



Maternal and Child Homelessness in Pima County

Summer 2017

Pima County Community Development and Neighborhood Conservation

DRAFT

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EXECUTIVE SUMMARY

Project Summary

The Pima County Department of Community Development and Neighborhood Conservation (CDNC) has identified homelessness among women and children as an immediate priority. This vulnerable population has unique needs and risk factors not often shared by other subpopulations of homeless people, such as chronically homeless individuals or homeless veterans. Much attention and funding has been directed toward assisting those populations, but families with children—especially those headed by women—have not received the same attention. The intent of this project is to evaluate the success of homeless service delivery systems in meeting the needs of homeless mothers and their children, and to identify places where these systems can be improved. The focus of this project is on homeless mothers' knowledge of services, access to those services, any barriers to services, and if services are guided by evidence-based best practices.

This report serves as a landscape analysis of the homeless service delivery system in Pima County, incorporating interviews with shelter residents, interviews with service providers, as well as a secondary data analysis. This landscape analysis informs the development of recommendations to Pima County service providers in order to improve quality of and access to services.

The Cycles of Housing Instability

Homelessness and housing instability often occurs in a cycle, as the effects of homelessness impacts individuals, as well as family generations. When compared to her housed counterparts, a homeless mother is more likely to suffer from health problems, and is more likely to struggle with substance abuse or mental health issues such as depression or anxiety in response to the hardships being exacerbated. She is also very likely to live with post-traumatic stress disorder (PTSD), often stemming from being a victim of sexual or domestic violence. Living in poverty, as well as homelessness, the consequential feelings of powerlessness, as well as lack of security can be traumatic. Some even experience symptoms of PTSD.

In consideration to these factors, it is difficult for a woman to bond successfully with her baby, and that lack of attachment can have long-term consequences for her and the baby's health throughout life.

Children growing up in homelessness are at a higher risk of experiencing negative physical, mental, and social health effects compared to children who have lived in more stable environments. Homeless children are more likely to experience developmental delays and learning disorders, but less likely to receive treatments for them. The constant stress of housing instability experienced in early life can cause children's fight/flight response to be permanently altered as adults. Chronic conditions such as asthma or cardiovascular disease disorders are also more common in homeless children than in housed low-income children, as are environmental hazards such as lead poisoning. Most notably, children growing up in homeless or unstable families are significantly more likely to enter the foster care system, which itself is strongly associated with homelessness after "aging out" of the system when foster children become adults. In general, there is a strong correlation with many homeless mothers often being homeless as children.

Mothers who were homeless in the past are very likely to become homeless again, without adequate intervention. One focus of this project was to identify the factors that make a woman likely to

enter homelessness, to find housing when leaving a shelter, and—most importantly—if she will reenter the shelter again or be permanently housed. A number of factors can drive a woman toward or away from stability once she has exited a shelter and found potentially long-term housing. Younger, socially isolated mothers who are members of racial/ethnic minorities or have very young children are more likely to lose their housing and be cycled back into repeated episodes of homelessness. In contrast, women who are older, have better social support networks, and increased self-efficacy (a sense of their own capability of maintaining a job, paying rent, parenting well, etc.) tend to stay stable once placed in a home outside the shelter. This could contribute to the amount of prior knowledge to the sheltering system and the active pursuit in seeking resources throughout the community. However, the most impactful factor is subsidized housing -- rental housing reduced in cost by the government in order to be more accessible to low-income residents. Receiving a housing subsidy drastically increases the likelihood that a mother will be able to maintain her housing for the long term.

Definitions of Homelessness

A variety of definitions of “homelessness” exist, and different services are available depending on which definition is applied. The Department of Housing and Urban Development (HUD) generally defines homeless persons as those residing in shelters, the street, or in other places that are not safe or appropriate for human habitation (i.e., empty buildings, condemned homes with no utilities, etc.). However, this definition does not account for people who may be doubling up (living alongside another family, possibly distant relatives or friends), living in their cars, or staying in motels. Mother-led homeless families are one of the most likely groups to live in these scenarios, rather than in shelters or on the street. Under HUD’s definition of homelessness, families under these circumstances may encounter barriers in receiving services or may not be eligible.

These “hidden homeless” families fall outside of HUD’s definition of homelessness, meaning mother-led families are routinely underrepresented in homeless counts. Many methods of measuring the prevalence of homelessness in communities involves counting people on the street or in shelters, and cannot account for people who are less visible. As families are less likely to be found in these public and visible locations, they may not be counted. This leads to a chronic undercount of the number of homeless families in communities and across the United States.

For these reasons, other definitions should be applied to include these “hidden homeless” populations. The most commonly used definition is that of the McKinney Vento Act, a Department of Education statute intended to provide resources and assistance to help homeless children remain and succeed in school. The McKinney Vento Act definition of homeless youth and children better captures the realities of the students it is most likely to serve, as many of these students are doubled up, or are otherwise hidden.

The McKinney Vento Act defines homeless children and youths as individuals who lack a fixed, regular, and adequate nighttime residence. The McKinney Vento Act also expands on these criteria, including:

1. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations;
2. Children and youth living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

3. Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
4. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings;
5. Migratory children living in the above circumstances.

Housing Models and Shelter Types

Two primary schools of thought exist on the subject of providing services and assistance to homeless populations. The first is a linear approach or traditional model, which suggests that some homeless people are not “housing-ready”—that is, they require life skills training, budgeting assistance, substance abuse cessation, and other preparation before they will be able to live self-sufficiently. Programs following the linear approach provide housing to their clients along with mandatory training. Over time, the client increasingly takes on the additional responsibilities of paying their rent and utilities and managing their home until they are fully independent. Transitional housing is the primary housing program type that follows the linear approach.

The second approach, which has risen in popularity through recent years, is the Housing First framework. Housing First proponents state that the linear approach makes pretentious assumptions that all homeless people are incapable of managing their lives and housing independently. They also suggest that the homeless people who do need support, particularly those with substance abuse disorders, may not be ready to address those issues when they are still living in upheaval in a transitional or shelter setting. Housing First suggests that providing people with housing immediately, then providing necessary services or case management after they are at least temporarily stable, will result in more successful outcomes of substance abuse cessation and life management.

A major outgrowth of the Housing First approach is Rapid Re-Housing (RRH) -- a program that straightaway places families into housing and provides case management for short-term adjustment. RRH has become more common largely because providing immediate housing and short-term services to clients is generally most cost-effective with more successful outcomes than a longer-term gradual program like transitional housing.

Homeless Service Delivery Systems

In order to coordinate the various homelessness services present across any given area, HUD has mandated that every community form a Continuum of Care (CoC), a collective body of the various agencies and service providers aiding the homeless in a given area – usually on a city and/or county level. HUD funds the CoC as an entity whole, so the CoC can use the funding to improve accessibility to and delivery of services for homeless individuals and families.

Coordinating services as a CoC is a web of inter-systemic moving parts that must comply with HUD requirements. The most important HUD-mandated activity is the use of the Homeless Management Information System or HMIS, a software application that stores client-level data. The HMIS allows service providers to see the services a person has already accessed and any demographic information provided, as well as to count persons served without duplication. HUD uses the information captured by HMIS to determine any nationwide changes in the prevalence of homelessness, shelter usage, and other issues that factor into funding and policy decisions.

Another key component of a CoC's function is coordinated entry. Coordinated entry provides the means by which any person in the community can receive a referral to the most appropriate agency for homeless and housing-related services. Since an individual may not be aware of available services, coordinated entry allows clients to go to any agency belonging to the local CoC, work with a trained service provider who conducts an assessment via a standardized measurement tool, and receive a referral to an agency that can address their specific needs. While coordinated entry reduces the amount of time and number of steps needed for a client to reach the service(s) that can help them most, it requires an immense investment of time and resources from participating agencies.

Pima County Maternal and Child Homelessness

Pima County has made it a goal to emphasize the issue of family homelessness in their services, although providers have had mixed success. In an effort to be inclusive of all homeless experiences, especially the hidden homeless, the County utilizes the broadest definition of homelessness as described by the McKinney Vento Act. Because this definition includes people living out of cars, motels, or a doubled-up situation, many more families are entitled to services.

The local CoC is the Tucson-Pima Collaboration to End Homelessness (TPCH). TPCH, like other CoCs, is not a legal entity but rather a network of agencies, both direct service providers (such as shelters) and wraparound service providers (such as food or diaper banks). TPCH enacts numerous committees and workgroups, all focused on different aspects of homeless care such as coordinated entry, veteran homelessness, or family and youth homelessness. At its most current stages, TPCH is finalizing their Five-Year Strategic Plan, a document that lays out the goals and objectives for homelessness service delivery moving forward. TPCH is also in the process of implementing their digitized coordinated entry referral system, in an effort to simplify the referral process.

Preliminary interviews conducted with Pima County shelter residents and service providers emphasized the need to consider homeless women and children's unique needs when building homeless services. It is necessary to consider evidence-based best practices that have been proven to work most effectively with mothers and their children. Based on the interviews, it was also clear that two major factors—knowledge of services, and access to those services—played a role in whether the Pima County homeless service delivery system was functioning successfully. Women would encounter obstacles locating services, and even their case managers or providers had difficulties with finding what resources were available. Even when they knew of services, it was no guarantee that mothers could utilize them. Long waiting lists, struggles with eligibility requirements such as legal documentation, and transportation could all prevent a woman from accessing services from which her family might benefit.

PART I: GENERAL BACKGROUND

1. Introduction

The Pima County Department of Community Development and Neighborhood Conservation (CDNC) has identified homelessness among women and children as an immediate priority. This vulnerable population has unique needs and risk factors not shared by other subpopulations of homeless people, such as chronically homeless individuals or veterans. Much attention and funding has been directed toward assisting those populations, but families with children—especially those headed by women—have not received the same attention. The intent of this project is to evaluate the success

of homeless service delivery systems in meeting the needs of homeless mothers and their children, and to identify places where these systems can be improved.

This section provides general background on maternal and child homelessness. The multigenerational cycle of family homelessness is discussed, as are the impacts of maternal and child homelessness on the individual, the family unit, and the community. Various definitions of “homelessness” are presented, and their implications for policy are explored. The paper illustrates the way that mothers become unstably housed and factors affecting their ability to re-stabilize, with special focus on the social and economic factors affecting their housing status. We discuss the continuum of care model, a U.S. Department of Housing and Urban Development (HUD)-funded, community-wide collaboration between service providers who work on homelessness. In addition, we cover various housing models and other standards of service delivery. Lastly, best practices in maternal and child homelessness are reviewed and a general list of barriers to service access is explored.

2. Why should we care about maternal and child homelessness?

Introduction

“Given the broad definition of ‘health,’ it is important to recognize that homeless women inherently cannot be healthy.” (Silver and Pañares 2000)

Homelessness can do irreversible damage to both mothers’ and their children’s health and wellbeing. In 2010, the U.S. federal government set a goal to end family homelessness by 2020 (USICH 2015), acknowledging that it was an issue requiring more attention. This goal has not yet been achieved. In fact, in a survey of community homelessness service providers, 85% of respondents said that family homelessness had increased in their service area from 2013 to 2015 (Bassuk, DeCandia and Richard 2015). While the term “family homelessness” usually denotes any homeless household with children and adults of any gender, women head 90% of homeless families (Silver and Pañares 2000). For these reasons, it is worthwhile to focus on the needs and struggles of homeless mothers in particular. This section will explore the impacts of homelessness on mothers as a special population.

The Intergenerational Cycle

Homelessness tends to be cyclical. While some families experience a one-time loss of housing and never return to homelessness after re-stabilizing, for many families, the factors predisposing original homeless episodes often persist after becoming rehoused. The impact of poverty, gender, race, and other causes of initial homelessness is not eliminated by finding housing. If families struggle with the same issues as before, they may become homeless again. The cycle of homelessness persists not only within a family, but between generations. The risk factors leading to homelessness can pass from parent to child, and being homeless as a child puts that child at higher risk for becoming homeless as an adult. This section will discuss the various impacts that homelessness can have throughout a family’s generations.

Homeless mothers tend to be significantly less healthy than housed mothers in many aspects of their life. Their physical wellness will often be impacted, often due to difficulty accessing a primary care physician. There are 75% of women who become or are at risk of becoming homeless that hold jobs in sales or the service industry, significantly more than the 61% rate of women in the United States overall (Silver and Pañares 2000). These positions may offer unpredictable hours, low pay, and few or no

benefits, making doctors' visits almost impossible. As a result, they tend to utilize emergency departments as their main medical care more often than housed women (Weinreb, Goldberg, and Perloff 1998). This also means that they may put off visiting a doctor until a problem becomes catastrophic, leading to higher hospitalization rates than housed mothers (Silver and Pañares 2000). Homeless mothers also tend to have a more limited food supply, and the low quality of most affordable food means that they—and their children—consume a higher fat intake amount than is recommended (Drake 1992). They may also experience mental health concerns, including anxiety and depression, as a result of the social isolation that often results from homelessness. In some cases, this depression can be so severe that mental health services cannot combat it (Silver and Pañares 2000).

Although disorders such as depression and anxiety can cause extreme distress for homeless mothers, psychological trauma is arguably even more damaging, and is highly prevalent in this population. Homelessness—both the sudden loss of housing and security, and the prolonged experience of an unstable and unpredictable situation—are themselves causes of trauma (Goodman, Saxe and Harvey 1991). In addition, homeless women are far more likely to be exposed to both violence and assault, which contributes to the disparities between them and housed mothers (Dupere 2016). One study indicates that up to 91% of homeless women surveyed had been physically abused at some point in their lives, with 48% experiencing battering both while housed and while homeless (Fisher, Hovell, Hofstetter, and Hough 1995). In addition to physical battery, 56% of women in the study were survivors of sexual violence. As many as 15% reported being sexually assaulted at some point in the last year (Fisher, Hovell, Hofstetter and Hough 1995). These women are particularly vulnerable to assault from friends, partners or relatives (Bassuk, DeCandia and Richard 2015).

Aside from risks in abusive partnerships, homeless women often face challenges with reproductive agency. Nearly 73% of pregnancies among homeless women are unintended during the time of conception (Gelberg et al 2008). There is limited access and knowledge surrounding contraception (Gelberg et al 2008). Whether or not the pregnancy was planned, women may still choose not to access publicly provided prenatal care or other resources, fearing they will draw attention from child welfare services for parenting while homeless (David, Gelberg and Suchman 2012). There are multiple barriers that homeless women face when using contraception such as an inability to prioritize health due to competing demands, shelter-related hurdles and restricted provider practices that prevent access to services related to contraception, and risks of sexual exploitation due to power dynamics in sexual relationships (Kennedy et al 2014).

Homeless women who are age a childbearing age are more at risk for cancer, poor nutrition, sexually transmitted infections (STIs), and adverse pregnancy outcomes (Stringer et al 2012). A lack of medical care, healthy food, and a safe place to live all contribute to the fact that children born into homelessness are more likely to have a low birth weight (Hart-Shegos 1999, Brumley et al 2015, Cutts et al 2015). After birth, a mother's first priority is to ensure that her child has food, shelter, basic safety, and other necessities for survival. The day-to-day exhaustion of filling these needs means that a homeless mother will probably not have the energy or time to bond with her child or attend to their emotional needs (David, Gelberg and Suchman 2012). That lack of attachment can affect the child throughout their lifetime.

Children growing up in homelessness have their own struggles with regards to health and wellbeing. The overstimulation of living on the street or in a shelter can cause an infant to become

overwhelmed and frustrated (David, Gelberg and Suchman 2012). Living in a constantly stressful environment without the emotional mediation of the mother can permanently alter the infant's hypothalamic-pituitary-adrenal (HPA) axis, the biological pathway that allows humans to respond to stress (Cutuli et al 2010). The HPA axis produces cortisol, a hormone that provokes the "fight or flight" response as a response to stress. When chronic stress occurs, the body regularly overproduces cortisol, putting the body into constant "fight or flight" mode. Children whose HPA axes have been altered in this way will experience chronic cortisol overproduction—and thus an unhealthy reaction to stress—for much of their lives (Cutuli et al 2010).

