand the complex causes behind family homelessness so they will stop the direction they are taking and, instead, implement an effective response. A large-scale, institutional solution that prioritizes policing and security within a shelter culture bound by rigid rules and regulations will not help families return successfully to the community.

Policymakers must confront the reality that up to one-half of families in New York City return to homelessness again after being rehoused in the community—proof of systemic failure of the shelter system that further increases the ever growing numbers of families who are homeless. We hope this report persuades the City to reimagine its approach. The Bassuk Center is ready to help.

Introduction

This report analyzes New York City's Tier II Family Shelters that house over 14,800 families and more than 22,160 children (New York City Department of Homeless Services, 2017). We offer a critical review of the Mayor's plan to address homelessness and advance a comprehensive solution to reduce family homelessness in the City. We focus solely on families and children. We embrace the need for affordable housing as critical to the solution but focus on the role of services in improving the current family shelter system.

To write this report, we made site visits to family shelters and conducted virtual focus groups to talk with shelter leadership, supervisors, case managers, housing specialists, child care providers, security staff, and residents, including parents and children. We also interviewed people in the City's child welfare system, child development specialists, early intervention staff, public school system staff, housing specialists, and advocates. We reviewed shelter intake forms and other paperwork required by shelters such as documentation of activities, logs, compliance reports, job descriptions, organizational charts, and policies and procedures. We read secondary reports about families and children experiencing homelessness in New York City, relevant federal government reports, program descriptions, and media articles. We also reviewed relevant academic literature.

The Bassuk Center on Homeless and Vulnerable Children & Youth is a national non-profit organization founded in 2015 to carry on the pioneering work of Ellen L. Bassuk, MD and her colleagues who helped to create the knowledge base about the causes, correlates, and consequences of family homelessness and possible solutions. For more information, please visit www.bassukcenter.org. We recommend that readers also download from our website and read *Services Matter: How Housing and Services Can End Family Homelessness* for further discussion of the challenges and solutions presented here.

We wish to acknowledge the dedicated, compassionate staff in the City's family shelters. They commit untold hours to helping families and children, working against daunting odds without sufficient recognition or resources. We also acknowledge the thousands of family members in Tier II shelters who strive daily to prevail despite unspeakable hardships, and the children who struggle to grow and thrive. We hope this report will make a difference for them.

I. Tier II Shelters are Harming Children

Overview

According to data gathered by New York City's Department of Homeless Services (DHS), 70 percent of people experiencing homelessness in the City are families—almost twice the national percentage of families experiencing homelessness of 35 percent (HUD, 2016). While homelessness among various subgroups such as individuals, veterans, and those who experience chronic homelessness has decreased nationally (HUD, 2016), the numbers of families who are homeless are soaring in most places in America. New York City reports a daily census that exceeds 14,800 families and more than 22,160 children (New York City Department of Homeless Services, 2017).

While some families who are homeless are two-parent families, the majority are headed by single mothers who are parenting alone (HUD, 2015a). The mothers are young, with young children in their care; half of the children are younger than age 6. Families with children used emergency shelters for a median of 47 nights during a one-year reporting period (HUD, 2015a). In contrast, the average length of shelter stay in New York City is more than 400 days (Routhier, 2017). To compound matters, the rate of return to homelessness for families in New York City who have left shelter and have been rehoused in the community is estimated to exceed 50% (ICPH, 2013).

The City's lack of affordable housing is a primary driver of family homelessness and shapes the City's response. The federally-established poverty levels of $37,060 for a family of three and $29,420 for a family of two do not support a family's basic needs for housing, food, clothes, healthcare, transportation, and child care in New York City. With the average monthly rent for a one bedroom apartment exceeding $2,500, decent affordable housing is a rare commodity in the City and out of reach for a head of household earning minimum wage (Yentel et al., 2016). According to the Mayor's recent plan (de Blasio, 2017) to address homelessness, "The scale of the affordability crisis is vast" with median rents increasing by 19 percent as household incomes have decreased by 6.3 percent:

> According to the *Housing New York* plan, between 1994 and 2012, the City suffered a net loss of approximately 150,000 rent stabilized apartments. This affordability crisis was made worse for working New Yorkers in April 2011, when the City

and State ended the Advantage rental assistance program. The program, which began in 2007, had offered subsidies for people in shelters if they took part in job training. In the years following its elimination, from January 2011 to January 2014, the shelter population increased by 14,000 people. (*Turning the Tide on Homelessness in New York City*, de Blasio, 2017)

With elimination of the Advantage rental assistance program, the already constricted affordable housing situation worsened dramatically and the family homeless population steadily increased to become one of the City's most pressing social problems. City planners acknowledge that it is unrealistic to believe that a sufficient number of affordable housing units can be built quickly enough to accommodate the sheltered homeless family population. Commenting on the Mayor's plan in a recent Op Ed in the Daily News, two housing experts conclude:

> Rental vouchers help some tenants afford apartments, but with far from enough to go around. Meanwhile, nearly 63,000 New Yorkers will sleep in shelters tonight. Because of the scarcity of permanent housing options, the average length of a New Yorker's shelter stay is likely to remain north of a year. This is a very long time in the lives of children enduring the stress of homelessness in aging shelters, emergency cluster site apartments and hotels, who now number more than 24,000. De Blasio is saying that we can no longer ask these children to wait patiently for the day their family will finally find an apartment. We must invest in and transform existing shelters and build new shelters to create safe places that reduce the trauma of a homeless episode, not add to it. (Houghton & Traylor, 2017)

Another central pressure on the City's shelter system is the right to shelter, first mandated with the settlement of *Callahan v. Carey* in 1981 in which New York City and New York State agreed to provide shelter to men who were experiencing homelessness "by reason of physical, mental, or social dysfunction." Subsequent court decisions extended this right to women experiencing homelessness, then to families, and finally to families with children (Coalition for the Homeless, n.d.). Enforcement of the right to shelter in the City has required ongoing legal attention.

The growing numbers of families experiencing homelessness in New York City, and the high rate of return to homelessness, has created a city within a city approaching the size of Niagara Falls, Troy, or White Plains. New York City is now the homeless capital of America, exceeding Los Angeles, which previously held this undesirable distinction.

In our exploration of the New York City Tier II shelters, we encountered dedicated shelter staff—both human service and security staff—committed to helping the families in their care. We also found examples of innovative services that supported the goal of moving families back to stable housing in the community and saw incremental efforts at improving the system. However, the extent of family homelessness in the City and the urgent needs of the children and parents are not being adequately addressed. The current Tier II shelter design and culture, inadequate shelter services and staffing, and the overriding focus on rules, compliance, and safety rather than the development of secure, trusting relationships and the provision of services are damaging young children in the shelters.

The Impact of Adverse Childhood Experiences (ACEs)

Children who are homeless have poor physical health that often begins at birth, with many babies born with low birth weight (Richards, Merrill, & Baksh, 2011). They have higher rates of acute and chronic illnesses, including anemia, gastrointestinal disorders, ear infections, and asthma and other respiratory illnesses (Weinreb et al., 1998). Almost one-quarter have had a medical problem or physical disability that interferes with their ability to function in routine activities (Hayes, Zonneville, & Bassuk, 2013). Because of their transient situations, many homeless children do not have regular health care providers, delaying routine health screenings and immunizations (Weinreb et al., 1998).

But the story doesn't stop there. Tonight, more than 22,000 children will be trying to fall asleep in the City's family shelters. While other children are playing with friends, learning math and reading, and developing social skills, children in City shelters are being damaged daily in ways that harm their brain development, plague their lives with poor physical and mental health, and return many of them to homelessness when they become adults. This has been documented by researchers who have studied the nature, impact, and neuroscience of Adverse Childhood Experiences, or ACEs.

How ACEs Were Uncovered

> We now know that adversity early in life can not only disrupt brain circuits that lead to problems with literacy; it can also affect the development of the cardiovascular system and the immune system and metabolic regulatory systems, and lead to not only more problems learning in school but also greater risk for diabetes and hypertension and heart disease and cancer and depression and substance abuse.
>
> -- Jack P. Shonkoff, M.D., Professor of Pediatrics at Harvard Medical School, Director of the Center on the Developing Child

In 1998, Vincent Felitti, a physician working in the preventive medicine department of Kaiser Permanente Health Maintenance Organization, was operating an obesity clinic focused on weight loss. To his surprise, half of the women who were successfully losing weight were dropping out of the program. To understand why, he interviewed more than 250 of them and found that the majority had been abused during childhood. He concluded that obesity was a protective factor for these women. Felitti collaborated with Robert Anda at the Center for Disease Control (CDC) to design what became a landmark epidemiological study which is changing the face of medical care.

