BUILDING ON STRENGTHS AND ADVOCATING FAMILY EMPOWERMENT (BSAFE):
An Intervention to End Family Homelessness
IMPLEMENTATION GUIDE

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The Building on Strengths and Advocating Family Empowerment (BSAFE) model was developed over many years as we learned more about what families need to move back into the community and stabilize and thrive in permanent housing. Along the way we received input from many sources. We want to thank our friends and colleagues at the Center for Social Innovation (C4) and The National Center on Family Homelessness (NCFH) for their contributions to the BSAFE model. At C4, Molly Richard, Mary Poor, and John Kellogg contributed substantially to editing the manual, and Kristen Nichols provided graphic design. At NCFH, Kathleen Guarino, Rose Clervil, and Beryl Ann Cowan offered invaluable clinical and practical guidance in the early days of developing BSAFE. Our thanks also go to pioneers of Critical Time Intervention (CTI), upon which BSAFE is designed; Dan Herman and Sally Conover of the Silberman School of Social Work at Hunter College; and Judith Samuels, who led the way in studying how CTI can work for families. Most of all, we are grateful to the hundreds of homeless families with whom we have worked over many decades. They taught us about strength and resiliency and have shown us how people can move beyond the devastating experience of homelessness to reconnect with family, friends, and community.

ACKNOWLEDGMENTS

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Building on Strengths and Advocating Family Empowerment (BSAFE) is a housing and case management intervention designed to support families and children who are homeless or formerly homeless as they transition back to the community. BSAFE addresses the needs of all family members and tailors the approach to their strengths, needs, goals, wishes, and priorities. Its goals are to help families

- Stabilize in community-based permanent housing
- Ensure physical and emotional safety
- Become economically self-supporting
- Work towards family preservation
- Enhance the well-being of parents and children

Provided during the transition from homelessness into permanent housing, BSAFE integrates community-based services and social networks, as well as broader systems of medical and behavioral health care with housing, education, and employment. This family-oriented, trauma-informed, recovery-oriented intervention is designed to strengthen child and family coping skills, relationships, and support networks.

BSAFE is a focused, time-limited, 12-month housing and case management intervention. The model begins with a process of engagement, assessment, and provision of supports (pre-BSAFE) while a family is still in emergency shelter or other transitional situations. During Phase 1 it moves into the context of permanent housing. In Phase 2 BSAFE focuses on creating opportunities that strengthen community connections. Finally, in Phase 3, it transfers the care to the families themselves and to community supports.
The staffing of the BSAFE team can vary to fit the needs of each program or community. BSAFE case managers can be part of Community Outreach Teams similar to CTI; they can also serve multiple shelters and transitional facilities in each community. Alternately, BSAFE case managers can be hired as part of a program’s staffing structure, similar to a program-based family stabilization team. A case manager (the BSAFE Partner), in coordination with the BSAFE team, oversees the intervention. The BSAFE team works with families from their stay in shelter into permanent housing and provides a framework for case management interventions that integrate the need for housing and services for all family members.

THE PHASES OF BSAFE ARE AS FOLLOWS:

PHASE 1:
Transition to Community (4 months)

As soon as housing is secured and the family moves into permanent housing (e.g., Housing First, Rapid Re-Housing, Section 8, Housing Choice Voucher), Phase 1 begins. This is the first of 3 time-limited (4 month) phases. During Phase 1, the BSAFE Partner supports the family in obtaining household supplies, ensures that children are enrolled in school, and stabilizes all family members in their new setting. The parent(s) also work with the BSAFE Partner to review the assessment findings and modify the service plan if necessary, and to focus on 3 to 5 concrete goals that are most likely to ensure stabilization. During Phase 1, the BSAFE Partner makes multiple referrals and mobilizes community-based programs to support the family in achieving its goals. BSAFE services and supports are provided by frequent home visits, telephone check-ins, and, when necessary, accompanying the family to appointments.

PHASE 2:
Strengthen Connections (4 months)

During Phase 2, which begins in month 5, the BSAFE Partner strengthens relationships with potential community partners, explores available resources and services, and ensures that families are connected with appropriate community services and supports. Phase 2 focuses on making sure adequate supports are in place so that the family will achieve its goals. The BSAFE Partner seeks programs that offer continuous, coordinated, and flexible care and are motivated to work with families who have experienced homelessness. As the family connects to community resources, frequency and duration of visits begin to decrease.

PHASE 3:
Solidify and Transfer Care (4 months)

During Phase 3, the final phase, the BSAFE Partner works with families to consolidate new skills and connections, solidify relationships with community service providers, and become self-directive. As the family becomes increasingly independent and integrated into the community, the BSAFE Partner and team gradually
transfer responsibilities to the family and to community-based programs. During this Phase, hands-on support from the BSAFE Partner and team taper. The transition should be complete 12 months after the family has moved into housing.

Pre-BSAFE: Engage, Assess, Support
Families in shelter experience many stressors: length of stay is often long, rates of maternal depression are extremely high, and many children are at critical developmental stages and may be adversely affected by long stays in shelters or motels. The pre-BSAFE (or BSAFE in Shelter) phase starts the day a family is admitted to a temporary housing facility (e.g., shelter or transitional housing program). During this period, the BSAFE Partner engages the family and shelter staff in assessing immediate housing and safety needs; building collaborative, trusting relationships among family members, staff, and the BSAFE team; and developing plans for connecting family members to housing, services, and supports. In addition, during this period, BSAFE teams support the provision of trauma-informed care, identify and address maternal depression, ensure that parenting supports are in place during the family’s shelter stay, and identify and begin to address the developmental needs of children.

BSAFE is modeled upon Critical Time Intervention (CTI), an evidence-based, time-limited, phased treatment approach developed to bridge the service gap for people with serious mental illness as they move from homelessness into housing. (Herman, Conover, Felix, Nakagawa, & Mills, 2007; Shinn, Samuels, Fischer, Thompkins, & Fowler, 2015). CTI helps individuals transition into housing by providing case management and emotional and practical supports that ensure connections to essential community resources. Designated an evidence-based practice by SAMHSA's Registry of Evidence-based Programs and Practices (NREPP), CTI addresses the needs of individuals who formerly experienced homelessness and are now in permanent housing by building a network of supports and services that
ensures stability and well-being. It is one of the few evidence-based interventions designed specifically for people who have experienced homelessness.

A complete training and implementation package accompanies the BSAFE intervention; it equips providers with the tools to assess family needs, engage families in services, develop housing/service/support plans, and help families build skills and connections to community supports. BSAFE training provides critical information that providers can use to anchor and inform their work, including parent and child assessment; housing programs such as rapid re-housing, Housing First, and permanent supportive housing (PSH); service and support planning; parenting supports; child development and early intervention; mental health and substance use supports; service user involvement; and best practices such as trauma-informed care and motivational interviewing.

Many programs serving homeless families and children do not have sufficient resources to implement all components of BSAFE. Although we strongly recommend that the entire BSAFE housing and service package be implemented, the full program may have to be put into place more gradually as resources become available.

Permanent housing is an essential foundation of BSAFE and must be implemented. Additionally, comprehensive assessment of each family member must be conducted as delineated in the BSAFE model in order to understand the needs of all family members, ensure adequate services, and increase the likelihood of positive outcomes for families.

At a minimum, programs with limited resources should initially commit to implementing three other BSAFE components:

1. Organizational trauma-informed care
2. Parenting supports
3. Family-centered, developmentally appropriate services for children

Because implementation of these three components represents shifts in philosophy, culture, and attitudes within organizations, these can begin with staff training in each of these areas. Training can be a feasible and affordable way to target limited resources.

For more information about the BSAFE intervention and training and implementation resources, please contact info@center4si.com or 617-467-6014.
WHAT IS BSAFE?

Building on Strengths and Advocating Family Empowerment (BSAFE) is a promising practice designed to address the needs of families and children who are homeless or formerly homeless as they transition into the community and stabilize in supportive housing. Developed within a social ecological framework, BSAFE emphasizes the integral connection among permanent housing, the health and well-being of families and children, community-based services and social networks, and broader systems of care. This trauma-informed, family-centered intervention is designed to strengthen child and family coping skills, relationships, and support networks in order to ensure family stability and well-being. BSAFE is designed to address the needs of all family members and to tailor the approach to their strengths, needs, goals, wishes, and priorities.

The structure of BSAFE is modeled after Critical Time Intervention (CTI), a time-limited, phased treatment approach that was originally developed to bridge the service gap for people with serious mental illness as they moved from shelters and institutions back into the community (Herman et al., 2007). CTI helps individuals and families transition by providing case management services and emotional and practical supports that ensure connection to essential community resources (New York Presbyterian Hospital and Columbia University, n.d.). After providing essential supports and services to families in transition, it is then divided into 3 phases, each 4 months long. The first phase focuses on the transition back to the community and developing a working relationship with the client and a housing/service plan. During Phase 2 the proposed services are “tried out” to ensure that adequate linkages are in place. Once this is accomplished
and the plan is implemented, the client enters the final phase in which care is fully transferred to the community.

Designated an evidence-based practice by the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Registry of Evidence-based Programs and Practices (NREPP), CTI addresses the need to build a network of supports and services that ensures the stability and well-being of people experiencing homelessness in permanent housing in the community. Dr. Judith Samuels expanded the model for mothers experiencing homelessness with mental illnesses and substance use disorders and called it Family Critical Time Intervention (FCTI), but it has not yet been implemented widely (Shinn et al., 2015). Furthermore, FCTI focuses primarily on the process of transitioning back to the community, while BSAFE expands this model by addressing the unique needs of families and children residing in transient situations as well as during and after their move back to the community.

The evidence-based practice of CTI provides the scaffolding for BSAFE, which serves families experiencing homelessness. Similar to individuals, the transition into permanent housing and the connection with community-based supports and resources is critical for stabilizing families over time. In many communities the demand for affordable housing often exceeds the supply, and many families end up in shelter for long periods. The pre-BSAFE phase begins while the family is residing in shelter, focuses on assessment and providing essential supports and services, and may be more prolonged since it depends on the availability of housing. Furthermore, because families consist of both adults and children, we have increased the intervention to 1 year, consisting of 3 phases of 4 months each.

BSAFE can be readily integrated with rapid re-housing. For young children, lengthy stays in shelters can have an adverse impact. Since the case managers will be working with families that have multiple members and complex needs crossing diverse systems, the case managers may require additional time to coordinate housing as well as services. Other modifications in the CTI model are based on the unique needs of families and their children and the settings in which BSAFE may be implemented (e.g., Section 8 Housing, scattered sites, emergency shelters, transitional housing, permanent supportive housing).
The primary goals of the BSAFE intervention are to connect families and their children who are experiencing homelessness with community-based housing, services, and supports as they transition back to the community. It provides a framework for case management interventions that integrate the need for rapid re-housing and services for all family members.

BSAFE promotes
- Housing stability
- Physical and emotional safety
- Economic self-support
- Family preservation
- Parental well-being
- Child development, self-regulation, and educational success

BSAFE is a 12-month phased intervention. Pre-BSAFE occurs in the context of shelter or transitional programs, focusing on engagement, assessment, trauma-informed care, and parenting supports.\(^1\) Phase 1 begins with the transition to housing and includes a continuing assessment of a family’s housing, service, and support needs followed by referral and connection to community supports. During Phase 2, these connections can begin to form the network that families will need to stabilize in the community. Phase 3 solidifies ownership of housing and services with the family and fully transfers care to community supports. Finally, BSAFE can be used as a homelessness prevention strategy in various subsidized housing settings such as public housing.

In addition to the benefits described above, BSAFE minimizes costly contacts with other systems such as child welfare, criminal justice, and hospital services. The BSAFE intervention can accomplish this in various ways. For example, family members who have primary care physicians with whom they maintain regular contact may have fewer emergency room (ER) visits. Screening for child maltreatment and providing organizational trauma-informed care will reduce the need for involvement with the child welfare system. Providing parenting supports may minimize adverse child outcomes.

WHO ARE THE BSAFE CASE MANAGERS?

The staffing of the BSAFE team can be accomplished in a variety of ways to fit the needs of each program or community. BSAFE case managers can be part of Community Outreach Teams, similar to CTI, who serve multiple shelters and transitional facilities in each community. Alternately, BSAFE case managers can be hired as part of a program’s staffing structure, similar to a program-based family stabilization team. The team coordinates the pre-BSAFE phase with the shelter staff and then continues to work with the family upon transition to

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\(^1\) Given the high rates of traumatic stress in the lives of families who experience homelessness, an essential component of quality care will include organizational assessment and training on trauma-informed care (see Appendix I for a description of the TICOMETER©, developed by the Center for Social Innovation).
the community. Each program determines a staffing structure for the BSAFE team that aligns with available resources.