Children in unstable living conditions such as shelters or low-quality apartments also experience environmental hazards. These include lead poisoning, for which they are more likely to test positive and to have more severe symptoms than children in stable housing. In addition, homeless children with asthma are hospitalized three times as often as housed children with asthma (Hart-Shegos 1999, Brumley et al 2015). As homeless children grow older, their environment and the other health complications of homelessness compound to cause chronic illnesses. Approximately 16% of older homeless children have at least one chronic health condition such as a neurological disorder or cardiac disease, significantly more than the 9% of housed children with similar diagnoses (Hart-Shegos 1999). Children growing up homeless often experience emotional impairments (Hart-Shegos 1999), which may cause difficulty expressing themselves and cause them to "act out." They may also struggle with inappropriate behavior in school, difficulty working with others, and other social dysfunctions (Brumley et al 2014). Mothers who struggle with emotional or behavioral self-regulating due to substance abuse (SA) or post-traumatic stress disorder (PTSD) may also have difficulty regulating their child's behavior, which puts the family at risk of being removed from a shelter if the child is disruptive (David, Gelberg and Suchman 2012). Shelter rules determining residents' schedules, behavior, and discipline may also conflict with established family rules and routines, making it difficult for mothers to maintain a sense of normalcy for their children (David, Gelberg and Suchman 2012, Anthony et al 2017).

In addition to causing health concerns, homelessness impedes a child's development and educational attainment. When women experience traumatic life events during pregnancy, it can affect their unborn child for years to come. A study examining young adults whose mothers had experienced negative events such as homelessness during pregnancy used different, less flexible learning strategies for problem solving than did individuals whose mothers had not experienced trauma (Schwabe, Bohbot, and Wolf 2012). Past the infancy stage, homeless children have twice the incidence of speech delays, dyslexia, and other learning disabilities (LDs) as other children (Hart-Shegos 1999), but only 38% of homeless children with LDs receive treatment for them, compared to 75% of housed children with LDs (Hart-Shegos 1999). Homeless children with or without LDs are four times as likely to score at the 10th percentile or below in vocabulary and reading skills as other children (Collins 2015). Their educational abilities are further inhibited by frequent moves between schools, as 41% of homeless children attend two schools in a single year and 28% attend three or more (Hart-Shegos 1999).

The U.S. Department of Education requires schools to assist families in keeping their children at the same school if the family loses their housing (ED 2001), but families are not always aware of this resource, and schools may not perform adequate outreach. Low educational attainment and failure to receive a high school diploma can perpetuate poverty over generations, increasing the likelihood that children who grew up in homelessness will become homeless as adults, especially single female heads of household (Hart-Shegos 1999).

Family housing instability can lead to the intervention of child welfare services and removal of children from the home, which—rather than protecting the child from homelessness—tends to have lasting negative impacts for both mother and child. Up to 70% of homeless mothers are separated from at least one child under the age of 18 (David, Gelberg and Suchman 2012), and anywhere from 18 to 44% of homeless children will be separated at least temporarily from their family (Bassuk, DeCandia and Richard 2015). Homelessness is a major cause for removal of a child from a family, playing a greater role for out-of-family child placement than either parental substance abuse or parental mental illness (Zlotnick 2009).

Child welfare services cannot remove children from their families just because of homelessness; there must be a risk of imminent harm, abuse, or neglect (AZ Auditor General 2002). However, families living in shelters are under scrutiny by staff that may result in contact with child welfare services or even child removal (Barrow and Lawinski 2009). Homeless children are up to seven times as likely as housed children to be removed by child welfare and placed into foster care (Hart-Shegos 1999). This difference in risk of foster care persists even when a housed parent experiences drug dependency or domestic violence and the homeless parent has neither risk factor (Barrow and Lawinski 2009). Even if the Department of Child Safety (DCS) does not remove the child, other factors may cause the parent to voluntarily separate from their child, such as fear of exposing children to the shelter environment, or shelter rules prohibiting older men or boys (Barrow and Lawinski 2009).

These factors, combined with the grief of separation, can make it difficult for a mother to motivate herself to work toward family reunification (David, Gelberg and Suchman 2012). Separation from her child places her at greater risk of incarceration, as well as experiencing a longer period of homelessness (David, Gelberg and Suchman 2012). A mother whose children have been removed by DCS or another child welfare agency are likely to have a reduced sense of self-efficacy as a parent (that is, the confidence that they are capable of performing the duties required of a parent), as well as a damaged sense of self-meaning (David, Gelberg and Suchman 2012).

Once separated from their mother, children who were homeless previously often enter the foster care system. While foster care may connect a child to a safer home, they may still encounter barriers to housing and economic stability later in life. As children grow up and age out of the foster care system, they may not have resources or a place to go. As a result, 15-22% of youth who age out of the foster care system will experience homelessness within a year (Zlotnick 2009). Even without aging out of the system, women who entered the foster care system as children have a greater risk of becoming homeless as adults (David, Gelberg and Suchman 2012). Being placed in foster care can also impact a child's future children. There are 70% of homeless women who had been in foster care as children that will have at least one of their own children placed into foster care (Hart-Shegos 1999).

In general, it appears that people who were homeless as children are significantly more vulnerable to homelessness and poverty as adults. This cycle of poverty also affects the community at large. Because homeless people use hospitals, shelters, or even jails as their primary resources, it can be very costly for local organizations and taxpayers to cover their needs. Hospital visits can cost up to \$44,400 a year per homeless person, depending on their needs and location (Green Doors, "The Cost of Homelessness Facts"). Shelter itself is expensive to provide. A study of family homelessness in several U.S. cities found that shelter costs depended on the family's length of stay; temporary stays cost

anywhere from \$3800 to \$13,900 per family, repeated stays cost anywhere from \$17,000 to \$38,500, and long stays (over six months) cost upwards of \$21,000 to over \$55,000 (HUD 2010).

3. Defining, Measuring, and Recording Homelessness

Introduction

How we define “homelessness” impacts the distribution of services for homeless populations. Should an individual or family not meet the defining criteria, they may not have access to certain sources of assistance. Varieties of definitions exist, originating from a variety of federal and legal sources such as HUD and the U.S. Department of Education. Some populations may fall in a gray area where they are not stably housed, and cannot guarantee how long they can stay in their current housing, but they are also not “sleeping rough” (living outside) or staying in a shelter. Many woman-headed homeless families fall in this category, so the service delivery system’s ability to support them depends heavily on which definition they use.

Definitions of Homelessness

HUD Definition

HUD’s definition of homelessness includes four groups:

1. *“Individuals and families who lack a fixed, regular, and adequate nighttime residence”* (HEARTH Act 2011, p.75995): A person or family living out of their car, on the street, squatting, etc., or staying primarily in homeless shelters or transitional housing (NAEH 2012)
2. *“Individuals and families who will imminently lose their primary nighttime residence”* (HEARTH Act 2011, p.75995): Individuals or families who are being evicted within the next 14 days and have been unable to locate new housing (NAEH 2012)
3. *“Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition”* (HEARTH Act 2011, p.75995): Families who do not qualify under HUD’s definition of homelessness (for example, people lacking their own legal residence but who are doubling up with friends or family), but may be defined as homeless by other agencies and who would benefit from federal homelessness services
4. *“Individuals and families who are fleeing, or are attempting to flee [...] dangerous or life-threatening conditions that relate to violence against the individual or a family member”* (HEARTH Act 2011, p.75995): Individuals or families fleeing some kind of violence such as stalking, domestic violence, or sexual assault, and who have nowhere else to go nor the money and resources to secure housing on their own (NAEH 2012)

“Hidden Homelessness”

Defining “hidden homelessness” is also inconsistent. HUD, for instance, draws a distinction between what is referred to as “hidden homeless”—people sleeping on private property in garages, tents, cars, etc.—and “precariously housed,” or people staying with friends on a temporary, needed basis (HUD 2008). Most agencies, however, use “hidden homeless” as an umbrella term to cover any individual or family that is not captured by common definitions or methods of counting the homeless, but an individual or family who does not have a fixed and stable residence.

McKinney-Vento Homeless Assistance Act

The McKinney-Vento Homeless Assistance Act (“McKinney-Vento”) is a U.S. Department of Education statute designed to support homeless children throughout their school career, and utilizes more flexible criteria for defining homelessness than HUD’s definition. McKinney-Vento covers school-age children (and by proxy, their families) who are doubling up, living in cars, or whose families are paying out of pocket to stay in hotels, as opposed to being housed in a hotel using an agency-provided voucher. McKinney-Vento data from 2014-2015 suggests that almost 75% of identified homeless students were doubling up with other people, illustrating the importance of including this population when defining homelessness (USICH 2017).

Methods of Counting Homelessness

The prevalence of homelessness in a community must be accurately measured in order to demonstrate need when seeking funding for services. A number of methods are used to count homeless individuals and families within a community. These methods address different portions of the population or the community’s capacity to serve them. While there are some limitations to these collection methods, they provide the best estimates that a community has to determine what services or housing units are needed.

PIT (Point-in-Time) Counts

Currently, the most commonly used method of enumerating the homeless in the U.S. is the point-in-time (PIT) count. PIT counts are intended to measure the number of sheltered and unsheltered homeless present in a community. In order to track changes in the homeless population in a given community over time, any CoC receiving HUD funding for homeless services is required to conduct PIT counts at least every two years. On a night near the end of January, the number of sheltered and unsheltered homeless individuals and families in a given community are counted. The count takes place in January because it is generally expected that shelters will be at their fullest capacity on cold winter nights.

Depending on a community’s size, there are two ways to conduct a PIT count. One is the census count, where every known homeless person or household is counted. The other is a sample count, where a representative portion of the community is counted and used to extrapolate the total number of homeless people in the area. During the PIT count process, volunteers often interview the people they are counting to determine whether they are chronically homeless, whether they are alone or part of a household, and other information that adds detail to the community’s understanding of the demographics of homelessness. PIT data can be used for evaluating changes in homelessness trends over time.

Drawbacks of the PIT count are generally tied to the fact that it is only performed once a year, and can only access people who are visible to volunteers. It is assumed that shelters will be at their fullest capacity in the month of January due to cold temperatures, thereby allowing CoCs to engage greater numbers of individuals. While this is not necessarily true in climates like those of Southern Arizona, Pima County’s PIT count is conducted annually in January. As for any PIT count, CoCs capture the visible homeless persons in a canvassed area and its nearby shelters. Street counts can therefore exclude people who may be taking shelter inside abandoned buildings or in unreachable areas. Youth often avoid the PIT out of concern that they will be picked up by child welfare services if they are included. Families, too, are often missed by PIT counts, since they may double up with other families,

stay in their cars, or separate from their children, and will not be visible in either shelter or street counts. The 2014 report of PIT counts from across Arizona found a total of 2,615 minors in households with both adults and children (HUD 2014). In contrast, the count of homeless AZ public school students in the 2013-14 school year found almost 30,000 homeless children in households with adults (ED 2014). The school count is able to pick up many more homeless families than are noted in the PIT count. This may result from the targets of the school count. Schools define homelessness as including doubling up with other families, cars, hotels, motels, etc.—that is, hidden homelessness—whereas PIT counts cannot pick up families in this situation.

HICs (Housing Inventory Counts)

The Housing Inventory Count (HIC) examines the capacity and utilization of shelter beds or units in a CoC. HIC divides shelters and specialized housing units into five program types: emergency shelters (ES), transitional housing (TH), rapid re-housing (RRH), safe havens (SH), and permanent supportive housing (PSH). Using the HIC, shelters and service providers count their total number of beds or housing units, the number of beds or units that are currently occupied, and a shelter utilization rate based on that information. This provides the community with an overview of shelters that have been performing at full capacity, as well as shelters that may be under-utilized. Beds or housing units that are rarely used might be repurposed, or the funding providing them might be reallocated to somewhere with greater need and utilization. Where the PIT tells a community how many homeless individuals and families exist in their area, the HIC tells the community how much space there is to house them.

While HICs provide insight into shelter utilization, they are not able to represent the entire community's housing availability. In particular, RRH units are not counted in the same way as other housing units, due to differences in the way they are administered and distributed.

Counting the Hidden Homeless

Hidden homeless people tend to be living in their cars, staying in hotels, or doubling up with others, rather than living visibly on a street or in a shelter. Because they are neither sheltered nor visibly unsheltered, HICs and PIT counts are generally unable to capture the hidden homeless. This means that both counting measures tend to underestimate the number of homeless in a community. Homeless mothers and their children are especially likely to double up or stay in hotels rather than to go to a shelter or stay on the street compared to other homeless groups. How can CoCs account for homeless families in these situations if they are unable to locate them?

One possible strategy is to look at services that even unsheltered homeless people are likely to use. This might include Health Care for the Homeless clinics, soup kitchens, food banks, and even the Social Security or TANF (Temporary Assistance to Needy Families) office, where parents can apply for financial assistance (HUD 2008). Outreach at these locations might allow a community to account for a broader range of homeless individuals. However, the challenge of this approach lies in ensuring that the individuals addressed at these locations are unduplicated, and that they have not been counted or added to the service system elsewhere.

Studies attempting to examine the needs or number of hidden homeless also provide a possible strategy for finding these people in a community. Some approaches involve using a random telephone survey that simply asks whether any hidden homeless individuals or families are residing at the home (Agans et al. 2014). This approach benefits from the fact that it can reach out to, theoretically, the entire

population of people who might be letting a homeless individual or family double up with them. However, it can be somewhat invasive, not to mention it requires the person hosting the homeless people to reveal information that may not be theirs to provide. Other studies have utilized snowball sampling, where a few individuals are identified by the researcher or by referring agencies, and those individuals in turn refer their friends or contacts who are in similar situations. Again, the issue of confidentiality and privacy arises from this approach, since it may require friends or relatives to disclose information that is not theirs to share. Additionally, this puts the burden on homeless individuals themselves to find participants, which only adds strain to a group that is already overstressed.

Methods of Recording Homelessness

HMIS (Homeless Management Information System)

An HMIS, or Homeless Management Information System, is a data system used to collect information on homeless individuals and families who are served within a community. The HEARTH Act (Homeless Emergency Assistance and Rapid Transition to Housing Act), enacted by HUD in 2009, requires all recipients of HUD funding through the Emergency Solutions Grant (ESG) or Continuum of Care (CoC) programs to utilize a community HMIS (HUD, "HMIS Requirements"). While each community can choose exactly which information system they wish to use as an HMIS, all systems must fulfill a number of qualifications and requirements to be officially recognized by HUD.

When utilizing most homeless services in a community, a homeless individual or family will generally be entered into the HMIS as a unique record. (As required by federal law, providers of services for homeless individuals and families, such as emergency shelters, must document all clients accessing services. This information is collected on a voluntary basis, and clients can opt out of being entered into HMIS, but the actual number of (hopefully) unduplicated people served must always be captured.) Having this record means that the community can estimate the number of homeless utilizing services without duplications. It also makes the process of referring people to other services simpler, since HMIS information is generally shared between all service providers in an area. This means that HMIS can show individual or family patterns of service usage, record repeated episodes of homelessness, and indicate general community trends. The information from a local HMIS is also reported back to HUD, which can use it to understand nationwide trends and changes.

Survivors of domestic violence are exempt from the federal mandates of HMIS, and shelters focusing on DV survivors do not input their data into the local HMIS out of concern for their clients' confidentiality and safety. HUD still requires a comparable system be in place for this population, but individual-level data is only available within each shelter and not shared with the community at large. Only aggregate data is provided to the rest of the CoC and to HUD. Clients can also refuse to allow their information to be entered into HMIS, and this cannot be used as a reason to refuse to provide services. A client may refuse to participate in HMIS for a variety of reasons. They may not feel comfortable sharing their personal and identifiable information, particularly with anyone connected to the government, if they have had negative perceptions of the government in the past. For families in particular, parents may worry that child welfare services will identify them through HMIS and target them for investigation, or even remove their child. Undocumented immigrants may have similar concerns that HMIS will allow immigration services to locate and deport them. While HMIS information cannot currently be used by government entities in this way, many clients are misinformed about the subject and still do not feel safe. Even some service providers are concerned about the eventual

possibility that Homeland Security or other entities may try to access private information for purposes other than providing housing and services.