The study sample of 17,337 volunteers were primarily middle and upper class, white, college educated older adults with good jobs and quality health care. The study asked participants to complete a questionnaire about whether they had experienced certain adverse events

during their childhood. Events were divided into two categories: (1) Maltreatment: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect and (2) Household Dysfunction: mother treated violently, household substance use, household mental illness, family separation/divorce, and an incarcerated household member.

When researchers examined the responses, they were stunned to find a very high correlation between the presence of multiple ACEs and long-term medical and mental health disorders that occurred over a person's lifetime. They and other researchers also documented that the presence of multiple ACEs correlated with:

- Earlier morbidity in adolescents and adults
- Higher rates of risk-taking behaviors
- Lifetime homelessness
- Multigenerational difficulties

The original Felitti study (Felitti et al., 1998) has since been extensively replicated both in the United States and internationally, confirming and strengthening the results (Brown et al., 2009; Danese et al, 2009; Gilbert et al., 2015). The CDC has subsequently established a state-by-state surveillance system to monitor ACEs in the population (Behavioral Risk Factor Surveillance System).

These studies have documented that ACEs are common in the general population and they tend to cluster. In the original study, almost two thirds (64%) of participants reported one ACE and 22 percent reported three or more (Felitti et al., 1998). As the numbers of ACEs increased for any individual, the odds of developing multiple adult health conditions increased, indicating a graded-dose response.

Ace Score (# of ACEs)	**Condition**	**Increased Risk** (compared to no ACES)	**Percentage Of Risk Increase**
4	Diabetes	x 1.6	60%
4	Cancer	x 1.9	90%
4	Heart Disease	x 2.0	100%
4	Stroke	x 2.4	140%
4	COPD	x 3.9	290%
4	STD	x 2.5	150%
4	Alcohol Abuse	x 7.4	640%
4	Drug Use	x 4.7	370%
4	Injecting Drugs	x 10.3	930%
4	Suicide Attempt	x 6.2	520%
7 or more	Suicide Attempt	x 30.1	2910%

(Felitti et al., 1998; Dube et al., 201)

ACEs Change a Child's Brain and Body

> "What looks like a social situation is actually a neurochemical situation."
> --Dr. Nadine Burke, MD, MPH, FAAP (as cited in *The New Yorker*, Tough, 2011)

ACEs are characterized by a chronic stress response in which body and brain responses persist over time, leading to lasting changes that cause long-term adverse outcomes (Center on the Developing Child at Harvard University, 2007a). These body and brain responses include:

- Increased and sustained stress characterized by an increased autonomic nervous system response with release of epinephrine and signals to the HPA axis—hypothalamus, pituitary gland, and adrenal glands—to release adrenocorticotropic hormone (ACTH) and cortisol
- Secretion of hormones (e.g., increased cortisol, a glucocorticoid that stimulates the body and keeps it on high alert)
- Elevated neurotransmitters
- Release of inflammatory proteins that course through the bloodstream
- Changes in DNA through a methylation process

Multiple ACEs lead to a sustained stress response that results in altered homeostasis of multiple organ systems, decreased immune functioning, and curtailed inflammatory response. These changes lead to medical and mental health disorders in adolescence and in adulthood. Dr. Burke, the physician highlighted by *The New Yorker* (Tough, 2011) reported that only three percent of her patients with an ACE score of zero displayed learning or behavioral problems; for patients with an ACE score of 4 or higher, the figure was 51 percent.

Mothers' ACEs occur in both categories of maltreatment and household dysfunction. Recent studies have documented that mothers with high ACE scores have children with high ACE scores. Dr. Burke, a pediatrician, has suggested that similar to protocols developed for heart disease (e.g., screening for elevated cholesterol levels), protocols be designed that focus on the ACEs to determine children's risk of developing health and mental disorders later in life.

ACEs and Homelessness

Not surprisingly, multiple ACEs predict lifetime homelessness. Children who are homeless often experience multiple moves, evictions, repeated changes in schools, exposure to trauma and violence, illness and injury, hunger, and abrupt family separations. When stress is chronic and unrelenting, some children develop what Harvard University's Dr. Shonkoff has identified as "toxic stress," which can occur when a child experiences profound and prolonged adversity without the help of a supportive, nurturing, and soothing parent. The child may develop a persistent stress response that can "...disrupt the development of brain architecture and other organ systems and increase the risk for stress-related diseases and cognitive impairment, well into adult years."(Center on the Developing Child, 2007b).

Long Tier II Shelter Stays Compound ACEs

The impact of ongoing exposure to traumatic stress combined with the presence of high rates of ACEs leads to psychological, cognitive, social, and health changes in children. As described above, this also leads to changes in the physiology of the brain and body. Younger children, who depend on the support and nurturance from their mothers, are especially affected. Mothers are understandably stressed, frequently depressed and preoccupied, and may be more irritable and unresponsive to their young children. This may result in toxic stress in the child. As Shonkoff has described:

...when toxic stress response occurs continually, or is triggered by multiple sources, it can have a cumulative toll on an individual's physical and mental health—for a lifetime. The more adverse experiences in childhood, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse and depression. Research also indicates that supportive responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response. (Center for the Developing Child, 2007b)

The effect of homelessness and ACEs can have its earliest effect during a mother's pregnancy. Mothers experiencing homelessness are less likely to receive prenatal care and are more likely to have low birth weight babies who have a greater risk for infant morbidity and mortality. The bond between mother and child can be compromised early with children manifesting insecure attachments, developmental delays, and difficulties with self-regulation as they grow (Richards et al., 2011, Stein, Lu, & Gelberg, 2000).

A study based on data from the U.S. Department of Housing and Urban Development's (HUD, 2015b) Family Options Study showed that children 18 to 41 months old experiencing homelessness have poorer outcomes than national norms, 20 months after shelter (Brown, Shinn, & Khadduri, 2017). They have more developmental delays; behavioral challenges such as hyperactivity, conduct problems, and difficulties in peer relationships; lower reading readiness; and underperformance in school.

A recent systematic review and meta-analysis of mental health disorders in children experiencing homelessness documented the high prevalence of children requiring further clinical evaluation of mental health problems compared to housed children (Bassuk Richard, & Tsertsvadze, 2015). Findings from the Child Behavioral Checklist (CBCL), showed emotional problems in 10 to 26 percent of homeless preschoolers and 24 to 40 percent of homeless school-aged children. The rates among homeless school-aged children were two to four times higher than poor housed children in the National Survey of America's Children. Despite the high rates of mental health problems in children experiencing homelessness, few receive appropriate clinical evaluation or ongoing care.

Given the impact of homelessness and traumatic stress on children, it is not surprising that children experiencing homelessness manifest many difficulties in school. They often attend school erratically given the many transitions in their lives. In addition to mental health and behavioral issues, they have higher rates of learning disabilities, low reading and math achievement, often repeat a grade, and have a low probability of graduating from high school. They tend to be preoccupied, minimally engaged in learning, lack confidence, and have difficulties building and sustaining friendships.

Although many children experiencing homelessness have mental health issues, the population is not homogeneous. One study using cluster analysis versus a variable-

centered approach found that some children were resilient in the face of extreme adversity (Huntington, Buckner, & Bassuk, 2008). The researchers combined behavior problems, adaptive functioning, and school achievement and identified two clusters: higher and lower functioning children. The two groups were differentiated by maternal mental distress and a history of childhood physical and sexual abuse in the lower functioning children. Protective factors included the following: stable housing, positive parenting, secure attachments, self-regulation, good problem-solving skills, and community supports for the family,

Untreated Trauma Compromises Parents as Caregivers

The vast majority of parents experiencing homelessness are young, single mothers parenting two children—with more than half less than 6 years old. African American women are overrepresented in this population. The mothers are extremely poor and tend to have limited education, job skills, and work experience. They struggle with poor physical and mental health. Their social networks have been depleted, including their family, friends, and professional caretakers. Their lives are characterized by high levels of physical and sexual abuse that compromise their capacity to simultaneously be head-of-household, breadwinner, and caregiver to their children (Bassuk et al., 1996; Hayes, Zonneville, & Bassuk, 2013).

