Interagency Council on Affordable Housing
Public Hearing: Tuesday, 12/11/2012 from 10:00-11:00AM

The Interagency Council on Affordable Housing conducted a public hearing at the Lyceum in order to receive public comments on the establishment of the new Department of Housing. A total of seven individuals provided oral testimony; an additional five pieces of written testimony were submitted.

Summary of Oral Testimony

The first three speakers testified in opposition to the recommended transfer of the Supportive Housing for Families (SHF) program from the Department of Children and Families into the new Department of Housing. From **The Connection, Inc**., **Acting President and CEO Lisa DeMatteis** and **Attorney Beth Hogan, Project Developer,** emphasized that the SHF is primarily a child welfare program. SHF offers clinical case management for at risk children and families, in which housing is utilized as a platform in which care is given. **Dr. Anne Farrell, an Associate Professor of Human Devleopment and Family Studies at UConn**, testified on the uncertainty surrounding the transfer of the SHF program and the implications of the transition. DCF was recently awarded a $5M grant for the federal Administration of Children and Families, in which Dr. Farrell, and her colleague Dr. Preston Britner, are the principal investigators of the evaluation component. Dr. Farrell explained that the move to a new department would jeopardize the implementation of this grant, which is very prestigious – Connecticut was one of only five national sites to be funded, as well as the only statewide initiative.

Raphael Podolsky from the **Legal Assistance Resource Center of Connecticut, Inc.** offered two brief comments regarding the transfer process:

1. As with any reorganization, adequate staffing levels must be ensured. Especially in this time of budget crisis, it is important to make sure that these programs being transferred are not being put into a weaker context as a result.
2. Entireties of programs, instead of parts, should be transferred to the new department. Some of the proposed statutory provisions to be transferred are not all-inclusive of a particular program.

Erin Kemple, Executive Director of the Connecticut Fair Housing Center, urged the Council to affirmatively further fair housing by making fair housing a priority within the new department, incorporating affirmative fair housing strategies into the workplan of every state employee involved in housing policy, and examining restrictive municipal zoning ordinances. In addition, Ms. Kemple suggested promoting a unified

housing policy, which would include CHFA programs such as the low income housing tax credit and the public housing portfolio.

Mary Wilton Campbell, **member of the Northwest Connecticut Property Owners Association**, testified that the Council should add a rental property owner as a member, and receive input from rental property owners and property managers before the report is finalized.

John Bradley, Executive Director from Liberty Community Services, testified that, after the transition, he hopes to see the same commitment and sense of importance from the new Department of Housing staff that he has received through DSS. In addition, he shared concerns that the timing of the transition may result in the delay of a new contract and quarterly payment for his AIDS Housing grant, and proposed a three month contract extension that could be executed before July 1st in order to prevent a disruption in services.

Summary of Written Testimony:

Mag Morelli, President of LeadingAge Connecticut: Ms. Morelli submitted testimony in support of including the coordination of senior housing within the Department of Housing. She expressed the importance of recognizing the unique role and needs of elderly housing sites and offered the expertise and assistance of the provider members of LeadingAge Connecticut to the Council and new Department of Housing.

Susan Salters, Community Inclusion Specialist at Independence Unlimited: Ms. Salters proposed the addition of new program under the Department of Housing that would focus on the provision of accessible housing for people with disabilities. She expresses the chronic need for accessible housing in affordable units, especially for those using wheelchairs or other mobility devices.

David Fink, Policy Director for Partnership for Strong Communities: Mr. Fink emphasized the promotion of mixed-income housing and called for a revaluation of how "housing affordability" is measured, particularly regarding the exclusion of related costs such as transportation, and location-specific costs of healthcare, nutrition, environmental quality, and education.

Alicia Woodsby, Deputy Executive Director for the Partnership for Strong Communities*:* Ms. Woodsby emphasized that the new Department of Housing should be designed and structured with an understanding of the following needs of the system:

a coordinated, statewide crisis response system to prevent homelessness and more efficiently target resources; affordable and supportive housing to meet the needs of homeless and at-risk populations in the state; income growth and employment for people who are homeless or at-risk of homelessness; improved health and housing stability among those who are homeless or at-risk of homelessness; and a service delivery system for runaway and unaccompanied youth who are homeless.

Betsy Crum, Chair of the Reaching Home Housing Workgroup: Ms. Crum's testimony supplements and expands upon the recommendations submitted by Alicia Woodsby. The Workgroup's recommendations include: implementing a unified approach to accessing financing for affordable housing; implementing a true one-stop application process; transforming staff to focus on development, program administration, and production, rather than regulation; and investing in capacity-building activities that will result in high quality, "ready-to-go" proposals that meet both local needs and state priorities.

The Connection
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The Connection
Written Testimony and Exhibits

for

The Honorable Anne Foley OPM and
The Interagency Council on Affordable Housing

12/11/2012

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The Connection®
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Founded 1972
www.theconnectioninc.org

Building Communities. Rebuilding Lives.

Building safe, healthy, caring communities; inspiring people to reach their full potential as productive and valued citizens.

Lisa DeMatteis,
Senior Director Supportive Housing for Families,
Acting President and CEO
The Connection, Inc.
100 Roscommon Drive, Suite 203
Middletown, CT 06457

December 10th, 2012

Chairperson Anne Foley, Undersecretary for Policy Development and Planning
Office of Policy and Management
Interagency Council on Affordable Housing
State of Connecticut
450 Capitol Avenue
Hartford, CT 06106

To the Honorable Chairperson Ann Foley and Council Members,

When *Supportive Housing for Families* (SHF®) was formed in 1998, we created a *child welfare* program operating under Connecticut's Department of Children and Families. The program's name is a misnomer and we are in the process of re-branding the program and changing its name. It is important to clarify that SHF is not a "housing first" program; it is a clinical case management program for at risk children and families that utilize housing as a platform through which care is given. DCF's clinical supports to vulnerable populations through SHF puts the program outside of the selection criteria and within the exclusion criteria set forth by this council. That is: "Clinical services provided by state agencies with expertise working with sub-populations, such as individuals with mental illness, developmental disabilities, criminal offenders, etc."

We are not opposed in principle to the idea of having a state operated pool of housing funds to make affordable housing a seamless process. Our partners, and developers believe that this is an innovative way to assist people whose primary need is affordable housing. The intricacies of the SHF blended model, however, make it impossible to extricate the funds we receive for housing, from the clinical case management supports. SHF focuses on families that have intensive child welfare involvement, both family reunification and preservation cases. Over the life of the program we served 5,918 unduplicated families; and in FY 2011, we served 648 families, 1,464 children, in 76 towns. Still there was far more need. Currently SHF is serving over 500 families. Our clients not only suffer from chronic homelessness but 75% of the adult clients have been diagnosed with trauma, mental illness or substance abuse upon intake, and 100% of the clients were given behavioral health referrals upon intake.

We have proven positive outcomes that have been validated by independent sources based on our child welfare approach. UConn's Department of Human Development and Family Studies has evaluated the program for many years and has shown successful outcomes. A recent review showed:

- 80% of SHF clients referred to the program complete successfully.
- 85% of clients with substance abuse issues were drug free at exit.
- 73% of clients had improved access to healthcare.

UCONN has published two articles in peer-reviewed journals about SHF's impact. SHF was evaluated by PRIB in 2009 and was reviewed most favorably of the 5 like-programs that were evaluated. SHF has been cited as a model program by the Child Welfare League of America.

This past October, DCF was awarded a $5 million grant from the federal Administration of Children and Families in recognition of and to further develop the existing SHF model. If SHF was modified from its current form, the comparison group for this new Connecticut-based ACF initiative would no longer exist and there would no longer be a basis in which to build an enhanced model.

The following exhibits that we have included to demonstrate; 1) an expense detail for the program, 2) facts about who SHF serves, 3) program facts, efficacy and outcomes, 4) a budget analysis, and 5) client support of the program.

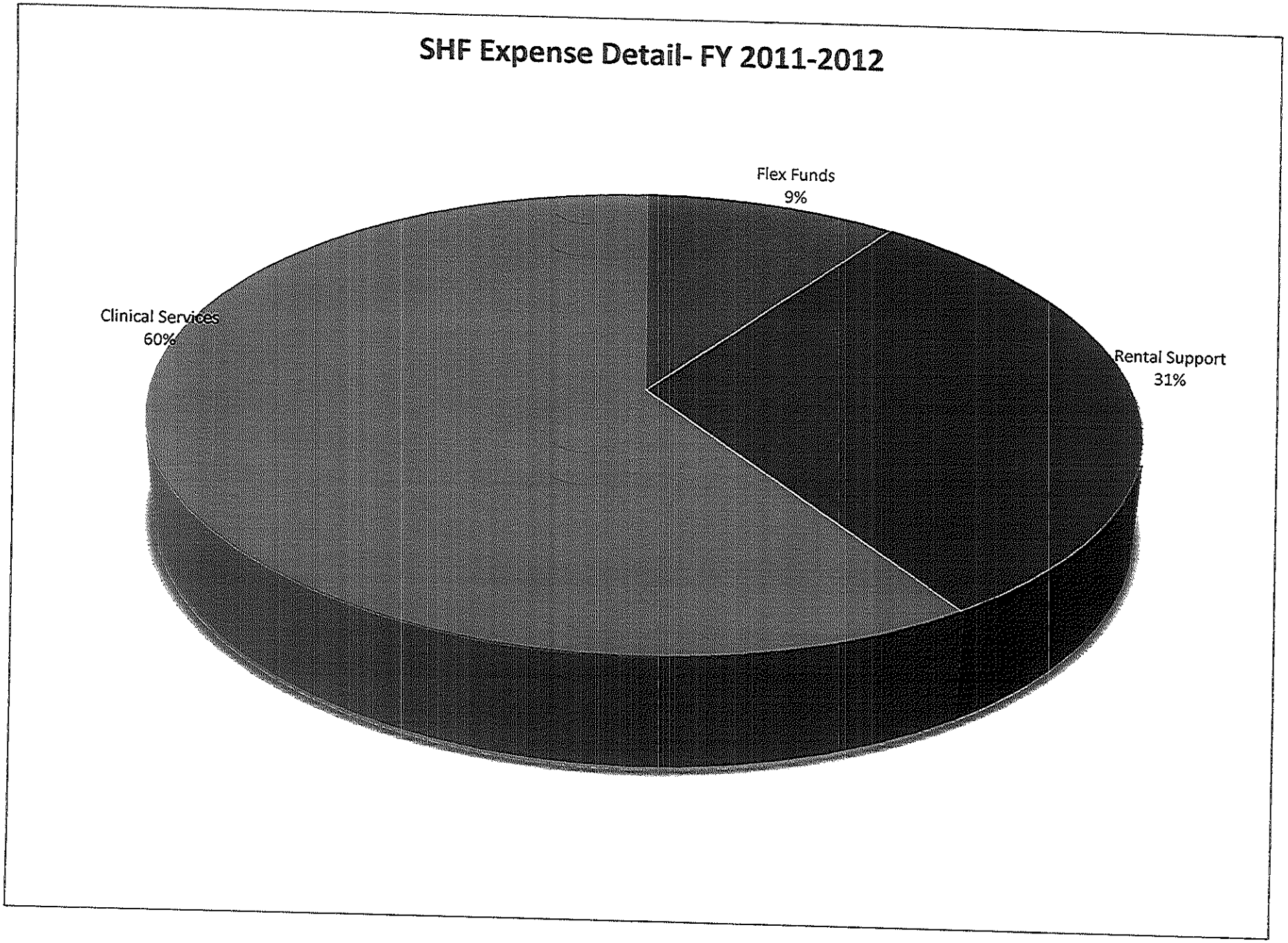
On behalf of The Connection I would like to thank you for this opportunity to share with you the accomplishments of the nationally recognized SHF program. We look forward to continuing to work with our partners and hope to create new partnerships as we develop our blended SHF model to intensify our clinical services for vulnerable DCF-involved families.

Sincerely,

Lisa DeMatteis

Lisa DeMatteis, Acting President and CEO

[4] Exhibits


SHF Expense Detail- FY 2011-2012
Flex Funds
9%
Rental Support
31%
Clinical Services
60%

Towns Served	Number of Families Served	Number of Children Served
Ansonia, CT	10	22
Ashford, CT	1	4
Bantam, CT	1	2
Berlin, CT	1	5
Bethel, CT	3	6
Bloomfield, CT	3	4
Bolton, CT	1	1
Branford, CT	2	2
Bridgeport, CT	41	95
Bristol, CT	13	27
Broad Brook, CT	1	2
Brooklyn, CT	1	1
Cheshire, CT	1	1
Colchester, CT	1	2
Cos Cob, CT	1	2
Danbury, CT	9	14
Danielson, CT	4	7
Dayville, CT	2	6
Derby, CT	5	12
East Granby, CT	1	1
East Hartford, CT	18	40
East Haven, CT	5	10
Ellington, CT	1	2
Enfield, CT	6	7
Fairfield, CT	1	5
Glastonbury, CT	1	4
Groton, CT	4	11
Hamden, CT	8	20
Hartford, CT	62	158
Jewett City, CT	3	5
Manchester, CT	15	30
Meriden, CT	32	70
Middletown, CT	14	25
Milford, CT	3	9
Moosup, CT	3	7
Naugatuck, CT	2	6
New Britain, CT	55	133
New Haven, CT	81	170
New London, CT	13	26
New Milford, CT	2	1
Newington, CT	2	5
North Grosvenordale, CT	1	4
North Haven, CT	1	4
Norwalk, CT	23	59
Norwich, CT	19	42
Oakdale, CT	1	1
Old Lyme, CT	1	2
Old Saybrook, CT	2	5
Putnam, CT	4	9
Rogers, CT	1	6
Seymour, CT	1	2
Shelton, CT	4	9
Sherman, CT	1	2
Simsbury, CT	1	2
Somers, CT	1	2
Southington, CT	2	4
Stafford Springs, CT	3	10

Towns Served	Number of Families Served	Number of Children Served
Stamford, CT	20	66
Stonington, CT	1	3
Stratford, CT	4	10
Taftville, CT	4	7
Thomaston, CT	1	3
Torrington, CT	12	34
Uncasville, CT	2	5
Vernon, CT	8	28
Wallingford, CT	3	5
Waterbury, CT	54	105
Waterford	1	2
West Hartford, CT	6	11
West Haven, CT	10	25
Westport, CT	1	1
Wethersfield, CT	4	6
Willimantic, CT	7	10
Windsor Locks, CT	3	6
Windsor, CT	3	8
Winsted, CT	5	11
Total clients Served FY12	648	1464

SHF Fact Sheet

What is SHF?