5. The Cycle of Housing Instability

Introduction

Homelessness, or the broader experience of having housing instability, may be a single, isolated event in the life of a person or family. It is more often the case that homeless persons recidivate – that is, they encounter multiple episodes of homelessness. Simply finding a living space to rent is not enough to keep a family stable. Over time, they may struggle with the same issues that caused them to become homeless in the first place, and lose their new residence in the process. Certain factors make an individual or their family more or less likely to exit homelessness, obtain housing, and achieve long-term stability. Identifying those factors gives service providers a starting point in designing homelessness prevention tools for the precariously housed, or interventions to move people out of the cycle of instability onto a path of permanent, long-term housing. This section will examine the initial factors that push women and their children into homelessness, those factors that determine whether they will be able to find housing once homeless, and the factors predicting whether homeless women with children will become stable or if they will repeatedly find housing, lose it, and become homeless again. Many of these factors play a role at various stages in this repeating cycle of housing instability.

Predictors of Entering Homelessness

- **Poverty:** Many impoverished families are one illness or car breakdown away from becoming homeless. 75% of working low-income or homeless women are in the sales or service industries, compared to 61% of all women nationwide (Silver and Pañares 2000), which leads to lower income, fewer benefits, and more unpredictable hours than other positions. A sudden financial decline resulting from job loss, divorce, or other upheavals can also lead to homelessness (Kirkman et al. 2015).
- **Lack of education:** More than 50% of homeless women lack a high school diploma (Dupere 2016).
- **Age of mother:** Women under 35 are at higher risk of homelessness (Lehmann et al 2007), and pregnant homeless women tend to be very young, sometimes still in adolescence (David, Gelberg and Suchman 2012). Age also affects income, since young people are less likely to have enough work experience to make living wages.
- **Age of child:** Young families with children under five years are at greatest risk of becoming homeless (Shinn, Rog and Culhane, 2005).
- **Domestic violence (DV):** Women who are victims of DV or intimate partner violence (IPV) are four times as likely to become homeless than women who are not (Sullivan, Bomsta and Hacskaylo 2016), and one in four homeless women consider IPV to be the main factor in their current housing instability (Dupere 2016).
- **Social isolation:** Women who are pregnant and homeless tend to be socially isolated (David, Gelberg and Suchman 2012).
- **Racial/ethnic minority status:** African American families may be at the highest risk of homelessness (Shinn, Rog and Culhane, 2005).

Predictors of Finding Housing

Once homeless families make contact with service providers, they are able to access resources such as temporary shelter placement, case management, and assistance finding or paying for new housing. However, some families will have greater success locating housing outside the shelter than others:

- **DV:** Domestic violence is associated with a lower chance of receiving subsidized housing access, which puts IPV survivors at a financial disadvantage (Bassuk and Geller, 2010).
- **Age of child:** Some landlords and property owners will not rent to families with small children (Shier, Jones and Graham, 2011).
- **Racial/ethnic minority status:** Non-White or Hispanic families may be more likely to become housed than White or non-Hispanic families in some areas, possibly because the location of affordable housing may be tied to racial distribution across an area (Donley et al. 2017).
- **Poverty:** Income may be the greatest predictor of whether a woman remains homeless or successfully finds housing (Donley et al. 2017).

Predictors of Recurrent Homelessness vs. Long-Term Stability

Finding a residence outside of the shelter is not a guarantee of long-term stability. Many newly-housed families will experience multiple episodes of homelessness. Some families are at a higher risk for homeless recidivism based on the following predictors:

- **Age of mother:** Older mothers tend to be more successful at finding long-term stability than younger mothers. In one study, for every year increase in the age of heads of household, the likelihood of reentering a family shelter dropped by 2.5% (Wong, Culhane and Kuhn 1997). The same researchers found that older heads of household tended to spend longer in shelters before locating housing, but that their eventual housing placement is more likely to be permanent than younger families (Wong, Culhane and Kuhn 1997).
- **Racial/ethnic minority status:** African-American and Hispanic families spend more time in shelter than do Non-Hispanic whites, and also have a higher risk of shelter reentry (Wong, Culhane and Kuhn 1997).
- **Social support:** Long-term stability is almost impossible without trust and support from family networks (Tobin and Murphy, 2013). A homeless woman's social supports and her perception thereof often predict her self-efficacy in finding and maintaining employment (Brown and Mueller 2014). One study found that having relatives who live in the same state can be protective against homelessness (Lehmann et al 2007).
- **Subsidized housing:** Housing subsidies are financial supports provided by the government that assist low-income families in locating affordable housing. These may take the form of government-owned public housing available at low rates to families with high need. Subsidies may also take the form of housing choice vouchers (HCV), or "Section 8," which families can use to pay for an apartment of their own choice. Access to subsidized housing vouchers may be the greatest predictor of long-term stability for homeless families (Nemiroff, Aubry and Klodawski 2010).
- **Substance abuse:** Substance abuse among homeless mothers is not a pervasive risk factor, when compared to unaccompanied homeless individuals (Kirkman et al. 2015). It has been

indicated that substance abuse disorders may occur as a coping mechanism in reaction to encountering homelessness, rather than the cause of homelessness (Tobin and Murphy 2013).

A Profile of Risk

Statistically, a family that is likely to become homeless will have the following risk factors:

- A young mother, possibly pregnant, with children under 5 years
- The mother has a very low income, or has recently lost her job
- She has experienced domestic violence and may be currently fleeing from her abuser
- She is a member of a racial or ethnic minority
- She does not have an extensive education
- She is socially isolated and cannot rely on family or friends to help and support her when money becomes tight or her living situation becomes fragile

With this snapshot of homeless families, we can build strategies that identify and prioritize single female-headed families to ensure they have the greatest chance of achieving permanent stability and self-sufficiency.

DRAFT

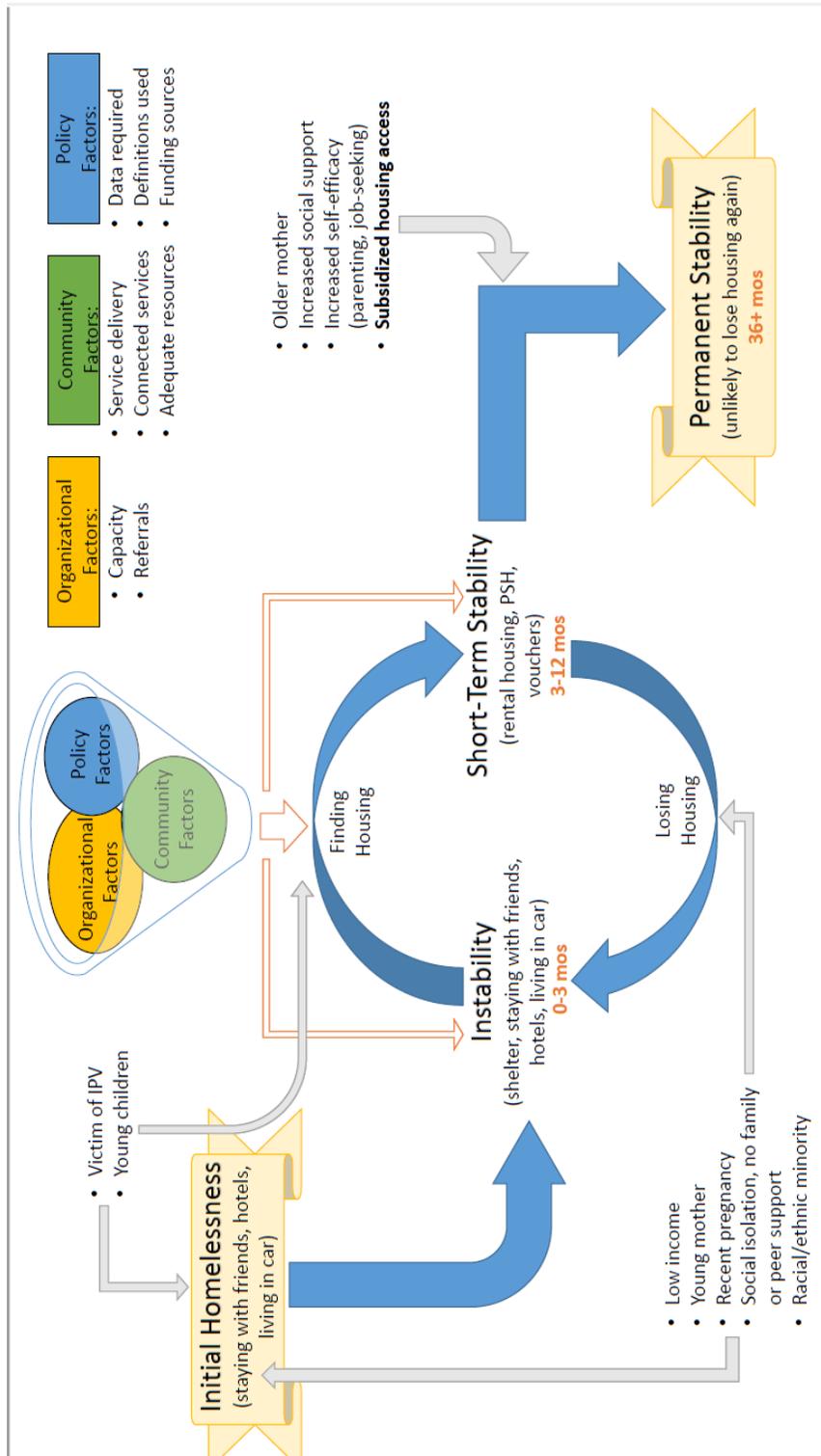


Figure 1. Illustration of the cycle of housing instability, showing the different time periods of stability as well as factors affecting whether a woman and her children will become stable or continue through the cycle.

6. Service Delivery for Homeless Women and Children

Types of Shelters

Table 2. Different types of shelters by the length of stay, the target population, and the general description of services offered.

Type of Shelter	Length of Stay	Target Population	Description
Emergency Shelter (ES)	Very short time, typically 7 days (often required to leave shelter during the daytime)	Anyone who needs somewhere to stay overnight (may be divided by gender or by family vs individual)	Safe place to sleep and sometimes meals provided; may be no guarantee of a bed the next night; may be armory-style (many bunks in one room), smaller rooms with several bunks, or units divided by household/family
Short-term Housing	Usually 30, 60, or 90 days	Sometimes individuals, but more often families	Often one household/family per unit, kitchenette may be included rather than meals provided; place to stay while permanent housing is sought
Transitional Housing (TH)	Up to 24 months	People who may not be able to sustain themselves independently right away	Gradual housing independence program where participants take life skills/financial training and are given more responsibility over housing until they are fully independent
Permanent Supportive Housing (PSH)	No time limit	People with disabilities who will continue to need services or assistance long-term	Long-term subsidized or low-rent housing with supportive services—case management, life skills training, etc.
Safe Haven (SH)	No time limit, 24-hour residence allowed	People with substance abuse or severe mental illnesses but who cannot or will not access other supportive services (children not admitted)	Low-barrier, so few expectations—no requirements to participate in services, not required to be clean or sober
Domestic Violence Shelter (DVS)	Depends on shelter	Women and their children fleeing domestic violence	Can be transitional or emergency/short-term in nature, but focuses specifically on keeping women and families safe

Housing Models

Philosophical models for rehousing homeless individuals and families vary among communities and organizations. Some stakeholders believe that people need to be prepared for permanent housing placement by participating in substance abuse or mental/behavioral health counseling, employment or financial training, or gradual adjustments to living independently. Others believe that placing homeless individuals and families into permanent housing as quickly as possible should be the first priority. This section examines a number of housing models and discusses the benefits and disadvantages of each, focusing on applicability to homeless women with children.

Place-Based vs. Scattered-Site Housing

Where a family will spend their time in a shelter or housing facility depends on the setup of the program they are utilizing. Some programs have a place-based (or “single-site”) setup, where all clients are housed in the same location, similar to a single apartment building. This may make it easier for the service provider to monitor their participants, and for participants to engage in services since they do not have to travel outside their living area to receive them. However, it can uproot families from their area of work or school, since they have no choice in where the single site is located. Alternatively, the scattered-site approach allows families to be placed in various areas throughout a community depending on what is most appropriate for their needs (close to their work, their school, a health clinic, etc.). This can be more complicated to manage, but it makes it easier for families to maintain their normal routines. Scattered site housing is the preferred method for working with women and their children because it can reduce the additional stressors for those experiencing homelessness, such as transportation, schooling, and childcare. One special type of scattered site, “transition-in-place,” even allows families who are still housed (but are at risk of losing that housing) to stay in their current home while still receiving services.

Linear Approach

In the past, most agencies utilized a linear approach in placing homeless individuals and families into permanent housing. The linear approach required clients to participate in substance abuse treatment, counseling, financial education, and other preparatory programs, completing a gradual pathway through services before they were allowed access to housing outside of shelters. This sprang from the perception that people must be made “housing-ready” and prove that they are responsible enough to maintain their housing status once placed (HUD, 2014).

Transitional housing sprang from the linear approach to housing programs. TH helps families become responsible for their own housing by providing them temporary housing (with a 24-month maximum length of stay, per HUD policy) as well as training and services to help clients develop financial literacy, employment skills, and other things needed to hold a job and afford a lease (Moynahan et al. 2006). These services may include case management, assistance with locating and applying for employment or permanent housing, or connection to other community services. Enrollment in transitional housing requires a number of background characteristics to be present for the individual or family, such as a commitment to sobriety and willingness to follow through with a treatment and development plan (Moynahan). Not all transitional housing programs are identical, nor are their requirements. Some programs reject people with serious, persistent mental illness, while others specialize in working with that population (Moynahan). Because of this, transitional housing is considered by some to be a “high-barrier” program that is not appropriate for everyone’s needs.

Housing First

The housing first model resists the idea that a person or family must be “housing-ready” before they are allowed to access affordable housing. Instead, Housing First proposes that people cannot successfully recover from substance abuse, mental illnesses, or other conditions if their immediate need for housing is not satisfied. Therefore, it is necessary to consider housing placement as the first service priority, and follow it with other services later if the client wants to use them. Housing first also encourages client choice when considering housing placement, suggesting that clients who are able to choose where they live and what services they use will be more successful. Housing first has almost completely replaced the linear approach as the preference of service providers, due to the growing body of evidence demonstrating positive outcomes. (National Alliance to End Homelessness, 2016).

Rapid re-housing, an application of the housing first model, is intended to reduce the amount of time that individuals and families spend homeless, and to get them into permanent, stable housing as quickly as possible. Once clients are placed into housing, the provider will assist clients in becoming fully self-sufficient. Generally, this involves three steps:

- **Housing identification:** The service provider helps the individual or family locate housing that will suit their needs (taking their choice and preference into consideration).
- **Rent and move-in assistance:** the service provider pays part of the individual or family’s rent while they contribute the rest; the provider also helps with immediate home needs such as furniture or amenities, depending on what funding is available and what is allowed (Dan Sullivan, personal communication, 6-16-2017). The portion of rent paid by the provider diminishes over time as the family or individual gains an income, until the resident pays the entirety of their rent.
- **Case management and services:** If the client chooses to participate in case management, the service provider offers programs that will help them maintain their housing on a long-term basis, as well as connecting them to other services such as financial education, counseling, etc.

Rapid re-housing is most appropriate for families who have moderate (rather than high) needs, as measured by any standardized tool used to prioritize the provision of services. For example, an individual with serious mental illness who is not capable of taking care of themselves most likely will not succeed in a rapid re-housing program. On the other hand, a family whose members have few chronic health conditions and which became homeless due to a sudden financial emergency rather than long-standing issues with substance abuse or other conditions will be more likely to succeed. Some families may benefit more from the gradual, longer-term support provided by a transitional housing environment.

For individuals who are not likely to succeed in rapid re-housing or transitional housing, permanent supportive housing can provide needed services and housing for an unlimited amount of time. In general, permanent supportive housing is offered to people with very high need, such as people with disabilities or serious mental illnesses. Whereas RRH and TH both have time limits imposed, PSH is intended to be a permanent housing placement and can be utilized for as long as the client desires, although they may choose to relocate.