Mothers Have High Rates of Abuse

The level of abuse for most women experiencing homelessness is astonishing. Multiple studies have documented that more than 90 percent of mothers experiencing homelessness have been exposed to at least one severe traumatic stress (Bassuk et al., 1996; Hayes, Zonneville, & Bassuk, 2013). Forty-three percent of mothers experiencing homelessness reported being sexually abused by the age of 12—usually by multiple perpetrators (Bassuk et al., 1996). Violence continues into adulthood with more than two-thirds reporting severe physical assault by an intimate partner and 27 percent requiring medical care (Guarino & Bassuk, 2010). Advocates estimate that one-third of families in a New York City shelter are homeless as a result of domestic violence (Women in Need, 2016).

Compared to the general female population, mothers experiencing homelessness are more frequently assaulted by partners, relatives, or friends (Bassuk et al., 1996; Hayes et al., Stainbrook, 2006). A recent longitudinal study of homeless families suggests that posttraumatic stress disorder (PTSD) may be the primary driver of many families' inability to maintain housing (Hayes et al., 2013). Failure to acknowledge or address the mothers' severe trauma may help to explain the very high rate of return to homelessness for rehoused families in New York City that is estimated to be as high as half of the families (ICPH, 2013).

Major Depressive Disorders Are Prevalent

Current and lifetime prevalence rates of major depressive disorders in mothers experiencing homelessness are much higher than in the general female population (Bassuk & Beardslee, 2014). Approximately 12 percent of women from all socioeconomic groups are depressed (Grote et al., 2007; Kessler et al 2003). Lifetime rates of depression among mothers experiencing homelessness range from 45 to 85 percent (Bassuk et al., 1996; Weinreb et al., 2006). Depression is often unrecognized among homeless parents and viewed as a circumstantial issue that will resolve with housing rather than a medical disorder requiring treatment (Bassuk & Beardslee, 2014). Major depression and its co-occurring disorders can significantly interfere with effective parenting and obtaining and maintaining housing and services, and can limit the opportunity for mothers to become self-supporting (Knitzer, Theberge, & Johnson, 2008; Center on the Developing Child at Harvard University, 2009).

The impact of maternal depression on children is profound. A meta-analysis of 193 studies demonstrated that poverty seems to be a broad-scale enhancer of risk in relation to depression in mothers, but when controlling for socioeconomic status, maternal depression alone predicted greater adverse outcomes among children (Goodman et al., 2011; Kiernan & Huerta, 2008; Riley et al., 2009). Children living with a depressed parent have poorer medical, mental health, and educational outcomes (Center on the Developing Child at Harvard University, 2009; Knitzer et al., 2008), and having a depressed parent may compromise children's growth, development, and school readiness (Knitzer et al., 2008).

Tier II Shelters Do Not Prioritize Family Preservation

Tier II shelters rarely offer critical services that support family preservation. Mothers who are compromised often have difficulty caring for their children, leading to adverse child outcomes. When this is complicated by separations and child welfare involvement, children often feel abandoned and may develop a range of difficulties including attachment disorders. Tier II shelters put young children at risk by failing to offer three services that support family preservation and are well within a shelter's capacity to provide.

Shelters Do Not Properly Assess or Treat Maternal Depression

As discussed, rates of maternal depression are very high among mothers who are experiencing homelessness. Unaddressed, depression severely limits opportunities for mothers to become self-supporting and fully care for their children. Despite the high prevalence of depression, PATH and local Tier II shelter intake processes focus more on determining eligibility for shelter and enforcing rules than uncovering mothers' depression.

Studies have documented that when mothers are treated for depression (e.g., parenting supports, medication, psychotherapies, and behavioral interventions), their children develop fewer emotional and behavioral problems (National Research Council & Institute of Medicine 2009). The acknowledgement, identification, and treatment of maternal depression by Tier II shelters will have perhaps the best payoff of any service because it will improve functioning and outcomes of the mothers while also improving outcomes for their children (Bassuk & Beardslee, 2014).

Shelters Do Not Provide Adequate Parenting Supports

Children in families exposed to severe adversities and stress tend to have high rates of emotional and behavioral problems, cognitive difficulties, and underperformance in school (Buckner, 2008; Cutuli et al., 2013; Bassuk, Richard & Tsertsvadze, 2015). Mothers stressed by their circumstances tend to provide less structure and stimulation, may be more irritable, and express less warmth toward their children. Mothers experiencing homelessness also tend to use coercive disciplinary practices more often than housed mothers (Perlman et al., 2012). Despite the various risk factors confronting children in shelter, when children are surrounded by nurturing caregivers and a supportive environment, they can fare well (Herbers et al., 2014; Masten, 2001, 2014, 2015; Hungtington, 2008, Shonkoff, 2010).

The presence of a stable, supportive caregiver serves as a buffer against ACEs. Systematic studies of parenting supports for low-income mothers have shown promising outcomes that include stronger parent-child relationships, improved child adjustment and functioning, improved parenting practices, greater knowledge of child development on the part of mothers, and—most importantly—decreased prevalence of maternal depression (National Research Council & Institute of Medicine, 2009; Bassuk & Beardslee, 2014). Many of these programs are under the heading of "home visiting" and have demonstrated effectiveness with impressive outcomes. Although few have been specifically adapted for homeless families, an evidence base is beginning to emerge (Bires et al., n.d.; People's Emergency Center, 2017).

Rates of Family Separation Are High

Within families experiencing homelessness, separation of children from their mothers and between partners are all too common. The greatest risk factors for family separation are long-term homelessness, multiple moves, intimate partner violence, and drug abuse. In these situations, family reunification becomes more difficult (Cowal et al., 2002, Rog and Buckner, 2007, Hurley, 2017).

Approximately 25 percent of homeless families in NYC are involved with child welfare services (Center for New York City Affairs, 2015; Hurley, 2017; Miller & Harte, 2014; Park, Metraux, & Culhane 2004). Half of these families are working with the Administration for Children's Services (ACS) to prevent foster care placement, while the remainder have children in foster care (Hurley, 2017).

A recent report that examines family separation in New York City shelters (Hurley, 2017) describes how placement in shelters far away from the neighborhoods where families had been residing isolates them from supports and resources, and may push the family to the "breaking point." When families finally leave shelter, approximately half are placed in unfamiliar struggling neighborhoods with high rates of food insecurity and crime, and low-performing schools. According to the Mayor's plan, the City will commit to returning families to the communities in which they lived before becoming homeless. However, this commitment is likely to be difficult to implement since neighborhood resistance is high and the pressure to move families into shelter is urgent.

II. Tier II Shelters Preclude Effective Services

This report documents the necessity of providing essential services to families and children in New York City shelters that will support their return to permanent housing in the community. However, before an effective service system can be implemented in the City's family shelters, various challenges must be addressed.

Foremost among these challenges is the reality that Tier II family shelters are large-scale, custodial warehouses that are more like detention centers or prisons than family-focused, human service environments in which essential services can take hold. The relationships among family members and service providers are the linchpin of success. Nothing can move forward for the families without engaging the families and establishing trusting relationships. This requires adequate staffing, time, and attention. There are no shortcuts. When trust is established, services can be effective. A caring, family-focused environment is the prerequisite for progress. The Tier II shelters could not be further from this goal.

Tier II shelters are large institutions without adequate staffing. Rules, compliance, and documentation override human service concerns. The culture is based on control and compliance and is not relational in nature. Because of the size of the shelters and emphasis on safety and documentation, case managers have little time or energy to address human service needs. Although a few families receive some services, the shelters do not provide consistent access to necessary supports.

The massive scale of Tier II shelters precludes the possibility of providing effective services to families. DHS oversees 167 facilities for homeless families with 10,868 housing units. Individual shelters range in size from 30 to 40 units to more than 200. One large Tier II family shelter has 216 units that house 315 adults and 609 children for a total of 924 people. Even the smaller shelters serve households with multiple members, bringing hundreds of parents and children into these shelters. As we discuss later in this report, the direction of the shelter system is headed toward even larger numbers as the rates of return grow and the numbers of families increase. Very large numbers of individuals in one shelter served by limited staff virtually eliminates the chance to build trusting, supportive relationships between service providers and clients and thwarts attempts to implement effective services.

The Tier II shelters present unwelcoming environments with no common spaces for residents to gather or visit with family and friends. The bare hallways are often painted grey or maroon. Residents are discouraged from interacting. Visiting in each others' rooms is forbidden, and outside visitors are rarely allowed. Residents are discouraged from forming a community. Residents told us they generally keep to themselves and do not interact with others in the shelter. Although there is variation in room size, many units are 16 feet by 14 feet for two to three people, with small galley kitchens and bathrooms.