A *child welfare* program that provides supportive services to families with DCF involvement. The program is committed to preserving families at risk of separation and reunifying families who have been separated by assisting the families in securing permanent stable affordable housing.

Supportive Housing for Families® uses a three-pronged approach:

1. Intensive case management services
2. Provide flexible funds to assist with security deposits, utility bills, etc.
3. With the assistance of DSS provide families with Section 8 vouchers or RAP certificates

Why do we need SHF?

SHF is not a "housing first" program, it has an intricate blended clinical and housing supports model. SHF is dedicated to activities that renew and preserve vital parent/child relationships-activities that strengthen families' support systems through the provision of intensive case management services and safe, quality housing. Similar programs often provide only case management or housing, which creates greater challenges for coordination of services.

How much do services cost?

On average it costs $15,600- $20,000 per year to serve each family. This amount is inclusive of rent, utilities, furniture, miscellaneous expenses.

Expected Outcomes for 2012-2013

- Within 90 days after the initial NCFAS screening, at least 80% of clients who have a documented behavioral health disorder (e.g. mental illness, substance use disorder) will be referred to services to treat the disorder
- At least 60% of clients referred to behavioral health services will attend the intake session
- 100 % of clients will have a written individualized service plan
- At least 85 % of clients will receive an average of four hours of face to face meetings with their case managers each month
- At least 85% of clients will be provided with safe and affordable housing within the first year
- 100 % of clients will live in homes inspected and approved by the Housing Quality Standard (HQS) of the federal governments office of Housing and Urban Development (HUD)
- After 180 days of receiving services
    - 75% of clients will have increased their baseline score in the Overall Environment portion of the NCFAS
- After one year of service at least 75% of clients will have maintained or increased their score in Overall Environment portion of the NCFAS
- By discharge at least 85% of clients will have increased their Financial Management score on the NCFAS
- By discharge at least 80% of clients will have completed more than 90% of their Individualized Service Plan goals.

For further details, see http://www.theconnectioninc.org/SHF.html

Ladies and Gentlemen, thank you so much for allowing me the opportunity to present my testimony to you this afternoon.

My name is Evelyn Santiago, I am a former client and graduated from The Supportive Housing for Families Program. I would like to share with you this afternoon my experience of myself and my sons Craig and Tishawn Tillman. This is how my story began, I was a victim of domestic violence from another state. I escaped along with my sons and came to Connecticut. I had no possessions and went for help to the State of Connecticut Dept. of Social Services. A worker helped my family with a temporary stay at a hotel where I first lived. I started my life over again, finding a day care for my sons and a part-time job for myself.

Then, I found a one bedroom apartment for a small start with myself and my sons. As years passed by, I started to have a difficult situation. I lost my father and my best friend suddenly passed away. It took a toll on me. As I continued to struggle on my path, my sons were growing older then, and the place I lived in was beginning to have problems. They changed the landlord and the agent was in another state. The apartment became roach infested, there were mice. There was a leak in the roof and my bathroom ceiling was collapsing. Both of my sons have asthma, and the mold and mildew was affecting their health. My son Craig was having emotional and behavioral challenges. I lost my job then my mother suddenly got ill. I was receiving disability checks for $950.00 a month and had to pay $650.00 a month for my rent and expenses, it wasn't enough. The landlord wouldn't fix anything if I didn't pay in full. I attempted to pay my bills and assist my mother. I was devastated, I had no where to go. Things fell behind and I was threatened with evictions several times. If I had had to stay in that apartment, DCF could have removed my children from my care, but they didn't. They referred me to the Community Child Guidance Clinic for services for the boys, they referred me to Supportive Housing for Families, they referred me to CHR for emotional support for me. I remember standing in my then living room with my DCF worker, with Robin from Child Guidance and with Chelsea from Supportive Housing for Families. They walked around my apartment, they noticed the bathroom ceiling. They saw how disoriented we were at that time.

Chelsea's first reaction was to be sure my family was well. However the apartment wasn't in good condition. She was very concerned for my family and the environment. Chelsea (my SHF Case Manager) started to work on helping me and my family as quick as possible to find another place to live and work on my budget expenses and other support services for me and my sons. Within a few months, I received a Rap Certificate from the state, which was such good news. My family will not have to deal with this kind of situation happening again. Chelsea kept in touch with my other providers and together, they helped me and my boys start a new life. To have all of those providers working together with me in my home is what worked. It was hard for me to trust, but I felt a strong Connection with my Supportive Housing Case Manager and with my DCF worker. Together with all of the services I was referred to and a new apartment, things got much better.

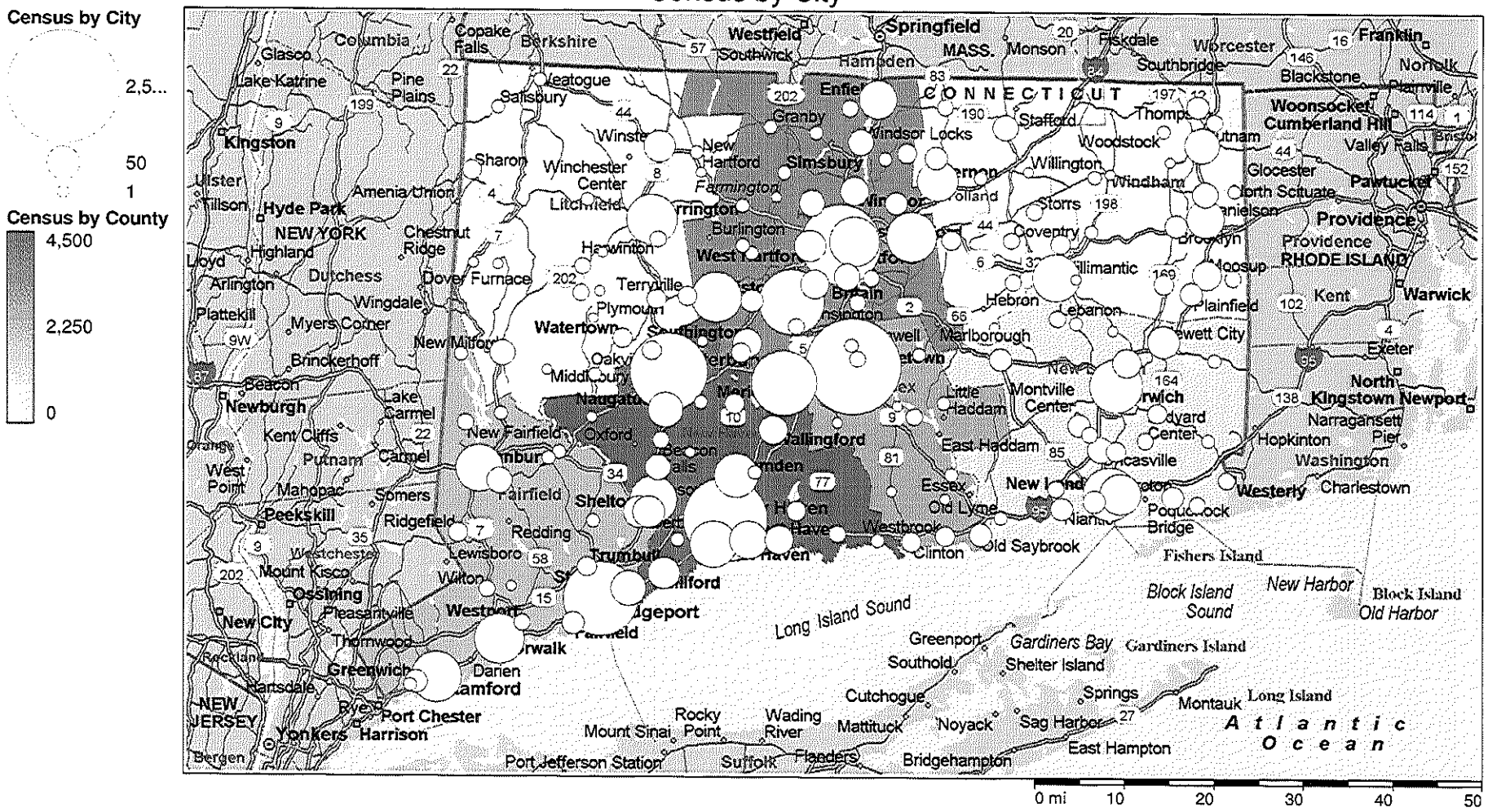
Chelsea worked very hard with my family and continued to visit one day weekly, month to month on basic needs for myself and my sons. Chelsea found a place for my family to live. We both went to look at the place. I don't know what I was thinking but saw a 3-bedroom duplex house. I was so excited I decided to take it. I was so happy. A few months later, my mother passed away. I began to pick up my pieces slowly. I worked on my voice to advocate for my son's needs, looking after myself, decorated our new house, even bought plants, flowers and garden tools which I never experienced of gardening in my life. It changed the whole image so rapidly of my outlook and my emotional well-being. As months passes by I completed this program and graduated. I didn't think I could have had so much success. I was very fortunate to have Chelsea to be my case manager.

I went from hopeless to hope. We were completely overjoyed at how much this program has helped my family with their support, my family was very happy. We came a long way and want to say thank you to DCF and Supportive Housing for Families.

My two sons are doing well the younger one Tishawn, is in his senior year at Manchester High School, plans to graduate and to go to college. He wants to major in psychology and practice culinary arts. My oldest son Craig, has graduated Manchester High School. He is attending Manchester Community College majoring in Fine Arts. As a single mother myself I am very proud of my two sons for being successful in their goals and they are heading to their future and to college. I, myself I am a cake decorator at home and am looking for a job.

My family and I want to thank Supportive Housing for Families, their Director, and DCF, for doing such hard work for the clients and future clients and for the outstanding support. This program has been a wonderful support and that will benefit the families in the communities in the state and nationwide. With all the possibilities this program has made a tremendous difference. The housing and the supports together is what made the difference for my family. Thank you again and God Bless.

Census by City



University of Connecticut, Department of Human Development & Family Studies

December 11, 2012
Public Comment, Connecticut Interagency Council on Affordable Housing

We are pleased to provide comment on the Council's proposed recommendations for programs to be transferred to the new Department of Housing and thank the Council for its attention to the critical issue of housing in the state.

Our comments relate specifically to the proposal to relocate the **Supportive Housing for Families** (SHF) program, funded by the State and coordinated with the Department of Children & Families (DCF), to the Department of Housing. Our comments are informed nearly 20 years of combined professional association with supportive housing and child welfare programs. We are both residents of Connecticut and faculty at the University of Connecticut in the Department of Human Development & Family Studies.

For the past several years, we have evaluated The Connection, Inc.'s SHF program. SHF is a multi-component clinical intervention that began as a clinical program for women in recovery and their children. Today, the program aims to prevent the placement of children in foster care and hasten family reunification. SHF includes intensive case management to address economic, social, educational, vocational, and health needs, along with access to scattered-site permanent housing. The program serves families who are engaged in recovery and related services, and who are working with DCF. SHF helps clients create safe, stable, and nurturing family environments and attain self-sufficiency. Housing is one of several critical services offered through the program, and its ability to stabilize families is critical to the program's success; yet, housing is just one of several facets of SHF.

We have published two studies on the results of our research[1,2] and had a principal role in the design and development of a $5 million grant that was awarded recently to DCF by the federal Administration on Children and Families (ACF). We serve as Principal and Co-Principal Investigators on the evaluation component of the ACF grant, entitled "Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System." Connecticut is one of just five national sites and is the only statewide initiative to be funded. This is a 5-year initiative to develop, implement, and study the effectiveness of an intensive Supportive Housing for Families program, an integrated, collaborative, cross-system intervention model for families in the child welfare system with severe housing issues and high service needs. Because this is a demonstration project, funding is contingent upon rigorous implementation, the availability of housing and clinical services included in the proposal, process and outcome evaluations, and a cost analysis. The grant funds clinical and related services for families and requires careful

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[1] Farrell, A. F., Britner, P. A., Guzzardo, M., & Goodrich, S. (2010). Supportive housing for families in child welfare: Client characteristics and their outcomes at discharge. *Children and Youth Services Review, 32*(2), 145-154.

[2] Farrell, A. F., Luján, M., Britner, P. A., Randall, K., & Goodrich, S. (2012). "I am part of every decision": Client perceptions of engagement within a supportive housing child welfare programme. *Child and Family Social Work, 17*(2), 254-264.

evaluation of outcomes including child welfare, child well being, parental employment, and family self-sufficiency.

We interface regularly with other researchers and practitioners and have examined carefully the professional literature on child welfare and housing. Housing and child protection are intertwined systems that can play a significant role in preventing costly out-of-home placements and facilitating family reunification, resulting in cost savings for the state. SHF represents exactly the model needed to support dually vulnerable families; indeed, the SHF model has been highlighted at several national conferences and by the ACF (in the grant announcement) as an innovative, effective cross-system partnership. Connecticut is considered a national model in housing and child welfare, in part because DCF has taken a leadership role in the arena of housing and child welfare.

We will not claim to envision exactly how a relocated SHF program might look or understand all the implications of relocating it. We can state with confidence, however, that such a move would jeopardize the implementation of the ACF grant, which brings substantial resources and capitalizes on other federally funded child welfare projects that Connecticut recently was awarded. The supportive housing grant project entails the creation of a more intensive service program designed to support the most needy and complex families in the child welfare system. We are studying whether there are differential child and family outcomes based on presenting characteristics and the specific intervention components that families experience. This includes comparing experimental conditions, namely examining the current SHF model alongside the newer, more intensive one. Dismantling or relocating the SHF program to another department may occur at exactly the wrong time: just as this funded project is getting underway. Such an organizational move has high potential to disrupt the context for implementation, causing shifts in service delivery within the programs, threatening the fidelity with which interventions are delivered, and interfering with fundamental aspects of the project design. Administrative relocation of a program may seem like a reasonable and attractive option, yet it would cause contextual changes that are highly likely to affect DCF's effective implementation of federal resources.

Along with our DCF colleagues, we recently met with ACF Commissioner Samuels. He indicated that this project has the capacity to transform child welfare as we know it. The national child welfare community is watching. We believe that transferring the SHF program will cause unnecessary disruption, which may threaten the smooth implementation of a nationally recognized program at a time when its stability is critical.