(Oliva, Cho, and Knotts 2014)

Voucher Systems

Vouchers are a means of assisting families in making their rent payments. When a family (either homeless or vulnerably housed) is unable to pay for affordable, safe housing due to being very low income, having a disability, or being elderly, the federal government can offer a Housing Choice Voucher or HCV to help them find appropriate housing. The HCV program is also known as Section 8. While vouchers are funded by the federal government, they are administered and managed through community public housing agencies (PHAs). A number of voucher programs exist, focusing on different populations such as parents at risk of separation from their children, homeless veterans, and people with disabilities (HUD, “Housing Choice Vouchers List”). The success of a voucher system is dependent on how many eligible housing units are available; increasing a community’s supply of section 8 vouchers has no effect if there aren’t enough homes to which the vouchers can be applied. On the other hand, some communities may have a sufficient number of housing units in an area to house their homeless families, but these units are not affordable without a voucher, and there are not enough vouchers available to subsidize them all.

Service Delivery Systems: Continuum of Care (CoC)

System Structure

Establishing a Continuum of Care

In 2009, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act amended the McKinney-Vento Act, combining a number of homelessness services into an umbrella of service provision known as a “continuum of care,” or CoC. HUD’s CoC Program is intended to encourage communities to develop a coordinated, unified response to needs of their local homeless individuals and families. In order to receive CoC funding from HUD, an area must generate an organized collaboration of nonprofits, government entities, businesses, and other homelessness stakeholders. HUD money goes to that collaboration, and the community is left to divide that funding up amongst the different participants depending on their current priorities. While funding must be spent within one of five categories (permanent housing, transitional housing, supportive services, HMIS, and homelessness prevention), the way that funding is distributed throughout the CoC is decided by the community stakeholders themselves.

While the exact composition of a CoC is left to the discretion of a geographic area, HUD has a number of requirements about what sorts of agencies and members the CoC must have, as well as its structure of responsibility. All CoCs must create a board, and may supplement this with committees focused on specific working objectives or projects. Notably, HUD requires that all CoC boards must include at least one individual who is either currently or formerly homeless, providing the perspective of the population being served—particularly important when the population is especially vulnerable, like homeless individuals or families. Specific subpopulations of the homeless must also be represented on the board, by including organizations who serve those subpopulations (people with HIV/AIDS, victims of domestic violence, families, etc.).

Data Sharing

Once the CoC has been established, they must perform a number of actions that enable them to coordinate their service delivery, the most major of which is creating a unified Homeless Management

Information System (HMIS). The HMIS is a repository for client data, including all clients served by the CoC's member agencies (with some exceptions, discussed below). Having a single HMIS used by the entire CoC means that records from anyone using a single service can be accessed (in a limited fashion) by other service providers in the area. This can simplify service delivery as well as illustrate homeless individuals' and families' paths through service use. While providers receiving HUD CoC funds must participate in their local HMIS, clients may refuse to let providers enter their information into the system, and they cannot be denied service as a result. Some organizations, such as domestic violence services, are not allowed to submit their information to HMIS, because it constitutes a security risk that could put their clients (who may be fleeing an abusive partner and need to be kept hidden) in danger.

Coordinated Entry

CoCs are required to have some form of coordinated entry (CE) process. Coordinated entry is intended to make the process of applying for services easier for homeless individuals and families. The general idea is that a person in need who comes to any agency participating in the CoC can be assessed there and then redirected to the service they need most in the community. This means the person or family in need is not forced to shop around and apply at several different agencies until they find the correct one; they are directed there automatically. In addition to saving them time and effort, this means that vulnerable clients are not forced to continually explain their circumstances and history. Having to disclose what led them to homelessness can be frustrating, exhausting, and humiliating. It may even be retraumatizing if, for example, they have PTSD from prior abuse and must continuously explain this as a reason for their homelessness.

An efficient, effective coordinated entry system requires constant and thorough communication among organizations. The system must include all relevant services and programs to which a person in need can be referred, and the client's data must be transferrable between agencies so they do not need to repeat the information collected at their initial assessment. For many CoCs, the CE system is run through their HMIS since they are already required to input their data into it. However, other CoCs may use alternative systems. This generally happens when the CoC needs to serve a subpopulation separately, such as people fleeing domestic abuse or families with children, and a system is already in place for coordinating their care.

Like HMIS, individual CoCs have some freedom when developing their CE system, but HUD has a number of regulations that must be followed. Primarily, these requirements focus on making the CE system accessible to anyone who needs service. This can involve anything from making CE entry points physically accessible to people with disabilities, to lowering barriers so that even people suffering from substance abuse, serious mental illnesses, or criminal records can access services through CE. In addition to making service access easier for the homeless, CE should be used for CoC planning. It provides information about services needed, the most common entry points, the most common referred agencies, and general patterns of change in homelessness. Another major focus of HUD's CE requirements are that the process be person-centered: clients must have choice in the type of housing they access, the services they receive, and the location of their housing and services. The CoC in general is intended to be person-centered and incorporate homeless individuals' and families' desires in service delivery, rather than deciding for them what is appropriate.

Prioritization of Clients

One of HUD's core requirements for CE systems is that the system must be able to prioritize clients based on need and vulnerability. Rather than functioning on a first-come-first-serve basis, or choosing clients who will be "easy" to serve, CE operates as a triage, using the client's entry assessment to evaluate need and giving aid to people with the greatest need first. This prioritization process can be completed through a number of different common assessment tools (CATs). In general, CATs rank a person's need (how vulnerable they are, how urgent their issues are, and what sort of care should be referred to them such as PSH or RRH) using information about their history, health, housing status, and other factors. Some communities use common CATs such as the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), which includes questions on risk behaviors, trauma, victimization, and social support in addition to the more typical questions about chronic health or mental conditions. Other communities may develop their own CAT to more effectively deal with their unique concerns or resources available.

Programs and Services within Shelters: What Is Needed?

- Child development services
 - Supporting mother/child bonding, family connectedness
 - Support to keep kids in school and performing well
 - Supplement to McKinney Vento?
- Differentiating between single and parenting women in shelters
 - Consideration for "invisible mothers" who are separated from their children
- Attempt to prevent long term negative outcomes of homelessness
 - Reduce amount of time spent homeless
 - Long-term care even after housing is found—follow up and continuous support
- Trauma informed care and services
 - Focus on harm reduction, not victim-blaming
- Social support
 - Lack of social support a) makes it easier to become homeless and b) makes it harder to get out of homelessness
 - Foster relationships between shelter residents (may be hard in short-term facilities), homeless and their surrounding community (especially when moving into intended permanent housing—makes it easier for them to stay stable there), and clients with service providers
- Approaching hidden homelessness
 - Better outreach—go where the hidden homeless go (services they use other than shelters—food banks, SNAP application facilities, etc.?)
 - Not everyone will call themselves homeless even if they are—how do we get them into services without insulting or patronizing them?
- Homeless prevention/diversion
 - Where do people at risk of homelessness go? How can we catch them before they end up homeless?
 - This may be beneficial both for their sake and for the community's financial sake— is it cheaper to prevent than to treat after the fact?
- Asset, capacity, resilience building

- Capacity of shelter to not only physically hold everyone but address their needs (ties back to TICO)
- Incorporate personal control and autonomy—builds self-esteem, self-efficacy, confidence as a parent
 - Don't have rules in shelters that invalidate family routines or rules
- Ease of access to services
 - Case management to help navigate the system
 - Make requirements for services reasonable
 - Consider making more low-barrier shelters as a first step?
 - Bolster coordinated entry system
 - Who else can be brought into the system that will benefit it? Who isn't required to be in HMIS or CE but could be helpful? How do we incentivize joining?
- Affordable housing
 - Need both physical housing units and sufficient vouchers/subsidies
 - Making sure affordable housing is also safe—monitoring landlords, etc.
 - City landlord accountability project?
- **BETTER EVALUATION OF PROGRAMS AND SERVICES**
 - Not a service but cite major spending and reforms for fy2018—many suggested cuts cited “lack of evidence of success” as a reason to drop program funding—need to prove that our programs work, and be willing to change and improve them if they don't—otherwise may lose vital funding

Accessibility Barriers

- Fear of “parenting while homeless”—child welfare services taking their children
- Pride/shame/stigma
- Not knowing what is available and where
- Gaps in eligibility (not making enough to support self but making too much to qualify for supportive services, etc.)
- Lack of availability in services (qualified for services but put on waiting list indefinitely)
- Complicated application processes, difficult to understand—especially for people with low education or non-English speakers
- Transportation
- Childcare

PART II: PIMA-SPECIFIC

1. Introduction

The second half of this report examines state and local policies affecting homeless services in Pima County, the structure of the local CoC, and an evaluation of needs and assets of the local service system. This final section, consisting of secondary data analysis as well as pilot interviews with shelter residents and service providers, has been used to shape the scope and direction of this project as it moves forward into 2018.

2. State and Local Policies

Locally Used Definition of Homelessness

As of 2016, Pima County Administrator Chuck Huckelberry referred to people who are homeless as “individuals and families who lack a fixed, regular, and adequate nighttime residence” (Pima County, 2016). While most definitions of homelessness include the components of “fixed,” “regular,” and “adequate,” the Pima County definition is notable in that it has no other qualifications. This broad definition expands homelessness to persons doubling up with family, those sleeping in cars, and those living in hotels on their own dime—populations that do not fit HUD’s definition.

General Policies Applying to the Homeless

People experiencing homelessness may choose to relocate to Tucson, often due to the warm climate. In addition, the rural landscape in Pima County is easier live outside undetected. Pima County periodically removes homeless encampments, particularly if the encampment provokes a citizen complaint or is threatening health and safety (either of the surrounding areas or the occupants themselves) (Pima County, 2015). However, the residents of these encampments often simply relocate somewhere nearby, rather than being discouraged from living rough. The Pima County Sheriff’s Department (PCSD) conducts the removal of encampments, but while they may make arrests if there is an incident of criminal activity, they are also expected to provide occupants with assistance reaching a shelter or finding other resources (Huckelberry to the Pima County Board of Supervisors, 2016).

As of 2016, an evaluation of homeless-targeted “prohibited conduct” (banned public activities that are more likely to be performed by homeless individuals or families than the general population) found that Tucson had ordinances concerning four prohibited conduct categories: sleeping in particular public places (as opposed to anywhere in the city), camping in particular public places, sitting or lying down in particular public places, and begging in particular public places (NLCHP 2016). However, of the five other major AZ cities surveyed, only two (Glendale and Scottsdale) had fewer conduct restrictions. Phoenix, in comparison, prohibits sleeping in vehicles, as well as “loitering, loafing, or vagrancy” anywhere in the city (NLCHP 2016). Since homeless families are likely to live out of their car rather than living publicly on the street, this means Tucson is somewhat less aggressive toward homeless families than other cities in AZ.

However, there are some regulations active in Tucson that, while not necessarily targeted toward the homeless, can be harmful. The “Crime Free Multi-Housing” policy is used by many apartment complexes throughout the city. The intended purpose of this policy is to prevent crimes from occurring on shared residential property by having zero tolerance for any criminal activity. Under this policy, landlords have the authority to remove any tenant who is involved in any kind of crime. In practice, however, this can contribute to housing discrimination against the formerly convicted. Formerly incarcerated persons are at a high risk of homelessness immediately exiting prison.

In San Jose, CA, the Law Foundation of Silicon Valley argued against a comparable policy, pointing out that victims of domestic violence have lost their housing due to the crimes committed by their abusers (Law Foundation of Silicon Valley, September 30, 2015). Female survivors of domestic violence are already at exceptionally high risk of becoming homeless; a policy making them more vulnerable to unfair eviction exacerbates their situation.

Funding Sources for Homeless Services

Interviews with service providers identified a number of funding sources for homelessness services. Direct service providers in particular mostly depend on a combination of federal funds (HUD, Department of Economic Security or DES, and the Substance Abuse and Mental Health Services Administration or SAMHSA), state, and local funding and partnerships to deliver housing services in Pima County. A number of federal sources are at play. Two major grant programs fund a number of homelessness programs. The first is the Community Development Block Grant or CDBG, which provides highly flexible funds to communities (HUD, “Community Development Block Grant Program – CDBG”). CDBG can fund almost anything intended to improve community resources and infrastructure, from fire hydrant repairs to youth sports programs, but a large portion of Pima County’s CDBG funds are directed toward homeless shelters and services (Pima County Community Development and Neighborhood Conservation, 2017). The second major grant program, the Social Services Block Grant or SSBG, is designed to assist individuals and families in becoming self-sufficient or in finding resources and housing that will support them if they cannot live independently (OCS, “Social Services Block Grant Program (SSBG)”). There are 29 categories of services that can be funded by SSBG, several of which are relevant to family homelessness. These include housing, which covers emergency shelters, transitional housing, and housing searches, among others; day care services for children, which can be used to help homeless parents search for jobs and housing more easily; and employment services, which includes job training and placement (AZDES, “State of Arizona Social Services Block Grant Plan 2017-2018). Both of these block grants are allotted to state and local governments, who evaluate where the money is distributed based on proposals submitted by community agencies. At time of writing, the President’s proposed federal budget for FY2018 removes both the SSBG and CDBG completely, reallocating their funds elsewhere (Office of Management and Budget, 2017). Currently it is unclear whether this part of the budget will be approved, and what effects the grants’ removal will have if it is.

Community homelessness services can also be funded by two additional HUD programs: the Continuum of Care (CoC) program and the Emergency Solutions Grant (ESG) program. CoC funds are provided by HUD to local CoCs to allow them to perform their various functions related to homelessness, as well as administration of the CoC itself. For example, CoC funds can be applied to HMIS implementation, permanent supportive housing, assistance with finding leases for homeless individuals or families, providing supportive services to the homeless, and rapid re-housing (HUD, “CoC Program Toolkit...”). While most CoC funding goes directly to local CoCs who act as a pass-through for nonprofit subrecipients, HUD is also able to fund nonprofits and public housing agencies directly using CoC money (HUD, “Continuum of Care (CoC) Program Eligibility Requirements”). Where the CoC program focuses mainly on broad community housing solutions and supportive services for homeless individuals and families, the ESG program focuses specifically on preventing homelessness, outreach to people who are currently homeless, and shelter (either emergency or RRH) for homeless people. ESG funds are granted to local or state governments, who then may distribute those funds to nonprofit subrecipients (HUD, “ESG Requirements”). ESG funds may pay for additional homeless shelters and their operations costs, outreach services and case management, and essential services for sheltered people such as child care or employment assistance (HUD 2016, “Emergency Solutions Grants...”). Primavera, Emerge!, Old Pueblo Services, and Our Family Services are examples of local agencies that receive ESG money for RRH and emergency shelter services, but they acknowledge that ESG is a steadily shrinking source of funding.

While federal funds are often distributed to providers via state or local government entities, those entities also provide their own funding to community projects and agencies. The Arizona Department of Housing or ADOH, one major state funding source, provides money for Rapid Re-Housing so that providers can work with “imminently homeless” families up to 14 days before they lose their current housing, rather than having to wait until they have already become homeless. Both the Pima County and City of Tucson governments support services, either as direct funders or through partnerships in programs like Section 8/Housing Choice Voucher programs.

Governmental funding is supplemented through outside foundations, grants, private donations, and other entrepreneurial activities. Some organizations like Primavera receive funds from the Arizona state lottery that are directed toward programming. Agencies may also conduct their own fundraising to provide more flexible funding, with which they can offer additional activities or programs that are more responsive to the specific needs of their client base. Support services such as YWCA are funded mainly through sources not tied to homelessness but rather funding for childcare (the Child Care and Development Block Grant or CCDBG) or protection for women (authorized by the Violence Against Women Act or VAWA), etc. (YWCA, “A Fair Budget...”). These support organizations do not focus specifically on the treatment of homelessness, but do play a role in homelessness prevention.

Housing and Shelter Policies

Pima County’s service providers generally focus on Housing First initiatives and RRH, per HUD recommendations. Transitional housing does exist in the community, such as the Pio Decimo Center and Old Pueblo Services’ shelter for recently incarcerated individuals, but federal funding for it has become more limited. Funding and housing availability in general are rare commodities. By HUD standards, rapid re-housing services can last up to 24 months, but Pima service providers tend to enforce a 9-month maximum due to cost (Dan Sullivan, personal communication, 6-16-2017).