Families receive few services during very long shelters stays, damaging babies and young children during critical development years. The very long stays in the Tier II shelters impede critical development for thousands of children and is likely creating the next generation of homeless families in New York City. The average length of shelter stay for a family in New York City is more than 400 nights (Routhier, 2017). Some families have been in shelter more than three years. The majority of the children are six years or younger, including many toddlers and babies—a critical time for healthy brain development. As discussed in this report, scientists have documented the adverse cumulative impact of multiple, traumatic events on brain development in young children (Shonkoff, 2010; Shonkoff et al., 2012; Center on the Developing Child at Harvard University, 2007a; Cutuli et al., 2017). This can lead to poor physical and mental health in the childhood years and over the lifespan, characterized by difficulties with learning, self-regulation, executive functioning, and impulse control (Cook et al., 2005; Felitti et al., 1998; Shonkoff et al., 2012). Long shelter stays are also a prescription for early failure in school and social settings that can place a child on the path to poverty, low-wage employment, high use of health care, incarceration, and homelessness.

The youngest children (zero to three years) tend to spend the day in their rooms with their parents. A few of the shelters have playgrounds and child care rooms for younger children, but these are not well-utilized. Even at shelters that have some onsite services, too few families take advantage of them. In one shelter that offers onsite child care, few children were attending. In another shelter with an onsite clinic that provides medical and substance use services, residents attended infrequently.

Despite the general lack of shelter services, many families are superficially involved with multiple service agencies: Department of Homeless Services, Human Resources Administration, Administration for Children's Services, Department of Education, Department of Corrections and Community Supervision, Family Justice Centers, Department of Health and Mental Hygiene, Head Start, and various child care agencies. But this involvement is rarely coordinated, and case managers are only required to meet regularly with their ACS representative, parole services, and schools. Additional coordination depends on the shelter case manager's initiative and availability. Because of mothers' alienation from shelter staff as well as multiple emotional and logistical barriers, many children are not attending early intervention programs that are currently available to them.

Centralized PATH assessment and local shelter intake processes are not useful for helping families. DHS conducts centralized assessment for families at the Bronx PATH facility. The assessment interview focuses on detailed housing histories that are then investigated through field visits and phone questionnaires. Information about household composition, income and benefits, employment, criminal justice history, health status, and intimate partner violence is also collected. The purpose of the assessment is to determine eligibility for shelter. PATH functions primarily as a gatekeeper to reduce the numbers of families coming into New York City shelters rather than as an opportunity to gather useful information about families that will help in their care.

Local shelter intake processes vary, but are focused first and foremost on command and control of the families. From the first hour of the first day in shelter, the message is clear: you are lucky to be here, and you will follow the rules to the letter or you will be out on the street again. This tone is undoubtedly the result of the many disruptive things that can occur when too many people who are already maximally stressed are placed in massive, impersonal shelters with few supports and minimal human interaction. However, a precious opportunity has been lost to gain vital knowledge about experiences that have left the family destitute and at the shelter's door—information that would speed their recovery and successful return to the community.

Shelter staff are overburdened and spend most of their time complying with rules and regulations. Case managers typically have bachelor degrees. They receive intermittent

training that does not align with the complexity of the challenges faced by the families. Ongoing training, consultation, and technical assistance about human service issues is erratic and lacks a cohesive plan or adequate follow-up. At one shelter, the approximate salary for case managers is $37,000. Their untenable large caseloads lead to high staff burnout and turnover.

Although the pressure on families to locate housing and exit the shelters is constant, there are few housing specialists onsite. One shelter with over 140 units has only two housing specialists. Case managers report that they must spend as much as 80 percent of their time filling out forms, documenting activities, and complying with regulations rather than working collaboratively with families. Because the staff is working for the shelter system rather than for the families and children, they are frustrated about having so little time to engage with families, provide counseling, and develop service plans that reflect family members' needs, priorities, and goals.

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A primary focus on shelter safety isolates families and prohibits the effective delivery of essential supports and services. Shelter buildings are locked down, with buzzers to enter, identification requirements, sign-in logs, and surveillance video cameras everywhere except in residents' rooms. For example, one Tier II shelter has 130 security cameras throughout the facility. Security personnel are constantly present, patrolling the halls and watching everything. Similar to case managers, security staff are required to document everything they see. The focus on security, and the related fixation with rules and documentation, render the shelters prison-like and casts the families as prisoners. The number of security personnel far exceeds the number of shelter staff serving families. Even case managers are sometimes drafted into security roles, carrying out regular room inspections.

Security staff cover the shelters around the clock, often admitting families who arrive from the PATH center after hours. Earning about $25,000 to $33,000 per year (an estimate provided by one shelter), security personnel have high school diplomas or GEDs, but little to no human services experience. Some security supervisors have law enforcement backgrounds. Security staff training mainly involves issues such as safety compliance, reporting, and confidentiality. There seems to be little collaboration among case managers, housing specialists, and safety staff who tend to have different reporting lines, meetings, and training.

Residents generally feel grateful about how safe they feel, although the trade-off is zero tolerance of conflict. If a family is heard having a loud argument in their room, security will enter and it is very likely that ACS will be called if the conflict is not immediately resolved. As noted, about 25 percent of homeless families in New York City find themselves involved with child welfare services (Center for New York City Affairs, 2015; Hurley, 2017; Miller & Harte, 2014; Park, Metraux, & Culhane 2004).

Making shelter safety the primary focus of shelter staff works against developing a relational, community-focused environment that can lead to improved outcomes for families. The recent decision to place shelter security in the hands of the New York City Police Department is likely to amplify the prison-like atmosphere of the shelters and further isolate families as they retreat into their own rooms to escape cameras and the ever-present eyes of security personnel.

Families have high rates of return to homelessness. Perhaps the most telling outcome for families in Tier II shelters is the high rate of return to homelessness for families who have left shelter to be rehoused in the community. With the mounting numbers of New York City families who are homeless, continually returning up to half of the family to homelessness is unsustainable (ICPH, 2013). It is proof that the shelters are failing to support families' successful return to stable housing—the true goal of any shelter.

At present, Tier II shelters focus primarily on command and control of families, enforcing myriad rules and regulations. There is constant pressure on parents to find housing so they can exit the shelter, regardless of the lack of affordable housing and their capacity to return successfully to the community. Unless families receive the support they need while in shelter, the high rate of return to homelessness will continue to overwhelm the shelter system.

III. The Mayor's Plan Will Not Turn the Tide

The Mayor's plan to address homelessness, recently outlined in *Turning the Tide on Homelessness In New York City*, aggressively doubles down on the current Tier II family shelters, suggesting that City planners and policymakers do not understand the drivers of family homelessness or what is required for the solution.

While the plan offers some constructive elements, it will create more family shelters on an even larger scale. If this plan goes forward, it will result in a continued increase in family homelessness. With the numbers of homeless families continuing to climb, building more shelters, similar to the current Tier IIs, will not stem the tide.

The Plan Includes Constructive Elements

The Mayor's plan to address homelessness contains positive components that will contribute to a more robust response to homelessness in the City, including strengthening prevention efforts, eliminating use of hotels and cluster sites, trying to place families in their original communities, and garnering increased community involvement and support.

Expanding Homelessness Prevention

The plan calls for streamlining the City's rental assistance programs, expanding support for families who house family members at risk of homelessness, and increasing prosecution of landlords who turn away tenants with rental assistance vouchers. The plan commits additional funds for free legal services for New Yorkers facing eviction or landlord harassment. It also expands Homebase—a homelessness prevention program that provides financial assistance, landlord and family mediation, educational services, employment support, and financial literacy services.

Eliminating Commercial Hotels and Cluster Sites

The plan calls for ending the use of commercial hotels and cluster site apartments as shelters. As families are moved out of cluster site apartments, 400 of these apartments will be converted into permanent, affordable housing units, using existing resources to increase the City's limited affordable housing supply.

Keeping Families Connected to their Community

The plan recognizes the value of keeping families connected to their own neighborhoods where they have developed deep connections to family, friends, schools, employment, medical services, and religious communities. Currently, space in shelter is so limited that DHS must place families in any open unit, regardless of location. To place families close to their original communities, the plan proposes distributing shelters more evenly across the City and its boroughs. This is intended to help families have the option of remaining in their home community when seeking and leaving shelter.