Preston A. Britner, Ph.D.
Professor of Human Development & Family Studies
University of Connecticut, U-2058
Storrs, CT 06269-2058
(860) 486-3765 Preston.Britner@UConn.edu

Anne F. Farrell, Ph.D.
Associate Professor of Human Development &
Family Studies, University of Connecticut, Stamford
One University Place, Stamford, CT 06901
(203) 240-3610 Anne.Farrell@UConn.edu

STATE OF CONNECTICUT

GOVERNOR DANNEL P. MALLOY

GOV. MALLOY: STATE AWARDED $5M TO EXPAND AND ENHANCE SUPPORTIVE HOUSING

Targeted Communities Include Norwich, Willimantic and Middletown

(HARTFORD, CT) – Governor Dannel P. Malloy and Department of Children and Families (DCF) Commissioner Joette Katz today announced that the state has been awarded a $5 million federal grant to expand and enhance a DCF program designed to reduce the number of children in foster care by providing supportive housing and necessary services to vulnerable and homeless families. Connecticut is one of five jurisdictions around the country to be awarded the funding.

"This goal of this supportive housing program is to keep families together and help those who are in greatest need get back on their feet," Governor Malloy said. "Under the leadership of Commissioner Katz, DCF has been accelerating their efforts to keep families unified and stable. The federal funding our state has been awarded will allow DCF to continue their efforts to create stability for our state's youngest residents."

The program currently serves more than 500 families annually and is credited with helping to reunify families whose children are in state care and to prevent the removal of children in circumstances where stable housing is a barrier. The grant, awarded by the federal Department of Health and Human Services and four national foundations, means at least an additional 50 families will receive these comprehensive, intensive and evidence-based services.

DCF Commissioner Joette Katz said the expansion will help accelerate progress already made in reducing the number of children in care.

"Since January 2011, we have achieved an 11 percent reduction in the number of children in state care. Supportive housing is one of the critical ways we can keep more families together and reunify families where a removal was necessary," she said. "Connecticut is just one of five jurisdictions in the nation to receive this grant, and it is a real expression of confidence in the direction we are taking. Expanding this very effective program without additional state resources is an added bonus."

The expansion will focus on chronically homeless families with multiple episodes of homelessness in eastern Connecticut, where the department determined the available services do not meet the existing need. Targeted communities include Norwich, Willimantic and Middletown.

The first year of the grant, beginning October 1, will be for planning and implementation. Additional families will be receiving services beginning in the grant's second year.

The supportive housing program, which began in 1998 by serving caretakers recovering from substance abuse problems, combines intensive case management services, behavioral health services and housing support for families who need assistance with stable housing. The program now serves families with mental health, substance abuse, domestic violence and other treatment needs. The Department of Social Services (DSS) and local housing authorities supply housing vouchers to many of the families. DSS is committed to providing 50 additional vouchers in conjunction with the federal grant.

The federal grant will not only increase the number of families in the program but also will enhance it to include employment services to help parents obtain meaningful work and increase income. An employment specialist will work with the families to develop relevant skills and help them find work. This will be done in conjunction with the state Department of Labor's Office of Workforce Competitiveness. The families pay up to 40 percent of their income toward rent.

The other jurisdictions to be awarded grants are Broward County, Florida; Cedar Rapids, Iowa; Memphis, Tennessee; and San Francisco, California.

CHILD & FAMILY SOCIAL WORK

doi:10.1111/j.1365-2206.2012.00831.x

'I am part of every decision': client perceptions of engagement within a supportive housing child welfare programme

Anne F. Farrell*, Melissa L. Luján†, Preston A. Britner†, Kellie G. Randall† and Samantha A. Goodrich†

*Department of Human Development & Family Studies, University of Connecticut, Stamford, CT, and †Department of Human Development & Family Studies, University of Connecticut, Storrs, CT, USA

Correspondence:
Anne F. Farrell,
Department of Human Development & Family Studies,
University of Connecticut,
Stamford, CT 06901
USA
E-mail: anne.farrell@uconn.edu

Keywords: child welfare, engagement, family-centred practice, mixed methods, Parent Engagement Measure, supportive housing

Accepted for publication: January 2012

ABSTRACT

The majority of children in the child welfare system enter because of neglect and come from poor families with high rent burden, substandard housing and risk for homelessness. In this paper, we describe a model programme for families with dual vulnerability in housing and child welfare. Clients presented with a variety of parenting, substance use and/or mental health issues. The Supportive Housing for Families (SHF) programme prioritizes prompt family access to housing and related supports and operates from an intensive, family-centred casework that promotes client engagement as a mechanism for change. We used a mixed methods approach that included the administration of Alpert and Britner's Parent Engagement Measure (quantitative) and open-ended interviews (qualitative) with 41 parents involved in the child welfare system. Results indicate high levels of client engagement, with convergence across the formal measure and interview themes. SHF promoted client engagement through the swift provision of tangible resources, as well as caseworker resourcefulness and responsiveness. The Parent Engagement Measure performed well psychometrically. We compare findings with prior research and discuss implications, limitations and future directions.

INTRODUCTION

The placement of children in foster care is the culmination of a multidetermined problem with roots in individual, family and social vulnerabilities. Recently, housing has gained recognition as a pivotal factor in child welfare involvement. Among approximately 425 000 children placed in foster care in 2009 in the USA, 71% was referred for neglect (U.S. Department of Health and Human Services 2010), and substandard housing conditions likely influenced a majority of placement decisions (Harburger & White 2004).

Lack of access to affordable housing places children at risk for diminished health and developmental outcomes, increases the likelihood of foster placement and delays family reunification (Culhane *et al.* 2003; Courtney *et al.* 2004). Housing difficulties are not only associated with maltreatment (i.e. neglect and abuse); they play an important role in caseworker judgements of parenting (Ernst *et al.* 2004). In one study, child welfare involvement doubled after families' first homeless episodes and risk of foster care placement increased with subsequent occurrences (Park *et al.* 2004). Reunification rates are about 50% lower for families with homeless episodes (Courtney

Melissa L. Luján's current affiliation is: Children and Family Futures (CFF), Irvine, CA.

et al. 2004). When mothers lose custody of their children, they often lose housing subsidies linked to household size (Cohen-Schlanger *et al.* 1995). Furthermore, parents who complete inpatient substance abuse treatment may face long housing waitlists and live in temporary housing that is unsuitable for visitation or reunification (Shdaimah 2009). Whether child welfare investigations result in monitoring, preventive services or foster care placement, housing influences family outcomes.

In this paper, we review briefly the factors associated with 'dual vulnerability' in housing (e.g. substandard housing, eviction threats, doubled up and periods of homelessness) and child welfare (i.e. child protection investigations and interventions). We discuss child welfare-involved families with housing challenges that pose risks, precipitate child removal and pose barriers to reunification from foster care (Shdaimah 2009). We review recommended practices for meeting family needs and focus on engagement as a potential facilitator of change. Then, we present a community supportive housing (SH) programme that provides intensive, multicomponent and family-centred services, and share the results of a mixed method (quantitative and qualitative) investigation of client engagement.

Dual vulnerability in housing and child welfare

There is ample evidence regarding the factors that predispose families to child welfare involvement, including: social, community and economic factors such as poverty, education, race/ethnicity, mobility and neighbourhood (American Psychological Association 2009; Anyon 2011; Sykes 2011); parent factors such as substance abuse, childrearing beliefs and mental illness (DeBellis *et al.* 2001; Brook & McDonald 2009; Marsh *et al.* 2011); and child factors including developmental characteristics and problem behaviours (DePanfilis & Zuravin 1999).

Housing is recognized as a stabilizing factor for families (Khadduri & Kaul 2007). Families with dual vulnerability have parenting problems, substance abuse, mental illness, limited educational and vocational attainment, and scattered employment (Bassuk *et al.* 1996; Rog & Buckner 2007). To borrow from Buckner's (2007) comments on poverty and homelessness, it is hard to demarcate where housing-specific sources of risk end and child welfare-specific risks begin. Although it is not entirely clear why these dual vulnerabilities characterize some families and not others, scholars point to the need to address the structural issue of housing as a means of prevention (Courtney *et al.* 2004; Shdaimah 2009). Zlotnick (2009) describes the overlap among the child welfare and homeless populations and makes a case for 'a shift in the service delivery approach' (p. 323).

Models and recommended practices in SH

Housing programmes for families

Families are an increasing segment of the homeless population (National Coalition for the Homeless 2009). Shinn (2009) describes four types of housing for low-income families: affordable housing, affordable housing with links to community services, transitional housing (TH; single or 'scattered' site programmes with time-limited, intensive supports) and permanent SH (subsidized housing and intensive supports). Although housing programmes show success in stabilizing families, methodological limitations hamper an assessment of the relative contributions of housing vouchers and supportive services. Some studies suggest that case management is of relatively little impact (Shinn 2009). In one, the best predictors of family stability were the type of housing obtained and families' comfort in their new communities (Weitzman & Berry 1994). Burt (2010) interviewed 195 graduates of TH programmes and found housing vouchers to be the best predictor of stability 1 year later.

Housing models for families with dual vulnerabilities

Leventhal & Newman (2010) propose an ecological model of housing and child development; it includes several risk factors and adds 'macrolevel forces' such as policy. Consistent with this comprehensive approach, others recommend an array of assessments and services to meet the needs of dually vulnerable families: identification of substance abuse problems and parent mental health; transitional stays with subsequent moves to permanent housing; community services that endorse clients' roles as parents; developmental, educational and behavioural supports for children; and vocational and budgeting assistance (Locke *et al.* 2007; Center for Substance Abuse Treatment 2009; Shdaimah 2009; Zlotnick 2009; Marsh *et al.* 2011).

The U.S. Substance Abuse and Mental Health Services Administration proposed a logic model that informed the successful implementation of a community programme with permanent, affordable, scattered

housing and case management (Beyond Shelter 2011). Federal intervention for the intertwined problems of housing and child welfare exists in the Family Unification Program (FUP), which funds partnerships among public housing authorities and child welfare agencies (National Center for Housing and Child Welfare 2011). Since 1990, FUP vouchers have prevented foster care or enabled reunification of over 200 000 children (National Center for Housing and Child Welfare 2011). A recent review of substance abuse and child welfare services endorsed the need for integration at systems and service levels (Marsh *et al.* 2011). Werner *et al.* (2007) describe a continuum of family-centred services for women with substance abuse problems. Elsewhere, we described characteristics and initial outcomes for over 1700 families referred to a SH programme (Farrell *et al.* 2010). Although the study lacked a control group, enrolled clients were successfully housed in preferred neighbourhoods, suggesting initial endorsement for an intensive case management model paired with access to community supports and housing vouchers.

Recommended practices in child welfare

Contemporary child welfare models embrace a family-centred approach (Child Welfare Information Gateway 2010). Family-centred practices (FCPs) promote competency by providing a continuum of supports (Pecora *et al.* 2001) that capitalize on strengths (Leitz 2011), and empower parents towards self-determination, safety, self-sufficiency and permanency (Dawson & Berry 2002; Graves & Shelton 2007). Inasmuch as change requires client–professional collaboration, the non-voluntary nature of child welfare services is a barrier to family centredness (Pecora *et al.* 2001; Kemp *et al.* 2009).

FCP has five components (Allen & Petr 1998): family as the unit of intervention; parent–professional collaboration; honouring family choice; building on strengths; and individualized supports. Each component assumes that effective services are culturally and linguistically appropriate. Whereas FCP is one approach to engaging families, long-term stability also requires the provision of immediate, concrete and integrated services that help families build and sustain support networks outside of formal helping relationships (Dawson & Berry 2002).

Alpert (2005) states that the child welfare service experiences of parents are a 'missing element' and argues that the caseworker–client relationship has a pivotal impact on outcomes. Indeed, unmet service needs predict client dissatisfaction and recidivism (Festinger 1996; Chapman *et al.* 2003). Alpert gives four reasons why parent perspectives need to be considered: (i) parents feel underserved and overlooked; (ii) exploration is congruent with family-centred models; (iii) mandated services are not always available and accessible; and (iv) programmes should determine if parents engage out of obligation or desire. Service gaps in the child welfare system may reflect the unavailability of specific resources, ineligibility for services or parental refusal because of the low acceptability of interventions (Festinger 1996; U.S. General Accounting Office 2002). Research has begun to include parent voices as a means of understanding 'what works' (Alpert 2005; Maiter *et al.* 2006; Altman 2008a,b; Bloom & Britner 2012).

American child welfare policy (Adoption and Safe Families Act; P.L. 105-89) stresses the need for swift, diligent efforts towards family reunification. Child welfare workers are compelled to address parent, child and family needs promptly. They are in the unenviable position of needing to engage clients rapidly yet meaningfully in mandatory services. Although the literature is replete with references to engagement, and it is considered 'vital' to change (Altman 2008b, p. 42), little is known about the effectiveness of various models and approaches (Alpert & Britner 2005, 2009; Yatchmenoff 2005; Ingoldsby 2010). Furthermore, it is difficult to distinguish the processes from the products of engagement (Altman 2008b) and to disentangle it from other variables that may induce change.

Client engagement as an influence

The engagement of parent clients has been defined as 'compliance or adherence to treatment or service plans' (Yatchmenoff 2005, p. 86). Yatchmenoff (2005) derived five dimensions of engagement: receptivity, expectancy, investment, working relationship and mistrust. Alpert & Britner (2009) state that when parents 'feel empowered, supported, respected, and understood . . . they will be more actively engaged in services, and, therefore, more likely to succeed' (p. 137). Although definitions vary, they usually reference client behaviours (e.g. service usage, duration and completion) and attitudinal or affective aspects (Altman 2005). Yatchmenoff (2005) contends that only the client can truly know their level and state of engagement within an agency.

A few studies cite client engagement as a major contributor to successful outcomes in child welfare services. One study used in-depth interviews to glean perceived positives and negatives of client–social worker relationships, linking them to differing levels of client engagement (Maiter *et al.* 2006). Alpert & Britner (2009) found that increased geographic distance to services was associated with lower client engagement. Littell (2001) examined and modelled two components of client participation: collaboration in treatment planning and compliance with programme expectations. Controlling for case characteristics and duration of services, results indicated that greater collaboration was associated with higher compliance. Compliance, in turn, predicted significant reductions in recidivism (i.e. subsequent maltreatment reports and out-of-home placements). Altman (2008a) did not find a relationship between engagement and case outcomes.