Both place-based and scattered-site housing are present in Pima County. Service providers who manage scattered-site units, such as Our Family Services, suggest that long-term stability is easier for families who are able to choose their home location more freely, leading to higher outcomes than seen in place-based shelters (Laurie Mazerbo, personal communication, 6-20-2017). However, not all service providers are equipped to provide scattered site housing, particularly emergency or short-term shelters such as Primavera Greyhound Family Shelter.

Affordable Housing

HUD provides HOME (Home Investment Partnerships Program) funds to Pima County and the City of Tucson (CoT) to construct and repair affordable housing, as well as to assist with down payments (Pima County CDNC, “Affordable Housing Development...”). HOME money can be used by low-income families to pay their down payment on a home, as well as building and repairing affordable housing. Local developers can also apply for funds to build affordable housing for either sale or rental through this program. In addition to HOME funding, the City of Tucson Public Housing Authority or PHA maintains approximately 1,500 city-owned “public housing” units for which qualifying low-income individuals and families can apply (City of Tucson, “Public Housing Examples”). Section 8 housing choice vouchers are also maintained by CoT’s PHA for families and individuals with high need and low income. These vouchers can be applied to housing owned by service providers, such as the Primavera Foundation, or by landlords participating in the affordable housing program. Around 4,700 households in Pima County receive vouchers from the CoT PHA (City of Tucson, “Housing Choice Voucher Program”).

Currently, both the housing choice voucher and public housing program waitlists are closed until further notice, so no further applications will be accepted.

3. Pima Continuum of Care

Introduction

The Pima County CoC is supervised by the Tucson-Pima Collaboration to End Homelessness, or TPCH. TPCH describes itself as “a coalition of community and faith-based organizations, government entities, businesses, and individuals committed to the mission of ending homelessness and addressing the issues related to homelessness in our community” (“Mission Statement,” TPCH). Not all agencies within the Pima County CoC are officially part of the TPCH, nor are all agencies providing homelessness services part of the CoC in general (for example, individual churches who may offer night-by-night shelter but are not officially service providers).

Participating Membership

As of May 2017, 36 service providers and other local agencies acted as TPCH voting members. This list includes shelter providers such as Primavera and the Gospel Rescue Mission, health services such as CODAC and El Rio Health Center, faith-based services such as Hope of Glory Ministries, and government entities such as the State of Arizona DES (Department of Economic Security) and Pima County. Many other organizations and specialties are included as voting members as well. In addition to the voting members, the Arizona Department of Housing receives grants from the TPCH but does not vote. Several board members also are not voting members of TPCH, but are still integral to its day-to-day functioning. (A complete list of voting members of TPCH is included in the appendix, p.!!.)

TPCH System and Operations

Organizational Structure

TPCH is composed of a board of directors and an executive committee, as well as a number of lower committees and subcommittees. These roles are filled by service providers, government employees, faith-based organizations, members of law enforcement, and other indirect stakeholders, as well as the most direct stakeholder group: currently or formerly homeless individuals. The specific structure of TPCH is below:

- **Board of directors:** Responsible for policy and direction, while day to day operations are performed by staff and committee
- **Chair, vice chair, secretary-treasurer; designated-appointed seats** (including HMIS lead agency Pima County, government representatives, funding agency, VA); **nominated-elected seats** (represent other stakeholders—faith-based organizations, health care orgs, CoC grant recipients, actually homeless or formerly homeless individuals, philanthropic agencies, law enforcement, utilities, etc.); **non-voting seats:** chairs of the committees
<http://www.tpch.net/tpch-board-of-directors.html>
- **Executive committee:** runs general council meetings where all committees report on their progress; assigns issues to appropriate committee, acts as the primary community contact
<http://www.tpch.net/executive-committee.html>
- **committees and subcommittees** dedicated to particular topics such as youth homelessness, HMIS, and coordinated entry; often collaborate with one another on projects

Coordinated Entry

As a recipient of HUD CoC funds, TPCH operates a coordinated entry system through its HMIS. This system utilizes a “no wrong door” approach, where any person seeking services can approach a designated TPCH access point, complete a VI-SPDAT assessment to determine their level of need, and be rerouted to the appropriate services when possible. These access points are generally service providers participating in the local CoC. As of June 2017, there are eight access points within service provider buildings as well as three mobile access points that perform outreach throughout the community (Pamela Moseley, personal communication, 6-7-2017).

The coordinated entry system, while required by HUD, is not popular with every CoC participant. Agencies no longer have the freedom to refuse service to clients who are referred to them. This forces them to accept “difficult” clients (clients who are hard to reach, who might have a number of complicating conditions such as substance abuse, who might be resistant to services). Serving such clients may cause a decrease in demonstrated positive outcomes for that agency’s programs and services, simply because they are working with people for whom it is more difficult to reach a positive outcome. This fact may not be reflected in HUD’s analysis of program success, which may result in lowered funding or support for services that have not actually changed in quality (Dan Sullivan, personal communication, 6-16-2017). However, the referral system does make the service provision process more objective. Services are offered to people based on their need, as measured by the VI-SPDAT assessment tool, rather than on who has an emotionally affecting story or who is seen as an “easy” client to service (personal communication, 6-16-2017).

Data

TPCH members generally utilize the HMIS software Service Point to share data between agencies. However, many members of TPCH do not input their data into HMIS. This may be because of confidentiality rules affecting those agencies. For example, domestic violence services are not allowed to enter information into HMIS that may be identifiable, as it could put their clients at risk. Other providers who do not receive HUD funds directly may not be required to participate in the HMIS system. This is also true of non-TPCH providers who serve the homeless community but are not technically part of the CoC, such as churches who provide night-to-night shelter but are not officially housing providers. As they are not required to input data into HMIS, the clients they serve may not be accounted for within the system.

4. Assessment of Community Assets and Needs

Demographics of Homelessness in Pima

According to the 2016 AHAR (Annual Homeless Assessment Report) generated by TPCH, approximately 7,653 people were homeless and in some form of shelter in Pima County from October 2015 to September 2016, of which approximately 1,527 were members of families (about 447 families in total). The majority of families resided in transitional housing or permanent supportive housing, rather than emergency shelters. Families were mainly led by women (the majority of adults in families in all types of shelter were women). White Hispanic/Latino family members were more common than any other race, with White Non-Hispanic/Non-Latino people coming in second. Most individuals in families had been staying with family or friends, in an emergency shelter, in a place not meant for human habitation, or paying their own way for a hotel/motel the night prior to entering a program. However,

family members who ended up in PSH were much more likely to have been in an emergency shelter, and somewhat more likely to have been in a rented housing unit.

The AHAR only examines sheltered individuals and families, and does not include people on the street, staying with friends, in hotels, or other forms of “hidden” homelessness. The PIT count provides somewhat more information about these unsheltered people. However, the PIT still depends on whether homeless individuals and families are visible to the counters. The 2016 PIT count in Pima County located only one unsheltered family, with one child and one adult. The likelihood that only one family in the entire county was homeless and unsheltered during 2016—or even during the single night in which the PIT was carried out—is small. The 2016 Tucson-Pima PIT states that areas for examination were not selected randomly, and that a relatively small number of locations were observed. Between the limited frame of the PIT census, and the fact that most homeless families are found in friends’ or relatives’ homes or in cars rather than on the street, families in Pima were being systematically undercounted. In 2017, the PIT was unable to locate any unsheltered families with at least one adult and one child. This does not mean there were no unsheltered homeless families in Tucson this year, but rather indicates that the vast majority of homeless families are either in shelters or living off the street in unstable and unpredictable housing situations.

Service Providers’ Perspective

Pima County interviewed eight local homeless service providers in early 2017. Four of the participating agencies worked directly in homeless or housing services, such as shelters, while the other four provide ancillary or support services such as food assistance. Ancillary services were included because hidden homeless mothers who are doubling up or residing in places other than shelters may still access other services such as food banks or domestic violence recovery support. Participants were asked about the Pima service delivery system, data collection, the new coordinated entry (CE) structure, and funding. They were also asked to identify barriers to service access and gaps where services were needed but not offered. The intention of these interviews was to shape the direction of future interviews and focus for the project, as well as to identify gaps in providers’ knowledge where their priorities did not match those of their clients.

The service providers interviewed identified a number of issues present in the Pima service delivery system. One major issue is the fragmentation of care experienced throughout the system. Services are located in many different agencies and geographic locations, making it difficult for women to access all the services they need. The HMIS system and CE are intended to simplify the process of referrals, but not all providers—particularly those providing ancillary services, or any outside the CoC not receiving CoC funds—do not participate in HMIS, and so do not send or receive referrals through it. Even for those participating in HMIS, referrals between agencies are often slow enough that families languish in shelters longer than necessary while waiting for service access. (However, providers suggested that this may be rectified as the CE process becomes digitized.)

Providers also mentioned that insufficient resources were an ever-present concern in the Pima system. The current level of funding available for local services was labeled as inadequate in comparison to the depth of need in the community. The system now is unable to provide assistance to everyone in need. This manifests in many ways in Pima County, including many agencies offering RRH services for a maximum of 9 months when the federal maximum is 24 months. This shorter time period may not be enough to achieve long-term stability, so many families are at risk of reentering the homeless service

system after RRH resources are gone. Flexible funds were also identified as a rare but essential source of assistance for tangible needs such as bus vouchers. Since most grants and government funding have strict rules about how the money is spent, more flexible money must often be fundraised independently by the agency. The lack of resources in Pima County are not just monetary; the local CoC also lacks enough agencies that are able to care for special populations. Very few homeless shelters exist that can accommodate an entire family, and only one domestic violence-specific shelter (Emerge!) exists within Pima County.

The interviews with service providers indicated that knowledge of available resources in Pima County may be limited even by the agencies providing those services. When asked which services they would want to see in the local system, providers identified multiple services that do currently exist in the community. This may reflect a desire to expand those services, but it may also mean that agencies are not aware of the services offered by their collaborators within the CoC. Part of this may result from the sheer number of resources in Pima County, as well as the differing eligibility requirements between them all—there may be too many options for case managers or providers to know them all well enough to refer clients to them. The increasingly widespread use of coordinated entry may alleviate this problem, as options for service will be readily visible available to agencies through the HMIS system.

(For a more detailed review of the pilot service provider interviews, see p.!! in the appendix.)

Shelter Users' Perspective

Pima County conducted ten pilot interviews with clients of homeless shelters and services in early 2017. The results of those interviews guided the continuing development of this project. Mothers from Pio Decimo Center or PDC (a transitional shelter) and Primavera Greyhound Family Shelter or PG (an emergency/short-term family-oriented shelter) participated in either individual mixed-method interviews or a mixed-method focus group. All participants were asked the same question, regardless of interview format. Interview and survey questions assessed demographics such as race, ethnicity, and monthly income; family composition; shelter and service use history; self-efficacy; social support; assets and motivation; and participants' opinions of homeless services they have used, including barriers to access.

Women from the PDC and women from PG expressed different needs and priorities, which is unsurprising due to the difference in circumstances between transitional and emergency housing. Women from PG were mainly concerned with passing credit applications for rental housing; finding toiletries and food for their families; and locating some kind of employment. Their focus was generally on short-term needs and plans. While some of them expressed long-term professional or personal goals, they were often discouraged about their chance of reaching those goals. In contrast, women from PDC were more confident about basic needs like food, shelter, and toiletries, and focused more on higher-level goals and aspirations. Most were employed, and when not at work they spent time attending skills trainings and educational meetings offered by PDC. They were often isolated because they prioritized working and saving money over socializing or fun. When personal or professional goals were expressed, they had generally identified or taken steps toward achieving these goals, and felt reasonable confidence that they would reach them. This difference in outlook and priorities between emergency and transitional housing residents indicated a need to examine homeless services as different places on a spectrum of movement toward stability, rather than as one large and interchangeable group. This resulted in Pima County dividing the research project into multiple phases depending on the type of

services offered, with consideration to where women using each service might be in their path toward stability (i.e. whether they are able to focus on professional development or if they are still concentrating on meeting baseline needs).

Despite their differences, women from both PDC and PG expressed similar use of wraparound or support services, and similar barriers accessing those services. Many women had located their current shelter or service through Internet searching, generally via their phone or the public library. Some also heard of services through word of mouth from friends. However, several expressed difficulty finding services, or found that when they contacted help resources like 211, they were forced to repeat their often traumatic housing and family history multiple times without being referred anywhere. Women also mentioned that their case managers did not always mention services for which they were eligible, or even requirements they must fulfill to receive certain benefits. In general, case managers were described as overworked and unable to spend as much time with clients as the mothers desired.

Impact of Pilot Interviews

Based on the results of the pilot interviews with service providers and shelter residents, Pima County has framed the current project around measuring knowledge of and access to services for mothers experiencing housing instability or homelessness. The intention is to evaluate whether resources are being allocated as effectively as possible to meet women's needs; to understand whether women are aware of resources, and whether they can reach them once they know of them; to identify any gaps in service throughout the Pima County system; and to make recommendations to service providers on how they can improve service delivery.

When examining knowledge of services, Pima County has focused not only on mothers, but also on service providers' knowledge of what is available in their community (or, at least, on their ability to refer women to the appropriate resource). It is likely that providers and their clients will have different priorities as well as different levels of knowledge about available services. However, interviews with both groups suggested that knowledge of services is limited and blind spots exist for case managers as well as women in need. Understanding where those blind spots are most common may help agencies direct their case managers' focus to be more applicable to clients' needs.

Knowing that services exist is not enough; it is also necessary to evaluate whether there are systemic or logistical barriers to accessing those services for mothers. The fragmentation of care can challenge women experiencing transportation difficulties or lack of time. Other factors, such as lack of legal documentation and language barriers, can cause additional struggles for mothers attempting to seek services. The current project is designed to identify common obstacles to service access, as well as current efforts in the system to overcome these obstacles.

5. Next Steps: The Current Project

Introduction

The current project is designed to evaluate whether the Pima County service delivery system is capable of addressing the particular needs of homeless women and their children, with an emphasis on knowledge of and access to services. A team of CDNC employees will be conducting the evaluation and will incorporate the expertise, knowledge, and priorities of stakeholders in the community, specifically

service providers -- both direct housing providers and ancillary/support services, as well as homeless single mother clients of services.

Timeline

The homeless mothers project has been divided into a number of phases (see Table 3). Pima County CDNC, with support from University of Arizona Public Administration and Public Health graduate students, completed Phase I of the project in the spring of 2017. Phase II took place during the summer of 2017, consisting of compiling the pilot interview reports, conducting a literature review and search of best practices, interviewing emergency shelter and transitional housing service users, and holding meetings with community stakeholders. Future phases, focusing on interviewing mothers in other stages of stability (rapid rehousing or Section 8, prevention, etc.), as well as interviewing service providers, will take place between fall 2017 and spring 2018. A sub-project focusing on prevention services will be carried out by another group of MPH students, while all other phases will be completed by new CDNC interns.

Table 3. Timeline of phases of the homeless mothers and children project.

Phase	Description	Timeline and Responsibility
Phase I	Pilot interviews with service providers and recipients	Spring 2017 semester (MPA/MPH students)
Phase II	ES and TH service users	Summer 2017 (CDNC interns)
Phase III	RRH and Section 8 recipients	Fall 2017 semester (CDNC interns)
(Phase III-2)	Prevention service users	Fall 2017 semester (MPH students)
Phase IV	Interviews/surveys with service providers	Spring 2018 semester (CDNC interns)

Project Plan

Best Practices

The Pima County team will be compiling a list of best practices for services and programs targeting homeless women and their children. These will be used to make recommendations to Tucson service providers about what programs to prioritize and where they can look for funding. These best practices will include:

- **Intake methods:** does the intake questionnaire such as VI-SPDAT cover all the information that is needed to direct homeless women and their children to the appropriate services as efficiently as possible?
- **Services offered by providers:** are shelter, housing, and ancillary services appropriate for the needs of this subpopulation? Are additional services needed, such as childcare? Are there long-term services available to help recently housed women maintain their stability?
 - **Services targeting intergenerational effects of homelessness:** do the programs offered assist children as well as their mothers? Is there consideration of the developmental and educational effects that homelessness can have on children, especially young ones?
- **Coordinated entry:** Does the service provider participate in the CoC coordinated entry (CE) process? What is the most efficient and easily accessible structure for coordinated entry that maximizes the number of participating agencies without adding additional stress on their infrastructure?