After arriving at the shelter, each family is assigned a BSAFE Partner (e.g., case manager, case worker, social worker) who collaborates with the organizational intake worker to complete an assessment. Whenever possible, the same BSAFE Partner works with the family before, during, and after their transition into the community—until the family is well connected with adequate supports. Together, they identify needs and challenges, set goals, plan housing/services/supports, and connect families to community resources. This process is continuous and should reflect changing needs, especially if shelter stays are lengthy. For families with children who have more intensive needs (e.g., mental health conditions, developmental delays), a child advocate can also be assigned. The child advocate works in partnership with the BSAFE Partner but focuses primarily on coordinating child services. It is critical that the BSAFE Partner and the child advocate work closely together. However, in under-resourced settings the allocation of additional staff may not be feasible. Since the needs of many families are extremely complex, it is important that a clinical supervisor be part of the BSAFE team. Supervisors should have experience with a range of health, mental health, substance use, and trauma issues. It would also be helpful if the supervisor has experience working with both adults and children.

In general, the ratio of families to BSAFE Partners should be approximately 10-15 to 1, but may also depend on family composition and resources, as well as the availability of the shelter case manager and the division of responsibilities. In Phase 1 when the Partners are working closely with families following transition to housing, the workload will be more intensive. In contrast, in Phase 3, as families transition into community-based services, the roles of the Partners may require less time. In the family CTI model, researchers found that during Phase 1 each family case was the equivalent of 2 cases in which usual services were provided, in Phase
2 each family case was the equivalent of 1 case, and in Phase 3 each family case was the equivalent of one-half of a family receiving services as usual (Shinn et al., 2015).

WHAT TRAINING AND SUPERVISION IS NECESSARY?

A complete training package accompanies the BSAFE intervention and is designed to offer the necessary education to help providers assess family needs, provide critical services and engage families, develop housing/service/support plans, provide and transfer resources and supports, and help families build skills and solid connections to community supports. The training associated with the BSAFE intervention provides critical information that providers can use to anchor and inform their work. The training includes strategies and topics relevant to working with families experiencing homelessness (Bassuk, DeCandia, Beach, & Berman, 2014) including:

1. Assessment;
2. Housing issues, such as rapid re-housing and eligibility for permanent supportive housing (PSH);
3. Service and support planning; and
4. Special topics relevant to working with families, including parenting supports, child development and early intervention, mental health and substance use issues, service user involvement, and best practices such as trauma-informed care and motivational interviewing.

It is recommended that staff members at all levels of an organization receive BSAFE trainings. Supervisors and case managers will then have a similar level of knowledge regarding the intervention and needs of the families. To ensure that members of staff are able to convert knowledge into skills that drive their everyday practice and that the principles of BSAFE are readily implemented, it is important that ongoing trauma-informed supervision be available.

THE CRITICAL ROLE OF HOUSING

Housing is the foundation for ending family homelessness. Housing provides safety, stability, privacy, comfort, and predictability for children and their parents. It also provides refuge from chaos and confusion and improves health and well-being. Housing makes it easier for parents to obtain and maintain stable employment and for children to do well in school. Housing provides a platform for connection to family, friends, neighborhood, and community.

Without safe, decent, affordable, permanent housing, families remain at risk for homelessness and have no pathway back to the community.

Without safe, decent, affordable, permanent housing, families remain at risk for homelessness and have no pathway back to the community.

Permanent housing is the first-line response to family homelessness. Numerous studies have shown that housing subsidies are essential for preventing and ending family homelessness (Bassuk & Geller, 2006; HUD, 2015; Shinn et al., 1998; Wong, Culhane, & Kuhn, 1997). Yet the overall stock of affordable housing and available subsidies are
inadequate to meet the need. Many families are on waiting lists for public housing, Section 8, or other programs for months or even years. In some communities, waiting lists are closed altogether. In this context, homeless families and the providers serving them must explore all possible housing options. When working to stabilize these families, consider the following resources and housing options (listed in alphabetical order):

**Affordable Housing**
Some communities have properties that were built, bought, or rehabilitated using federal funds, state funds, tax subsidies or tax credits and are now required to provide below-market rents for low-income households, persons with disabilities, and seniors.²

**HOME Tenant-Based Rental Assistance (TBRA)**
In some communities, federal funding received through the HOME Investment Partnerships Program (HOME) is used for TBRA that helps households afford the costs of market-rate units. The amount of subsidy is based on the household’s income, and the subsidy moves with the tenant if the household relocates to another unit. Rental assistance may be provided for up to two years.³

**Market Rate Housing**
Market rate housing is bought or rented at market value, and there is no subsidy for housing. For families experiencing homelessness that have a source of income, it may be possible to identify a market rate unit that the family can afford without a subsidy or to transition the family to a market rate unit after participating in another program or receiving a subsidy.

**Permanent Supportive Housing**
Permanent supportive housing (PSH) is community-based housing with indefinite leasing or rental assistance paired with ongoing supportive services for individuals or families experiencing homelessness. To be eligible for permanent supportive housing, an adult or child member of the household must have a disability. PSH is accessed through the local Continuum of Care (CoC).⁴

**Public Housing, including Housing Choice Vouchers and Project-Based Section 8**
Public housing provides subsidized housing to low-income families, seniors, and persons with disabilities. Public housing options range from scattered site apartment units to large housing projects. Housing Choice Vouchers and Project Based Section 8 vouchers are obtained through the public housing agency (PHA) and allow the household to identify suitable housing of their choice as long as it meets program requirements. The PHA pays an ongoing housing subsidy based on the household’s income to the landlord.⁵ Many communities currently have long waitlists for public housing and housing vouchers.

**Rapid Re-Housing**
Rapid Re-Housing (RRH) helps individuals and families exit homelessness quickly by

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² As a starting point on some HUD-funded affordable housing programs, see U.S. Department of Housing and Urban Development, HUD Exchange: Affordable Housing. [https://www.hudexchange.info/affordable-housing/](https://www.hudexchange.info/affordable-housing/)


⁴ For more information, see United States Interagency Council on Homelessness, Permanent Supportive Housing. [https://www.usich.gov/solutions/housing/permanent-supportive-housing](https://www.usich.gov/solutions/housing/permanent-supportive-housing)
providing access to permanent housing, usually on the private market, through housing search and relocation services, short-term or medium-term rental assistance, and accompanying case management and supportive services.  

Supportive Services for Veteran Families (SSVF)

SSVF funding is provided to local non-profits to offer homelessness prevention and rapid re-housing services to low-income veterans and their families experiencing or at risk of homelessness. For veteran families experiencing homelessness, housing location, short-term rental assistance, case management, and other supportive services, such as connection to VA benefits, are offered through the program.

Temporary Assistance for Needy Families (TANF)

TANF resources may be used for short-term, non-recurrent benefits to families. States can use this option to provide families experiencing homelessness up to four months of TANF-funded rent assistance.

Transitional Housing

Transitional housing (TH) provides up to 24 months of temporary housing, usually in a group residence, combined with intensive services. TH is intended to give interim support to help families move to and maintain permanent housing. Transitional housing programs are also usually accessed through the CoC, and may focus on specific sub-populations.

In addition to the above options—many of which target families—other housing programs are designed to serve individuals, but families may be eligible as well. Housing Opportunities for Persons With AIDS (HOPWA) is one such program. Persons living with HIV/AIDS and their families may qualify for housing funded through the HOPWA program. HOPWA Tenant-Based Rental Assistance (TBRA) provides ongoing rental assistance payments for low-income households in units of their choice. In some areas, HOPWA-funded facility-based housing programs may be available, although program models vary and may not be designed to accommodate families.

Additionally, HUD-VASH Housing Vouchers are designed for veterans experiencing homelessness. HUD-VASH combines Housing Choice Vouchers with clinical and supportive services through the Veteran’s Administration health care system. While most people entering HUD-VASH are single adults, veterans with families may be eligible as well. The vouchers provide veterans experiencing homelessness and their families ongoing subsidies for rental units in the private market.

The BSAFE model relies on both housing and services to assist families in exiting homelessness, reconnecting to the community, and creating long-term stability.

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6 For more information, see National Center on Homelessness among Veterans, Supportive Services for Veteran Families (SSVF) Evaluation. [http://www.endveteranhomelessness.org/research/program-development-evaluation/supportive-services-veteran-families-ssvf-evaluation](http://www.endveteranhomelessness.org/research/program-development-evaluation/supportive-services-veteran-families-ssvf-evaluation)

7 National Alliance to End Homelessness, Making Effective Use of Temporary Assistance to Needy Families (TANF) to End Family Homelessness. [http://www.endhomelessness.org/page/-/files/MAking_Effective_Use_of_TANF.pdf](http://www.endhomelessness.org/page/-/files/MAking_Effective_Use_of_TANF.pdf)

8 U.S. Department of Housing and Urban Development, HOPWA Eligibility Requirements. [https://www.hudexchange.info/hopwa/hopwa-eligibility-requirements/](https://www.hudexchange.info/hopwa/hopwa-eligibility-requirements/)
One of the most unique aspects of BSAFE is that it accounts for both housing and services. While the case management aspects of BSAFE are phased and taper over the course of the intervention (see Phases below), access to safe, decent, and affordable housing is essential for supporting a family's reintegration into the community and long-term stability.

The phases of BSAFE are modeled on the CTI phases that include pre-CTI (engagement), transition to the community, try out, and transfer of care. The BSAFE program is implemented in similar phases, each described in details in this section:

Pre-BSAFE: Engage, Assess, Support
- Engaging Families
- Assessing Parents and Children
- Building Relationships
- Providing Onsite Supports
- Service Planning

Phase 1: Transition to Community
- Creating a Home
- Providing Ongoing Assessment
- Service Planning and Connecting to Supports

Phase 2: Strengthen Connections
- Mobilizing Support
- Ensuring Continuous, Coordinated, and Flexible Care
- Building Family Resources

Phase 3: Solidify and Transfer Care
- Ensuring Ownership of the Process
- Strengthening Community Relationships
- Transitioning to Mainstream Services and Supports
**PRE-BSAFE:**
**ENGAGE, ASSESS, REPORT**

**ENGAGING FAMILIES**

The BSAFE intervention starts at the moment of destabilization, when the family becomes homeless and is admitted to a temporary housing facility (e.g., shelter, transitional housing program). During this time, many families and their children must wait long periods before permanent housing becomes a reality. However, families and children should not be neglected while they languish in shelter. Although it is ideal if rapid re-housing is possible, in many communities subsidies and affordable housing are not available. Given the possibility of lengthy shelter stays, the process of assessment, engagement, and support should begin immediately in preparation for the transition back into the community. Thus, the Pre-BSAFE Phase may be lengthy and depend on housing availability.

Regardless of the circumstances, family members should be assessed upon arrival at the shelter or temporary housing facility—and the staff should begin engaging the family by establishing rapport and building respectful, collaborative relationships with family members. While families are waiting to return to the community, trauma informed care, parenting supports, and services for the children should be provided. Three to 6 months in the life of a preschool child may feel like an eternity and is an opportunity to stabilize the child and family. For example, parenting supports can have a salutary effect on a mother’s depression and her ability to bond with her child.

Given the possibility of lengthy shelter stays, the process of assessment, engagement, and support should begin immediately in preparation for the transition back into the community.

The goals of Pre-BSAFE are to:

- Assess immediate housing and safety needs.
- Build collaborative, trusting relationships between the staff and family members so that the family’s needs and wishes...
can be identified and prioritized and they become engaged in the BSAFE process.

- Determine the need for specific services and supports.
- Build supports onsite and in the community while the family is still in transition.
- Develop realistic plans for connecting family members to community-based housing, services, and supports.

In this initial phase, the staff intake worker and the BSAFE Partner can work collaboratively to engage the family and complete the assessment; they should identify and prioritize the needs and wishes of parents, children, and the family unit. Formal assessment tools can be used as needed (see Appendix II for assessment tools). Once the family’s needs are prioritized, goals can be set, and a collaborative plan developed. The process of beginning to identify community housing, services, and supports should also be started. At the same time, while they are in shelter, various services and supports should be provided.