Context for the study

This study took place in a SH programme in Connecticut that serves child welfare-involved families facing housing as a barrier to unity or reunification. The programme, Supportive Housing for Families (SHF), operates under a partnership between The Connection, Inc. (a private agency) and the Department of Children and Families (DCF, the state child welfare agency), with support from the Department of Mental Health and Addiction Services and the Department of Social Services. (Although some SHF components more closely resemble TH than permanent SH, we retain its formal name here for the sake of consistency.)

SHF includes intensive case management, access to statewide scattered-site permanent housing, mental health and related interventions, housing, employment and vocational assistance, and support for building community. DCF funds the programme and provides referrals, parenting interventions and other child welfare resources. Housing subsidies are available through Federal Section 8 Housing Choice vouchers and State Rental Assistance Programs (RAP). These are tenant-based programmes that support existing apartments in the private market through direct rent subsidies.

Clients undergo three phases of programme involvement: assessment and engagement; stabilization and community integration; and healthy connections (see Farrell *et al.* 2010 for additional detail). Average length of stay is approximately 12 months. At intake, each family undergoes a comprehensive home-based assessment and is paired with a case manager who collaborates with the client to create a care plan. Reviewed at least monthly, the plan specifies strengths and needs, details client activities and agency supports, and addresses family goals. Depending on child welfare involvement, the client may have urgent need for housing (e.g. threat of child removal, doubled up and in shelter) or await family visitation and reunification pending housing. Case management occurs primarily in the client's home. Clients receive an average of nearly 10 hours per month of direct interaction with their case managers. Comprehensive reassessment occurs every 6 months.

The stabilization and integration phase initiates once the parent obtains a housing voucher or is otherwise prepared to proceed with housing search. Tasks include locating and moving into safe, affordable housing, preparing for family reunification (if indicated), and developing skills needed to retain housing and ensure self-sufficiency and well-being. Family choice of neighbourhood is a high priority for dedicated housing specialists who cultivate relationships with landlords and assist clients in locating housing. SHF has flexible funds that can be applied towards security or utility deposits or to eliminate debt that serves as a barrier (e.g. unpaid utility charges that preclude new service). In the final phase, parents mentor other families.

DCF caseworkers refer families with open child welfare cases for whom housing poses a risk to unity or reunification. Families retain a DCF worker as long as they have active cases. Both client and SHF case managers maintain contact with DCF. The programme serves predominantly women who are heads of household, the majority of whom have past substance abuse problems. At the time of the study, exclusion criteria included active substance abuse, severe and persistent mental illness, intellectual disabilities and risk of harm.

Purpose and research questions

The purpose of this study was to examine client perspectives on the level and nature of their engagement in the programme. Additionally, we sought to validate further an existing measure of engagement. We used Alpert & Britner's (2009) definition and measure and supplemented it with narrative information. Our research questions were: (i) What is the level and quality of client engagement in SHF?; (ii) Are there trends in engagement across programme enrolment?;

(iii) How do clients perceive their relationships with their case managers, especially with respect to engagement?; (iv) Do quantitative measures of engagement match client narrative reports?; and (v) Does the Parent Engagement Measure (PEM) effectively capture client engagement?

METHOD

Participants

Setting

The study was conducted at three of eight SHF sites. We selected the sites with the highest case volume and the largest staff in order to efficiently recruit as many clients as possible within a limited time frame. To mask the identities of clients and staff, we refer to these as sites A, B and C. Some clients (site B) were accustomed to visiting their case manager's office; in other cases, this was not common practice, so we offered clients a choice of interview location (e.g. home, office). Most from site A chose their homes, most from site B chose SHF offices and site C clients were mixed (i.e. combination of home and office).

Participants

Participants were one male and 40 female parent clients participating in SHF for a year or less. Nine clients were from site A, 12 were from site B and 20 were from site C. We selected subgroups of clients who were enrolled for 3, 6, 9 and 12 months (n = 10, 14, 5 and 12, respectively). Staggered enrolment durations were chosen so we might assess when engagement is visible and whether it evolved over time. There were no associations between site and duration of enrolment.

Client demographics were: Nearly 44% of participants were self-identified as Latino/Hispanic, 22% as African-American, 15% as European American, 15% as other and 5% as Caribbean-American. Most (90%) were single parents, and nearly all (98%) reported annual income under $25 000. Two-thirds had a high school diploma/general equivalency degree, and the remainder had some college. The mean age was 33.6 years (standard deviation [SD] = 7.9), and the mean length of enrolment was 7.4 months (SD = 3.5). The largest family had six children. Twenty-one families had children under age 5, and 33 families had children over 5. Although we used a convenience sample within the programme, these sample demographics aligned well with the entire programme's client characteristics reported elsewhere (Farrell *et al.* 2010), suggesting a representative sample.

Procedures

We planned the study in collaboration with SHF management and with the approval of the Institutional Review Board. Data were collected for approximately 5 weeks following a general orientation to programme managers, who invited eligible clients to participate. Managers did not collect formal data on recruiting, but provided clients a description of the study. Clients were offered $15 gift certificates to a general merchandise national chain as an incentive. Case managers coordinated and facilitated initial meetings between researcher and client.

Client encounters

Encounters were scheduled for 60 minutes with one researcher and the client present. As part of an informed consent process, confidentiality was assured and clients were informed that non-participation or withdrawal would not result in negative consequences. Participants provided demographic information, completed the PEM, responded to open-ended queries about the ease of completing the form and the extent to which it 'captured' their engagement, and participated in an interview about their involvement in service planning. All clients recruited completed the process (i.e. no attrition). Interviews were recorded for later transcription into documents whose contents were coded and analysed.

Measures

Parent engagement measure

This 22-item measure (Alpert & Britner 2009) is based on major themes from the casework literature, which indicates that family-centred casework promotes parent engagement by making parents feel empowered, supported and respected. It taps two dimensions of parent experience: the degree to which parents perceive their caseworkers to be family focused in their actions and the degree to which parents feel respected, understood, empowered and supported (Alpert & Britner 2005, 2009). Parents rate their agreement with statements using an anchored 6-point Likert scale (1 = strongly disagree and 6 = strongly agree), such that higher scores denote greater engagement. Alpert & Britner (2009) report strong internal consistency (α = 0.94; 2009).

Queries about PEM

After the PEM was administered, the researcher queried participants on how well the measure tapped their engagement and asked if any items were confusing. Examples include: Do these questions capture important elements of your relationship with your caseworker? Are there any items that are not so important or questions that you wish would have been asked?

Interview

The client interview was designed to elicit perceptions of engagement with the case manager and service planning. The interviewer posed a predetermined set of questions and followed up with probes as needed. Examples of open-ended questions include: How would you describe your caseworker's job? Do you feel involved in your child welfare case and with SHF? (Questions are paraphrased in Table 1.)

Data analyses

Following data collection, PEM responses were entered using the Statistical Package for Software in the Social Sciences (SPSS Inc., Chicago, IL, USA) and descriptive statistics were obtained. In keeping with the research questions, we conducted quantitative analysis of PEM responses (e.g. calculated means, compared them across programme involvement, and demographics) and qualitative analysis of client interview data. We then compared and contrasted quantitative and qualitative findings.

Auerbach & Silverstein's (2003) grounded theory approach guided the qualitative analysis, with the questions serving as a primary organizing theme (Tesch 1990). Auerbach and Silverstein state that coding can be thought of as a staircase of sorts that moves from lower to higher levels of understanding. First, one researcher read through all responses, keeping interview questions in mind. In this stage, it was apparent that certain words and phrases were commonly used (e.g. 'helpful' emerged in the first round). On the second reading, applicable words and phrases were colour-coded according to emerging topical relevance. After all responses were reviewed at least twice and content was aggregated, themes were established by naming them and cross-checking the content. After themes were established, we collected representative quotes (rather than choosing the existing content to 'fit' themes). Uncertainty as to thematic content was rare and was resolved by discussion among two of the researchers. In sum, three researchers have reviewed all questions, themes and corresponding content.

RESULTS

PEM results (quantitative analysis)

We inspected PEM data for completeness and trends. There were two missing data points and the sample item mean was used to replace them. One PEM item ('My caseworker helps me meet my goals, so that I can visit with my children often') was excluded because 20 parents rated it as not applicable. (They were engaged in family preservation, not reunification, efforts.) The PEM demonstrated high internal consistency reliability (Cronbach's $\alpha = 0.963$). A mean engagement score was created for each participant by summing the items and dividing by 21 (items). Individual means ranged from 2.76 to 6.00. The grand mean (5.67) and the three site means were all above 5 on a scale of 1–6, indicating high levels of engagement in this sample.

Pearson correlations revealed that neither client age [$r(41) = 0.049$, $P = 0.767$] nor duration in programme [$r(41) = 0.214$, $P = 0.179$] was significantly associated with PEM mean, nor was enrolment duration. There were two (low) outliers in the data set, e.g. mean scores of 4 or lower, and they were at 3 and 6 months. In examining site differences, we found the following PEM means: $M_A = 5.3$, $SD_A = 1.14$; $M_B = 5.7$, $SD_B = 0.33$; and $M_C = 5.9$, $SD_C = 1.14$. These site differences were different at the level of $P = 0.05$ [$F(3,37) = 3.527$], with site A significantly lower than the others. Practically speaking, however, these are relatively small differences.

Client responses to queries about the face validity of the PEM were scant. Other than the irrelevance of the family reunification item for some, clients characterized the instrument as generally capturing their engagement.

Interview findings (qualitative analysis)

Table 1 presents interview findings organized by question and theme and includes illustrative quotes. Highlights include the clients' general view (38 of 41 responses or 96%) that the caseworker's job is challenging and that 'helping' clients (locate housing and related resources) is their central task. When asked about the balance of the caseworkers' efforts to help parents and children, responses (questions 2 and 4)

Table 1 Summary of qualitative findings (by theme)

Question	Theme	Illustrative quotes (*italics*), client site (A, B and C) and enrolment duration
1. Caseworker's (CW) job: 'How would you describe your CW's job?'	Helps locate resources	*Points me in direction of where to go for resources. I am new to area but she helps . . . Makes herself available.* (A, 6 months)
		Helps me get everything I need in my care plan. (A, 12 months)
	Helps family secure housing	*Help families to get and keep a stable home.* (B, 6 months)
		Helps me with everything . . . The main thing is housing issues . . . to help people get better jobs and reach goals. (B, 3 months).
	Difficult job, handles self competently	*It's a difficult job, but the CW is positive. Very hard . . . dealing with me calling every day and figuring out about what was going on . . . a hard job keeping up with everybody.* (C, 3 months)
		Job is tough for her but she handles her business. She has to work with me and still help other clients too. (C, 12 months)
2. Helping children: 'In what ways should your CW be helping your children?'	Nothing more	*Already helping . . . has a good relationship and rapport.* (A, 12 months)
		She has done far beyond what she needs to do with them. Very informative about resources. (C, 6 months)
	Resources and instruction	*Teaching them, connecting them with resources.* (A, 6 months)
		Teaching them about finances and how to be responsible. After school programs she helps with. (A, 9 months)
	Helping parent is helping children	*By helping me keep my home and other things needed.* (B, 6 months)
		She asks how they are doing. Available for any questions about anything they need. Helps me connect to resources for them. (B, 12 months)
3. Helping parents: 'In what ways should your CW be helping you?'	Efforts are sufficient	*They are doing what they can do, so it is up to me now.* (A, 3 months)
		She is doing everything she possibly can . . . But you have to do it yourself first and . . . then we make it happen together. (C, 9 months)
	Continue to be supportive	*Honestly she is like a friend, immediate family. She can just continue to be supportive.* (C, 6 months)
	Retain housing	*She's doing everything already. Keeping me housed!* (B, 6 months)
	Need more assistance	*Hasn't helped. I had asked about balancing budgets and stuff like that and he hasn't really helped.* (A, 3 months)
		Finding a job. (A, 6 months)
4. Balancing help between children and parents: 'Should your CW spend equal time on you and your children or should they spend more on one than the other?'	More on parent, to help parent help their own children	*More energy on me because then I have energy for my kids* (A, 3 months)
		Make time with the parent because if they parent is ok then they help the kids. (C, 9 months)
	More on parent because of child age, service needs and absence	*Move me* (housing) . . . *that's needed, my kids will follow.* (B, 12 months)
		They can't talk yet, but maybe when they grow up a little. (B, 6 months)
		More with me. My child isn't around but will be soon! (C, 3 months)
	Both, equal time	*Both . . . She's there for all of us.* (A, 6 months)
5. Client involvement and engagement: 'Do you feel involved in your case with DCF and SHF?' (Give examples of times you feel involved and not involved).	High involvement and communication	*Always feel involved. Anything going on with case, she is there to explain the process. She informs me of every little thing.* (A, 6 months)
		She never gives up. Makes me want to be involved. (A, 6 months)
		I am part of every decision. (B, 6 months)
	Low engagement with DCF	*I don't feel involved at all. I don't know what they do. I am only informed on decisions . . . I am never involved . . . I don't think it's fair.* (A, 6 months)
	Appreciate DCF referral to SHF	*I hated DCF but they put me through to SHF . . . the best thing!* (C, 9 months)
		I feel very involved. If it wasn't for the DCF worker who set me up with this program, I wouldn't be so happy. (C, 3 months)
6. Follow-through: 'Does your CW follow through (do what they say)?'	Good follow-through	*Always does what she says.* (A, 12 months)
		On time at that! Her word is gold. When she says something, she does it . . . even after the case closes, I will call her. (C, 9 months)
7. Improve relations: 'What could your CW do to improve your relationship? What could you do?'	Change not needed, stay the course	*She is really good. I don't see anything she could improve in.* (A, 6 months)
		The relationship is great. My (CW) *is great. Just keep it the same.* (C, 6 months)
	Strong, personal relationship, desire to sustain it	*She is like a mother, a friend. If I have questions or something, she is there . . . She is a good* (CW) *and I don't know what I am going to do when they close my case. I will probably call her.* (C, 12 months)
	Continue clear communication	Keep communications open. Most important thing. (C, 3 months)
		We have a good relationship . . . she takes time to get to know me, contrary to the DCF worker. I could not continue to procrastinate! (B, 12 months)
	Areas for improvement, both	*I can have less attitude towards her. She can come once a week like she's supposed to . . .* (A, 6 months)
		I could be more forceful, but I am depressed . . . if my (CW) *helped when I requested, that would be better. He isn't very knowledgeable.* (A, 3 months)
	CW areas for improvement	*Be on time for appointments . . . be courteous . . . call to reschedule.* (B, 3 months)
		Be more compromising especially with scheduling. (A, 3 months)

DCF, Department of Children and Families; SHF, Supportive Housing for Families.

suggested that helping parents is helping children, e.g. when parents have access to housing (the clear priority), they are empowered to care for their children. Approximately half stated that support efforts should be equivalent; nearly 40% stated that the primary focus should be on the parent, and the rest were non-committal.