- **Standardization of data collection:** how is data collected in each agency? Are these methods compatible between agencies? If not, how can they be made compatible so data sharing is possible? What information does each agency collect and why/for whom?
- **Continuum of care:** How does the organizational structure of TPCH compare to other CoCs? Are other systems more effective than the TPCH structure? How can TPCH be adjusted to capitalize on these successes?

Best practices will be found in research literature, as well as from other communities or CoCs in the Western U.S. which are well known for successfully handling the issue of maternal and child homelessness.

Evaluation of Current Pima System

Using the best practices list, as well as input from local service providers and stakeholders (including shelter residents), the team will determine appropriate measurements of quality or success that will accurately represent Pima providers' ability to serve homeless women with children. After these measurements have been accepted by the community, the team will complete an evaluation of services and programs provided by local agencies by:

- Interviewing and surveying shelter residents about their experiences, their needs, how the shelter and other services utilized were helpful, ways the services they used might be improved, needs that were not addressed, how they initially found the services they utilized
- Interviewing and surveying previously homeless people in section 8 housing, etc. about their experiences getting to stability, any long-term services they are still utilizing, what may have made their situation different from people who had more difficulty finding permanent housing
- Interviewing and surveying service providers on the programs they offer, their needs, what they perceive as the strongest parts of their programs, services or programs they would like to improve or programs they would like to offer in future, gaps in service, how coordinated entry has worked for them so far

From these interviews, the team will identify any gaps in service where homeless women and their children are not being adequately served in Pima County. These interviews will hopefully also indicate ways that the service delivery system (specifically, the CoC's coordinated entry system) can be made more efficient and accessible, both for homeless families in need and for providers attempting to collaborate.

Landscape Analysis and Recommendations

All data previously collected will be combined into a landscape analysis examining potential sites of improvement for service delivery, as well as opportunities and threats to making positive change. This report will be used to make recommendations to TPCH and other stakeholders in Pima County. Ideally, service providers and the TPCH will collaborate with the Pima County CDNC team during the entire data collection and evaluation process, so that the end product is a guide for how to make improvements they were already hoping to make, rather than a forced directive that goes against agencies' priorities. This process of collaboration should help to keep the power of decision-making amongst community advocates, rather than being the sole responsibility of CDNC.

Project activities are listed in the table below, as well as the ways the CDNC team will need assistance from stakeholders, and the ways in which stakeholders will benefit from participating.

Table !!. List of project activities that will be conducted by the CDNC team during summer 2017, the ways providers can participate in the project, and the reasons they will benefit by participating.

Project Activities	How Providers and Other Stakeholders Can Help	How Stakeholders Will Benefit
Regular meetings with stakeholder group to discuss project progress, future directions, any new obstacles or questions	Attend, participate, give feedback on what you want to see or what you need from the project	the recommendations made will incorporate your priorities, experience, and knowledge—they exist to help you improve things that matter to your organization, not to tell you what to do
Create list of “best practices” for maternal and child homelessness	Share best practices (housing models, program standards, recommendations, etc.) your organization uses with us	Share your evidence base with other agencies and access their evidence base in return
Create measures of quality or success that can be used to evaluate programs in Pima	Share how your organization evaluates its programs, how your funder evaluates you, how your clients evaluate you	Have input on evaluation process so it suits your needs and recognizes your achievements or the unique qualities you bring to the system
Interview clients (esp. current shelter residents, post-homeless section 8 residents)	Connect us with clients, assist us in compensating them for their time,	Get a better understanding of your clients’ perceptions of your services, your strengths, and their perceived unaddressed needs
Interview service providers	Set up interview times with us, tell us your perception of service gaps, the strengths in your programs, etc.	Share your viewpoint on what your organization does best, the important services you bring to the community, how you would like to improve
Create landscape analysis of service gaps, recommendations, and funding opportunities in Pima	Provide feedback/edits of analysis through writing and development process	See and shape the analysis process, potentially receive funding from future grants obtained to pay for recommended actions

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7. Appendices

Figures and Diagrams

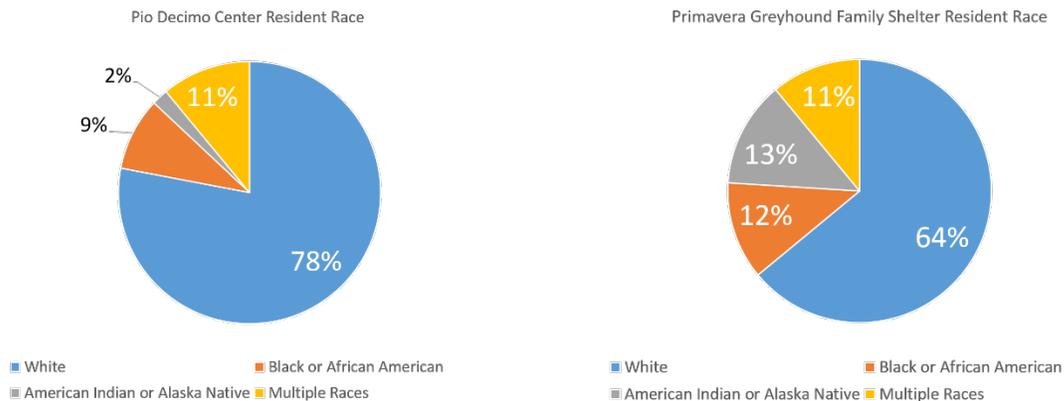
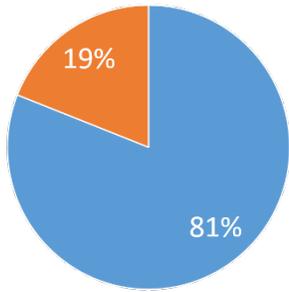


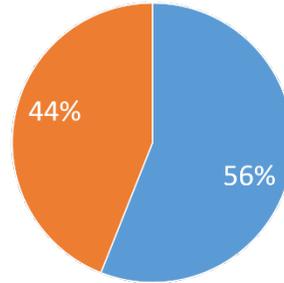
Figure !!. Race of all PDC (left) and PG (right) residents during 2016. Majority of both shelters were white.

Pio Decimo Center Resident Ethnicity



■ Hispanic/Latino ■ Non-Hispanic/Non-Latino

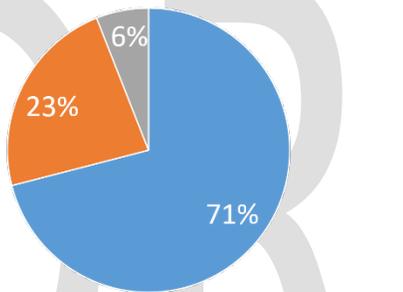
Primavera Greyhound Shelter Resident Ethnicity



■ Hispanic/Latino ■ Non-Hispanic/Non-Latino

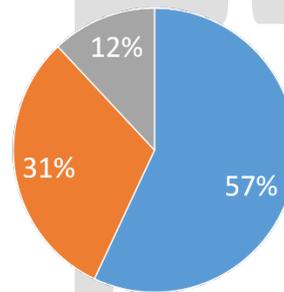
Figure !!. Ethnicity of all PDC (left) and PG (right) residents during 2016. Majority of both shelters were Hispanic/Latino.

Pio Decimo Center Household Composition



■ Female Single Parent ■ Two-Parent Family ■ Male Single Parent

Primavera Greyhound Family Shelter Household Composition



■ Female Single Parent ■ Two-Parent Family ■ Male Single Parent

Figure !!. Household composition (two-parent family, single female parent, or single male parent) of all PDC (left) and PG (right) residents during 2016. Majority of both shelters were single female parent-led families.

Primavera Greyhound Family Shelter
Income at Shelter Entry (%)

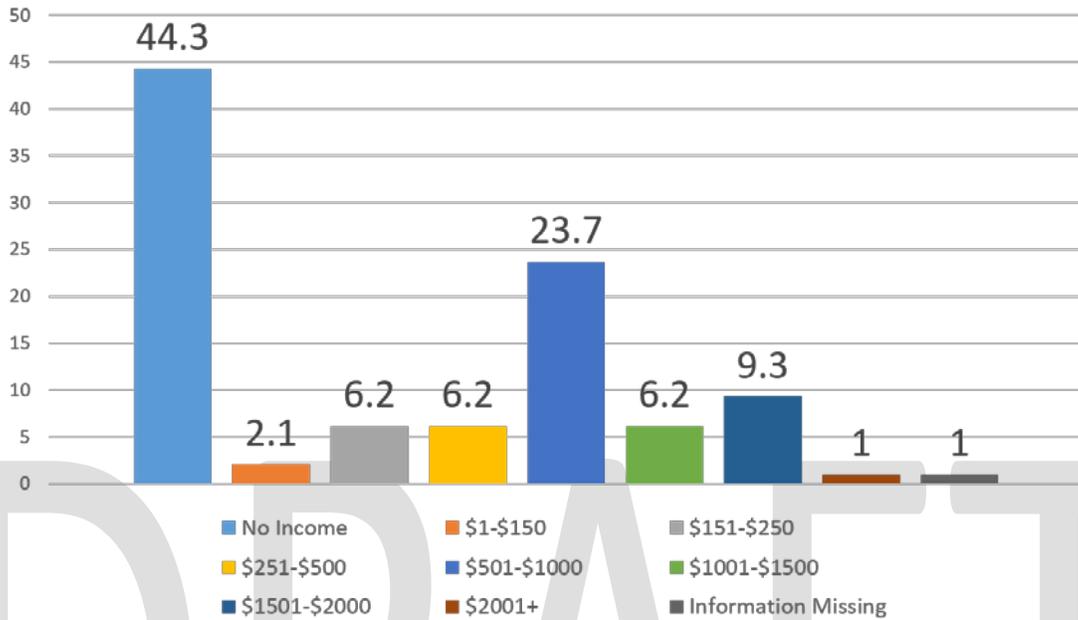


Figure !!. Distribution of income at entry for households at Primavera Greyhound Family Shelter. The most common income level was \$0 per month, or “no income.” The average income was between \$151 and \$500 per month.

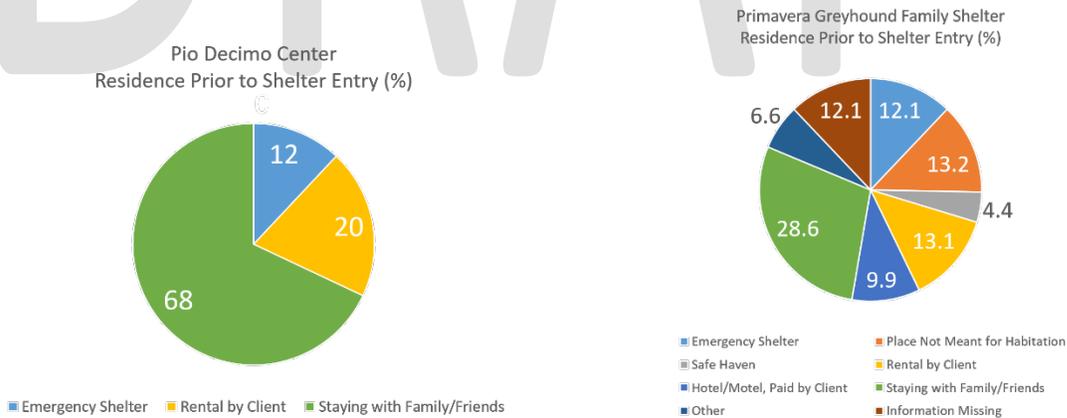


Figure !!. Families’ residence prior to shelter entry for PDC (left) and PG (right) residents in 2016. The majority of PDC residents had been staying with family or friends prior to program entry. This was also the largest group for PG residents, but their prior residence varied more widely than PDC residents’.

TPCH VOTING MEMBERS AS OF MAY 2017

1. American Red Cross
2. Amity Foundation
3. Cenpatico Integrated Care
4. City of Tucson
5. CODAC
6. Community Bridges, Inc.
7. Community Health Associates
8. CPSA
9. Compass Affordable Housing
10. COPE Community Services
11. El Rio Health Center
12. Emerge
13. Esperanza en Escalante
14. Gap Ministries
15. Goodwill
16. Gospel Rescue Mission
17. HOPE, Inc.
18. Hope of Glory Ministries
19. Interfaith Community Services
20. La Frontera Inc
21. MHC Healthcare
22. Old Pueblo Community Services
23. Our Family Services
24. Pima County
25. Pio Decimo Center
26. Primavera Foundation
27. John Roldán, Consultant
28. Salvation Army
29. SAAF (Southern Arizona AIDS Foundation)
30. So. AZ VA Healthcare System
31. Stand Up For Kids
32. State of Arizona (Department of Economic Security)
33. TMM Family Services
34. Tucson Preparatory School
35. Tucson Veterans Serving Veterans
36. Youth On Their Own

Pilot Interviews: Service Providers

Methods

Interviews were conducted with local service providers to understand their perception of the greatest concerns and needs for Pima's population of homeless women and their children. Four of the participating agencies worked directly in homeless or housing services, such as shelters, while the other

provide important perspectives on the varied and systemic needs of this population, particularly since hidden homeless mothers may not immediately seek help from shelters, but may still get support from ancillary services.

During the interviews, the participants were asked about their perception of Pima County's service delivery system, their means of data collection, the new coordinated entry (CE) structure, and their opinions on whether funding in this area was adequate. They were also asked about homeless women's barriers to access (obstacles that make it difficult for women to reach the services they need) and gaps in service for this population (services that are needed but not offered, or that must be improved). Examining providers' perception of what is offered, what is needed, and why services may not be accessible provides an expert perspective on the current system's function, and may also illustrate places in which providers' understanding may be limited.

Overview of Participating Agencies

Providers working directly in homeless/housing services:

- *The Primavera Foundation*: “provides pathways out of poverty through safe, affordable housing, workforce development, and neighborhood revitalization” (Primavera Foundation, “About Us”); emergency and short-term shelters, rental housing, job training
- *Our Family Services*: “providing stability in times of crisis, linking people to support and resources, supporting social connectedness, and engaging our neighbors to tackle tough community issues” (Our Family Services, “Home”); emergency shelter, family reunification services, affordable housing
- *Old Pueblo Community Services*: “offers housing, counseling, and support services to help [people facing homelessness] transform their lives” (OPCS, “About Old Pueblo Community Services”); supportive housing, bridge housing, veteran support, homeless work program, assistance with home ownership; focus on “people struggling to reenter mainstream society after [...] military service, incarceration, substance dependency and/or homelessness” (OPCS, “About Old Pueblo Community Services”)
- *City of Tucson*: “working to address homelessness by providing necessary resources for local agencies and programs” (City of Tucson, “Homelessness”); affordable housing (public housing and section 8 voucher support), rental assistance, supporting local shelters

Providers of ancillary or support services:

- *YWCA*: “eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all” (YWCA Southern Arizona, “Get to Know Us”); job skills workshops, political action, access to menstrual products, work clothes, etc.
- *Emerge! Center Against Domestic Abuse*: “provides the opportunity to create, sustain, and celebrate a life free from abuse” (Emerge!, “About Us”); emergency shelter for women or families fleeing domestic violence, support and educational groups, legal assistance, housing stability programs
- *Pima County Health Department*: “dedicated to help the residents of Pima County achieve and maintain an optimal level of wellness” (Pima County, “Health Department”); behavioral health support and crisis services, Women, Infants, and Children (WIC) program

- *Community Food Bank of Southern Arizona*: “responds to the root causes of hunger and seeks to restore dignity, health, opportunity, and hope to people living in poverty” (Community Food Bank of Southern Arizona, “Who We Are”); emergency food boxes and community meals, community resource centers, skills training

Results

Barriers to stability: some providers suggested that 3-9 months (general time for RRH) is not enough time for families to achieve stability before being made independent again

Some providers suggested that 3-9 months (the time period usually allocated for RRH services) is not sufficient time for families to achieve stability, and that a longer service period was usually needed before families should be made independent again.