Strengthening Community Engagement

The plan seeks to engage all communities in addressing homelessness to ensure that the whole City contributes to the solution. To implement a borough-based approach where shelters are evenly distributed across the City, the Mayor has committed to notifying communities in advance when there are plans to open a new shelter and holding community forums to discuss residents' concerns. Community advisory boards will be established to encourage ongoing community support and address community issues. New shelter space will be designed to include ground-floor retail or community space in the neighborhood.

More Human Service Staffing in Shelters

New York City has committed to providing funds to hire Licensed Clinical Social Workers (LCSWs) as client care coordinators in all DHS family shelters (McCray, 2016b). While there are challenges to accessing this funding, recruiting LSCWs to work in shelter settings, and providing the training and support that will be needed, this begins to address the need to increase the presence of human services in shelters.

To maximize this opportunity, shelters will need to address LCSW recruitment and hiring issues; integrate new LCSWs into current shelter staffing; delineate LCSW roles and responsibilities to distinguish them from case managers, housing specialists, and supervisors; and define new ways in which LCSWs can support families, such as coordinating care across the many agencies involved in shelter life, and supporting families' search for housing, employment, and child services.

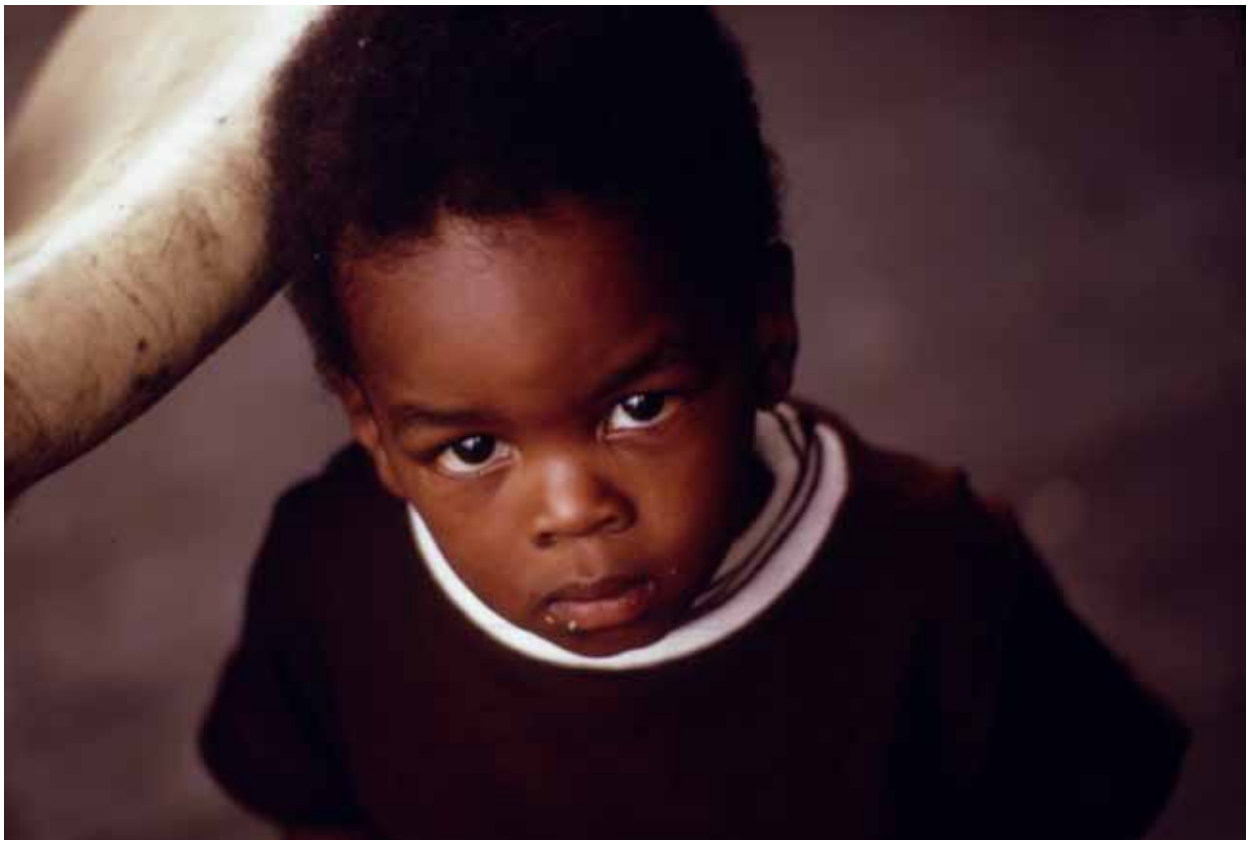
The Plan Will Perpetuate and Expand Large-Scale Shelters

This report concludes that the current, large-scale approach to addressing family homelessness is failing to prepare families to successfully maintain permanent housing, leading to high rates of return to homelessness amidst growing numbers of homeless families. Despite this reality, policymakers are directing the City to go further in the wrong direction.

At the heart of the Mayor's plan is the commitment to build 90 new shelters within the next five years. Of those, 25 will be developed directly by the City, with the other 65 shelters developed by independent organizations contracting with the City. Thirty existing shelters will be modified as well. Overall, the plan seeks to reduce the absolute number of shelters by 45 percent, including closing all of the hotels/motels and cluster site apartments that are excessively costly, have very limited services, and are currently housing people who are experiencing homelessness.

With the number of homeless families creating daily pressure for shelter space, it is likely that new shelters developed by the City—unless planners read this report—will be designed and built on the same or even larger scale than the Tier II shelters already in operation. The top priority for the City is likely to be an increase in the total number of shelter units in the most cost-efficient manner. This predicts that 25 very large, City-owned and operated shelters will become a cornerstone of the system within 5 years.

At the same time, independent contractors will seek the City's financial support to build 65 new shelters within the next five years. It is likely that the largest projects will attract the City's interest due to its primary goal of achieving the greatest number of shelter units to respond to the growing crisis. As the City selects which 30 existing shelters to modify, it will be drawn to those with the greatest number of beds. Furthermore, modifying existing shelters is likely to focus on adding new units wherever possible. This suggests that 30 larger-scale shelters will be the result of the plan's shelter modification efforts.



If the Mayor's plan goes forward, the City's family shelter system will very likely be composed almost entirely of large-scale shelters, presenting all of the challenges enumerated in this report. If this happens, the City's 90 new shelters and 30 modified shelters will continue to fail to meet families' needs.

The Plan Disregards Systemic Obstacles

As detailed in this report, most families require essential services to become stably housed. If these services are to be effective, Tier II shelters must be transformed from massive, custodial warehouses to smaller-scale, family-friendly, human services environments. As already discussed, this requires not only achieving a functional scale for each family shelter but also addressing major barriers that the families face. By disregarding these systemic obstacles, the Mayor's plan is set up to fail.

The plan does not allow for creating relational family shelter environments. A primary requirement for effective services is small-scale shelter environments that support trusting relationships between service providers and clients. The first step to scaling down the family shelters is to consult with architectural and design professionals on how to reduce shelter size by dividing existing large shelters into smaller, separate shelter areas. Reducing shelter size creates opportunities to reconfigure staffing patterns, create community rooms, and develop trauma-informed spaces. The availability of welcoming community spaces is essential to developing a relational, family-focused system. This rescaling will require financial investment to transform current shelter spaces, but can become a standard component of designing and building new shelters in the years ahead.

Many cities understand the value of small-scale shelters, and have succeeded in designing and siting these facilities. The ideal shelter size is 50 units (personal communication, Valerie Fletcher, Institute for Human Centered Design, 2017). For example, Washington, D.C. Mayor Muriel Bowser is ending the use of the former D.C. General Hospital as a family homeless shelter because it is too large. Short-term family shelters of no more than 50 units are slated to replace it (Government of the District of Columbia, 2016). The largest of Chicago's family shelters has 130 units but most are 50 to 55 units. Toronto offers a model that has been effective and in place for many years: Robertson House, an in-town location, is a mix of adaptive reuse and new construction and has a balance of private and shared safe indoor and outdoor spaces for 90 people (Hariri Pontarini Architects, Robertson House Crisis Centre project, 1998).

In order to create shelter environments capable of effectively delivering essential services, the City must commit to developing small-scale shelters, and creative solutions exist for ensuring successful implementation. For example, Parsons School of Design offered a

course entitled Housing the Homeless in NYC that resulted in 20 final projects focused on the needs of low-income and homeless populations (DenHoed, 2015; Walz & Schweder, 2015). The resulting designs, all of which were required to fit into real spaces in New York City and have reasonable budgets, demonstrate how creative and intentional design can transform spaces into environments that foster engagement and community integration.