Consistent with quantitative results, 95% of client responses about caseworker follow-through were positive. Where caseworker efforts were insufficient, clients noted specific instances or practices (limited flexibility in scheduling appointments and attending meetings) that could be improved. Clients spontaneously drew contrasts between their engagement with DCF and SHF. Specifically, they described themselves as underinvolved with DCF and quite engaged with SHF and expressed appreciation for DCF's referral to SHF. A majority discussed their relationship with their caseworker as a very personal one. Clients credited the caseworker's behaviour and parent–caseworker relationship as crucial to promoting their own engagement in efforts towards permanency in housing and child welfare.

Several themes relate to the clients' perceptions that 'helping' in this context means first providing tangible housing supports (i.e. access to housing, advocacy, assistance with voucher applications and material support towards housing) followed by access to community-based services and supports (e.g. intervention for parents/children, substance abuse services, parenting supports and vocational/educational counselling). Additionally, clients stress the importance of easy access to their caseworkers and the critical benefits of ongoing, open communication between caseworkers and families. Indeed, clients link their access to and communication with their caseworkers as pivotal to their own engagement.

Linking quantitative and qualitative findings

Overall, qualitative findings aligned well with quantitative scores on the PEM. At the site level, the site (A) that had been implementing the model the longest and with the greatest success (according to anecdotal observations and reports from SHF administration) had the highest mean score on the PEM.

To explore further the quantitative and qualitative linkage at the individual client level, we compared outlying cases (highest and lowest scores) using qualitative data to contextualize our examination of the PEM response validity. Qualitative findings confirm and elaborate service aspects that are associated with relatively high and low engagement, e.g. within this sample. Some illustrative examples are provided here.

Lower mean engagement

We explore the lowest four PEM scores here (e.g. means below 5.3). The first client had 6 months in the programme and a mean PEM score of 2.76. Her response to a question about what her case manager's job entails was uncertain, 'don't know . . . to have her sign paperwork?' The client said she 'Doesn't have a relationship [with her case manager]' (6 months). Another client (3 months) had a mean engagement score of 4.04. She viewed the case manager's job as 'To help me to complete the paperwork to help me receive RAP [Rental Assistance Program] certificate. Because [that is] all we have been working on.' In response to a query about how to improve the relationship, she stated, 'If my case manager helped me when requested, then it would be better. He isn't very knowledgeable with services in my area. At least he shows up to meetings, unlike my past (DCF) caseworker. Maybe because my home is tidy, they think I am not in need in other ways.' A client (3 months) with PEM mean of 5.19 stated that the relationship could be improved by 'advocating more . . . about how I am doing all right things to get my kids and get them in right programs.' Finally, a client (6 months) with a mean engagement score of 5.29 responded 'keep communication going' when asked how the relationship could be improved.

Higher mean engagement

We explore seven cases with means of 5.9–6.0. Among the five clients with means of 6.0, qualitative responses underscore caseworker responsiveness. 'There isn't much she can do [to improve]. She is there for me and puts a lot of effort . . . She is really there 110%. She is the best . . . Amazes me how they extend themselves (6 months).' 'She is like a mentor, supportive (6 months).' '[She is there] to better us. Help you get into any programs you need . . . Helps you get things. Motivates me to want me to do better' (6 months). 'She goes way beyond her job . . . way beyond what I even imagined. She gives me information and resources that I had no clue about. Does things that made me get to where I am' (12 months). 'A tough job . . . I wouldn't want to do it. In the beginning I asked her about her background . . . experience she had to be able to handle and understand issues with my son. I understood she did have the clinical background to handle it' (9 months).

Two clients with mean scores of 5.90 and 5.95 (respectively) speak to caseworker accessibility and resourcefulness. 'She keeps reminding me of how to manage my days, to take small steps to keep my life going in the right way. If I continue to be honest and do what she says, things work out' (6 months). 'Mine does everything. Maybe I just lucked out. I can call her anytime and she is there for anything I need' (9 months).

DISCUSSION

Findings and implications

Client engagement

This study examined client engagement in a family-centred SH programme for families in the child welfare system. Results indicate that programme engagement is high (on average, above 5 on a 6-point scale) and site differences were marginally significant. Engagement was evident by 3 months enrolment duration and did not differ by time in programme. Qualitative findings suggest that engagement relates to the programme's focus on prompt, tangible outcomes (e.g. housing) and caseworkers' resourcefulness and responsiveness. This conclusion is supported as well by the fact that narrative reports (mixed methods analysis of outliers) are consistent with quantitative scores. By comparison, Alpert & Britner (2009) examined the engagement of 46 parents in a large non-profit child welfare agency. They obtained PEM item means generally above 4 and an average parent engagement mean of 4.74.

Client responses indicated higher acceptance of and engagement in SHF case planning than with the state's child welfare agency (DCF). It may be that the designation of a primary, external case manager positively influences engagement. That is, SHF caseworkers inform DCF workers but do not make decisions regarding disposition. Clients may feel more comfortable establishing open communication with an individual who is thus removed from permanency decision-making processes.

This study validates the PEM in four ways. One, our analysis yielded high internal consistency reliability ($\alpha = 0.963$). Two, engagement was evident within 3 months of enrolment, supporting use of the PEM fairly early in the case management relationship. Three, few comments emerged from our queries regarding clarity. Themes derived from the interviews suggest both face and convergent validity. Finally, quantitative and qualitative findings link meaningfully in this sample. As such, the PEM appears to capture engagement effectively.

Support for the SHF model

The quantitative and qualitative data paint a picture of clients who feel respected and engaged and 'buy' the programme model. Consistent with prior findings (Farrell *et al.* 2010), SHF appears to be a promising SH model. Other studies (e.g. Chapman *et al.* 2003; Maiter *et al.* 2006) link prompt, responsive services and caseworkers' interpersonal characteristics with client satisfaction and outcomes. Perhaps, clients who 'opt in' and 'buy in' are more motivated and/or resilient. These findings mirror those of Yatchmenoff (2005), in which client expectancy and investment combined to form a single dimension called 'buy in'. Caseworkers play a valued role in helping clients to secure tangible supports (i.e. housing) associated with family stability (Littell 2001; Burt 2010). There is a need to examine further the effectiveness of SHF and related models, with specific emphasis on client and programme characteristics.

Limitations and future directions

As is true for many field studies with hard-to-reach populations, our main limitations are the lack of experimental control and small sample size. This research was cross-sectional; it is important to measure parent engagement over time and in response to caseworker characteristics, worker–client interactions, etc. Additional research might link programme outcomes with levels of parent engagement and examine the influence of engagement on costs and outcomes. Essentially, this calls for a mediation model in which client factors interact with early programme experiences to influence engagement, which in turn mediates client behaviour and affects outcomes. Ideally, future research will examine SHF vs. 'child welfare as usual' models within a randomized, repeated measures model that includes client, programme, and caseworker characteristics and long-term results. In the interim, data from the present study provide evidence of SHF as a promising model for engaging parents in child welfare case planning and the PEM as a viable measure for assessing client engagement.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the parents who participated in this study and thank the following for their support of this work: The Connection, Inc.

Supportive Housing for Families Program, The CT Department of Children & Families, and the Center for Applied Research in Human Development at the University of Connecticut. The opinions expressed here are solely those of the investigators and do not necessarily reflect the official positions of these entities.

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Children and Youth Services Review 32 (2010) 145–154

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Supportive housing for families in child welfare: Client characteristics and their outcomes at discharge

Anne F. Farrell [a,b,*], Preston A. Britner [a], Mariana Guzzardo [a], Samantha Goodrich [a]

[a] Department of Human Development & Family Studies, University of Connecticut, United States
[b] A.J. Pappanikou Center for Excellence in Developmental Disabilities, United States

ARTICLE INFO

Article history:
Received 24 April 2009
Received in revised form 18 June 2009
Accepted 22 June 2009
Available online 27 June 2009

Keywords:
Foster care
Housing
Child welfare
Program evaluation
North Carolina Family Assessment Scale
Case management
At-risk
Reunification
Stability

ABSTRACT

Housing problems present barriers to family unity and reunification among families in the child welfare system, yet few programs address both child welfare and housing needs. To date, the field lacks data for understanding families with dual vulnerabilities in these arenas and the programs that support them. This study aimed to address that gap by reporting the characteristics and outcomes of 1720 families referred to a Supportive Housing for Families (SHF) program over a 10-year period. This report describes client characteristics, progress, and outcomes at discharge. Positive shifts in employment and housing were evident across the entire sample. Clients who completed the program successfully had longer stays, were more likely to have a history of permanent housing and employment, and had higher initial and exit scores on a measure of environment of care. Higher client–staff involvement and service utilization were associated significantly with positive discharge, but not with procurement of permanent housing. This report provides initial endorsement for the SHF model and makes suggestions for program practice, future research, and policy. More research is critical if we are to understand the optimal mechanisms of support and change that lead to child safety and family self-sufficiency.

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1. Introduction

In 1990, The U.S. Congress affirmed as a "national goal" that every American family should be able to "afford a decent home in a suitable environment" (National Affordable Housing Act of 1990). Although suitable housing is critical to family stability, children and families traditionally have not been the focus of U.S. housing assistance and policy (Weicher, 2006). Among families living in poverty, the peril of homelessness is one of several threats to child well-being, which also include abuse and neglect, single parenthood, parental substance abuse, and low social support (Ammerman, Kolko, Kirisci, Blackson, & Dawes, 1999; Beeman, Kim, & Bullerdick, 2000; Higgins & McCabe, 2000). Programs serving vulnerable families need to be multi-faceted if they are to improve quality of life and encourage the long-term safety, health, and self-sufficiency of these families.

This paper addresses the evaluation of a unique collaborative community program developed to meet the complex needs of child welfare-involved families, for whom housing is a barrier to family stability, unity, or reunification. We begin with a discussion of issues at the intersection of housing and child welfare, describe the context for and components of a supportive housing (SH) model for families, and provide data on initial, interim, and outcome measures of family functioning.

2. Housing as a factor in child welfare

Approximately 10% of poor children and adults experience homelessness each year (Burt & Pearson, 2005). Haber and Toro (2004) conclude that children are affected directly or indirectly in about half of the U.S. cases of homelessness. According to the most recent *National Incidence Study of Child Abuse and Neglect* (U.S. Department of Health and Human Services, 1993), 47% of children with demonstrable harm from abuse or neglect and 96% of endangered children came from families whose annual income was less than $15,000.

Not only are housing difficulties associated with child abuse or neglect, but there is a link between housing conditions and caseworker judgments of parenting adequacy once protective services are involved (Ernst, Meyer, & DePanfilis, 2004). Child welfare systems and policymakers support family preservation programs because they keep families together, are less costly than later interventions, and can result in fewer days spent in foster care (Farrow, 2001; Heneghan, Horwitz, & Leventhal, 1996). Despite the existence of several promising practices in family preservation (National Center for Injury Prevention and Control, 2004), approximately half a million children are placed in foster care annually (Administration for Children and Families, 2008). Harburger and White (2004) suggest that some placements could be prevented if collaboration and cooperation

* Corresponding author. Department of Human Development & Family Studies, University of Connecticut, One University Place, Stamford, CT, 06901, United States. Tel.: +1 203 251 8590/+1 203 894 9260.
E-mail address: anne.farrell@uconn.edu (A.F. Farrell).

0190-7409/$ – see front matter. Published by Elsevier Ltd.
doi:10.1016/j.childyouth.2009.06.012

among child welfare and housing systems were more prevalent and extensive. They assert that SH programs cost 70% less than foster care and estimate that average annual cost savings of $36 million per year, per state (on average), could be achieved if sufficient supportive housing was available.

3. Housing difficulties and homelessness in families

According to Burt, Aron, Lee, and Valente (2001), homelessness emerges from structural (e.g., job opportunities, economic climate) and individual factors (e.g., social support, financial resources, disabilities). Haber and Toro (2004) offer an ecological-developmental perspective on homelessness, stressing that the impact of limited and lost resources (e.g., employment, income) on housing status relates to the larger social structure (macrosystem) as well as family resources and relationships (microsystem). Burt et al. (2001) assert that individual factors are commonly overstated in models of homelessness and emphasize the fact that housing affordability is its immediate cause.

Homelessness reflects and contributes to health, education, and social problems. Compared to poor, housed children, homeless children are more likely to: experience maltreatment investigations; demonstrate higher anxiety, depression, and behavior problems; have poorer school attendance and achievement; and, have poorer health and more developmental delays (Bassuk, Weinrub, Dawson, Perloff, & Buckner, 1997; Buckner, 2004; Shinn & Weitzman, 1996). Housing instability also has negative effects. In one study, children who moved at least three times demonstrated more behavioral, emotional, and school problems than those in stable housing, regardless of income (Shinn & Weitzman, 1996).

Among the housed poor, substandard housing is associated with increased behavior problems and lower task persistence among children, even when income and maternal mental health are taken into account (Evans, Saltzman, & Cooperman, 2001). Most families (86%) in the child welfare system experience low housing quality, but, because they often do not own their housing, they may not have control over problems (e.g., disrepair, vermin) that place children at risk (Ernst et al., 2004).

Weicher (2006) states that housing affordability is measured as a ratio of rent to income, with a ratio of 50% or more considered a high rent burden. He asserts that housing affordability for renters with children is a major problem, and one that is increasing. The effects of the current economic and housing crisis on marginal families are not yet clear. What is clear is that safe, decent, and affordable housing not only reflects stability in the lives of children and families, it *promotes* stability. Conversely, families facing both individual and structural barriers to housing stability experience increased risks in regards to child-rearing. Housing and child protective services must work together if families are to be safe and unified (CWLA, 2005).