**ASSESSING PARENTS AND CHILDREN**

The BSAFE assessment is designed to address the needs of the parents, the children, the family unit, and the family’s social networks and available systems of care. Identifying family members’ needs and wishes is an ongoing process of collecting and organizing information. Generally, the assessment portion of Phase 1 can be completed within the first 2 weeks of a family’s intake into shelter (or assignment to the BSAFE team). Ideally, the BSAFE Partner meets with the family 2 to 3 times per week for the first couple of weeks to establish a relationship, gather information, and begin to identify goals. Flexibility is important. The time it takes to complete the assessment can vary depending on a family’s circumstances; for working parents or for families with multiple children, the assessment may extend to 30 days or even longer. During Pre-BSAFE, the BSAFE Partner and the family prioritize needs (e.g., immediate, short, and

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10Sample assessment questions for each domain will be developed after the expert panel reviews BSAFE.
long-term), set goals, and develop a family housing and services plan. Based on the assessment and plan, the BSAFE Partner begins to link families to community-based housing, services, and supports as they move into Phase 1.

Assessment is more than gathering information and filling out forms. At its core, it is about developing a safe and trusting relationship with a service user and learning about the needs and wishes of the parent(s), children, and family unit. In this way, family-centered assessments consider the needs of all family members, view adults as parents first, and assess child development in relation to the parents’ functioning. Parents’ desires and wishes for their children are central and guide the process (DeCandia, 2015).

Assessment is not a one-time event. For example, a mother’s goals for her family may change over time. In addition, as the relationship between the family and BSAFE Partner develops, new information not previously disclosed may impact service needs (e.g., trauma history or mental health concerns) and may only come to light after a relationship has been formed. This is to be expected. Developing trust with providers is a gradual process. For those with trauma histories or previous experiences with service providers that were unfavorable, the process can be more challenging. It is important that BSAFE Partners meet the family where they are and not try to rush the process; respecting a family’s pace is critical. Over time, as the Partner and family develop a trusting relationship, the Partner may be able to gather more in-depth information. Thus, if the Pre-BSAFE Phase is prolonged due to the unavailability of permanent housing, it is imperative that evolving needs and goals are periodically re-assessed.

BSAFE provides homeless and housing providers a two-generation approach to addressing family homelessness. This model uses a holistic case management process, assessing strengths and issues impacting family functioning, and addressing the needs of each child and the parents (The Center for High Impact Philanthropy, 2014). The goals, preferences, and priorities of all family members are elicited.

**Assessment of families experiencing homelessness covers a range of topics, including:**

- Family demographics
- Safety needs (e.g., domestic violence, suicidality, health crisis)
- Housing and Homelessness
- Self-sufficiency: income and benefits, education, employment history, transportation, child care
- Parental functioning: health, mental health, substance use, traumatic stress, parenting, social networks and supports, and criminal justice involvement
- Family separations
- Children’s development: developmental status, health, mental/behavioral health, and education
- Service needs and involvement

To reliably identify needs of families experiencing homelessness, the BSAFE model recommends that standardized instruments be incorporated into the assessment process to reduce or eliminate...
potential provider bias. The Family Service Prioritization Decision Assistance Tool (F-SPDAT) is a new instrument that assesses demographics, housing eligibility, income, education, employment, and various safety needs (OrgCode, 2015). Programs can use the F-SPDAT or their own assessment forms as long as they cover all these domains. In addition, we recommend that programs supplement the F-SPDAT or their own assessments with standardized instruments to screen for health and mental health conditions that are common in this population (e.g., depression, trauma exposure and impact, developmental delays). These tools are brief, often taking less than five minutes to administer, enabling the BSAFE Partner to better match a family’s needs with appropriate services and then make timely and targeted referrals (DeCandia, 2015).

The following section reviews components of a comprehensive assessment of parents and children and strategies for implementation. For programs that already have established assessment processes, it is not necessary to replace them. However, it may be important to expand or adapt existing tools if all domains are not included (See Appendix II for sample assessment tools for all domains).

Assessing Parents

**Family Demographics:**
Identifying information is routinely collected as part of an intake or assessment process. This generally includes age, gender, race/ethnicity, marital status, primary language, sexual orientation, pregnancy, family composition, age, number and custodial status of children, family religious preference, and veteran status.

**Safety: Address Intimate Partner Violence (IPV) and Immediate Needs**
Intimate partner violence is pervasive in the lives of homeless and formerly homeless families. Sixty-three percent of mothers experiencing homelessness report IPV, more than twice that of women in the general population. The consequences of IPV for mothers are numerous, including poor medical and mental health outcomes (Black & Breiding, 2008; Bonomi et al, 2009; Campbell et al, 2002) increased risk for anxiety, depression, substance use (including tobacco use), and posttraumatic stress disorder (Bonomi et al, 2009; Golding, 1999; Nicolaidis Curry, McFarland, & Gerrity, 2004; Woods, 2000). Children under age six are at greatest risk for exposure to IPV (Osofsky, 1995), leading to greater risk of psychological, socio-emotional, behavioral, and school-related difficulties (Levendosky, Bogat, & Martinez-Torteya, 2013).

In addition to IPV assessment, it is critical to assess the immediate physical and emotional safety of all family members (Davies, 1998). Therefore, a careful assessment of current and past abuse is essential to understanding a family’s immediate safety and service needs. This includes asking about active restraining orders, location of the perpetrator and potential threats, and whether children witnessed or experienced physical, emotional, or sexual abuse. In addition, safety assessments should inquire about immediate medical needs of all family members and mental health or substance use crises (e.g., need for evaluation or
Families experiencing homelessness are often more isolated than other low-income families (Goodman, Smyth, Borges, & Singer, 2009). Providers need to develop networks of care and work to bridge siloed services (Smyth, Goodman, & Glenn, 2006). Helping women to address their immediate financial situations while working toward long-term financial stability should be a cornerstone of any intervention (Economic Stability Working Group, 2002). In addition, providers need to empower survivors and prioritize their needs and preferences for housing and services (Goodman & Epstein, 2008).

**Housing and Homelessness:**
A key goal of BSAFE is to evaluate a family’s housing needs and develop a plan for rehousing. The BSAFE Partner must assess which housing option is a good fit for the family and available in their community. In addition, the Partner should be familiar with the eligibility criteria for permanent supportive housing. Questions used to assess housing-related needs vary, depending on where the family is currently residing and the availability of decent affordable housing units and subsidies. Assessment topics include housing history (e.g., previous tenancies, reasons for moving, evictions), housing needs (e.g., number of bedrooms, community preferences), and available options and eligibility for various supportive housing and subsidy programs (e.g., Section 8, transitional or permanent supportive housing). For families who are already stably housed, assessment questions should include whether the parent paying their rent on time, are they having difficulties with housing managers, and are they honoring their lease agreement.

A history of residential instability and episodes of homelessness should also be obtained. Homeless families often move multiple times before entering a housing program. Assessing the degree of residential instability is key. Questions should focus on where the family stayed immediately before coming to shelter, the reason for leaving, and a list of the family’s residences over the past three years, including reasons for any moves. Homelessness history is assessed by asking about the number of times a family has been homeless and the duration of each episode over the past three years. For programs funded by HUD the homelessness history aligns with required information for Homeless Management Information System (HMIS).

**Self-Sufficiency**
An important goal that will help families achieve residential stability is to develop a process for becoming economically self-supporting. The BSAFE Partner evaluates parents’ financial situation including whether they are receiving or eligible for income support programs (e.g., TANF, SSI, 

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11At present, eligibility criteria for permanent supportive housing varies widely across programs. Determining criteria for eligibility will help determine the minimal package of services necessary to provide quality care for these families. Criteria will be addressed and further developed at an additional expert panel to be completed at a later date and will be outlined in an Appendix in the final BSAFE intervention package.
SSDI), child support, and other benefit programs (e.g., child care vouchers, food stamps). Parents’ ability to pay their bills on time, prioritize necessities (e.g., gas, heat, food) over extras (e.g., entertainment), budget money, and plan for their financial future should also be determined. Typically a credit history is obtained, along with an assessment of savings and debts. A savings plan can then be constructed to help guide the family towards economic independence. The BSAFE Partner must also assess a parent’s educational status, job history and training, work skills, and goals and aspirations. Gathering information about the availability of transportation and childcare are also critical.

Parental Functioning

Physical Health

The BSAFE Partner should ask the parent(s) about their health history, current health problems, disabilities, HIV status, health insurance status and eligibility (including enrollment in Medicaid/Medicare), and whether or not he/she has a primary care physician. In addition, the SF-8 Health Survey, a brief practical tool can be used to assess the degree to which health issues have interfered with the parent’s functioning in the past 4 weeks. If the parent scores high, the provider can ask more detailed questions about the nature of specific health issues to better determine the need for services (Ware, Kosinski, Dewey, & Gandek, 2001). See Appendix II.

Emotional Needs

Identifying the mental health needs of the parent is a critical part of the assessment process. A parent’s mental health issues can interfere with the ability to access critical services, maintain housing, become self-supporting, and parent effectively. Considering that a mother’s emotional status is often the most important mediating factor influencing the outcomes of her children, these findings are especially important. Areas to be addressed include current emotional state, history of mental health issues, psychiatric hospitalizations, use of psychiatric medications, involvement in therapy, history of violence (childhood and adulthood) and exposure to other traumatic stresses, coping skills, parental functioning, and services/treatment. We recommend a variety of standardized instruments to supplement assessment questions in the following

12Discussing trauma and mental health issues can be very difficult. BSAFE partners may need to come back to these topic areas as they build a more trusting relationship with the parent. It is important that the Partner avoid asking intrusive questions early on, particularly if the parent is not ready to share personal information. The goal is to gain the information necessary to make appropriate referrals to services without re-traumatizing parents by asking them for information that may be emotionally overwhelming.
areas: depression, trauma, substance use, parenting, and social support. A complete description of all instruments can be found in Appendix II.

**Maternal Depression**
Mothers experiencing homelessness have astoundingly high rates of childhood sexual and physical abuse, current histories of interpersonal violence, and depressive disorders (Bassuk et al., 1996; Hayes, Zonneville, & Bassuk, 2013). Depression is unrecognized among homeless women; it is often viewed as a circumstantial issue that will resolve with housing rather than a medical disorder requiring treatment (Bassuk & Beardslee, 2014). When untreated, maternal depression profoundly impacts the ability to parent effectively and obtain and maintain housing and employment. Identification is the first step to proper care. Various brief depression screeners and more formal depression inventories for use by programs with clinical resources are listed in Appendix II.

**Trauma and Post Traumatic Stress Disorder (PTSD)**
When assessing for trauma and PTSD, two main components are required: exposure and symptoms. Skilled mental health professionals are generally required to assess the nature and severity of symptoms, but case managers can reliably screen for exposure and identify the need for further evaluation by using standardized screening tools (see Appendix II).

**Substance Use**
Substance use issues (i.e., alcohol, drugs including prescription drugs) can seriously compromise the stability of families and their ability to maintain housing and to parent effectively. Some mothers use substances as a way to self-medicate post trauma responses or depressed feelings. The first step is to identify the presence of a substance use issue and then to use strategies such as motivational interviewing and harm reduction to address them. At a minimum, it is important to ask parents about their history of substance use, date of last use, current frequency of use, legal issues related to substance use (e.g., Department of Motor Vehicles violations, Child Protective Services involvement), participation in Alcoholics Anonymous and Narcotics Anonymous, and participation in other substance abuse services. Over time, the Partner and parent may want to address substance use issues in more detail. Self-report instruments can be used as screeners (see Appendix II).

**Parenting**
The demands of parenting can increase chronic strains and significantly add to the stress experienced in the family. An important component of the assessment is to determine whether the family needs additional parenting supports. BSAFE Partners should also begin to assess the quality of the parent/child attachment. Partners can do this by observing how parents interact with their children (e.g., eye contact, touch, soothing, and nurturing responses), by asking questions about their experiences with pregnancy and parenting, and by asking about their thoughts and feelings about their children. Standardized tools to assess parenting skills, stress, and attachment are listed in Appendix II.

**Social Networks and Supports**
Research suggests that social support can mediate the impact of adverse experiences
such as homelessness and domestic violence and moderate the subsequent functional limitations that can arise (National Center on Family Homelessness [NCFH], 2003). However, families experiencing homelessness, especially those who have experienced domestic violence, typically lack or have fractured support systems (Anderson & Saunders, 2003; DeCandia, Beach, & Clervil, 2013; Goodman, Smyth, Borges, & Singer, 2009). In addition, many families have had negative experiences with both formal and informal supports, making them reluctant to rely on others. Socially isolated, they typically lack the instrumental supports needed to help with daily life challenges (e.g., child care, transportation) and have few people to turn to for emotional support. Those who have stronger support networks, both formal (e.g., services) and informal (e.g., friends, family, faith groups), tend to function better (NCFH, 2003). Supports that are perceived as helpful are essential for ensuring a family’s stability and wellbeing following an experience of homelessness.