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The plan continues to use assessment for gatekeeping rather than helping children and families. Comprehensive and ongoing assessment is essential for understanding a family's needs and priorities and provides the basis for engaging and developing a trusting relationship between the service user and service provider. Relationships are the linchpin of service delivery and the foundation for ending homelessness. Revising the assessment process for New York City family shelters requires expanding the current process: gathering basic historical information that serves DHS requirements to classify families as officially homeless, as well as gathering information to better understand the family's needs, wishes, and priorities.

In collaboration with DHS, the shelter intake assessment used in the CARES (Homeless Management Information) System should be reviewed and revised to develop a family-focused, strengths-based, and trauma-informed process. The revised assessment should be a comprehensive, two generational tool that is family-centered, developmentally appropriate, recovery-oriented, trauma-informed, culturally sensitive, and assesses the family across multiple domains (DeCandia, 2015; DeCandia, Bassuk, & Richard, 2017). See section IV of this report for more details about the assessment process.

The plan perpetuates oppressive shelter rules and documentation that isolates families and overwhelms shelter staff. Current shelter documentation and paperwork requirements do not allow staff sufficient time to fully engage with families, which is key to achieving positive outcomes. Case managers report that as much as 70 to 80 percent of staff time is spent on documentation and compliance with regulations. Too much documentation is focused on safety issues and concerns. In smaller, relationally-focused shelters, appropriate safety measures can be better achieved by establishing a positive milieu without an onerous degree of documentation.

To develop a relational service system, the ratio of time spent on documentation versus client engagement must be reversed so the majority of staff time is spent on engaging and developing trusting relationships, and working with families towards their goals. DHS leadership must radically alter staff requirements so that working with families becomes 80 percent of staff focus, with 20 percent earmarked for documentation, meetings, and paperwork. DHS should review all current documentation and meeting requirements and identify areas where these can be streamlined or removed.

Community integration is key to developing a relational environment. Families are isolated by rigid shelter rules that discourage resident interaction, severely limit or prohibit visitors, and eliminate any chance to form a supportive community within the shelter. Security personnel and shelter staff can enter a resident's room at any time without notice, even when they are not there. Children can be removed and remanded to ACS. Families' recovery is predicated on gaining mastery over their lives and circumstances. Shelters strip families of many of their rights in a devil's bargain to have a bed for the night. The plethora of shelter rules and constant control of families must be relaxed to create a more nurturing atmosphere in which supportive relationships and trust can grow.

The plan focuses on increased shelter security rather than providing effective services to families. If the goal of a shelter is to move families back to stable community life in permanent housing, it is counterproductive to staff the shelter with more security personnel than human service professionals. Yet, security personnel in the City's family shelters far outnumber the case managers, housing specialists, and social service staff. In one shelter there were four case managers and 21 security staff. Safety is important, but to be safe in a prison-like environment that is bereft of essential services to help families move out of shelter into the community is counterproductive.

Furthermore, the plan places shelter security under the jurisdiction of the New York City Police Department, using language that underscores increased surveillance and more intensive responses to incidents in shelters. Some case managers report that police are already in the shelters "all the time." The modern, big city police force is necessarily trained and equipped to make split second, life and death decisions to deal with criminals and

terrorists. They are much less ready to interact in thoughtful, non-threatening ways to address the complex human problems that are common in family shelters.

It is not enough that the City's family shelters are clean and safe. They must also provide a way out. The Mayor's plan gives short shrift to shelter services. While ungenerously promising "adequate and appropriate social services," the plan vaguely commits to mental health services, employment training, and shelter programming. While these are among the essential services we prescribe in this report, the role of services in the Mayor's plan is disposed of in a few lines of text without detail. This silently speaks volumes about how the plan will unfold as a pure bricks and mortar approach (but not affordable housing) to a growing human crisis. The Mayor's plan makes claims about "standardized training" of shelter staff and "expanded placement of highly trained professionals" but offers no details about what this will be or how it will be accomplished. In the 128 pages of the plan, scant attention is paid to describing human services staffing or the nature of services in the shelters.

IV. Transforming New York City's Family Shelters

The primary goal of Tier II family shelters is to provide clean, safe housing to families who are deemed homeless. Once families are in shelter, the current focus is on enforcing shelter rules and pressing families to search for housing to make room for the families next in line for shelter beds. For the most part, Tier II shelters are meeting these goals, although the average shelter stay in New York City is now more than 400 nights. However, there is a fundamental flaw in the shelter system that causes so many families who leave shelter to return to homelessness once again. This flaw is that families are not receiving the services they need while in shelter to remain stably housed in the community and to ensure the well-being of the mothers and children.

Below, we present the essential services that children and families require to reduce shelter harm, support successful return to the community, and ensure that the children will grow and thrive. For more information on these services and specific steps for implementation of services in family shelters, inquire at info@bassukcenter.org.

The Linchpin: A Relational Shelter Culture

The formation of a trusting relationship between the provider and service user is a primary strategy for ending family homelessness. The relationship is the major vehicle for implementing services, motivating family members, and supporting their participation in the process. The primary and most crucial step in helping families is to support a greater level of self-esteem, hope, control, and power over their lives, and greater connection to sustainable supports. This is most likely to occur if the provider is able to engage the family and establish a collaborative relationship built on trust, understanding, and respect.

Forming a trusting relationship requires that providers use a complex set of skills, including: listening and communicating empathically, addressing immediate needs including safety, identifying long-term needs, understanding the family's priorities and wishes, encouraging shared decision-making, defining and collaborating on tasks, developing a consensus about tasks and goals, and collaboratively designing a service plan, all within the context of the family's cultural beliefs and norms. The provider must empower the family to be a partner in the process of choosing services and setting a direction that will achieve the

family's goals. This will more readily occur if services are coordinated to meet the family's immediate and longer-term needs.

As discussed in this report, the current Tier II family shelters cannot support relational shelter environments. These large shelters must be divided into smaller, discrete shelter spaces in which the ratio of shelter staff to families is significantly increased; this strategy will reduce caseloads and allow staff adequate time to work with individual families. Any new family shelter must also be developed on a smaller scale—no more than 50 units. Establishing smaller, self-contained shelters will require not only a different ratio of staff to residents but different staff skill levels. Attention must be shifted away from an overarching focus on safety to a serious investment in helping the families prepare to live stably in the community and have the necessary supports to become productive, participating citizens. There must be more shared spaces for service delivery and for families to learn and socialize. New shelter environments must be trauma-informed and will need to heed the importance of color, acoustical conditions, and easy navigation. Residents must be involved in prioritizing what spaces are created in the shelter and how they are designed.

The Framework: Family Critical Time Intervention

The ideal service model we propose for Tier II shelters uses an adaptation of *Critical Time Intervention* (CTI) as a framework for implementing services and supports. CTI is an evidence-based, time-limited case management model originally developed to prevent

homelessness and other adverse outcomes in people with mental disorders following discharge from hospitals, shelters, prisons, and other institutions (Herman & Mandiberg, 2010; Susser et al., 1997). CTI was developed and tested by researchers and clinicians at Columbia University and New York State Psychiatric Institute with support from the National Institute of Mental Health (NIMH) and New York State Office of Mental Health. Listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices, CTI was cited as an effective practice by the President's New Freedom Commission on Mental Health (2003).

Family Critical Time Intervention (FCTI) has been adapted from CTI for use with homeless families; emerging evidence suggests its effectiveness (Shinn et al., 2015). Because families and children in Tier II shelters have very long stays, this necessitates adapting FCTI for shelter stays that postpone transition to the community for as long as two years or more. To do so, we extended the timeframe of the Pre-FCTI phase and included elements normally in Phase 1. This continues for as long as the family remains in shelter, during which the case manager:

- Develops a trusting relationship with the family
- Engages in collaborative assessments
- Arranges home visits to the shelter
- Identifies and engages with existing supports
- Connects the family to people and agencies in the community that will become primary supports
- Provides support and advice to the family and caregivers

FCTI is divided into time-limited phases, ending with the family being stably housed in the community, and connected to necessary supports and services. Given the long lengths of stay in Tier II shelters before housing is identified, it is critical that the shelter identifies the needs of the family, begins to provide services, starts to find appropriate housing, and develops plans for connecting family members to essential community services and supports. When permanent housing is secured, this signals completing Phase 1 and focusing on transitioning to the community.