4. Housing and child welfare: intertwined problems

Housing and child welfare problems are intertwined. Housing difficulties precipitate admission to foster care and delay family reunification (Cohen-Schlanger, Fitzpatrick, Hulchanski, & Raphael, 1995). For poor heads of household (predominantly women), inadequate housing conditions may trigger a child welfare investigation and the placement of children in foster care. Culhane, Webb, Grim, Metraux, and Culhane (2003) found that women with histories of homelessness were nearly seven times more likely to have involvement with the child welfare system compared to low income, never homeless women. Moreover, losing custody of dependent children often leads to a cessation of housing subsidies (Cohen-Schlanger et al., 1995). Significant proportions of families whose children were in out-of-home care reported eviction (26%), living in a doubled-up situation (42%), or homelessness (29%; Courtney, McMurtry, & Zinn, 2004). Without these subsidies, it is difficult for the mother to provide an adequate home to which children may return. In fact, reunification rates for families in foster care are approximately 50% lower for families who experienced a homeless episode in the year prior to placement (Courtney et al., 2004).

The Adoption and Safe Families Act of 1997 (ASFA) was intended to reduce the amount of time spent in foster care by hastening timelines to permanency (Dicker & Gordon, 2000). In a review of state child welfare efforts, the U.S. General Accounting Office (GAO, 2002) concluded that poor access to services remains an impediment to permanency, noting that families lack comprehensive services like housing assistance. Dorre and Mihaly (1996) reported that up to 30% of children in foster care could be reunited with their parents if safe, affordable housing were available. Judges, lawyers, and social workers involved in child protection realize that housing places hurdles but view this challenge as insurmountable (Shdaimah, 2009). Courts and child welfare agencies are often forced to discontinue reunification efforts and pursue termination of parental rights because parents lack suitable housing (Harburger & White, 2004).

In sum, substandard housing, instability, homelessness, and the absence of accessible and comprehensive supports for families are associated with increased likelihood of maltreatment and may precipitate out-of-home placement. Further, these factors impede family reunification for children in foster care. Recognizing the importance of integrating community supports and housing for vulnerable families, agencies have developed new models for addressing housing and child welfare issues in tandem. Federal support exists in the form of the Family Unification Program (FUP), which encourages partnerships between local public housing authorities and child welfare agencies, and includes the provision of housing vouchers. This program is promising; however, active programs represent a small proportion of families in the system (National Center for Housing & Child Welfare, 2009). The Homelessness Prevention and Rapid Re-Housing Program provided (under the American Recovery and Reinvestment Act of 2009) nearly $1.5 billion to prevent homelessness and address homelessness, affording new opportunities for housing innovation. In 2004, Cohen, Mulroy, Tull, White, and Crowley noted recent growth in "housing plus services programs", yet there are few tested models, and evaluation has not been sufficient (Burt, 2006; Cohen et al., 2004; Haber & Toro, 2004).

5. Programs in housing and child welfare

Child abuse and neglect impair short-term health and functioning and inhibit children's long-term psychological, emotional, cognitive, and social development (Gaudin, 1999). Maltreated children demonstrate an array of difficulties in affective, behavioral, academic, and adaptive functioning (Cicchetti & Carlson, 1989; Reppucci, Britner, & Woolard, 1997). Housing problems of the birth family are one important factor to consider in preventing and intervening in child abuse cases. Logically, effective programs at the interface of child welfare and housing reflect best practices across these two arenas. As such, we briefly review aspects of programs with promise or demonstrated effectiveness in the housing and child welfare arenas.

5.1. Supportive housing programs

Supportive housing has no singular definition, but has been conceptualized as "a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives" (Corporation for Supportive Housing, 2007, p.1). The U.S. Department of Housing and Urban Development (HUD) defines SH as housing and related supports that help individuals and families establish stability, increase skills and income, and attain more control over decisions that affect their lives. Transitional housing (TH)

programs "facilitate the movement of homeless individuals and families to permanent housing" through "supportive services that enable them to live more independently" (HUD, 2009). SH and TH share the goals of stability, independence, and self determination; whereas TH programs are generally short term or temporary, SH tends to be long term or permanent.

To date, the landmark study in the supportive housing field is Culhane, Metraux, and Hadley's (2002) examination of the efficacy of SH for formerly homeless individuals with severe and persistent mental illness. SH produced stable, positive outcomes and was more cost-effective than medical and mental health programs and incarceration. In an examination of permanent supportive housing programs (Nolan, ten Broeke, Magee, & Burt, 2005), tenants were asked to identify which program characteristics were responsible for success. Several cross-cutting themes emerged. Good programs were tailored to unique population characteristics, facilitated communication between property management and tenants, and provided supports and activities that reflected tenant input and interests.

Research suggests that families who complete transitional and/or remain in supportive housing programs are more likely to secure and retain stable housing than those who leave early (Matulef, Crosse, & Dietz, 1995). Burt (2006) examined 53 SH initiatives for homeless families that operated under a variety of housing configurations including single site (centralized facilities), scattered-site (tenant- or community-based), and clustered-scattered (multiple units in a neighborhood or community). Programs offered varying degrees of client support, yet nearly all included case management. Most accepted families with serious problems (e.g., substance abuse, mental illness) with the proviso that there was no active substance abuse and that there was a demonstrated interest in supportive services, essentially requiring clients to demonstrate motivation to change. Programs generally defined "successful exit" as movement into stable housing with a reliable income source. Successful clients had an average length of stay (LOS) of about 13 months, whereas unsuccessful clients (about 25%) had an average LOS of six months or less. The most common reasons for unsuccessful exit were noncompliance with rules (e.g., substance abuse, threat of violence) and/or disinterest in supports available. Unfortunately, these programs did not specifically target the child welfare population, and child welfare involvement was not reported.

5.2. Child welfare interventions

There are a number of empirically demonstrated interventions for families in which maltreatment occurs, and model programs exist to support family preservation and family reunification/permanency. Because of the multi-determined nature of child maltreatment, comprehensive interventions are needed to "shore up" families, prevent foster care placement, and support family reunification if children are placed in out-of-home care. Common components include parent training, parent–child dyadic intervention, individualized services for parents (e.g., substance abuse and mental health interventions), interagency coordination, skills development, and vocational supports. Overall, effective interventions address the ecology of the home, including the physical environment and parenting, to improve the environment of care and reshape family interactions, and encourage parental warmth and attention (Gershater-Molko, Lutzker, & Wesch, 2003; White, 2005). Barth and Price (1999, 2005) found that parents who completed intensive child welfare interventions had better long-term outcomes (less recidivism and more stability) than clients who left prematurely.

5.3. Housing plus child welfare programs

Although there are some promising interventions for families with multiple risks and problems, programs that address child welfare and housing permanency goals *in combination* are virtually absent from the literature. A notable exception is the report by Kroner and Mares (2009) on the characteristics of 455 youth emancipating from foster care into an independent living program that provides housing and related supports. The authors state that their descriptive report might serve as "useful benchmark data" with potential to inform future policy and program development in the housing for youth aging out of care. Whereas the Kroner and Mares study illuminates the population of emancipating foster youth, the field lacks parallel benchmark data on families with dual vulnerabilities in housing and child welfare and the programs that support them. This paper addresses that gap in the literature.

6. Context for the current study

Connecticut (CT) faces significant housing problems and child welfare challenges. A recent nationwide side-by-side comparison of wages and rents estimated the "housing wage," which is the hourly wage required to afford a rental unit [National Low Income Housing Coalition (NLIHC), 2008]. CT's average housing wage ($17.05) ranks seventh among the states. On average, minimum wage workers need to work 110 h per week (the equivalent of 2.8 jobs) to afford a two-bedroom apartment. In the Stamford-Norwalk housing jurisdiction (the most expensive in the nation), that figure rises to 165 h (4.1 jobs) for a small to medium size family (NLIHC, 2008).

At any given time, there are usually six to seven thousand children in foster care in Connecticut (Child Welfare League of America (CWLA), 2007; Office of Legislative Research (OLR), 2006), a rate of approximately 8.1 per 1000 compared to the national median of 7.1 per 1000 (CWLA, 2007). Average caseloads for Connecticut child welfare workers (24 to 31 children) exceed the recommended 12 to 15. Although Connecticut is recognized for its affluence, it has more than its share of poverty (9.3%; CWLA, 2007). Rates of homelessness are notoriously difficult to assess, but some estimates place the number of homeless at 33,000 individuals (Connecticut Housing Coalition, 2005) and growing.

7. The Supportive Housing for Families program

The Connection, Inc.'s Supportive Housing for Families (SHF)[1] program was originally conceived as a housing program for women in recovery (from substance abuse) and their children. In 1998, the CT Department of Children and Families (DCF, the child welfare agency), with the support of the Department of Mental Health and Addiction Services (DHMAS), broadened referral criteria to include families facing housing barriers to family unity or reunification. SHF includes intensive case management, access to scattered-site permanent housing, coordination of mental health and related interventions, housing assistance, and support for building connections in the community. DCF funds the program and provides referrals, parenting interventions, and access to child welfare resources in coordination with SHF case managers. SHF collaborates with the CT Department of Social Services (DSS) to facilitate procurement of housing subsidies and to promote client employability.

The SHF client undergoes three phases of program involvement: assessment/engagement; stabilization/community integration; and healthy connections. At intake, each family undergoes a home-based

[1] Because of its intensive supports and emphasis on stability and self-sufficiency, SHF meets some definitions of "supportive housing," yet it also qualifies as a transitional housing program because families remain in the program temporarily. We retain the term "Supportive Housing for Families" here because it is the program's formal name and because it reflects its dual emphasis on family housing and child welfare.

assessment and is paired with a case manager to create an individualized care plan. The care plan, tailored to family strengths and needs, details individual supports and addresses collective goals for the family. Case manager contacts are ongoing and periodic assessment results (discussed below) are incorporated into the evolving plan of care. Case management occurs in the client's home (scattered-site community housing), at SHF offices, and in the community (e.g., consultation with service providers). The stabilization and community integration phase initiates once the parent obtains a housing voucher/certificate or is otherwise prepared to proceed with a housing search. The tasks associated with this phase are obtaining and settling into safe, affordable housing, preparing for family reunification (if indicated), and developing and maintaining skills needed to retain housing and ensure family self-sufficiency and well-being. In the final (healthy connections) phase, parents mentor other families. For a description of SHF program components, see Table 1.

8. Purpose of the study

The objectives of this study were to (1) empirically describe the families who participated in the SHF program between 1999 and 2008, (2) examine whether families evidenced change in employment, housing, and the environment of care during program participation, (3) determine whether client outcomes at discharge demonstrated significant improvement from entry, and (4) inform the program and the literature.

9. Method

9.1. Participants

This research concerns referral, intake, intervention, and outcome data on 1720 individuals referred to SHF over approximately 10 years. Among these, approximately 30% did not complete the screening/intake process, their referral was withdrawn, or they otherwise did not enter (but data were retained). The current sample includes 1327 closed (discharged) and 393 open cases, where each case includes heads of household ("clients") and their children. DCF caseworkers refer clients whose child welfare status is compromised due to housing factors. At entry, clients may be undomiciled, at imminent risk of losing housing, in substandard, temporary, or unstable housing, or in permanent housing deemed unsuitable for reunification (e.g., small). Although these referral criteria are uniform, we were not able to verify their application and an unknown proportion of families experiencing these circumstances may not have been referred.

9.2. Measures

9.2.1. SHF client assessment

Case managers completed the SHF client assessment form (The Connection, Inc., 1998). It includes basic demographic information, as well as background and family history, and lists housing and financial data, social supports, and community providers.

9.2.2. Client contact (activities)

SHF case managers conduct and log interactions with clients, contacts with community providers, and related activities (e.g., assessment, planning, consultation with service providers, DCF, and housing personnel), and coding them according to type, format, and length.

9.2.3. Discharge summary

Client discharge data are logged on a discharge summary form and entered into the database. As applicable, case managers note the reasons why clients did not enter the program following intake (e.g., not appropriate, referral withdrawn, refused the program) and the circumstances of discharge (e.g., successful outcome: program completion; unsuccessful outcomes: non-compliant, left against advice, arrested/incarcerated, substance abuse). Managers also made categorical judgments (yes/no) about whether there were improvements in housing status and access to health care. SHF did not track child welfare outcomes.

9.2.4. The North Carolina Family Assessment Scale for Reunification (NCFAS-R)

The NCFAS (Reed-Ashcraft, Kirk, & Fraser, 2001) is a family assessment inventory originally developed for use by programs providing family preservation services to at-risk families. Administered by case managers, the NCFAS helps caseworkers identify treatment needs, detect intervention-related changes, and predict the likelihood of future out-of-home placement. The original NCFAS consisted of five domains: environment, parental capabilities, family

Table 1
SHF components.

Component	Description of SHF aims, activities, and supports
Intensive case management (ICM)	• Home- and community-based support • Crisis management available 24 h a day, 7 days a week • 1:12 case manager–family ratio • Empower families to reach self-sufficiency by: creating care plans, making referrals to treatment and community supports, monitoring progress and reassessing client/family goals and needs, identifying problem areas and removing barriers to appropriate services, and mentoring.
Coordination of interventions for mental health and substance abuse	• Staff provides screening, coordination, support, and monitoring of services (does not provide direct behavioral, physical, or mental health services). • Case managers coordinate with new and existing community providers. • SHF staff consults regularly with DCF, which retains responsibility for child welfare assessment and decision making.
Transportation	• Case managers have the capacity to transport clients because transportation can be a significant barrier to attainment of health care, housing, and employment.
Housing supports	• Build relationships with landlords and housing authorities to create sustainable housing options and help families overcome barriers. • Housing coordinators help families identify high quality housing in preferred communities and support the procurement of Section 8 vouchers and Rental Assistance Program (RAP)[a] certificates.
Additional supports and services	• SHF provides clients with referrals, advocacy, crisis intervention, counseling, and parent training services as needed. • Case managers ensure that education, health and child care, and other needed supports are accessible for children; provide parents with information, support, and access to community resources. • Limited flexible funds available to remediate debt, provide security deposits, etc.

[a] RAP is a state-funded program to assist families with severely low income. Families pay 40% of their income toward rent and utilities.

interactions, family safety, and child well-being. The NCFAS-R added two additional scales (caregiver/child ambivalence, readiness for reunification) designed to evaluate appropriateness for family reunification when one or more children are in out-of-home care. When the NCFAS-R is used with intact families, only the first five domains are administered.