Strategies to assess forms of social support are varied. As homeless families often have fragmented familial and social structures, it is important to inquire about significant family relationships, extended family, friends, community supports, and providers, creating a picture or ecomap of a family’s support structure. An ecomap is a graphic illustration of a family’s close and extended networks. Families can work together with the BSAFE Partner to create a graphic illustration of the social supports in their life, whether positive or conflicted. The powerful image allows the family and BSAFE Partner to see, together, where the family has resources and what gaps exist. The family can identify areas of strength and support, and people and places where bridges may need to be rebuilt. In this way, BSAFE Partners can better understand who is important to the family, what kind of support they provide, and the family’s desire to maintain, strengthen, repair, or discontinue a particular relationship.
Standardized measures to assess social supports are available in Appendix II.

Assessing Children

Development is influenced by how risk and protective factors interact in a child’s life. Risk factors are indicators that put a child at higher probability of poor outcomes, while protective factors are qualities that help children cope with stress and develop optimally (Coie et al., 1993; Masten, 2001; Moore, 2013). Every child has a balance of both, which helps or hinders the ability to be resilient—that is, to adapt and thrive amidst adverse circumstances (National Scientific Council on the Developing Child, 2015). No single risk or protective factor determines a child's developmental trajectory. Rather, these factors bundle together so that in combination they help a child thrive or struggle.

Two primary protective factors in a child’s development include cognitive skills or “executive functions” and emotional self-regulation skills. Executive function skills include organizing, planning, problem solving, and exercising good judgment. Executive functioning develops rapidly in the preschool period (National Research Council & Institute of Medicine, 2000; Shore, 1997; Zelazo et al., 2013), enhancing school readiness (Blair, 2002). For preschool children, this includes the ability to pay attention, follow instructions, wait one’s turn, and remember rules. These skills may also predict positive school and social functioning (Bierman et al., 2008a, 2008b; Masten et al., 2012; Obradovic, 2010). For older youth, these skills are critical for academic success and later job performance. Self-regulation refers to an integrated set of abilities and skills that help children manage their feelings (Buckner, Mezzacappa, & Beardslee, 2009). Self-regulation skills develop in the context of strong attachment relationships with a primary caregiver (National Scientific Council on the Developing Child, 2015) and are the dominant characteristics that differentiate resilient from non-resilient children living in poverty (Buckner et al., 2003; Masten, 2014).

Children experiencing homelessness face physical, cognitive, and social-emotional threats to their development. They are sick four times as often as poor children who are housed and have four times the rate of asthma and respiratory problems (National Center on Family Homelessness, 1999). A quarter of parents report developmental concerns (Haskett, Armstrong, & Tisdale, 2015). Among homeless preschoolers age three to five, language and communication delays are most prominent, and among young school age children, communication and social-emotional problems are reported (Haskett et al., 2015). Additionally, 10% to 26% of homeless preschoolers have a mental health condition warranting attention; the prevalence soars to 24% to 40% for school-age children (Bassuk, Richard, & Tsertsvadze, 2015).

Despite this litany of risk factors, when children experiencing homelessness are surrounded by positive caregivers and a
supportive environment, they fare well (Masten, 2014; Huntington, 2008). The presence of a stable, nurturing caregiver buffers adverse childhood experiences (ACEs) (Gerhardt, 2004; National Research Council and the Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2015). ACEs are prevalent in minority and low-income groups (Nandi, Sweet, Kawachi, & Galea, 2014; Williams, Neighbors, & Jackson, 2003) and have been associated with diminished resilience in children (Bethell, Newacheck, Hawes, & Halfon, 2014) and poor health and mental health outcomes in adults (Felitti et al., 1998). A strong foundation for resiliency is built by diminishing the number of ACEs in a child’s life and building protective factors. This includes ensuring they have safe places to play (Ginsburg, 2007) and services to support their development (Center on the Developing Child at Harvard University, 2015). For children living in high-risk situations such as homelessness, comprehensive assessment is essential to prevent the development of mental health issues later in life.

Assessing children’s development and service needs is critical to designing effective family service plans. Assessments should expand beyond the needs of the parents to include an assessment of each child’s functioning. Domains include physical health, child development, emotional and psychosocial needs, educational status, and social networks and systems of care. Strategies to assess each area are outlined below and assessment instruments can be found in Appendix II.

**Physical Health**
The BSAFE Partner asks the parent for a detailed history of his/her child’s physical health that includes past and current medical needs and conditions; hospitalizations, surgeries, head injuries and other types of injuries; and medications and other treatments.

**Child Development**
The BSAFE Partner asks a parent about his/her child’s achievement of developmental milestones (e.g., walking, talking, toilet training). In addition to an interview with parents, the BSAFE Partner should use one of the recommended child development screening tools. The U.S. Department of Health and Human Services Administration of Children and Families now recommends that children experiencing homelessness receive routine developmental screenings. A comprehensive list of developmental screeners is provided in the Compendium of Screening Measures for Young Children (Moodie et al., 2014) and is available online.

**Emotional and Psychosocial Needs**
Self-regulation refers to an integrated set of abilities and skills that help a child achieve complex goal-directed behaviors, manage feelings, and function adaptively (Buckner, Mezzacappa, & Beardslee, 2009). The research literature has documented that self-regulation is a critical component and predictor of resilience among children living in poverty (Buckner, Mezzacappa, & Beardslee, 2003, 2009). Resilient children manifest greater cognitive abilities and emotional and behavioral regulation.

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13Trauma Systems Therapy (TST), an evidence-based practice, is focused on helping traumatized children regulate emotion while simultaneously adjusting the child’s social environment and system of care (Saxe, Ellis, & Kaplow, 2007). The goal of TST is to support a child’s capacity for self-regulation by working with the social networks and systems of care to help and protect the child. (See section below for assessment of social networks and systems of care.)
higher self-esteem, and the capacity to adapt to challenging and traumatic circumstances. Drawing from the literature and from elements of Trauma Systems Therapy’s (TST) assessment framework (Saxe, Ellis & Kaplow, 2006), BSAFE has developed a strategy for evaluating the emotional and psychosocial needs of children of different ages and provides tools that can be used by program and clinical staff. See Appendix II for a recommended list of assessment tools.

**Educational Status**

Poverty is strongly correlated with poor educational outcomes. Proficiency rates for homeless children in reading and math fall 16% lower on average than for all students. Less than one in four students who are homeless graduate from high school (The National Center on Family Homelessness, 2009). The BSAFE Partner should determine if each child in the family is attending the same school regularly, the nature of their school performance, has or requires an Individual Education Plan (IEP), has repeated a grade, or has been suspended or left back in school. Barriers to regular attendance, such as transportation or availability of school records, should also be addressed.

**Social Networks and Systems of Care**

The assessment of children is not complete unless it involves an examination of the child’s world. Evaluating a child’s individual functioning and developmental status is critical. However, to ensure healthy child development, an assessment must take an ecological perspective and assess the child’s familial and social systems (Horwarth, 2010).

The ability of these systems to meet a child’s needs plays an integral role in a child’s overall wellbeing.

**BUILDING RELATIONSHIPS**

The relationship among family members and the shelter staff and “BSAFE Partner” is the linchpin of service provision. This relationship can become the decisive factor in re-setting the direction of family life. Drawing from a Relational Advocacy Model (Goodman, Glenn, Bohlig, Banyard, & Borges, 2009), BSAFE adopts a person-centered approach to providing services that fosters a collaborative relationship between the family and provider. It draws on 4 foundational principles: mobilizing both emotional and instrumental supports, valuing the family’s perspective of
their own experiences and needs, honoring mutuality and developing a genuine relationship, and addressing the broader systems and circumstances that contribute to a family’s challenges (Goodman, Glenn, Bohlig, Banyard, & Borges, 2009).

Incorporating these principles means reaching out with empathy; remaining flexible and dependable; engaging each family member; understanding each member’s strengths, needs, and wishes; establishing a process of shared decision making; empowering family members; advocating for a family’s rights; and knowing where to turn for the right resources. Developing a trusting relationship with family members takes time and patience and may determine the pace of the assessment and treatment planning process. This relationship is ongoing throughout the various phases of BSAFE.

Providing Onsite Supports

Given the extremely high prevalence of trauma and its mental health consequences (e.g., PTSD and major depression) (Bassuk & Beardslee, 2014) and the urgent needs of the children (Bassuk, 2010; Bassuk et al., 2015), a core group of family-oriented best practices must also be integrated into all housing programs. With the exception of various therapeutic interventions for major depressive disorders, most of these practices can be implemented organizationally, becoming part of routine policies and procedures that shape the culture of the agency. Training and technical assistance are essential to ensure adequate implementation. With this support most programs have the capacity to implement these practices. Because these strategies can largely be implemented at an organizational level, they are relatively low in cost.

The best practices outlined below should be provided directly by programs serving homeless families. Despite the lack of randomized control trials to support a robust evidence base, preliminary findings in homeless services, as well as rigorous studies with low-income families, indicate their effectiveness. Since the majority of families are headed by women alone, these practices are discussed for use with mothers, but also pertain to two-parent families and father-headed families.

Providing Trauma-Informed Care

Researchers have documented that most homeless family members have been exposed to traumatic stressors, especially interpersonal and community violence (Browne & Bassuk, 1997; Guarino & Bassuk, 2010; Hayes et al., 2013; Shinn, Knickman, & Weitzman, 1991; Stainbrook, 2006; Weinreb, Buckner, Williams, & Nicholson, 2006; Weitzman, Knickman, & Shinn, 1992; Williams & Hall, 2009; Zugazaga, 2004). Abuse is...
prevalent and is perhaps the rule rather than the exception for most women experiencing homelessness, who often suffer from its debilitating consequences for the rest of their lives. Multiple studies have found that more than 90% of mothers have been exposed to at least one traumatic stress (Bassuk et al., 1996; Hayes et al., 2013). Compared to the general female population, homeless mothers are more frequently assaulted by partners, relatives, or friends (Bassuk et al., 1996; Browne, 1993; Browne & Bassuk, 1997; Hayes et al., 2013; Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012; Shinn et al., 1991; Stainbrook, 2006; Weinreb et al., 2006; Weitzman et al., 1992; Williams & Hall, 2009; Zugazaga, 2004). The ACE studies (Felitti et al., 1998) indicate that when people are exposed to multiple, unremitting stresses over time, they experience adverse mental health and medical outcomes in adulthood. Their children may develop “toxic stress responses” that alter brain architecture and have life-long adverse consequences (Shonkoff et al., 2012).

To respond to the extremely high prevalence of exposure to traumatic stress and to its mental health consequences (e.g., PTSD, major depression, substance use), all homeless service agencies should provide Trauma-Informed Care (TIC), a strengths-based organizational approach in which all services are provided through the lens of trauma. It is grounded in an understanding of and responsiveness to the devastating impact of traumatic stress. All staff members in an agency are trained to understand how trauma operates and how best to reduce “triggers” of post-trauma responses, encourage consumer choice, support empowerment, and level power differentials. Establishing trusting, supportive, collaborative relationships is the linchpin of these services. TIC prevents re-traumatization and creates opportunities for survivors to develop a sense of safety, control, agency, and self-efficacy, all of which increase the likelihood of achieving residential stability and becoming self-supporting. In addition to the mental health consequences of trauma, a longitudinal study of families experiencing homelessness suggests that PTSD may be the primary driver of many families’ inability to maintain housing (Hayes et al., 2013). Recent research documented that the severity of PTSD predicts residential instability at the thirty-month follow-up (Hayes et al., 2013).

The process of implementing and sustaining trauma-informed care within organizations begins with an assessment of organizational culture and practices. The TICOMETER®, the only validated brief instrument available to measure the degree of trauma-informed care within an organization, can be used to make this assessment. Consisting of 35 items across 5 domains, it is easy to administer to all staff. Based on the results, leaders can identify domains for development and target resources for training. The TICOMETER® can be re-administered at set intervals to reassess organizational growth and progress in becoming trauma-informed (www.ticometer.com; Bassuk, Unick, Paquette, & Richard, in press).