During Phase 2, relationships with community supports are strengthened, other available resources are explored, and the referral process begins. Community programs are identified that offer continuous, coordinated and flexible care to support families experiencing homelessness. In Phase 3, the shelter works with families to consolidate new skills and connections developed during Phase 2, solidify relationships with community service providers, and become self-directive.

As the family's become increasingly independent and integrated into the community, responsibilities are gradually transferred to the family and community-based programs.

When the family is fully settled and prepared to begin disengaging from FCTI, Phases 2 and 3 are especially important for addressing the high rates of return to homelessness by helping families stabilize in and sustain permanent housing, and maintain their connections to essential supports and services (Shinn et al., 2015; Felix & Samuels, 2006).

Six Essential Services for Families

The components of effective services for families include:

1. Comprehensively assess all family members
2. Provide parents with education and employment opportunities
3. Provide organizational trauma-informed care
4. Address medical and mental health needs of parents and children
5. Provide parenting supports in shelters
6. Optimize the shelter workforce

To successfully implement these services, concrete supports for parents and their children are required. It is critical that parents have adequate child care to leave the shelter when necessary. Transportation to and from services and meetings in the community may also be necessary.

1. Comprehensively assess all family members

Assessment should be aimed at gathering information, engaging service users, and planning services. Its purpose is to understand the context of the family's life, as well as their needs, wishes, priorities, and goals, and collaboratively work with family members to create a plan for ending homelessness, ensure residential and economic stability, and support well-being of all family members including children.

While gathering information, the provider can identify problems, barriers to achieving stated goals, available supports, as well as strengths and capacities of family members. At the same time, the provider can begin to establish rapport with the service user and engage them in the process, with the aim of establishing a collaborative relationship that will help families achieve their goals. This process should begin when the family enters the shelter and should then be carried out in a timely but flexible manner. Although it is useful to complete the assessment early during the family's shelter stay, it is important that the family be allowed to set the pace. Providers must consider the timing especially when asking about sensitive topics such as family conflict, trauma exposure, and behavioral health issues.

Assessment is not a one-time event, but an ongoing process. Using assessments to engage service users in a trusting, collaborative relationship can anchor the family and will more likely lead to positive outcomes and the active participation of each family member in activities that can help to end homelessness and improve their well-being. In contrast to intake procedures designed to perform gatekeeping and control functions, effective assessment should be comprehensive and include the following domains:

- Family demographics
- Safety and immediate needs (e.g., intimate partner violence, health crises)
- Housing and homelessness history
- Self-sufficiency, such as income and benefits, education, work history and skills, transportation, and child care
- Parental functioning and supports (including parenting skills and criminal background)
- Health issues, including medical, mental health (e.g., depression, PTSD, anxiety) and substance use
- Childhood and adult trauma exposure
- Service use, including history of medication use and hospitalizations
- Family separations
- Children's issues, including developmental status, early intervention, child care, health, emotional and behavioral issues, educational status, peer relationships, and presence of protective factors

- Family supports and services
- Social networks and systems of care
- Family strengths
- Parents' and children's wishes, priorities, and goals

Throughout the assessment process, service providers can use Motivational Interviewing (MI), a rigorously researched, evidence-based practice to enhance client motivation and support positive behavior change. It is characterized by a collaborative, evocative, and empowering style. The skills of MI—open questions, affirmations, reflective statements, and summaries—are used for engaging clients, agenda setting, exploring ambivalence, eliciting change talk, responding to resistance, and strengthening commitment (Miller & Rollnick, 2013).

2. Provide parents with education and employment opportunities

Families experiencing homelessness are extremely poor. Even with public benefits that may be available, they will require adequate income to remain stably housed in the community. With responsibility for child care, homemaking, and wage earning, and often with only a high school education, parents must find a job to provide income in a labor market characterized by wage stagnation and limited or no job benefits, particularly in the service sector (Women In Need, 2016).

Shelters should support education and employment opportunities for parents by providing GED and ESL programs, job training, and related work opportunities. Supports must address barriers to participating in these programs and, if parents are working, ensure they can attend work regularly. Families may need transportation, clothing, and child care, especially for children of different ages who are in programs with hours that do not align with their parent's work schedule. Parents must also be able to arrange coverage for children with medical problems such as asthma or disabilities that may result in erratic school attendance.

Shelters can use educational and employment programs developed for other subpopulations (e.g., people with mental illness and severe disabilities) and adapt components of the programs for homeless families. An example is the Individual Placement and Support (IPS) model of supported employment developed by Robert Drake for people with behavioral health needs. This can help people experiencing homelessness develop skills to find and keep satisfying jobs (Bond, Drake, & Becker, 2012; Hoffman et al., 2014).

The *Secure Jobs Initiative*, a demonstration program for homeless families supported by the Paul and Phyllis Fireman Charitable Foundation, was launched in five regions in Massachusetts in 2013. The program facilitates partnerships among workforce development, homeless services, and state agencies. Parents in short-term rapid rehousing

and rental voucher programs are identified; their work plans, skills, and readiness are assessed; and supports are put in place to help them overcome barriers to employment (Meschede, Chaganti, & Revis, 2013). The Melville Trust has partnered with grant makers in Connecticut to launch a similar program.

3. Provide organizational trauma-informed care

Researchers have documented that most homeless family members have been exposed to traumatic stressors, especially interpersonal and community violence (Browne & Bassuk, 1997; Guarino & Bassuk, 2010; Stainbrook, 2006; Weinreb et al., 2006). Early developmental trauma—including child abuse, neglect, and disrupted attachments—provides a subtext of the narrative of many people's pathways into homelessness (Hopper, Bassuk, & Olivet, 2010). Regardless of the pathway into homelessness, it is a traumatic experience. Trauma creates a sense of fear, helplessness, or horror, and overwhelms a person's coping resources (Hopper, Bassuk, & Olivet, 2010). The lack of a home combined with disconnection from community supports can be a devastating experience. Rates of exposure to both interpersonal and community violence among mothers experiencing homelessness are extremely high (Bassuk et al., 1996; Guarino & Bassuk, 2010; Hayes et al., 2013).

To respond to pervasive trauma in the lives of families who are homeless, Tier II shelters should adopt Trauma-Informed Care (TIC)—a strengths-based organizational approach in which all shelter services are provided through a trauma lens (Hopper et al., 2010). TIC emphasizes physical, psychological, and emotional safety for both providers and residents, and creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010). Implementing TIC often involves a cultural shift in all levels of the

shelter and shelter system (Bassuk, Unick, Paquette, Richard, 2016; DeCandia & Guarino, 2015). Staff may need to adjust their values, principles, and practices—resulting in a paradigm shift to a relational context in which the voices of service users are integrated into service delivery and an organization's procedures and policies. With input, feedback, and involvement from service users, all practices and policies can become trauma-informed.

In effective TIC training, all staff in an agency are trained to understand how trauma operates and how best to reduce "triggers" of post-trauma responses, encourage consumer choice, support empowerment, and level power differentials. In addition, all staff are involved in training about the nature (including neuroscience), extent, and impact of trauma on all family members, and how best to respond. Concepts, such as toxic stress, complex trauma, and Adverse Childhood Experiences (ACEs), are included in the training. Families can be empowered by being included in the governance process and having input into the design and implementation of services.

Implementing TIC in Tier II shelters will require a commitment at every level of the shelter, ongoing training, and periodic assessment of the adoption of TIC by all personnel from head administrators to security and maintenance staff. The Bassuk Center has developed the TICOMETER©, a brief, 35-item standardized instrument to evaluate an organization's level of TIC and monitor an organization's progress in implementing TIC. For more information, please inquire at info@bassukcenter.org.

4. Address the medical and mental health needs of parents and children

Family members experiencing homelessness have disproportionately high rates of medical, dental, mental health, and substance use issues compared to the general population (Buckner, 2008; Rog & Buckner, 2007). The health care setting can potentially be an ideal venue for addressing the complex issues of both parents and children. However, barriers to access must be addressed, including knowledge of the value of regular medical visits, setting up timely appointments, insurance issues, and transportation. Dental care providers should be identified for both children and parents and should become part of the health team. Families must feel comfortable with their medical providers. All interactions should be person-centered, trauma-informed, and culturally sensitive, with providers aware of the families' high rates of exposure to traumatic stresses and its mental health consequences, and the long-term effects of ACEs.