Each NCFAS domain and question utilizes a six-point rating scale that ranges from −3 (Serious Problem) to +2 (Clear Strength), through a "0" point (Baseline/Adequate). Scores at or above the baseline/adequate range signify no need for intervention. Each domain has a summary score as well as individual item scores. The summary score is not the arithmetic average of the other items; it represents the observer's judgment of the overall adequacy on that domain. NCFAS scores can be presented by using the −3 to +2 item scale, but they can also be transformed into a 1 to 6 scale, in which higher scores are indicative of relative weakness.

Reed-Ashcraft et al. (2001) established the reliability and construct validity of the NCFAS. Cronbach's alphas for the intake and closure ratings ranged from .76 to .93 and .90 to .93, respectively. The NCFAS-R was field tested with 81 families in three states by a cross section of child protective services, juvenile justice, and mental health staff (CWLA, 2002). Cronbach's alphas for all scales indicated good reliability (.90 or above) and change scores corresponded to the success of reunification. Initial construct validity was established by testing the relationship between the NCFAS and closely-related instruments (Child Well-Being Scales, Index of Family Relations, and Family Inventory of Resources for Management; Reed-Ashcraft et al., 2001), and replicated by Kirk, Kim, and Griffith (2005) using data from 1279 families. The alphas at intake and closure ranged from .72 to .90 and .79 to .91, respectively. Results indicated high internal consistency and acceptable concurrent and predictive validity. They also offered comparative scores for families at intake and closure.

In 2006, SHF staff began to use the NCFAS-R for assessment and case management. Clients are assessed shortly after entering the program, about every six months (interim), and near discharge. Because the program began to use the NCFAS several years after its operation began, data are available for a subset of cases. When it was first implemented, the NCFAS was administered to all families enrolled in SHF. Consequently, the time that elapsed between date of entry and the initial NCFAS administration differs across cases (a proportion of "initial" administrations were conducted beyond the typical initial administration period). Because SHF administered the supplemental scales on a very limited subset of cases, those results are not reported here. Case managers report anecdotally that they often assign a "baseline" score of zero when they lack adequate experience with the family to make an informed judgment.

9.2.5. Risk assessment tool

SHF adapted and expanded an existing screening tool, the MINI Screen, Suicidality Tracking Scale (Sheehan et al., 1998), by adding some items and converting it to a generic risk assessment measure. The MINI is a brief, structured interview for psychiatric disorders. The MINI Suicidality Tracking Scale consists of eight items: one yes/no item ("Over the past week, did you suffer any accident?") and seven other questions with Likert scale responses. Studies comparing the MINI to comprehensive diagnostic tools indicate acceptable reliability and validity (Sheehan, Baker, Janavs, & Harnett-Sheehan, 2006). The SHF adaptation has not been examined psychometrically and is used only for screening and descriptive purposes.

The adapted SHF risk assessment screener consists of 16 closed (yes/no) questions designed to assess suicidality, homicidality, and history of violence. Three additional open-ended questions probe for additional detail when positive responses are offered (e.g., if a respondent indicates a history of harming an authority figure, they are asked to detail the circumstances). Risk is assessed by summing the number of positive (yes) responses to selected items. SHF has employed the risk assessment tool as part of its initial family assessments since 2007.

9.3. Procedures

SHF maintains a database into which staff regularly input intake, assessment, activity, and discharge information. The dataset includes referral information (e.g., demographics, prior housing, employment), intake and assessment findings (e.g., risk status, NCFAS-R scores, family status), staff/client activities (e.g., time in staff–client meetings, consultation with service providers, home visits, procurement of housing vouchers, searching for housing), and outcomes (reason for leaving, housing, employment and income, substance abuse). Case managers and supervisors record client information in the database. For the current study, SHF program administrators anonymized client data (i.e., removed all identifiers) and shared them with the authors, who conducted data analyses.

9.4. Analyses

We approached data analysis in four steps. First, we clarified coding, obtained descriptives, and ensured accuracy by cross-checking selected cases and variables. Next, we began with a univariate approach, examining individual variables in order to understand client and program characteristics. Third, to determine if systematic differences existed between open/closed cases and those that did/did not enter the program, we conducted a series of *t*-tests and chi-square analyses on demographic characteristics. There were no significant differences across groups, but open/closed cases did differ significantly on the amount of staff time and client activities, as expected. The final portion of data analysis was bivariate, including comparisons of client function at entry versus at discharge (*t*-tests, chi-square) and change. Due to the fact that client data-entry tracking began at referral and procedures evolved, the number of cases varied across analyses; 1168 cases included dates of entry and intake information.

10. Results

10.1. Client characteristics

10.1.1. Referral, intake, and admission characteristics

Clients were mostly female (93%) and single (75%), and 14.3% were divorced or legally separated. Client ethnicity was 39.4% White, 29.5% Latino, 28.1% African American, and approximately 3% American Indian, Asian/Pacific, undisclosed, or other. English was the predominant first language (87%), followed by Spanish (11%). Client age ranged from 16 to 64 ($M = 32$), and 10.9 years of education was completed on average. Nearly half (48.8%) completed high school (HS), 10% had less than HS education, 34% had some HS, and 7.4% completed more than 12 years of education. The sample includes 3779 children (52% male, 48% female; mean age = 10.1 years). Ethnicity of children was 35% Latino, 31% White, and 28% African American.

During the 10-year period examined, the average number of DCF referrals per year was 172 (range = 16 to 397), and an average of 116 clients entered the program annually (range = 3 to 339). Most families (75%) entered from temporary housing, nearly 10% entered from permanent housing, 7% entered from residential treatment (e.g., inpatient drug and alcohol or psychiatric facility), 5% had been in homeless shelters, and 2% were undomiciled. Among families who were homeless, common reasons were family break-up (24%), eviction (21%), and unspecified need to relocate (22%); other reasons included substandard housing (4%), disaster (3%), prison release (6%), and loss of subsidy (2%). Household size averaged 3.3 individuals (range 1–10), and the mean number of dependent children was 2.4. Most (72.6%) children were in the care of their parent at entry, 13.8% were in non-relative foster care, 6.2% were in kinship foster care, 5.3%

were living with family members (informal custody arrangements), and 2% were in residential care. Overall, nearly 30% of families had at least one child in foster or residential care, and 8% had informally placed children with relatives.

The average client entered the program just under $2000 in debt. Over half (51.6%) received some form of governmental support/subsidy (e.g., public assistance, disability, unemployment), 31% reported some income from employment or pension, 11% had no income, and 4% received support from family or spouse, including child support. The majority (60.6%) were unemployed, 36% had recent or current employment (18.7% full time, 17.6% part time), and 3% were disabled. Clients indicate employment status and income separately, so proportions do not correspond exactly across these categories (31% had employment income and 36% reported recent work).

10.1.2. Risk and clinical status

The client risk screening conducted at entry (beginning in 2007; $n=630$) found few clients to be at risk of suicide, homicide, or other significant threat. On the risk assessment, 10 of 14 items had predominantly "no" responses (e.g., more than 98% of respondents denied these experiences). The four remaining items were: thinking about or wishing for one's own death (2.9% "yes" responses), feeling hopeless about the future (15.9% yes), lifetime history of suicide attempt (15.7% yes), and family history of suicide attempt/completion (3.8% yes). When "yes" responses were summed into a risk index, 87% of the sample had a score of 0 or 1. There appears to be a small cluster of depressive symptoms in this sample, but risk due to aggressive or homicidal urges is negligible.

On a question that queried substance use/abuse, 66% of clients denied current problems and some acknowledged use of cocaine or crack (11%), alcohol abuse (10%), marijuana use (8%), and heroin use (3%). However, more than half of cases are missing this information, and anecdotal reports from case managers indicate that clients are motivated to deny substance abuse (current or recent) out of concern that they may be denied admission. As such, these reports are not considered to be reliable and valid.

Initial NCFAS scores are available for 986 clients; however, the time between entry and initial administration was variable (on average 110 days after first contact, which occurs before admission). With the exception of the environment domain (37% baseline/adequate and 49% problematic), the majority of clients were rated within the "baseline/adequate" category. More information on NCFAS results appears below.

10.2. Client interventions and service utilization

At entry, more than half (55%) of clients were receiving outpatient mental health and related supports, which were monitored by case managers during their stay. The average length of stay (LOS) was 12.34 months. LOS was six months or shorter in 18% of cases, 6–12 months in 35%, 12–18 months in 28.2%, and 18 months or longer in 19%. LOS was fairly consistent from 1998 to 2003 (range = 10.2–16.2), but increased significantly in the years 2004 and 2005 (based on post-hoc analyses; $F(9, 843)=11.46$, $p<.001$); the reason for this is unknown.

Case manager activity logs reflect the amount of time staff spent interacting with clients and otherwise supporting their service plans during SHF enrollment. The mean amount of staff time for closed cases with nonzero activity totals was 100.5 h ($n=898$; SD = 80.4). Staff–client activities with the highest mean values were home visit ($M=33.4$), telephone contact ($M=31.1$), DCF contact ($M=7.8$), consultation with service providers ($M=7.6$), apartment search ($M=6.5$), and transportation ($M=5.8$). To approximate service utilization, we transformed activity totals into a ratio that represents the clients' relative use of program staff over the duration of program involvement. Specifically, we divided the activity total by the length of stay in months. The resulting service utilization ratio represents the average number of hours per month that case managers logged substantive client contact. The mean service utilization ratio was 9.4 h per month for closed cases (SD = 5.6).

10.2.1. Outcomes at discharge

The main outcome variables were categorical and included housing (improved vs. not improved, temporary vs. permanent), access to health care (improved/not improved), and employment (unemployed, part- or full-time employment, collecting disability benefits), and type of exit (successful/unsuccessful). Type of exit was coded as successful or unsuccessful according to reason for discharge. Successful clients left under "positive" circumstances such as readiness for family reunification, procured housing, etc., and unsuccessful clients left or were asked to leave due to dissatisfaction or non-compliance with program requirements, arrest, etc. Table 2 depicts a number of outcomes, beginning with housing, employment, and health care. At discharge, caseworkers judged most clients to have moved into improved housing situations and to have improved access to health care, including primary care for children. The majority of discharges (73%) were successful, most families moved into permanent housing, and half were employed or receiving disability benefits at exit. (It is unknown how many women in the sample were out of the workforce in part because of having young children at home.) There were significant, positive shifts in employment status and housing, when examined globally, as demonstrated by increased proportions of permanently housed families [$\chi^2(1, n=893)=32.26$, $p<.001$] and employed parents [$\chi^2(4, n=793)=338.44$, $p<.001$] from entry to exit. Whereas over 90% of families who entered from permanent housing returned to permanent housing, about 68% who entered from temporary housing achieved permanent housing at exit. Although employment shifts were significant, they were less dramatic, with the majority of clients evidencing stability rather

Table 2
Activities, service utilization, and outcomes, with bivariate analyses.

Factor or characteristic						
Housing			Initial %			Exit %
Temporary			82.6			29.0
Permanent			17.4			71.0
Improved housing situation			–			78.2
Employment						
Unemployed			60.6			50.0
F.T.			18.7			25.0
P.T.			17.6			19.8
Disability			3.1			5.2
Improved health care			–			72.6
Successful exit			–			72.5
NCFAS ($n=541$)			% at/above adequate			
NCFAS Sub-Scales	Initial	Exit	Initial mean	Exit mean	*t*	*p*
Environment	51.5	80.4	3.5	2.7	16.2	.000
Parental capabilities	74.7	80.8	3.1	2.7	7.8	.000
Family interactions	82.1	87.3	2.9	2.5	8.2	.000
Safety	85.1	88.7	2.8	2.3	9.1	.000
Child well-being	80.5	86.6	3.0	2.6	10.8	.000
Successful activities and service utilization						
	Yes (M)	No (M)		*df*	*t*	*p*
Activities	104.12	84.85		868	12.91	.000
Utilization (hrs/month)	11.92	8.54		868	4.49	.000
Permanent housing						
	Yes (M)	No (M)		*df*	*t*	*p*
Activities	97.56	30.18		896	12.91	.000
Utilization (hrs/month)	9.05	9.48		896	−.39	.614

than change. Nearly 30% of parents who were unemployed at entry had secured employment at exit.

10.3. Exploratory analyses: client characteristics, program elements, and outcomes

10.3.1. Length of stay (closed cases)

LOS related significantly to client success at discharge. Mean LOS for successful individuals was longer than LOS for unsuccessful ones and clients with LOS of less than 6 months were less likely to complete the program and to leave voluntarily than those with longer stays [$\chi^2(3, N=885)=63.63$, $p<.001$]. In order to compare these results with those of SH programs serving other populations, we transformed LOS into quartiles which corresponded with stays of six months or less, 6–12 months, 12–18 months, and 18 months or longer. When examined this way, LOS was not significantly associated with employment at entry or outcome, but was associated significantly with discharge to permanent housing [χ^2 (3, $n=867)=23.19$, $p<.001$; $t(883)=7.37$, $p<.001$)]. The quartiles with the highest proportion of permanently housed clients remained at SHF for 12–18 months (95.5% permanently housed) and 18 months or longer (94.8% permanently housed). Not surprisingly, shorter lengths of stay (less than 6 months and 6–12 months) were associated with lower rates of permanent housing.

10.3.2. Activities and service utilization

As Table 2 indicates, successfully discharged clients demonstrated significantly higher mean activity totals than unsuccessful cases. Because activity totals rise along with LOS, creating a potential confound, we examined whether service utilization was related to outcome. Significantly higher service utilization rates were evident among successful as compared to unsuccessful clients. Significantly higher activity rates were also evident among clients who procured permanent housing, but utilization rates did not distinguish housing status at exit. Employment status at entry [χ^2 (3, $N=885)=63.63$, $p<.001$] and discharge [χ^2 (3, $N=885)=63.63$, $p<.001$] was associated with type of housing at exit, such that clients with part- or full-time work at entry or discharge were more likely to procure permanent housing. Education was not significantly associated with employment, success, or type of housing at exit.

10.3.3. Environment of care

Initial and exit administrations of the NCFAS are summarized in Table 2 along with results of paired sample *t*-tests. Paired initial and exit NCFAS scores are available for 541 cases, and mean scores are significantly different (improved) across all NCFAS domains. (Declining mean scores indicates positive change because NCFAS scores are transformed to a 1 to 6 scale in which 6 denotes serious problem and 1 is a clear strength.) Significant mean differences were also seen between initial NCFAS administration and the first interim NCFAS, (which occurred on average nearly seven months since the initial NCFAS) and between the interim and exit administrations (on average, about five months since the last NCFAS). *t*-values for all subscales between initial and interim and interim and final NCFAS administrations had *p*-values <.001. (Only comparisons between initial and final administrations are included here.)