Preventing and Treating Major Depression in Mothers

Depression is a major public health problem for mothers with low incomes or experiencing homelessness. (Bassuk
Stressed by their circumstances, it is not surprising that current and lifetime rates of major depressive disorders in mothers experiencing homelessness are much higher than in the overall female population. Approximately 12% of women from all socioeconomic groups are depressed (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Kessler et al., 2003). This percentage approaches 25% for those living in poverty and for ethnic/racial minorities (Grote et al., 2007; Kessler et al., 2003), and 40% to 60% for low-income mothers with young children, and pregnant and parenting teens (Knitzer, Theberge, & Johnson, 2008). Lifetime rates of depression among homeless mothers range from 45% to 85% (Bassuk et al., 1996; Bassuk, Buckner, Perloff, & Bassuk, 1998; Weinreb et al., 2006). Depression and its co-occurring disorders can significantly interfere with obtaining and maintaining housing and services that families need. Lack of access to critical services limits the opportunity for mothers to become self-sufficient and fully support their children. For these reasons, prevention and treatment of depression must be part of any effective solution to family homelessness.

The impact of maternal depression on children is profound. A meta-analysis of 193 studies demonstrated that poverty seems to be a broad-scale enhancer of risk in relation to depression in mothers, but when controlling for socioeconomic status, maternal depression alone predicted greater adverse outcomes among children (Goodman et al., 2011; Kiernan & Huerta, 2008; Riley et al., 2009; Reinherz, Giaconia, Hauf, Wasserman, & Paradis, 2000; Nomura, Wickramaratne, Warner, Mufson, & Weissman, 2002). Children living with a depressed parent have poorer medical, mental health, and educational outcomes (Center on the Developing Child at Harvard University, 2009; Knitzer et al., 2008; National Research Council & Institute of Medicine, 2009). Depression adds to a mother’s difficulty in parenting effectively and may compromise her children’s growth, development, and school readiness (Knitzer et al., 2008). Despite these adverse impacts, depression among homeless mothers remains unacknowledged, unrecognized, and untreated.

We know a great deal about how to treat depression. Studies have documented that when mothers are treated for depression (e.g., medication, psychotherapies, behavioral interventions), their children develop fewer emotional and behavioral problems (National Research Council &

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14Major depressive disorder is characterized by feeling down and blue all of the time, or having no energy, plus five out of nine associated symptoms drawn from biological domains (e.g. trouble eating, sleeping, concentrating) and psychological domains (e.g., feeling hopeless, helpless, that life is not worth living, and feeling suicidal). These symptoms last two weeks or more and may be accompanied by functional impairments. They often last much longer. The symptoms cannot be caused by substance use, medical diagnosis, or bereavement. Dysthymia is a condition with fewer symptoms that lasts two years. In standard psychiatric practice, recognition of either diagnosis requires treatment (DSMIV, 2000).
Institute of Medicine 2009; Weissman et al., 2006; Bassuk & Beardslee, 2014). However, in general these treatments have not been adapted and implemented for use with mothers and children experiencing homelessness. Gewirtz et al. (2008) reported that “housing agencies lack infrastructure or expertise in children’s mental health” and these agencies did not screen or assess homeless mothers for depression. Furthermore, homelessness programs were less successful accessing community-based services and were less likely to have clinical staff onsite with expertise in mental health, parenting practices, and children’s issues.

All mothers experiencing homelessness should be screened for major depression and its co-occurring disorders, especially PTSD, substance use, and anxiety. In addition, homeless programs should provide preventive (e.g., parenting supports) and therapeutic interventions (Bassuk & Beardslee 2014). Studies indicate that programs benefiting parents experiencing depression and their children include center-based, developmentally oriented daycare/child care, and home visitation. Often these programs are enriched by outreach that increases the likelihood that depressed parents will engage in treatment. Additionally, some of the promising preventive interventions for low-income families with parental depression are especially relevant to families experiencing homelessness and can result in better outcomes (National Research Council & Institute of Medicine, 2009). For mothers with significant symptoms of depression, PTSD, and substance use, further evaluation and referral to treatment is mandatory. Minimizing symptoms and attributing them exclusively to the challenges of poverty and homelessness further burdens women who are already severely stressed and increases their risk of future episodes of homelessness (Miranda et al., 2006).
Ensuring Family Preservation

Being separated from one’s family is one of the most traumatic events for a child. Research shows that children who suffer disruptions in their primary attachments are at higher risk for impaired relationships and social functioning as adults, as well as a host of other behavioral difficulties (National Research Council & Institute of Medicine, 2000; Schore, 2001). Many homeless children are temporarily or permanently separated from their families, with rates ranging from 18% to 44% (Bassuk, Volk, & Olivet, 2010; Cowal et al., 2002; Zlotnick, Robertson, & Lahiff, 1999). Many of these separations are voluntary, with parents trying to protect their children from the experience of homelessness by placing them with relatives or friends. In addition, some shelters continue the practice of not allowing adolescent boys in family shelters, necessitating parents to have to place these older boys with family or friends. Lastly, 22% of children are separated from their families due to child welfare involvement and placed in foster care (National Center on Family Homelessness, 1999).

Various studies have focused on the factors that most highly predict family separations (Cowal et al., 2002). Independent risk factors include mother’s substance abuse, institutional placement most commonly for drug treatment, and interpersonal violence, but overall homelessness itself was the most powerful factor contributing to separations. Once these separations occur, children are often shifted between relatives, foster care placements, and shelters (Buckner & Rog, 2007).

Although homelessness itself is not a reason to remove a child from the family, it has played a large role in both family separations and barriers to reunification (Williams, 1991). Families requesting shelter have high rates of Child Protective Service Involvement (CPS) and foster care placement (Culhane, Webb, Grimm, Metraux, & Culhane, 2003). The likelihood of CPS involvement is greatest in large families, those with long or repeated episodes of homelessness, and in families with fewer adults (Park, Metraux, Broadbar, & Culhane, 2004).

For families with children in the foster care system, programs such as the Family Reunification Program (FUP) signed into law in 1990, helps them reunite. Through partnerships with local public housing authorities and child welfare agencies, FUPs provide families with housing subsidies and the services necessary to support the child’s safe return to the family (Bassuk, Volk, & Olivet, 2010). Interventions that facilitate reunification of the family include family engagement, comprehensive assessment, case planning, and service delivery. Parent-child visitation and involvement of foster parents and peer mentors are critical first steps. Especially when child maltreatment is a factor, family centered assessment is crucial to understanding each family member’s needs and current circumstances. Service planning should be aimed at ensuring that the environment the child is returning to is safe and can be sustained. This is often accomplished by concrete service planning, intensive case management, and provision of home-based services (Child Welfare Information Gateway, 2011).
Federal support has been primarily aimed at using supportive housing to minimize separations among “high-risk” families, those experiencing homelessness, and child welfare involvement (CSH, 2015a, 2015b). However, to protect the well-being of the child, family preservation is critical for all families experiencing homelessness.

Providing Parenting Supports

Women’s self-esteem is largely defined by their affiliations with others. Parenting is central to a mother’s identity. Like most mothers, mothers experiencing homelessness love their children and would do anything to support them. However, given the extreme stress experienced by these women, it is not surprising that studies have documented that they tend to provide less structure and stimulation and are less warm toward their children. They also tend to use coercive disciplinary practices compared to housed mothers (Perlman et al., 2012). Many systematic studies of parenting supports for low-income mothers have shown promising outcomes that include stronger parent-child relationships, improved children’s adjustment and functioning, improved parenting practices, greater knowledge of child development on the part of mothers, and decreased prevalence of maternal depression—a preventive outcome (National Research Council & Institute of Medicine, 2009; Bassuk & Beardslee 2014).

Parenting programs are a form of secondary prevention aimed at reducing the impact of stressors that families have experienced. The IOM (National Research Council & Institute of Medicine, 2009) proposed a developmental framework for creating and implementing preventive interventions for children, youth, and families. Principles driving these interventions included addressing the needs of children and families in which parents are depressed, strengthening parenting through psycho-education, and using a variety of preventive and therapeutic interventions. For example, psycho-educational approaches that combine information about strong parenting practices and mental health have a robust evidence base for use with low-income families. Many of these programs are suitable for adaptation for use with families experiencing homelessness.

The evidence base describing the effectiveness of these adapted programs for homeless families residing in shelter or supportive housing is beginning to emerge, and the outcomes are promising (Gewirtz et al., 2009; Perlman et al., 2012). Three parenting programs have begun to show early success with these families:

Parenting Through Change (PTC) is an evidence-based program that has been implemented in shelters. PTC targets 5 parenting practices: skill encouragement, problem solving, limit setting, monitoring, and positive involvement. PTC has been modified and tested for families in an emergency domestic violence shelter setting (Gewirtz & Taylor, 2009) and in supportive...
housing agencies (Gewirtz, 2007). Preliminary outcome data indicate high retention rates and satisfaction among participants.

**Family Care Curriculum** (FCC) is a strengths-based, 6-week program for women with children who are living in emergency and transitional housing (Hudson & Sheller, 2010). This intervention integrates best practice knowledge from 4 frameworks including effective black parenting, trauma-informed care, attachment theory, and self-care. FCC has been piloted in 7 shelters in a large, northeast city. Through learning to think about what they and their children are thinking, feeling, and needing, parents become more consistently sensitive and receptive to their children’s needs, leading to sustained behavioral changes.

**Triple P—Positive Parenting Program®** (Sanders, 2008) is an evidence-based, tiered suite of parenting support programs. The full 5-tiered system is associated with reduced child behavior problems, increased positive parenting, and reduced child maltreatment.

Parents require concrete supports in order to get the services they need for themselves and their families. For example, it is critical that mothers have adequate childcare so that they can attend groups. Childcare vouchers are available through the states and should become part of a coordinated community response. Transportation to and from group meeting may also be necessary depending on the location of services.

**Providing Children with Developmentally Appropriate Spaces**

Historically, the homeless system has primarily focused on the needs of adults; when children’s needs are overlooked, their development may suffer. For example, many shelters or transitional housing programs have rigid rules and lack the space for children to play. When children are unable to play, learning and social-emotional development is compromised (National Research Council & Institute of Medicine, 2000).

When children are unable to play, learning and social-emotional development is compromised (National Research Council & Institute of Medicine, 2000). In addition, school-aged children need quiet places to do their homework and appropriate places to socialize with peers.

Agencies should provide children and youth with developmentally appropriate programs and child-centered spaces to play and to complete schoolwork. The ability to play is extremely important to a child’s development. Research demonstrates that play for children is associated with healthy brain development including executive functions and enhances problem solving skills, learning readiness, social-emotional skills, and self-regulation—all of which are associated with resiliency (Center on the
Developing Child at Harvard University, 2015). Play also helps develop children's leadership and group skills and supports physical and motor skill development (Ginsburg, 2007).

The inability to play is also a hallmark of traumatic stress in children. Research has illuminated the connection between brain development and the body; body-based interventions and physical activity are now understood to be necessary for children's healthy development and as a treatment for healing from trauma (van der Kolk, 2014). Thus, all programs serving homeless children should incorporate child-friendly programming and play spaces to support resiliency and healing.

Child-friendly spaces must be developmentally appropriate. For infants, clean and safe floor spaces are needed so they can crawl and get needed “tummy time” to support healthy brain and motor skill development (Esteban-Cornejo et al., 2014). Play spaces for toddlers and school age children should include toys and learning materials appropriate to their age. Programs should have designated spaces where preteens and adolescents can hang out and do homework. A recommended program designed specifically for children in shelter is PEACH: Physical and Emotional Awareness for Children who are Homeless. PEACH is an innovative curriculum designed by The National Center on Family Homelessness and OrganWise Guys (2004). It teaches young children about good nutrition, physical activity, and dealing with the stress of being homeless. It is easy to use and fun to implement.

Finally, to serve children most effectively, staff members must be knowledgeable about developmental issues and the importance of attachment. Children who manifest serious emotional, behavioral, and developmental problems should be identified as early as possible through the assessment process and referred for clinical evaluation, early intervention, and treatment. Basic training on child development can enable staff to act as trained observers and be better able to identify a child in need of further evaluation and services.

**SERVICE PLANNING**

The BSAFE Partner should consider the following areas when developing a service plan for the child: engaging the family and building a treatment alliance; identifying and reducing sources of stress in the environment (e.g., family chaos, school/peer difficulties); advocating for services (e.g., housing, job training, domestic violence, mental health, substance use); and connecting the family to community-based services designed to enhance children's emotional regulation, executive functioning, and processing skills (Saxe et al., 2006).