-housing first, emphasis on rapid re-housing

Need to focus more on resilience and assets—“a family may come to you with a certain amount of needs but you need to identify what their strengths are... what resources they have is really important.”

Data Collection

The TPCH CE system is relatively new, and one service provider described it as “clunky.” Some providers have experienced problems with receiving client referrals in a timely manner, resulting in families being forced to stay in shelters longer than necessary while waiting to be referred. Providers also noted that most community members, including families in need, are not aware of the CE system or its access points. They may have to do substantial research before they discover a way to enter the CE system and get a referral to the service they need, and if they do not know about the system, they may never reach it at all.

The providers generally agreed that participating in the TPCH HMIS was necessary for coordinated entry (CE) to work effectively, but many still had reservations about its use. Several were concerned with HMIS’s collection of personal, identifying information that could be used to harm residents, particularly in cases of women or families escaping domestic violence. While domestic violence-focused shelters such as Emerge! Center Against Domestic Abuse are not allowed to input their data into HMIS and instead use a comparable but closed system, clients at other agencies who have experienced DV may still be entered into HMIS. Providers worried that the security of the HMIS system may not be adequate to protect the clients it contains. One suggested that one dedicated organization should focus on maintaining data security, in addition to each provider’s responsibility for their own data and clients. While HUD and Pima County provide financial support to CoC agencies when updating their information systems to accommodate the new HMIS shared structure, those funds do not support hiring and training people to supervise the data collection process and HMIS at each agency.

The providers interviewed raised additional concerns about HMIS. For instance, while providers receiving direct support from HUD through CoC funds must participate in HMIS, many providers of ancillary services are not required to participate. This includes organizations like YWCA of Southern Arizona and the Community Food Bank of Southern Arizona. These agencies often capture populations who are not accessing other services such as shelters, and many of their clients are at risk of homelessness or in early stages such as doubling up. In other words, these organizations are a rare

access point for the hidden homeless. Providers noted that opening up HMIS to include these agencies would help connect families to wraparound services, especially at an early point in their experience of homelessness. However, it may open the HMIS data to additional security concerns.

In whatever form it may take, providers emphasized the importance of data collection to their internal functioning. Data collected from participants was used to help understand why clients seek services, as well as the services they have used in the past. This can provide clarity for the long-term outcomes of local programs by pinpointing exiting clients' paths out of services. For example, whether a client enters permanent supportive housing, whether they maintain a subsidized rental, or whether they reenter a shelter later may indicate whether adjustments are needed in the program they utilized. For this reason, data was used as a tool for program planning and general adjustments. For example, YWCA realized they needed more transitional services after analyzing client surveys and post-exit outcomes, so they created an economic empowerment program to help women transition from housing vulnerability into stability. Client data was also used to demonstrate need when seeking funding by showing gaps in service and presenting solutions that might fill those gaps.

Funding

Every provider interviewed said that the current level of funding available for local services was inadequate considering the depth of need in the community. The quantity of funds provided by federal and state sources were not enough to cover everyone who requires assistance, and one provider stated that “it’s like treading water trying to help the amount of people walking through the doors.” Some local resources are theoretically adequate, but not accessible in practice, as a result. The number of affordable housing units (that is, housing provided at fair market rent or FMR) in Pima County could physically accommodate all who need them. A lack of additional funding, however, means providers cannot afford to subsidize rent for everyone who needs it, so the “affordability” of this option is a misnomer.

Funding sources' emphasis on established programs and concerns mean it is difficult to prioritize new issues or develop innovative solutions for subpopulations such as mothers and children. Many providers wanted to offer additional support or wraparound services to help address the subpopulation's additional needs, but were unable to do so because it would take crucial time and funding away from more general—but also more versatile—programs. The lack of flexible funding also contributes to this issue. Funding is generally allocated for specific activities or purposes, and these funding silos prevent money from being reallocated to clients whose barriers may fall outside of rent and utilities. The current funding system is reactive to issues that are well-defined and established, not proactive and intended to prevent problems becoming more widespread. This reactivity means the system is only able to serve women and families in acute crisis, rather than heading off their housing instability at an earlier stage. More flexibility with funding would allow providers to partner with other agencies that address issues of imminent eviction, homelessness diversion, general poverty, and other related issues that tend to precede homelessness. Partnerships such as this would help the service delivery system capture women and their families along the entire spectrum of need, rather than only seeing them at rock bottom.

Barriers and Service Gaps

Of the many barriers to access and gaps in service identified by the providers interviewed, one of the most significant barriers is the current fragmentation of the service delivery system. Services are

located in many different agencies and geographic locations, making it difficult for women to access all the services they need. Providers were confident that the growing CE system should alleviate this problem once it is better established, although its current state was still labeled as somewhat disjointed.

Another major barrier to access for homeless mothers was fear, in a variety of forms. Some providers suggested that mothers may be afraid to access services because they think it might draw the attention of child welfare services. They may also be ashamed and reluctant to expose themselves to judgment or stigmatization because they are “parenting while homeless.” Some families may have even more to fear: the possibility of deportation. While HMIS data cannot be accessed by Homeland Security, ICE, or any other organization that may seek to use it to identify undocumented homeless families (Dan Sullivan and Pamela Moseley, personal communication, 6-16-2017), service users may not realize or believe that. The Community Food Bank of Southern AZ mentioned that they had already received requests from clients to be removed from their database (which at time of writing is not connected to the community’s HMIS) out of fear that they might be tracked down or deported through it. Other services, such as domestic violence assistance, often results in a police record or other documentation of abuse, and women who are undocumented may be afraid that having that legal record puts them at risk. If women are afraid to access services, finding them and helping them can be almost impossible. This also emphasizes the need for confidentiality and data security in the TPCH HMIS. If providers want to convince their clients that accessing services through HMIS is safe, they must ensure that this is the case by protecting the data from tampering or outside viewing—even from other government entities.

While barriers to access and gaps in service are separate concepts, many of them overlapped in the providers’ descriptions. For instance, transportation and childcare were both barriers to access and representative of service gaps. Women have great difficulty reaching service providers, as well as getting to work or running errands, when they have no access to a car and must depend on public transportation (which is not free) or rides from friends. This issue is complicated by having young children, whom mothers must either bring along on trips (a difficult prospect when riding the bus or walking somewhere in the heat) or place them in childcare, which can be prohibitively expensive. Service providers do their best to address this need, sometimes providing bus vouchers or subsidized/free child care assistance. However, much of the funding directed at homeless women and children’s services cannot be used for these purposes, so agencies who wish to provide them must fundraise to support them financially. Often there are not enough vouchers or space in childcare locations to go around.

Some service gaps identified by providers actually already exist in the community, indicating either that those services need to be expanded, or that collaborating providers are not aware enough of what is available from other organizations beside their own. For example, providers mentioned the need for additional support services such as behavioral healthcare, assistance with obtaining SNAP or other food assistance, job training and education, and economic empowerment through savings counseling, legal assistance, and other programs. Many organizations in the community already offer services like this, so providers may be expressing the desire to offer these support services themselves to keep everything in-house or to supplement other providers who may be overburdened. It may also be that these providers are not aware of what else is offered in the community, pointing to a need for better communication amongst CoC participants. The CE system should help resolve this issue since it can automatically refer people to the services they need, rather than relying on human case managers’ ability to know, remember, and recommend any service offered in the CoC.

Other service providers clearly and deliberately asked for expansions of existing programs and services in the community. For example, multiple providers expressed the need for bilingual services, particular in behavioral health services. While the programs may already exist in English at multiple agencies, they are often inaccessible to women who do not speak English. This is a massive obstacle considering that a large portion of homeless women in Pima County are Hispanic/Latina, may be undocumented, and may speak Spanish as their primary language. In addition, there is only one contracted provider of domestic violence (DV) services in the CoC, Emerge!. While other agencies may provide services to people who have experienced DV, DV is not their focus, and they may not be able to incorporate all the unique needs of survivors into their funded programs. Emerge! noted that having only a single contracted DV provider made it immensely difficult to meet the needs of the community. This may especially affect homeless mothers, since the majority of homeless women have experienced DV in their lifetime or as a direct cause of their current housing instability.

Limitations

While the information collected from these service providers gives a valuable perspective of the Pima County service delivery system, there are some limitations of the data. The study surveyed eight providers, only four of which provide direct homelessness services. Many more providers are present in the community; there were 40 voting active members of the TPCH in May 2017, which still does not include the many services that are not officially part of TPCH. More local providers should be interviewed to make this information representative of Pima County providers as a whole.

It is also possible that social desirability bias—the tendency, sometimes unconsciously, to portray oneself in a more desirable light than is fully truthful—plays a part in this interview process. While the interviews were completed as a component of a student project, the project was overseen by Pima County employees. There may have been some concern on providers' part about disclosing what they perceive as the biggest service gaps or drawbacks of the current delivery system to government employees who are partially responsible for their funding.

Last, these interviews were conducted during early 2017, prior to the new US presidential administration. While providers were most likely considering the change in administrative viewpoint when discussing funding issues, etc., additional information has since been released by the federal government that may have affected their answers. For example, the proposed presidential budget for FY2018 completely cuts the Social Services Block Grant and the Community Development Block Grant, and slashes many other funding sources of homeless services. Had this information been available at time of interview, it seems likely that providers' description of funding inadequacies would be much more pronounced.

Pilot Interviews: Shelter Residents

Methods

It is necessary to understand how shelter residents find and use services to ensure that the delivery system is working as intended. Because of this, the County conducted a preliminary assessment of shelter residents' perspective. Two Tucson shelters, Catholic Community Services' Pio Decimo Center (PDC) and the Primavera Greyhound Family Shelter (PG), participated in this assessment. Four mothers from PD were interviewed individually, while six mothers from PG were interviewed together in a focus group setting. All participants completed a quantitative questionnaire covering demographics and financial status (sources of income, employment, etc.). The questionnaire also included validated self-

efficacy and social support rating scales, as these factors were identified as major determinants of entering and leaving the cycle of housing instability. The verbal, semi-structured interviews were comprised of open-ended questions about mothers' current use of shelter and community services, their social support systems, and their perceived obstacles to reaching stability. Mothers were also asked about a hypothetical peer support program designed to build self-efficacy by allowing shelter residents to educate each other about resources as well as to provide emotional support to one another. (For survey and interview questions, see appendix, p. !!)

Overview of Participating Programs

The Pio Decimo Center (PDC) is a multi-phase transitional shelter that attempts to help families “increase their income, enhance their employment, and establish savings” (“Transitional Housing,” CCS). Families begin by living in PDC’s furnished apartments for up to 12 months, then move to unfurnished apartments with PDC’s support for up to 24 months while they develop credit (“Transitional Housing,” CCS). PDC requires its clients to fulfill a number of criteria, including holding employment, utilizing a PDC case manager, and attending community meetings designed to inform residents of local services and resources.

Primavera Foundation’s Greyhound Family Shelter (PG) is a quasi-emergency shelter, one of the few in Tucson that allows families (in particular male adults or teenagers) to stay together. Their eligibility requirements are much less stringent than PDC, but they also allow a maximum stay of 90 days. Each family is provided their own apartment and may access case management services to work toward long-term housing and employment.

Demographically speaking, both PDC and PG serve primarily White Hispanic/Latino populations (see Figure !! in appendix). <Primavera Foundation, 2017> Of all households with children, the majority of both PDC and PG populations are headed by a single female parent (see Figure !! in appendix). In 2016, the average income of a PG resident at shelter entry was between \$151 and \$500 a month, although the most commonly reported income was “none” (see Figure !! in appendix). The average income of a PDC resident was \$21,800 yearly, or approximately \$1817 a month (Sonia Lopez, Pio Decimo Center, personal communication, 3-29-2017). While the majority of PDC residents were staying with friends or family prior to program entry (see Figure !! in appendix), residence locations prior to entry were more varied for PG, possibly because it is an emergency shelter and has less stringent entry requirements (see Figure !! in appendix). However, the largest group in PG was also those who stayed with friends or family.

Table !!. Comparison of overall populations of Primavera Greyhound Shelter (PG) and Pio Decimo Center (PDC) during FY2016. Whenever source data distinguished between households with and without children, only the data from households with children were included.

Characteristic	Primavera Greyhound Shelter	Pio Decimo Center
Number of families housed	64 during 2016 (avg. 10 at a time); 61 families with children	34
Average family size	4.02	3.74
Average age of head of household (HoH)	35.64 years	35 years
Average income level at entry	Between \$151 and \$500/mo	\$21,800/yr / \$1816/mo

Average length of stay	Between 31 and 180 days	11 mo in Phase 1 (furnished apts), 20 mo in Phase 2 (unfurnished + utility payments)
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Results

The results of the interviews, focus group, and surveys are summarized in Table !! below. Similarities between Pio Decimo and Primavera results are highlighted in yellow.

Social Connections

A few findings from the interviews and surveys are particularly illuminating. Both groups expressed a lack of strong relationship between themselves, their immediate family (children and partners/spouses), and their more distant family. This is common among homeless mothers, who tend to have very low family and social support. Similarly, women from both PDC and PG said that they received very few invitations to spend time and do activities with others, compared to the other types of social support they received. This is unsurprising, since many of the women said they were too busy working, looking for jobs, or looking for housing to spend time socializing with friends. This points to a potential need for connection and friendship between shelter clients, who are experiencing similar social difficulties and time constraints, and may be able to offer support to each other (and already do, in the case of the PG focus group, who were close prior to the interview process). PDC addresses this need somewhat through staff-client interactions. Multiple PDC residents mentioned that they viewed the staff as trustworthy and helpful allies, and even as friends. This relationship was much less pronounced for PG residents. This is most likely due to the differing nature of emergency or short term shelters vs transitional shelters, as well as the vastly different length of stay allowed at the two shelters. As PG’s short-term setup does not allow long-term relationships to form, the lack of connection between staff and residents (or amongst residents) is not a fault of the shelter’s staff. However, it may point to an opportunity to bring a more deliberately social aspect to the case management process, or at least to the day-to-day operations of PG and other similar shelters.

Barriers

While the issue of social isolation is important, the residents also identified more tangible needs and desires for the shelter. Both PDC and PG residents expressed a wish for Wi-Fi internet access at the shelter, since most housing, employment, and service searches are now conducted online. Multiple residents at both shelters said they were forced to go to the public library for internet access, which could be difficult given a lack of transportation and the complications of bringing children on public transit. The PG participants also mentioned that attending job interviews or running other errands could be difficult as a mother, because it may not always be possible to take your child, but the other PG residents are not allowed to babysit due to liability issues for PG. They suggested that PG offer a childcare service, or potentially offer a program where selected residents could become certified as caregivers for children and run the childcare service themselves while supervised by PG staff.

Finding and Accessing Resources

Knowing which resources are available and understanding how to access them was a major issue for women at both PG and PDC. The PDC participants generally appreciated the mandatory monthly meetings about local resources such as Habitat for Humanity, as well as the staff’s regular communications about helpful events. However, multiple residents were still often confused about

which services they were eligible for, how they could apply for them, and looking for additional resources on their own. Their ideal program would provide assistance with all these issues. PG residents had similar difficulties with finding and applying for services. They said their case managers were overworked and were not always able to spend as much time thoroughly explaining services as the clients wanted or needed. This was particularly a problem for residents from out of town or out of state, who had no prior knowledge of available shelters or programs or even of geographic locations of services. Some residents had done their own research and found a number of resources that they shared with the other mothers present at the focus group, many of whom were not familiar with these new options. This demonstrates the promising possibility of some peer support system wherein residents pool their knowledge and understanding, increasing everyone’s access to services without overburdening case managers who are already struggling.

Table !!. Comparison of results from qualitative and quantitative questions between Pio Decimo Center interviews and Primavera Greyhound Family Shelter focus group. Responses shared between both shelters are highlighted in yellow.