Shelter staff can help to ensure quality health care by:

- Holding educational groups in the shelter that address medical issues
- Encouraging case managers to work with parents to ensure they know about the availability of routine, preventive, and acute care
- Train case managers in the relationship between medical and behavioral health issues

- Coordinate regular visits of home visiting teams while mothers are pregnant and during children's infancy
- Assist parents in scheduling regular well-baby and pediatric visits
- Implementing a combination of the following:
    - Establish in-house medical clinics with regularly scheduled times for specific health providers to meet with residents
    - Connect with family teams from Health Care for the Homeless who provide regular medical care for family members
    - Ensure access to community-based health centers by using outreach workers from the health center or Health Care for the Homeless Programs to connect with residents
    - Refer family members to community-based medical clinics that give homeless family members priority and understand homelessness
    - Coordinate all systems that provide care to family members

Major mental health needs of parents include (1) depression; (2) posttraumatic stress disorder; and (3) substance use. Shelter intake assessment should carefully screen all homeless mothers upon shelter entry for major depression and its co-occurring disorders, provide counseling if possible, and refer them to professionals for treatment as necessary.

Children should be universally screened and formally assessed. A staff member should be designated to advocate for children or if possible, a child development specialist should be available. Shelters should ensure that school-aged children with mental health challenges receive necessary and appropriate accommodations in school (e.g., IEP, 504 plans; see National Center for Homeless Education/Education for Homeless Children and Youth, 2016).

Shelter staff should be trained in child development, traumatic stress and its neuroscience, adverse child experiences, parenting supports (home visiting programs), protective factors, and assessment strategies, and should be provided with ongoing consultation about the children's needs. Interventions for children should begin as soon as they enter shelter and as early in their lives as possible, including during mothers' pregnancy. All children should be referred to established early intervention programs available in the community from the first day they enter shelter (e.g., Head Start, Parents as Teachers). Case workers should support parents to become advocates for their children in school.

5. Provide parenting supports in shelters

As discussed in this report, when children in shelter are surrounded by positive caregivers and a supportive environment, they can fare well (Masten, 2001, 2014, 2015; Huntington, 2008). Stable, nurturing caregivers serve as a buffer against ACEs. The use of parenting supports for low-income mothers has shown positive outcomes, including stronger parent-child relationships, improved children's adjustment and functioning, improved parenting practices, greater knowledge of child development on the part of mothers, and decreased prevalence of maternal depression (National Research Council & Institute of Medicine, 2009; Bassuk & Beardslee, 2014).

Many parent support programs use a "home visiting" model that can be adapted to the Tier II shelter setting with specific goals of:

- Improving maternal and child health
- Preventing child abuse and neglect
- Encouraging positive parenting
- Promoting child development and school readiness
- Reducing the risk of family separations due to child welfare involvement

Shelters should identify and coordinate with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs that are evidence-based and aimed at improving the lives of at-risk families and children. Although they have not yet been specifically adapted for use in shelters, providers can begin that process by sharing their knowledge of homeless children and their parents with the home visiting teams. These programs are generally targeted toward pregnant mothers, expectant fathers, and children from birth to kindergarten. The most widely used evidence-based home visiting models offered by MIECHV include:

- Early Head Start – Home-Visiting (EHS-HV)
- Healthy Families America
- Nurse Family Partnerships
- Parents As Teachers (ACF, 2013)

- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Healthy Steps
- Family Check-up
- Child First

In addition to these programs, several others focus on newborns. This includes the Newborn Home Visiting Program, established by the New York City Department of Health and Mental Hygiene. This program supports mothers and their babies during the first few weeks after birth (zero to two months). The program focuses on the health of family members, development of the baby, tips about breastfeeding, ensuring safety during sleep, ways to bond with a newborn, support if parents are feeling depressed, and connection to other necessary resources and supports.

Home visiting programs in the local community that agree to serve families experiencing homelessness must modify their strategies for delivering services to ensure engagement and effective outreach, understanding of homelessness, flexible follow through, adequate training, and close partnerships with the Tier II shelter. A case manager in the shelter should be given the task of identifying and forming a partnership with home visiting programs in the community. If possible, a designated staff person can be appointed as a child advocate to ensure the implementation of an effective program.

6. Optimize the shelter workforce

Our service model necessitates that all shelter staff fully understand and embrace:

- Family-oriented comprehensive assessments
- Organizational Trauma-Informed Care
- Use of Motivational Interviewing
- Implementing Parenting Supports, especially Home Visiting models
- Family Critical Time Intervention as the service delivery framework

A sustained staff training effort will be required in each shelter to fully integrate new knowledge and skills across the entire organization, from leadership and administration to the front desk and maintenance staff. This, of course, includes all security personnel who have more frequent—and potentially more stressful—contact with family members than other staff. Security personnel should be equipped to be human service providers while they carry out their shelter safety responsibilities. This step alone will dramatically alter shelter culture.

Many Tier II shelters claim they already provide staff training, including Trauma-Informed Care and Motivational Interviewing. Overall, we saw little evidence that this training was impacting shelter culture or generally achieving desired outcomes. To be effective, staff training must involve a comprehensive approach to the needs of families and children; must be experiential, interactive, and ongoing with appropriate coaching and support; and must address all of the skills listed above.

A more difficult element of workforce optimization requires addressing unmanageable caseloads for caseworkers, the complexity and intensity of working with families who are homeless, and the understaffing and low pay of the shelter workforce. All of this leads to staff overload and burnout that erodes shelter culture and undermines any chance for success with helping families. Training and supporting staff can address some of these issues, but others must be confronted by City government. If shelters are to become places that truly serve families, more funding is needed to increase the number of skilled shelter staff available to work with families.

As previously discussed, one step to be taken immediately by the Mayor's Office and DHS is to dramatically reduce staff documentation and paperwork requirements to allow staff to spend 80 percent of their time with families and only 20 percent on paperwork and meeting regulatory requirements. This includes a similar paperwork reduction for all security staff who can use the additional time to master and implement new human service skills.

V. Call to Action

Based on the findings in this report, we have concluded that New York City's Tier II family shelters are harming young children by not responding to the Adverse Childhood Experiences (ACEs) that have plagued their lives. As the data indicate, many of these children are likely to develop serious medical and mental health problems that may result in early mortality. These illnesses include diabetes, heart disease, COPD, and cancer. They are also likely to develop significantly higher rates of alcohol and drug use, make repeated suicide attempts, and become homeless more often than children with no ACE's. Equally as worrisome, the research has documented that this pattern may become a multi-generational cycle.

After 30 years of research and service implementation, we know how to help families who are homeless stabilize their lives. But a large scale, bricks and mortar solution that warehouses families in prison-like environments with scant attention to their urgent needs is the wrong approach.

Tier II shelters are failing to support families to maintain stable housing when they leave shelter. The rate of return to homelessness for families who are rehoused in the community after they leave shelters is estimated to exceed 50%. We assert that this high recidivism rate is due to the lack of services and connections both in the shelter and later in the community.

We call on the Mayor to stop the plan his administration has outlined in *Turning the Tide on Family Homelessness in New York City*, and instead pursue a more effective course as presented in this report. We urge the City to design smaller shelters that are adequately staffed to provide children and families with the services they need to escape homelessness for good. Among the immediate, low-cost steps the City can take to chart a more promising course in the near term are:

- Develop consensus and buy-in among stakeholders to reimagine an appropriately sized and designed shelter system that can support essential services and adequate human service staffing.
- Consult with design professionals to understand how existing shelters can be transformed into smaller family-focused structures; new shelters can be similarly sized and appropriately staffed.
- Revise PATH centralized assessment and local shelter intakes to make them useful for helping families.
- Develop and implement approaches for creating a relational infrastructure in all shelters to support service delivery and promote community integration.
- Determine how to increase human services in the shelters, including staffing and programs.
- Ensure that at least one case manager in each shelter is knowledgeable about child development and dedicated to coordinating the care of children across agencies.
- Instruct DHS and local shelters to dramatically reduce documentation and paperwork requirements to allow all staff to spend the majority of their time working with families.
- Conduct staff training on how to develop a relational framework in the shelters, including implementing a trauma-informed approach.
- Bring parenting support programs, particularly home visiting programs, into the shelters.
- Foster the alignment of all the systems serving homeless families.

Transforming Tier II shelters from large scale, custodial warehouses to smaller relational human service environments will require greater investment by the City. But getting it right will dramatically reduce the cost of repeated returns to shelter, as well as reducing the personal and financial burden and costs of adverse medical and mental health outcomes. Our goal is to protect the children, ensure that they have the opportunity to grow and thrive, and help them become productive participating citizens.

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