After completing the assessment, the BSAFE Partner can use motivational interviewing (Miller & Rollnick, 2013) to work with families to prioritize the issues identified in the assessment that they are interested in addressing first and how barriers to achieving these goals can be removed. Attention must be paid to matching these needs with the availability and accessibility of community-based housing, services, and supports. Concrete, basic needs should be addressed first. Safety issues related to current or past domestic violence should
also be attended to in the first days of service planning. If the abuse is current, this may include creating a safety plan, identifying social supports, and connecting with local domestic service providers who can work with the family directly. If the domestic violence occurred in the past and immediate safety is not a concern, services to address post trauma responses for family members and connection to support groups for survivors should be considered.

Rapid re-housing into safe, affordable, permanent housing is a priority for families in shelter. In addition, families needing permanent supportive housing should be identified. The linkages between housing and services should also be identified. For longer-term needs, providers should choose agencies that are aware of the unique issues of homeless families and understand the often protracted and non-linear nature of recovery.

In addition to adult needs, service plans should account for the child’s needs as well as the characteristics of the social environment. Components include:

1. planning that is phase-oriented and based on a child’s self-regulation skills and the stability of the environment;
2. determining the availability and accessibility of supports and services; and,
3. altering the social environment to prevent re-traumatization (Saxe et al., 2006).
Phase 1 of BSAFE begins with the transition from homelessness (e.g., shelter, motel, transitional program) into housing. Upon transition, the first of 3 four-month BSAFE phases commences. During this phase, the emphasis is on stabilization in housing and connection to community resources. The same BSAFE Partner who engaged and worked with the family in shelter should continue to provide services and supports during the 3 Phases of BSAFE. Specific areas of focus during Phase 1 include the following:

**CREATING A HOME**

Basic housing supplies. When a family enters into housing after a period of homelessness, acquiring the necessary household supplies such as furniture, cleaning supplies, and food can be a time-consuming process. Acquiring basic household supplies can be especially crucial for families who have fled a domestic violence situation and left all their belongings behind. Concretely rebuilding a family’s home life is an important first step in the process of re-entering the community.

During this phase, the emphasis is on stabilization in housing and connection to community resources.

One of the primary concerns of many families upon transition into housing involves making sure the home is livable for the parents and children. As a result, BSAFE teams should work with families to stabilize as quickly as possible in their new homes with all the goods they need to function well. This may involve advocacy across community services and the faith community to obtain furniture and other household supplies. As many families have young children under age 5, it is important at this phase to help families ensure their home is safe for their child(ren). This may mean working with families to ensure that the home is “child proofed” (e.g., outlets are covered, cabinets with cleaning products are
locked, screens and guards are on windows, especially those on upper floors). The transition back to the community can be overwhelming for families; it is important to support parents to ensure their new home is a safe one for children of all ages.

**School enrollment**
It is critical that children miss as little school as possible during and after their experiences of homelessness. BSAFE Partners should have strong relationships with schools in their area, and, in particular, with McKinney-Vento Homeless Liaisons in their school districts. Enrollment in schools and access to school supplies are important considerations as families move into new housing situations. For parents who are working, an afterschool program may also be needed for school age children. Likewise, identifying programs for children to attend during the summer months may also be required for parents to work. It is also important that BSAFE teams understand the rights of families and children experiencing homelessness vis-à-vis education (e.g., children experiencing homelessness are allowed to stay in the same school even if they move during the course of the school year).

**Transportation**
To get children to school and parents to work and appointments, access to transportation is essential for families. BSAFE teams should budget for and ensure access to public transportation. This may include financial assistance to purchase bus or cab fare, subway or metro cards, taxi vouchers, or train tickets. BSAFE Partners should also plan to accompany parents to appointments, particularly during Phase 1.

**ONGOING ASSESSMENT**
While assessment begins during the Pre-BSAFE period, it is important for assessment to be ongoing. Once the family transitions to permanent housing, the BSAFE Partner should continue to assess and gather information about changing needs and when necessary administer standardized instruments. This includes routinely checking in about safety issues, especially for families
with a history of domestic violence. Family members’ individual functioning can be monitored and progress can be systematically re-assessed with measures used during the initial assessment. For example, developmental screeners for the children can typically be re-administered every few months depending on age to monitor progress and ensure a child is staying on track or making progress. The BSAFE Partner should continue service planning based on evolving needs and conduct service planning to prioritize areas of focus for each family member during this and subsequent phases.

### SERVICE PLANNING AND CONNECTING TO SUPPORTS

- Referral and accompaniment to services (medical, behavioral health, benefits, employment, childcare).
- Based on the assessment and service planning process, the BSAFE Partner will work with the family to make appointments with the most appropriate services and supports and accompany the family to these appointments.

The goal of these activities during Phase 1 is to connect the family with services and supports that will provide long-term stability for the parents and children. Services to address trauma, maternal depression parenting support, and children’s development naturally extend from the shelter into the home and school during Phase I.
PHASE 2: STRENGTHEN CONNECTIONS

Linking family members with community-based housing, services and supports is a critical part of the family stabilization process. Determining how, where, and when someone should be referred is an ongoing process that should account for the family members’ needs, goals, and wishes. During Phase 2, the Partner should continue to determine evolving needs, strengthen relationships with community providers, identify complementary resources, and begin the referral process.

MOBILIZING SUPPORT

The BSAFE Partner should become familiar with mainstream and specialized housing for families experiencing homelessness, other housing alternatives, and community services and resources, especially those that are targeted to the needs of families and children who are homeless. Ideally, the Partner should identify programs that offer continuous, coordinated, and flexible care and are motivated to deal with families experiencing homelessness. Whenever possible, they should choose agencies that are strengths-based, are family-oriented, are aware of the high rates of traumatic stress among families who are homeless, and have made some attempt to become “trauma-informed.” BSAFE Partners should be aware of both service gaps in their community and barriers to accessibility and then work to find the best resources for families.

ENSURING CONTINUOUS, COORDINATED, FLEXIBLE CARE

A major goal of BSAFE is to connect family members to community-based housing, services and social networks, and systems of care. Throughout

During Phase 2, the Partner should continue to determine evolving needs, strengthen relationships with community providers, identify complementary resources, and begin the referral process.
Phase 2, the BSAFE Partner facilitates the process of connecting family members to community providers with the goal of helping families develop the skills to negotiate systems of care on their own. Efforts to help families access mainstream services (e.g., Section 8, public housing, TANF, Medicaid, child care vouchers, food stamps) for which they are eligible is critical to ensuring long-term stability. For families who have experienced domestic violence and had to relocate for safety reasons, many have lost vital community connections. Helping families rebuild these connections to anchor them in their community is paramount. This may include facilitating connections to faith-based groups and community programs for children and exploring specific interests and needs the family has to solidify their sense of connectedness to their new community.

During this phase, the BSAFE Partner is actively involved with the family, meeting on a regular basis (once a week or more) to assist parents and children as they begin to “test and adjust” the systems of support that have been established in the community (Herman et al., 2007). Challenges to establishing a community network should be addressed, and strategies should be developed for resolving issues such as conflict and resistance, as well as concrete barriers. The connections to community-based services should be based on the client’s needs and requests and wishes and should be consistent with the priorities and goals established during the assessment process. Building and reconnecting with informal supports (e.g., religious institutions, support groups) and family and friends should also be an essential part of the process.

If the family has a child with intensive service needs (e.g., significant mental health conditions, severe emotional/behavioral dysregulation, developmental disabilities), or multiple children (e.g., 3 or more), a second partner or “child advocate” may be assigned during Phase 2. The child advocate will focus primarily on the service needs of the child and, drawing from the Trauma Systems Therapy approach, will be responsible for establishing a multidisciplinary team of service providers (e.g., physicians, teachers, counselors, psychiatrists) who meet quarterly to discuss and address the needs of the child and his/her parents.

Activities that the BSAFE Partner may engage in to support families’ connections to the community include the following: working with the family and housing managers to
anticipate any challenges that might threaten the family’s housing status, accompanying families to appointments, ensuring transportation and child care for other children, assisting families in understanding and completing forms, educating families about their rights (e.g., educational rights, housing rights), advocating for parent and child needs, and conducting ongoing “informal” assessments to identify changes in needs and progress towards goals.

In some communities, housing and essential services may be limited. In this situation, providers can attempt to implement their plans by creatively mixing available resources and building capacity within their own agencies. For example, a child needing mental health services might be referred to his/her pediatrician for care if mental health services are unavailable. If resources are largely absent, providers may need to arrange appropriate supports from within their own setting. In other situations, systems barriers (e.g., ineligibility, transportation, inflexible scheduling) may interfere with successful referrals. Providers should learn about the stumbling blocks in their locale, work with the program, and collaborate with the client about ways to negotiate them.

### BUILDING FAMILY RESOURCES

As the BSAFE Partner works to connect families to community-based resources, he/she also provides assistance to families to build skills and enhance their own resources. If the organization has already implemented trauma informed care and provided parenting supports, some of these needs may have already been addressed. The BSAFE Partner can then engage in various additional skill-building activities that will be tailored to the unique needs of each family member. These activities may include helping parents develop a realistic budget and timetable for paying bills, establishing routines and sense of safety in the home, reducing stressful situations in their environment, preparing for meetings, and learning to advocate for themselves and their children.
During the third and final phase of BSAFE, the BSAFE Partner works with families to consolidate new skills and connections developed during Phases 1 and 2, solidify relationships with community service providers, and become self-directive. As families become increasingly independent and integrated in the community, the Partner gradually transfers his/her responsibilities to the family and community-based programs.

ENSURING OWNERSHIP OF THE PROCESS

Throughout Phases 1 and 2, the BSAFE Partner works collaboratively with family members to enhance their motivation and obtain their buy-in about the direction of the planning process. The goal over time is to ensure that family members take “ownership” of both the plan and the process and learn ways of negotiating challenging treatment systems, maintaining progress, making decisions, and planning for the future.

STRENGTHENING COMMUNITY RELATIONSHIPS

During Phase 3, the focus of the BSAFE Partner shifts to solidifying the family’s community resources and relationships. The BSAFE Partner reviews the assessment and service plans to identify goals achieved and new goals that may need to be added. Support in achieving these goals is transferred to community providers as networks are built and become more functional. The Partner and family meet less frequently as community providers.
play a larger role in assisting families and supporting skill building. The Partner attends “transitional meetings” with family members and key community-based providers to ensure that connections have been made and are working well and that the family is well integrated into the community. During this time, the organization implementing BSAFE continues to provide skill-building opportunities, most prominently in the form of trauma-informed care, and helps families build ways to cope with the various stressors they may encounter in the community.

Another strategy for strengthening relationships and stabilizing families in the community is to encourage support from peers—other families who have been in similar circumstances and have successfully navigated the transition back to the community. For example, peer supports can be found through community agencies, faith groups, and school-based resources.

TRANSITIONING TO MAINSTREAM SERVICES AND SUPPORTS

By the end of Phase 3, the BSAFE Partner terminates his/her relationship and fully transfers care to community providers. This process must be handled sensitively and the family’s feelings processed. Depending on the circumstances of the termination, a final date might be set or a schedule of intermittent visits might be established. If the family is in permanent housing, there may be an option for the BSAFE Partner to end their formal relationship with the family but remain a resource.
BSAFE is an adaptation of multiple evidence-based and promising practices, and is designed to support families as they transition from homelessness back into the community. This team-based, time-limited intervention begins with engagement, assessment, and supports during their residence in shelter. Initially, the BSAFE team and shelter staff provide intensive supports that taper through the phases of BSAFE. By the end of the 12-month intervention, families will be stably housed, connected with services in the community, and will experience greater autonomy, self-sufficiency, and social connectedness.

For more information about BSAFE training and implementation, please contact info@center4si.com or 617-467-6014.


Bonomi, A.E., Anderson, M., Reid, R.J., Rivara, F.P., Carrell, D., & Thompson, R.S. (2009). Medical and psychosocial diagnoses in women with a history of intimate partner violence. *Archives of Internal Medicine, 169*, 1692-1697.