Topic	Pio Decimo Interviews	Primavera Focus Group
Demographics and General Information	Age: 25-46, average 33.75 yrs Race/Ethnicity: majority Hispanic, one biracial (Hispanic/White) Family: all had children with them; one spouse, one long-term partner living with them	Age: 31-47, average 38.5 yrs Race/Ethnicity: White majority; also Black, Hispanic, Asian (one each) Family: all either had children with them or were currently pregnant; generally do not have long-term partners or spouses
Financial Status	Employment: majority employed, all employed income above \$1000/month Benefits: all SNAP or child support	Employment: all unemployed Benefits: if any, TANF/SNAP or child support
Shelter Experience	Length of Stay: majority 1+ yr Previous Shelter: none--all were first-time homeless shelter users	Length of Stay: 3 mo max, one came in two days prior to meeting Previous Shelter: two women used shelters out of state; Gospel Rescue Mission, Tucson
Self-Efficacy (a person’s belief that they are capable of carrying out a task or achieving a goal)	Resiliency: difficulty staying positive through tough problems, overcoming discouragement when nothing works Family: very low scores for connecting with larger family, some trouble staying confident through difficulty Overall: Noted that they might be more motivated to make progress than other people in shelter	Resiliency: highest scores on bouncing back after failing; some trouble keeping spirits up, staying positive Family: on average lower than resiliency; lowest scores on supporting each other through stress, bouncing back quickly, connecting with larger family Overall: mentioned that repeatedly explaining your story to service providers without receiving benefits was exhausting and discouraging
Social Support (the networks to which a person belongs and from which they receive assistance; can be formal, like the shelter or service provider, or informal, like family or friends providing financial or emotional support)	Most support: useful advice about life Least support: invitations to do things with other people Overall: individual quant. answers varied widely; sense that hanging out with friends is a waste of time and should spend that time working; saw PD staff as friends/confidantes; variation on whether family was supportive or a negative influence they were trying to escape (either through physical abuse/violence or through “drama” that made it hard for women to function independently)	Most support: people who care about me Least support: invitations to do things with other people Overall: individual quant. answers varied widely; group relies on each other for assistance and companionship; variation in whether the extended family was supportive or a negative influence they were trying to escape (either through physical abuse/violence or through telling women they were worthless, would always be homeless, etc.)
How to Find Resources and Services	Sonia (admin at PD) provides info to residents; looking online on their own	Case manager at PV; other shelter residents (esp. members of this focus group); looking online on their own; feel they are not informed about enough resources by case manager and PV admin

Use of Services in Community	Public library , psych. services, primary care, food boxes, WIC, TMC, El Rio	Food banks, public library , daycares, bus, CODAC, COPE
Best Aspects of Shelter Programs/Services	Weekly educational meetings (mandatory) Kindness and helpfulness of staff (esp. Sonia)	Providing toiletries Letting family stay together Information about budgeting/bank accounts
What Services Are Needed/Desired in Shelter	Internet access at shelter Laundry at shelter Assistance understanding what resources are available (through shelter and community) and how to apply	More timely and detailed explanations of available resources by case managers and shelter staff Internet access at shelter Clearer list of resources for residents from out of town/state who are unfamiliar with local services Better transportation to/from services (esp. with small children) More staff in general
Obstacles to Stability	Down payment for buying a home Personal struggles--physical or mental illness, trauma from past experiences or being homeless Family cycle--grew up transient or homeless, have trouble breaking that habit	Credit applications (esp. re: prior evictions) Difficulty making payments when ineligible for other benefits (due to evictions, convictions, etc.)
“What keeps you going?”	Kids and wanting to give them a better life, wanting to break family cycle of homelessness Self-motivation and personal goals	Support of other women in focus group Kids and wanting to break family cycle of homelessness
“What would you want to see in a program designed to provide resources, assistance in accessing resources, and peer support?”	Emotional support Explanation of how resources are used/accessed Skills like résumé building May not need to be led by peer (homeless mother), having multiple leaders from different places (Habitat for Humanity, Section 8, etc.) could provide useful perspectives	May not need to be led by peer (homeless mother), most important thing is that mentor tries to understand participants’ circumstances and feels compassion/empathy for them Explanation of how resources are used/accessed Discussion of offering childcare for mothers who have appointments, etc., and can’t bring kids?
General Notes	The sense of responsibility toward PD environment--watching out for suspicious activity, helping each other, etc. Open with interviewers, but expressed difficulty sharing feelings or worries (most said they have improved on this since entering PD) Expressed long-term personal/professional goals, had already taken steps toward these (or could at least identify needed steps)	Close-knit group, wanted more opportunities to help each other but were limited by PV protocol (not entering each other’s apartments, etc.) Wanted to share information with all residents Expressed long-term personal/professional goals but seemed discouraged about difficulty reaching them

Limitations

While these results provide a valuable starting point for evaluating services and needs in the community, they may not be representative of the larger population of homeless mothers and their children. The participants were not randomly selected, and in PDC’s case were offered the opportunity to participate based on an administrator’s perception of which clients would be most likely to speak thoroughly and comfortably on their experiences. Further, since no one approached was required to participate, the interviewees were also self-selected. This may mean that the women who chose to participate might be more assertive, more communicative, more open, and more comfortable talking about their histories than the average shelter resident. The women themselves, particularly from PDC, mentioned that they perceived themselves as working harder to become independent than other residents, identifying yet another way that this group may have differed from the population. Due to time constraints, the samples from both shelters were also too small to be representative. Future data collection should strive to be more representative, ideally through random sampling and a larger participant pool. However, randomization is difficult with this population, as many homeless women

have been through significant trauma and may not feel safe discussing their experiences. Because of this, self-selection to some degree is unavoidable.

It is also important to remember that while the women are not representative of the shelters in which they live, the shelter selection is also not representative of the average experience of a homeless mother. Only two shelters were selected for this process, again due to time constraints, and there may be factors that make those shelters different in some way compared to others (for example, PDC's status as transitional housing, compared to emergency or short-term shelters) and therefore not representative. Women participating in a transitional shelter program are further along the path to stability than are the women from a short-term shelter, so their self-expressed needs are different. For example, while PDC women mentioned that their biggest obstacles to stability were the ability to save up the down payment for buying a home, home ownership was not on the radar for women from PG, who were more concerned with finding anywhere to stay after their three months at PG had expired. These differences mean that, while some experiences may be shared between all homeless women regardless of the program they are part of, there may be factors that make them incomparable, and trying to combine their experiences would oversimplify their situations.

The study was also limited to sheltered women, since they are easier to locate and approach through a nonthreatening channel (the service provider itself). As homeless mothers are highly likely to be "hidden" by staying with family or friends, or by sleeping in hotels or cars, interviewing only sheltered women excludes a large part of the population. However, interviewing these hidden mothers is difficult for the same reason counting them is difficult: it is impossible to locate them or know that they are present in a community if they do not make themselves known by accessing services of some kind. Future efforts to interview homeless mothers should make an effort to find services utilized by the hidden homeless and consider those as a possible entry point for finding participants.

Comparison of Perspectives

Multiple needs were identified by both service providers and their clients as major or unaddressed concerns. This indicates that providers have a reasonably accurate understanding of the difficulties their clients' experiences, although they may not be able to address those difficulties due to funding, staffing, etc. For example, both groups identified transportation as a major issue. Providers knew that transportation was a barrier for their clients that prevented them from accessing services or employment. However, bus vouchers and other assistance with public transportation are limited resources and providers do not have much money to devote to them. Similarly, both groups understood that lack of childcare could stand between a woman and her ability to become stable, but not every shelter is capable of providing their own childcare or securing financial assistance for their clients to pay for external care. It is possible that transparently communicating these limitations to clients might ease their minds and help develop a trusting relationship, since they would know providers are listening to them and understand their worries.

While providers and residents shared some concerns, each group noted things that were not mentioned or prioritized by the other group. When discussing how they access or use resources, no residents mentioned the continuum of care, supporting the providers' opinion that residents are not aware of it or how it can help them. The details of the Tucson CoC may not be helpful for residents to know, but at least knowing about access points or the basic idea of being referred to services no matter where you go might make the process of seeking services easier. It may be necessary for the TPCH to

focus on becoming more visible and accessible to residents who do not know where to start looking for help. Relatedly, providers mentioned that the current fragmented system of care (too many agencies doing interrelated activities with too little communication) could be an obstacle to service access, but residents were more concerned with learning about resources in the first place. In general, this meant they either did not know where to look for resources, or the places they looked (websites, case managers, etc.) did not give them sufficient information. Women who were able to locate their own resources almost universally said it was through online searching (often through their phone, since the shelters surveyed did not have Internet access). However, not everyone has the knowledge needed to search effectively for services. Even if they are skilled at using Internet search engines to find information, they may not know what services they qualify for, or what resources would be most helpful for their situation. If case managers' information is also incomplete, or they are too pressed for time to be thorough with their clients, residents will miss valuable opportunities. This may create additional costs for the shelter in the end, since it could mean the family stays longer rather than finding a resource that helps them leave early.

Another imbalance between provider and client perception was the issues of trauma, fear, and shame. Providers noted that homeless mothers might be afraid or ashamed to seek out help, worried that their children might be taken away or that they will be judged a "bad parent." Residents agreed, but pointed out another aspect of the fear of accessing services: disclosing their pasts in order to enter the service system. Residents have to repeatedly disclose their pasts, including traumatic experiences, to provider after provider in order to be placed in the correct service. Interview participants mentioned telling their story to 211 operators, during initial assessment by providers, to their case managers, and to providers of wraparound services. Being forced to relive a traumatic experience such as domestic violence or sexual assault (or, sometimes, the experience of homelessness itself) can distress or retraumatize a person, and is strongly recommended against by trauma-informed care standards (Fallot and Harris 2006). Service providers did not mention this as a reason for concern. The coordinated entry process may reduce unnecessary repetition of trauma, since the information collected during a VI-SPDAT or full SPDAT can often be shared between a client's various service providers via HMIS. While information about domestic violence is not entered into the shared HMIS, at least clients experiencing DV will be directed to the correct services as quickly as possible, rather than floundering from agency to agency repeating their story everywhere they go. However, the success of this plan depends on whether women know where to seek services, or whether 211 operators and other resource access points know where to send them.

Clients occasionally offered solutions to their obstacles that may not have been considered by providers. Regarding childcare, a few residents suggested that they or other shelter residents could be trained and certified as childcare professionals. This would give mothers who are seeking or attending work an opportunity to leave the shelter, and mothers who are still in the shelter would still have a way to make some money by working. The clients understood that this may be impossible due to providers' concerns about liability, but wanted to be able to support each other in this kind of fashion. However, there may be other positions with fewer risks where optional volunteer or paid work from shelter residents may benefit an understaffed and overworked agency. In particular, offering opportunities like this may help residents build their self-esteem and self-efficacy while working around their unique needs and schedule, as well as helping build a support network amongst residents. However, it may be important not to make these a requirement of receiving services, because not every resident will be

interested in or capable of performing the required tasks. A plan like this may operate more easily in transitional housing than in emergency shelters, where the high turnover of residents might make training inefficient.

1. What is your age? _____
2. How do you identify your race/ethnicity? (Check all that apply)
 - ___ White
 - ___ Hispanic/Latino
 - ___ Black or African American
 - ___ Native American or American Indian
 - ___ Asian/ Pacific Islander
 - ___ Other
3. Are you employed? (Yes / No)
4. What is your monthly income? (Check ONLY ONE)
 - ___ no income
 - ___ \$1-\$150
 - ___ \$151-\$250
 - ___ \$251-\$500
 - ___ \$501-\$1000
 - ___ \$1001-\$1500
 - ___ \$1501-\$2000
 - ___ \$2001+
5. Do you receive any of the benefits listed below? (Check all that apply)
 - ___ SSI
 - ___ SSDI
 - ___ Veteran's disability
 - ___ Private disability insurance
 - ___ Worker's comp
 - ___ TANF, SNAP or equivalent
 - ___ Retirement (Social Security)
 - ___ Veteran pension
 - ___ Pension from former job
 - ___ Child support
 - ___ Alimony (spousal support)

___Unsure

___None

5a.. What other income, if not listed, do you receive? _____

6. What is the makeup of your immediate family (you, partner/spouse, children, etc)?

Options (Check all that apply):

___Spouse (with me in the shelter)

___Spouse (not with me in the shelter)

___Long-term partner of 1 year or more (with me in the shelter)

___Long-term partner of 1 year or more (not with me in the shelter)

___Biological Child (with me) -- # children, age(s)

___Biological Child (not with me) -- # children, age(s)

___Additional relatives not listed (if any): _____

7. Is this your first time in a homeless shelter? (yes / no)

8. If yes, how long you've been in the shelter _____months _____yrs

9. If no, where else have you received shelter related services?

-SELF-EFFICACY QUESTIONS:

Rate your level of confidence in each skill by writing a number from 0 to 100 using the scale below.

0 Can't do at all, 50 moderately can do, 100 highly sure I can do

Resiliency of Self-Efficacy

1. keep tough problems from getting you down___
2. bounce back after you tried your best and failed ___
3. get yourself to keep trying when things are going really badly ____
4. keep up your spirits when you suffer hardships _____
5. overcome discouragement when nothing you try seems to work _____

Family Self-Efficacy

How well, working together as a whole, can your family:

1. support each other in times of stress_____
2. bounce back quickly from adverse experiences_____

3. build trust in each other_____
4. get the family to keep close ties to their larger family_____
5. remain confident during difficult times_____

-SOCIAL SUPPORT

Here is a list of some things that other people do for us or give us that may be helpful or supportive. Please read each statement carefully and place an X in the blank that is closest to your situation.

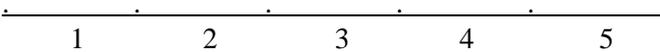
Here is an example:

I get...

Enough vacation time

Much less than
I would like

As much as
I would like



If you put an X where we have, it means that you get almost as much vacation time as you would like, but not quite as much as you would like.

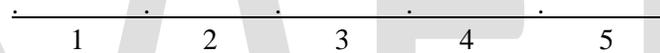
ANSWER EACH ITEM AS BEST YOU CAN. THERE ARE NO RIGHT OR WRONG ANSWERS.

I get....

People who care what happens to me

Much less than
I would like

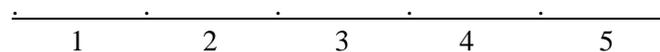
As much as
I would like



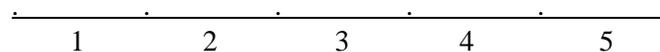
Love and affection



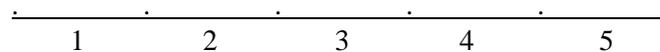
Chances to talk to people
I trust about my personal and family problems



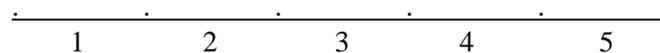
Chances to talk about money matters



Invitations to go out and do things with other people



Useful advice about important things in life



QUALITATIVE/OPEN-ENDED QUESTIONS

BACKGROUND

We are trying to understand what factors can lead mothers and families into and through the process of homelessness and find housing. What is your story, if you're comfortable sharing? (Make it very clear that they do not have to share their pasts if it makes them uncomfortable, just as they do not have to answer any other question we ask if they do not want to.)

SERVICE USE:

Which services do you currently use in the community? (shelter, job assistance, skills building, medical, etc)

How did you find out about them?

Which were the most/least helpful?

If you had a friend go through this experience, what would you recommend that they do or where would you tell them to go?

What services do you use through (shelter)? For example, do you just stay here overnight, or do you use job-seeking services, housing placement assistance, anything like that?

(if yes) How did you find out about them?

Which are the most/least helpful so far?

SOCIAL SUPPORT

Is there anyone that you feel comfortable talking to when you have a problem you cannot resolve on your own? What is an example of a problem you would have trouble resolving on your own?

If yes, who? What situation would you seek them out for?

PROGRAM DEVELOPMENT OPTIONS

If you had to list two or three things that were the biggest obstacles for you getting permanent stable housing, what would those things be? They can be internal or external.

What do you think are a few of the biggest things that are helping you get through this experience? They can be internal things, like aspects of your personality that make you strong, or external things, like friends or a service you use.

We are considering developing a program that would involve training homeless mothers to be peer mentors for other people living in shelters, and holding a support group where the mentor provides resources and information to the group and they can provide emotional support for each other. If this program existed, what would you want it to look like?

What kind of person should run it?

What would you want it to focus on (providing information, emotional support, both)?

Would you want to attend something like this? Why or why not?

DRAFT