Instrument available from the National Center for PTSD at www.ptsd.va.gov


APPENDICES

APPENDIX I

Evidence-Based and Promising Practices

Critical Time Intervention (CTI)

Critical Time Intervention (CTI) is designed to prevent recurrent homelessness and other adverse outcomes among persons with severe mental illness (Herman, D., Conover, S., Felix, A., Nakagawa, A. & Mills, D, 2007). CTI was designated an evidence-based practice by SAMHSA’s National Registry of Evidence-Based Programs and Practices. It aims to enhance continuity of care during the transition from institutional to community living. The intervention, which lasts roughly 9 months following institutional discharge, involves 2 components: (1) strengthening the individual’s long-term ties to services, family, and friends; and (2) providing emotional and practical support during the transition. Post discharge services are delivered by workers who have established relationships with patients during their institutional stay. CTI is intended to be used with individuals leaving institutions such as shelters, hospitals, and jails. The intervention is delivered in 3 main phases: (1) transition to the community, which focuses on providing intensive support and assessing the resources that exist for the transition of care to community providers; (2) tryout, which involves testing and adjusting the systems of support that were developed in the first phase; and (3) transfer of care, which completes the transfer of care to community resources that will provide long-term support. An adaptation of CTI, Family CTI, was developed by Dr. Judith Samuels to provide mental health and substance abuse treatment, trauma recovery, housing, support, and family preservation services to homeless mothers with mental illnesses and substance use disorders who are caring for their dependent children.

Relational Advocacy/ROAD

The relational advocacy model comes out of the work of Dr. Lisa Goodman, in collaboration with members of ROAD (Reaching Out About Depression), a grassroots mental health and organizing project for low-income women with depressive symptoms (Goodman, Littwin, Bohlig, Weintraub, Green, Walker, White, & Ryan, 2007; Smyth, Goodman, & Glenn, 2006). ROAD has served hundreds of low-income ethnically diverse mothers in
Cambridge, recruited through flyers and word-of-mouth, all of whom self-identify as struggling with symptoms of depression. One core component of ROAD is the Supportive Action Workshop Series, which provides a setting and workshop structure for low-income women to come together to support each other.

The relational advocacy model is the second component of ROAD. Dr. Lisa Goodman was a Board member and collaborator on ROAD from the beginning. She developed the original relational advocacy model in 2003, in close collaboration with ROAD’s founding project manager (a Harvard Law School fellow), a group of doctoral students, and women who were part of the original group of ROAD participants. This group engaged in a series of ongoing discussions about what type of role would be the most helpful in enabling women to move forward in their lives, who could perform it, and how it could be sustained. The model that emerged from these conversations was entirely responsive to the women’s firm insistence on 4 principles:

1. that isolation and stigmatization were core problems and that they needed someone (whom they decided to call an “advocate”) to help them engage (or re-engage) with others within their own families, within social service agencies, and in their communities;

2. that this advocacy role needed to integrate emotional and instrumental support to avoid the pitfalls of specialization;

3. that advocates needed to pay careful attention to the relationship itself as much as to the activities on which they collaborate; and

4. that the women’s own values, goals and needs, not the goals or desired outcomes of a particular system or agency, should drive the intervention.

Trauma-Informed Care
The prevalence of traumatic stress in the lives of families experiencing homelessness is extraordinarily high. Often these families have experienced on-going trauma throughout their lives in the form of childhood abuse and neglect, domestic violence, community violence, and the trauma associated with poverty and the loss of home, safety, and sense of security. These experiences have a significant impact on how people think, feel, behave, relate to others, and cope with future experiences. Families have learned to adapt to these traumatic circumstances in order to survive, but their ways of coping may seem confusing and out-of-place in their current circumstances.

Given the high rates of traumatic exposure among families who are homeless, it has become clear that understanding trauma and its impact is essential to providing quality care in shelters and housing programs. This realization has lead to the suggestion that programs serving trauma survivors adapt their services to account for their client’s traumatic experiences, that is, they become “trauma-informed.” In order to respond empathically to the needs of trauma survivors, ensure their physical and emotional safety, develop realistic treatment goals, and at the very least avoid re-traumatization, all practices and programs must be provided through the lens of trauma.
To support the process of becoming trauma-informed, organizations can use the TICOMETER®. Developed through fieldtesting with over 400 participants in 68 health and human service agencies, the Center for Social Innovation’s TICOMETER® (Trauma-Informed Care Organizational Meter) is the first and only validated measure of trauma-informed care. It has strong psychometric properties and consists of 35 items that break down into 5 statistically significant domains that make up trauma-informed care. The domains relate to the knowledge and skills of staff, the ability of staff to build trusting relationships with clients, and policies and procedures of the organization that inform how assessments and services are delivered. This instrument was developed to help organizations measure the level of trauma-informed care they provide, and serve as an ongoing resource for evaluating programs and monitoring progress.
## Appendix II. Resources on Screening and Assessment

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<th>Measure</th>
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<th>Sample Items</th>
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<tr>
<td><strong>General Assessment for Families</strong></td>
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| **The Family Service Prioritization Decision Assistance (F-SPDAT)** | The Family Service Prioritization Decision Assistance Tool (F-SPDAT) (OrgCode, 2015) assesses demographics, housing eligibility, income, education, employment, and various safety needs. The F-SPDAT relies on the assessor’s ability to interpret responses and corroborate those with evidence. As such, it may only be used by those who have received training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer. | • Is your family currently homeless?  
• Does your family have any “legal stuff” going on?  
• How are you and your family with paying bills on time and taking care of other financial stuff?  
• Does your family have playtime together? | 20 components with multiple prompts each. | 30-45 minutes | Staff who have received training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer. |
| **Assessing Parents**                              |                                                                                                                                                   |                                                                                                                                                                                                             |         |            |                                                                           |
| **Physical Health**                                |                                                                                                                                                   |                                                                                                                                                                                                             |         |            |                                                                           |
| **SF-8 Health Survey**                             | The SF-8 Health Survey (Ware et al., 2001) assesses the degree to which health issues have interfered with functioning in the past month.           | • Overall, how would you rate your health during the past 4 weeks?  
• How much bodily pain have you had during the past 4 weeks? | 8 items  | 5-10 minutes | Self-report or paraprofessionals.                                         |
| **Mental Health: Emotional Needs and Maternal Depression** |                                                                                                                                                   |                                                                                                                                                                                                             |         |            |                                                                           |
| **The Patient Health Questionnaire (PH-Q)**        | The Patient Health Questionnaire (PH-Q) is a 9 item self-report questionnaire that screens for the presence of depressive symptoms over the previous 2 weeks, and assess the degree of severity (Kroenke & Spitzer, 2002). It is based on the diagnostic criteria for major depressive disorders in the Diagnostic and Statistical Manual Fifth Edition (DSM-5) and can be helpful in identifying depression. Readily available for download and endorsed by SAMHSA, the PH-Q is the most common screening tool used to identify depression and can reliably alert BSAFE Partners to a parent’s need for mental health services. | Over the last 2 weeks, how often have you been bothered by any of the following problems?  
• Little interest or pleasure in doing things.  
• Poor appetite or overeating. | 9 items  | 5 minutes   | Self-report or paraprofessionals.                                         |
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| Beck Depression Inventory-II                       | The Beck Depression Inventory-II measures the intensity, severity, and depth of depression by asking 21 questions. The first 13 questions focus on psychological manifestations of depression while questions 14-21 assess physical symptoms. The BDI-II reflects revisions in DSM-IV-TR (Beck, Rush, Shaw, & Emery, 1979; Beck & Steer, 1984; Beck, Steer, & Carbin, 1988). | Read each group of statements carefully and pick the one statement that best describes the way you have been feeling during the past 2 weeks:  
• I do not feel sad.  
• I feel sad much of the time.  
• I am sad all of the time.  
• I am so sad or unhappy that I can't stand it. | 21 items | 5-10 minutes | Mental health or other trained professionals. |
| SCL 90-Revised                                      | The SCL 90-Revised evaluates a broad range of psychological problems and symptoms of psychopathology (SCL-90-R; Derogatis & Unger, 2010). It is a 90 item self-report measure designed to evaluate a broad range of psychological problems and symptoms of psychopathology. The test helps measure 9 primary symptom dimensions and is designed to provide an overview of a patient’s symptoms and their intensity at a specific point in time or over time to assess progress. A Global Severity Index can be used as a summary of the test. By providing an index of symptom severity, the assessment helps facilitate decisions about service needs. | In the previous week, how much were you bothered by:  
• Feeling lonely.  
• Feelings of worthlessness.  
• Spells of terror or panic.  
• Hearing voices that other people do not hear. | 90 items | 12-15 minutes | Mental health professionals. |

**Trauma and Post Traumatic Stress Disorder (PTSD)**

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| The Adverse Childhood Experiences International Questionnaire (ACE-IQ) | The ACE-IQ is a 43-item questionnaire intended to measure adverse childhood experiences in adults over 18 years (WHO, 2014).                                                                 | When you were growing up, during the first 18 years of your life:  
• Did you live with a household member who was a problem drinker or alcoholic, or misused street or prescription drugs? | 43 items | 5-10 minutes | Self-report, trained paraprofessionals, mental health professionals, and qualified researchers. |
| PTSD Checklist for DSM-5 (PCL-5)                             | The PCL-5 is a self-report measure that assesses the 20 DSM-5 symptoms of PTSD (Weathers et al., 2013b). The PCL-5 has a variety of purposes, including: a) Monitoring symptom change during and after treatment; b) Screening individuals for PTSD; and c) Making a provisional PTSD diagnosis. | In the past month, how much were you been bothered by:  
• Repeated, disturbing, and unwanted memories of the stressful experience? | 20 items | 5-10 minutes | Trained paraprofessionals, mental health professionals, and qualified researchers. |
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<tr>
<td><strong>Life Events Checklist (LEC)</strong></td>
<td>The Life Events Checklist for DSM-5 (LEC-5) is a self-report measure designed to screen for potentially traumatic events in a respondent’s lifetime (Weathers et al., 2013a). The LEC-5 assesses exposure to 16 events known to potentially result in PTSD or distress and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items.</td>
<td>Screens exposure/level of exposure to 17 kinds of events, e.g.:</td>
<td>17 items</td>
<td>5-10 minutes</td>
<td>Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers.</td>
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| **Life Stressor Checklist-Revised (LSC-R)**  | The Life Stressor Checklist-Revised is a self-report measure that assesses traumatic or stressful life events (National Center for PTSD). The measure has a focus on events relevant to women, such as abortion. The questionnaire includes 30 life events, including experiences with natural disasters, physical or sexual assault, death of a relative, and other events. It follows a yes/no format. | • Were you ever put in foster care or put up for adoption?  
• Have you ever had an abortion or miscarriage (lost your baby)?  
• Did you ever have sex (oral, anal, genital) when you didn’t want to because someone forced you in some way or threatened to harm you if you didn’t? | 30 items | 15-30 minutes | Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers. |
| **Brief Trauma Questionnaire (BTQ)**         | The Brief Trauma Questionnaire (BTQ) is a 10-item self-report questionnaire derived from the Brief Trauma Interview (Schnurr, et al., 1995; Schnurr, et al., 2002). The BTQ was originally designed to assess traumatic exposure according to DSM-IV but specifically asked only about Criterion A.1 (life threat/serious injury) because of the difficulty of accurately assessing A.2 (subjective response) in a brief self-report format. Criterion A.2 has been eliminated from the PTSD diagnostic criteria in DSM-5, so the BTQ provides a complete assessment of Criterion A. | • Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?  
• Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or thought you would be injured; or you received bruises, cuts, welts lumps, or other injuries? | 10 items | 5 minutes       | Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers. |
| **Trauma History Screen (THS)**              | The Trauma History Screen (THS) is a brief, 13-item self-report measure that examines 11 events and one general event, including military trauma, sexual assault, and natural disasters (Carlson et al., 2011). | The events below may or may not have happened to you:  
• A really bad car, boat, train, or airplane accident (Yes or No).  
  ° Number of times something like this happened. | 13 items | 2-5 minutes | Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers. |
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| **Traumatic Events Questionnaire (TEQ)** | The 11-item Traumatic Events Questionnaire (TEQ) assesses 9 events such as experiencing a serious accident (industrial, farm, or car), receiving news of serious injury or death of someone, and being a victim of physical or sexual abuse (Vrana & Lauterbach, 1994). It also allows for an unspecified traumatic event to be examined. For each event endorsed, respondents are asked to provide the frequency, age at the time(s) of the event, degree of injury, degree of life threat, degree of how traumatizing the event was at the time, and degree of how traumatizing the event is currently. | Have you witnessed someone who was mutilated, seriously inured, or violently killed?  
• How many times?  
• How old were you at the time  
• Were you injured?  
• Did you feel your life was threatened?  
• How traumatic was this for you at that time?  
• How traumatic is this for you now? | 13 items | 5 minutes | Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers. |
| **Traumatic Life Events Questionnaire (TLEQ)** | The TLEQ is a 23-item self-report measure of 22 types of potentially traumatic events including natural disasters, exposure to warfare, robbery involving a weapon, physical abuse and being stalked (Kubany et al., 2000). For each event, respondents are asked to provide the number of times it occurred and whether fear, helplessness or horror was present. Some events include a question about presence of injury, and for victimization questions, characteristics of the perpetrator (e.g., "Stranger?). The last question asks respondents to identify the one event that "causes you the most distress" among those endorsed. | Were you involved in a motor vehicle accident for which you received medical attention or that badly injured or killed someone? | 23 items | 10-15 minutes | Information on the measure is available to everyone. However, the assessment tool itself can only be distributed to qualified mental health professionals and researchers. |
| **Trauma Symptoms Inventory (TSI)/ (TSI-2)** | The TSI and TSI-2 are self-report measures of posttraumatic stress and other psychological sequelae of traumatic events, including the effects of sexual and physical assault, intimate partner violence, combat, torture, motor vehicle accidents, mass casualty events, medical trauma, traumatic losses, and childhood abuse or neglect (Briere, 1995; 2011). | Respondents are asked to rate how often each symptom has happened to them in the past 6 months. E.g.:  
• Pushing painful memories out of your mind. | 100 items in TSI; 136 items in TSI-2 | 20 minutes | Mental health professionals. |
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| **Clinician-Administered PTSD Scale (CAPS)** | The Clinician-Administered PTSD Scale (CAPS) is the gold standard for assessing PTSD. This 30-item structured interview corresponds to DSM-IV criteria for PTSD and can be used to make a current (past month) or lifetime diagnosis of PTSD or to assess symptoms over the past week. CAPS assessment is conducted in reference to up to 3 traumatic stressors (Blake et al., 1995; Orsillo, 2001; Weathers, Keane, & Davidson, 2001; Weathers, Ruscio, & Keane, 1999). The full CAPS takes approximately 45 minutes to complete, but it is not necessary to administer this tool in its entirety. | • Begins with administering a checklist of traumatic events.  
• For up to 3 traumatic events experienced, follow-up questions include “What happened?” and “How did you respond emotionally?”                                                                 | 30 items | 30-45 minutes | Mental health professionals. |
| **Substance Use**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                           |         |         |                 |
| Michigan Alcohol Screening Test (MAST), Revised | The 22-item Michigan Alcohol Screening Test (MAST), Revised, has valid psychometric properties and will help identify clients with substance use issues (Selzer, 1971; Teitlebaum & Mullen, 2000). It can be used with adults and adolescents.                                                                                                                                                                                                                                                                                                                                 | • Are you able to stop drinking when you want to?  
• Have you ever lost friends because of your drinking?  
• Have you ever been in a hospital because of drinking?                                                                 | 22 items | 8 minutes    | Self-report or paraprofessionals. |
| Drug Abuse Screening Test (DAST)           | The 28-item Drug Abuse Screening Test (DAST) also has valid psychometric properties and will help identify clients with substance use issues (Gavin, Ross, & Skinner, 1989). A 10-item screener, the DAST 10, is also available. Both can be used with adults and older youth.                                                                                                                                                                                                                                                                                                                                 | • Have you used drugs other than those required for medical reasons?  
• Have you abused prescription drugs?  
• Do you abuse more than one drug at a time?                                                                 | 28 items | 8 minutes    | Self-report or paraprofessionals. |
| **Parenting**                             | The Parenting Daily Hassles Scale is a self-report measure that assesses the frequency and impact of 20 potential “hassles” (Crnic & Greenberg, 1990) that parents might experience in the daily care of their children (e.g., cleaning up after him/her). This scale is highly reliable. The parent or provider can fill out the questionnaire, which takes about ten minutes to complete.                                                                                                                                                                                                 | Indicate how often these events happen to you:  
• Continually cleaning up messes of toys or food.  
• The kids will not listen or do what they are asked without being nagged.                                                                 | 20 items | 10 minutes   | Parent/caregiver and paraprofessionals. |
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| Parental Stress Inventory-4 (PSI4)          | Parental Stress Inventory-4 (PSI4) is a 120-item instrument designed to evaluate the magnitude of stress in the parent–child system. It focuses on 3 major sources of parenting stress: child characteristics, parent characteristics, and situational/demographic life stress. The PSI-4 is commonly used as a screening and triage measure and can reliably identify risk for maltreatment or problems in the parent-child system. Because it identifies the source of stress (e.g., situational, parent mental health issues, child temperament) it can help BSAFE Partners better target intervention and service referrals to address the issue. It can take 20-30 minutes to administer and is best conducted by a trained professional (Abidin, 2012). A short form (36 item) is available. | For life stress items, reporters indicate whether the events have occurred (Yes/No) in the past 12 months.  
  • Having a child caused problems with spouse.  
  • Child wakes in bad mood.  
  • Child is moody and easily upset.  
  • Never able to do things that I like to do. | 120 items | 20-30 minutes | Mental health professionals. |

### Social Networks and Supports

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| The Interpersonal Support Evaluation List (ISEL)-Shortened Version (1985) | The Interpersonal Support Evaluation List (ISEL)-Shortened Version (1985) is a 12-item measure of social support. It is reliable and valid (Cohen, Mermelstein, Kamarck, & Hoberman, 1985; Brookings & Bolton, 1988; Payne et al., 2012). It has 3 subscales that measure different dimensions of perceived social support: 1) Appraisal Support, 2) Belonging Support, and 3) Tangible Support. | Each dimension is measured on a 4-point scale: Definitely True, Probably True, Probably False, Definitely False  
  • I don't often get invited to do things with others.  
  • If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me. | 12 items | 5-10 minutes | Self-report or paraprofessionals. |
| MOS Social Support Survey Instrument         | MOS Social Support Survey Instrument (Sherbourne & Stewart, 1991) is an 18-item instrument that seeks to measure the dynamic and complex nature of social support systems. Measurements of social supports are conducted across the following domains: tangible support, affectionate, positive social interaction, and emotional or informational support. | People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to YOU if you need it?  
  • Someone to help you if you were confined to bed.  
  • Someone you can count on to listen when you need to talk. | 18 items | 5-10 minutes | Self-report or paraprofessionals. |
<p>| Social Support Questionnaire-6 (SSQ-6) | Social Support Questionnaire-6 (SSQ-6; Sarason et al., 1987) is a 6-item abbreviated version of the SSQ that asks participants to 1) list people in their environment who provide them with various types of help or social support, and 2) rate their satisfaction with the support they receive in each of these domains. Thus, the SSQ provides information about the size of the person’s social network as well as their perception of the support they receive. | • Who can you really count on to be dependable when you need help?  ◦ How satisfied you are with the overall support you have? | 6 items | 5-10 minutes | Self-report or paraprofessionals. |</p>
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| **Ages and Stages Questionnaires (ASQ)** | The ASQ is endorsed by the American Academy of Pediatrics, and recommended by the Administration of Children and Families, to screen for developmental delays among homeless children (Moodie et al, 2014). The ASQ, Third Edition (ASQ-3) identifies developmental progress in children between the ages of 1 month to 5½ years. It has a parent-centric approach and is easy for parents and paraprofessionals to administer. Different questionnaires are used for different age groups. Each addresses 5 key developmental areas: communication, gross motor, fine motor, problem-solving, and personal-social skills (Bricker & Squires, 1999). The questionnaires are 30 items each and take 10 to 20 minutes to administer and no more than 3 minutes to score. | • (2 month) Does your baby touch her face with her hands?  
• (18 month) Does your child walk well and seldom fall?  
• (4 year) Does your child catch a large ball with both hands?  
• (5 year) Can other people understand most of what your child says? If no, explain. | 30 items | 10-20 minutes | Parent/caregiver and paraprofessionals. Administration, scoring, and interpretation requires use of a manual. |
| **The Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ: SE-2)** | The ASQ: SE-2 is a parent-completed, highly reliable tool focused solely on social and emotional development in very young children. Administered to children ages 1-6 years, The ASQ-SE-2 assesses self-regulation, compliance, social-communication, adaptive functioning, autonomy, affect, and interaction with people in 6-month intervals (Bricker & Squires, 2002). | • (6 month) Does your baby like to be picked up and held?  
• (2 year) When upset, can your child calm down within 15 minutes?  
• (4 year) Does your child use words to tell her what she wants or needs?  
• (5 year) Do other children like to play with your child? | 30 items | 10-15 minutes | Parent/caregiver and paraprofessionals. Administration, scoring, and interpretation requires use of a manual. |
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<tr>
<td>The BRIGANCE Early Childhood Screens III</td>
<td>The BRIGANCE Early Childhood Screens III uses different forms to assess children age 0–35 months, 3–5 years, and in kindergarten and first grades. The BRIGANCE screeners assess children’s physical development, language, academic/cognitive skills, self-help, and social-emotional skills. Each Screen has at least 32 sections. Each section contains between 2 and 24 items. The screens take only 10–15 minutes per child. They are available for use by clinicians and paraprofessionals and include observation and parent report (Enright, 1991).</td>
<td>Depending on age, observational assessments include fine motor skill tasks like unwrapping objects (physical development), responding with a smile (social and emotional skills), and verbalizing the names of common objects (language development).</td>
<td>10-15 minutes per screen.</td>
<td>10-15 minutes</td>
<td>Mental health and other trained professionals.</td>
</tr>
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</table>
| BASC-2 Behavioral and Emotional Screening System (BASC-2 BESS) | The Behavior Assessment System for Children, Second Edition (BASC-2) Behavioral and Emotional Screening System (BASC-2 BESS) offers a reliable, quick, and systematic way to determine behavioral and emotional strengths and weaknesses of children and adolescents in preschool through high school (Kamphaus & Reynolds, 2007). The BASC-2 BESS consists of brief forms (25–30 items each) that can be completed by teachers, parents, and students allowing for a range of observations about a child’s behavior. They require no formal training for the raters. A single total score reliably and accurately predicts a broad range of behavioral, emotional and academic problems. | Client sample items:  
  • I am good at making decisions.  
  • I worry but I don’t know why.  

Parent sample Items:  
  • Seems lonely.  
  • Breaks the rules.  

Teacher sample items:  
  • Communicates clearly.  
  • Gets into trouble. | 25 to 30 items | 5-10 minutes per form | Mental health professionals, with administration including scales for client, teacher, and parent perspectives. |
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<td><strong>Behavior Rating Inventory of Executive Function (BRIEF)</strong></td>
<td>For children 5-18 years, the Behavior Rating Inventory of Executive Function (BRIEF), consists of a parent/teacher/provider questionnaire designed to assess behavioral regulation (Gioia et al., 2000). Children scoring in the clinical range on the BRIEF will require additional mental health and educational supports. For children between the ages of 2 years and 5 years 11 months, the Behavior Rating Inventory of Executive Function Preschool Version (BRIEF-P) can be used.</td>
<td>• Acts wilder or sillier than others in groups (birthday parties, recess). • When given things to do, remembers only the first or last. • Does not bring home homework, assignment sheets, materials, etc.</td>
<td>BREIF: 86 items BRIEF-P: 63 items</td>
<td>10-15 minutes</td>
<td>Mental health professionals.</td>
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<td><strong>Child Trauma</strong></td>
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<td><strong>Trauma Symptom Checklist for Children (TSCC)</strong></td>
<td>The TSCC is a 54-item self-report measure of posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have been a witness to violence. The instrument is suitable for individual or group administration (Briere, 1996).</td>
<td>The child is presented with a list of thoughts, feelings, and behaviors and asked to mark how often each thing happens to them. Examples: • Bad dreams or nightmares. • Wanting to hurt myself.</td>
<td>54 items</td>
<td>15-20 minutes</td>
<td>Mental health professionals.</td>
</tr>
<tr>
<td><strong>Trauma Symptom Checklist for Young Children (TSCYC)</strong></td>
<td>The TSCYC is a 90-item caretaker-report instrument that can be used to assess PTSD symptoms in children between 3 and 12 years old (Briere, 2005). It is the first fully standardized and normed broadband trauma measure for young children who have been exposed to traumatic events such as child abuse, peer assault, and community violence.</td>
<td>Items are rated by caretakers on a 4-point scale from 1 = &quot;Not at all&quot; to 4 = &quot;Very Often&quot; in reference to the previous month. Examples: • Looking sad. • Throwing things at friends or family members.</td>
<td>90 items</td>
<td>20 minutes</td>
<td>Mental Health or other trained/certified professional.</td>
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