Finally, we examined the relationship between NCFAS scores and successful program completion. We examined successful/unsuccessful cases categorically (chi-square tests) for initial and exit NCFAS administrations. Among successful cases, significantly higher proportions had final NCFAS administration scores that were at least Baseline/Adequate, and this held for initial and exit scores (with the exception of initial child well-being, which did not differentiate success). Similarly, *t*-tests indicated that mean domain scores differentiate successful from unsuccessful cases (except for initial Child Well-Being). These findings are summarized in Table 3.

11. Discussion

11.1. Overview and comparison to prior research

This study is among the first to describe empirically families for whom housing has implications for child welfare issues, as well as the characteristics of a supportive housing program serving this population and their outcomes upon discharge. Although direct comparisons to other research are limited because of the unique nature of this program, findings on the average LOS and proportion of successful families were similar to outcomes in Burt's (2006) review of SH programs. Also similar is the finding that clients with LOS of shorter than about six months were less likely to be successful and secure permanent housing than those who remain in the program longer. Although clients who entered from permanent housing and with employment income were more likely to retain those at exit, positive shifts in employment and housing were evident across the entire sample. LOS at SHF was significantly shorter than the state average LOS in foster care of 21.7 months (ACF, 2008). Because the cost of foster care is higher than that of SH, diversion into SHF may represent financial savings as projected by Harburger and White (2004), particularly if SHF clients demonstrate lower recidivism into child welfare and homelessness systems.

Research shows that effective programs improve the environment of care (White, 2005). In this study, improvements in the environment of care, as measured by NCFAS domains, were significant. Initial NCFAS scores also distinguish successful/unsuccessful exits, and clients with Adequate/Baseline ratings on NCFAS domains were more likely to

Table 3
Results of *t*- and chi-square tests on NCFAS scores and client success.

	Mean scores					% at or above baseline/adequate			
	Successful								
NCFAS domain	Yes	No	*t*	*df*	*p*	Successful	Unsuccessful	χ^{2a}	*p*
Initial									
Environment	3.33	3.72	4.84	553	.000	56.0	44.0	12.35	.000
Parental capabilities	2.96	3.26	4.36	553	.000	62.5	37.5	17.82	.000
Family interactions	2.83	3.15	4.10	553	.000	85.5	14.5	6.64	.010
Safety	2.73	2.90	1.97	553	.050	75.8	24.2	11.78	.001
Child well-being	3.04	2.97	.98	553	.326	82.2	17.8	.025	.874
Exit									
Environment	2.10	3.91	19.46	448	.000	98.1	1.9	208.18	.000
Parental capabilities	2.16	3.91	17.72	448	.000	97.5	2.5	178.42	.000
Family interactions	2.04	3.63	15.74	448	.000	98.3	1.7	114.89	.000
Safety	1.97	3.29	12.76	448	.000	98.9	1.1	119.57	.000
Child well-being	2.19	3.43	12.96	448	.000	86.5	23.3	98.84	.000

[a] *df* for initial NCFAS = 1, $n=555$; *df* for exit NCFAS = 1, $n=450$.

leave under positive circumstances. Trends on the NCFAS were grossly similar to those seen in studies of families involved in a North Carolina intervention family preservation program (Kirk, Kim, & Griffith, 2005; Jordan Institute for Families, 2005); however, mean initial and exit scores in the SHF sample were generally lower (denoting higher ratings). We speculate that the relatively high functioning of SHF clients may reflect an inherent "screening out" by DCF of less stable and more problematic families who might not ultimately adhere to program requirements. A distinctive aspect of SHF is its dual focus on avoiding out-of-home placement (prevention) and reducing its length when possible (intervention). Many parents had custody of their children as they entered SHF, and they may differ systematically from families that DCF deems to present imminent risk to children. This supposition cannot be confirmed, however, because we do not have comparison data on families who did not enter SHF.

Clients whose case managers logged more total staff–client involvement and higher service utilization were more likely to experience positive reasons for discharge. This finding is intriguing, yet difficult to interpret. On the one hand, it is possible that higher case manager activity simply brings results. On the other hand, higher levels of contact may reflect relatively high engagement among clients who eventually secure permanent housing and employment. We could not ascertain whether high levels of activity indeed reflect engagement, and whether engagement reflects client characteristics, case manager attributes, or an interaction. Higher utilization rates did not distinguish housing status at exit. Perhaps high levels of participation increase the likelihood of leaving the program under positive circumstances; however, no amount of diligence can alter the available housing stock. Clearly, these independent factors in the housing market may affect client outcomes. Whereas housing and employment outcomes improved significantly within the sample, clients with histories of permanent housing and paid employment were more likely to exit with them. Clients lacking prior employment and history of stable housing may represent a more challenging subset of factors that programs need to address.

11.2. Limitations

This study was observational in nature and the clients supported were not necessarily representative of the state or national child welfare populations; therefore, generalizeability may be limited. As stated earlier, DCF referrals were not random, and families with more troubled histories may have been inadvertently "screened out." The risk assessment tool used in the program provided relatively little information that might contribute to a fuller picture of client characteristics. Client reports of substance abuse were incomplete and judged to be unreliable. Some outcomes were judgment-based and several variables were dichotomous (e.g., client history, outcomes), making it difficult to discern the interaction of client and program factors. Other outcomes were reliant on external, non-controllable factors (e.g., fluctuations in the availability of paid work and affordable permanent housing), and these factors can vary significantly within the state. There were very limited data available on client utilization of mental health, substance abuse, and other services that might relate significantly to outcomes. The reliability of activity levels is dependent on case manager reports, which we could not verify. At the time of this inquiry, SHF did not track child welfare decision making or outcomes (open/closed, family reunification, etc.), and data were not available from DCF. Additionally, there was no way to determine whether clients were out of the workforce "by choice" (e.g., caring for young children), nor was there information on reasons for unemployment and underemployment. In sum, the data may not reflect the full variability of child welfare cases, are limited in scope, do not address child welfare decisions, and fail to address long-term outcomes. Without a comparison sample, it is not possible to determine whether the gains described here could be attained in standard child welfare or housing approaches. The exploratory analyses reported here (i.e., relation of client housing, employment, and NCFAS scores to outcomes at discharge) do not encompass the full range of possible predictors, and they should be interpreted and applied with caution.

11.3. Implications

11.3.1. Practice

These results endorse the essential utility of the SHF model, a cross-system collaboration between housing and child welfare. They also underscore a need for ongoing collection of program data, discussed below in research implications.

This research illuminates some client characteristics that are associated with employment and permanent housing at exit, and future practices should be attentive to client history in this area. Specifically, supportive housing staff should identify early in program involvement those client characteristics that were associated with diminished achievement at exit, and attempt to address them by providing targeted support in these areas. Clients who were ultimately successful had higher initial NCFAS scores, again suggesting that there may be early cues as to which clients may require more intensive casework efforts.

One practice implication involves more careful client triage at entry. Screening methods that scale clients on housing, employment, mental health, and child welfare factors might permit SHF to match client needs to graduated programming, for example from "limited" to "intensive" SH case management. Another implication concerns the findings on activities and utilization. Although these are difficult to interpret, SHF may wish to further examine staff–client activities as a potential measure of client engagement. Clients with activity/engagement scores in the bottom quartile and relatively low initial NCFAS scores might be more carefully assessed and supported within their first few months of program participation. More reliable assessment of substance abuse status and related problems is needed.

11.3.2. Research

Consistent with the limitations noted, we recommend additional measures of client characteristics (to be collected at intake and exit: income, employment history, extent and type of prior and current child welfare involvement, behavioral health, including substance abuse, etc.), program processes (type and intensity of health, behavioral health, and substance abuse interventions, vocational supports, parenting interventions), child characteristics and supports (adaptive function, educational and therapeutic supports), and family outcomes (client characteristics, child welfare decisions, e.g., whether and when DCF cases are closed, permanency outcomes such as family reunification, adoption, etc.). Future evaluation efforts should more directly assess child function and outcome and may need to control for economic factors such as affordable housing stock and unemployment rate. Whereas the current economic downturn may result in the availability of more housing, it has produced greater unemployment, and this may translate to extended LOS.

The data presented here were mostly descriptive and were not adjusted for potential mediators of outcome such as client adherence to parenting, substance abuse, and mental health interventions. These limitations might be addressed in more detailed multivariate studies under discussion. A randomized, controlled study of SHF would lend convincing support to this model, especially if enacted along with recommendations for additional measures of client and child function, program processes, and outcomes. It would be valuable for cost comparisons to be embedded in future studies, e.g., supported housing for families with dual vulnerability in housing and child welfare versus "business as usual" in child welfare.

11.3.3. Policy

This study provides benchmark data on housing and child welfare and indicates that programs designed to address unique considerations

across these arenas may offer important benefits in the form of family stability and self-sufficiency, child safety, and potential cost savings. Some authors (Harburger & White, 2004; Shdaimah, 2009) underscore the need to consider housing as a critical factor in families referred to child protection systems, advocate for expanded definitions of housing problems, and call for greater collaboration among housing and child welfare systems. Going forward, national and state policies should provide incentive for preventive cross-system collaborations. The Family Unification Program (FUP) and Homelessness Prevention and Rapid Re-Housing Program (HPRP) bring new promise for families with housing and child welfare challenges. It is critical for FUP and HPRP initiatives to be studied so that more can be learned about these intertwined problems and their solutions.

12. Conclusion

SHF started in 1997 as a small program serving a limited part of CT. It has grown into a statewide program that has served over 1100 families, the majority of whom left for permanent housing and demonstrated an improved environment of care. This report provides initial endorsement for the SHF model and makes suggestions for program practice, future research, and policy. Housing vouchers combined with individualized support appear to be an effective form of assistance for families. Continued research is critical if we are to understand the optimal mechanisms of support and change that lead to child safety and family self-sufficiency.

Acknowledgments

The authors wish to thank the staff and administration of The Connection, Inc. and the Supportive Housing for Families Program, the CT Department of Children and Families, and the University of Connecticut Center for Applied Research in Human Development.

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Legal Assistance Resource Center ❖ of Connecticut, Inc. ❖

44 Capitol Avenue, Suite 301 ❖ Hartford, Connecticut 06106
(860) 278-5688 x203 ❖ cell (860) 836-6355 ❖ fax (860) 278-2957 ❖ RPodolsky@LARCC.org

Transfer of programs to new Department of Housing

Interagency Council on Affordable Housing public hearing -- December 11, 2012

Statement of Raphael L. Podolsky

The purpose of this testimony is to submit two brief comments to the Interagency Council.

(1) We support the creation of an adequately staffed Department of Housing that brings all (or at least most) housing programs into a single agency. The 1995 merger of DOH and DED was supposed to create a combined agency in which housing would be viewed as a full partner with economic development and would receive the same prominence. In reality, that is not what happened; and almost immediately housing became a secondary program, seen more as management of existing "assets" than as promotion of the development of affordable housing, and especially of the low and very low income housing that the market is unlikely to produce on its own. Over time, the housing staff at DECD has decreased through attrition to a point that adversely impacts its ability to provide more than the most basic of services. It is time to restore a comprehensive Department of Housing.

It is critical, however, that this new Department be given the tools it will need to succeed. This means, in particular, that any reorganization plan should provide for **adequate staffing** -- both staff transferred from other agencies and new staff to make programs work.

(2) Full programs should be transferred and not merely isolated statutory provisions. It is possible that this comment is actually technical and not substantive. We are puzzled by the proposed program transfer list, because it cites specific statutory sections rather than complete programs. We assume that the recommendation is intended to include the entirety of each statutory program, but that is not clear from the document. For example:

- The list includes the Relocation Grant Program under C.G.S. §8-268 (see p. 16), but fails to include the rest of the Uniform Relocation Assistance Act (Chapter 135 of the General Statutes), which goes from C.G.S. §8-266 to §8-282.
- The list includes specific programs in Chapter 127c (which covers C.G.S. §8-37r through §8-37*LLL*) but does not include all of that chapter. Thus, it identifies the Window Repair and Replacement Program under C.G.S. §8-37ww (see p. 10) but does not seem to include the Rental Housing Revolving Fund under § 8-37vv, the income-targeting requirements of §8-37cc, and the affirmative action requirements §8-37ff.
- The list covers the old Condominium Conversion Act under C.G.S. §47-88b (see p. 9) but not the equivalent portion of the current Common Interest Ownership Act under §47-288.

These are just a few of many examples. Any proposal should assure that all DECD housing-related statutes are moved into the new department.

Connecticut
Fair Housing Center

December 10, 2012

Anne Foley
Under Secretary for Policy Development and Planning, Office of Policy and Management
Chairperson, Interagency Council on Affordable Housing
450 Capitol Avenue
Hartford, CT 06106

Re: The Creation of a Department of Housing

Dear Secretary Foley and Council Members:

Thank you for this opportunity to address the Interagency Council on Affordable Housing ("Council") as it completes this phase of its work regarding the creation of a new Department of Housing ("Department"). We appreciate the time and thought that the State, through the Council, has dedicated to the range of considerations at issue in the proposal for the new Department. Connecticut has long needed a unified housing strategy and it is our hope that the process you have begun will fill this void.

Whether or not the Council recommends the creation of the Department, we urge you to consider the fair housing issues which our State is confronting and to incorporate affirmative fair housing strategies into the workplan of every State employee involved in housing policy. While Connecticut is increasingly diverse, people of color, people with disabilities and others are segregated into our struggling urban areas and other geographies that are becoming commonly known as "lower opportunity areas." Connecticut's housing policies must include a reevaluation of the kind of investments necessary to help lower opportunity areas and the people who, largely as a result of historic segregation and exclusionary practices on the part of suburbs, currently live there. At the same time, the State must provide access to higher opportunity areas for lower income people of color through transportation, educational opportunities and, above all, housing.[1]

1. **Consideration of Fair Housing Issues:** The Connecticut General Assembly charged this Council with assessing the housing needs of low income individuals and families, reviewing and analyzing the effectiveness of existing state housing programs in meeting those needs, and identifying the barriers to effective housing delivery systems. Housing discrimination and historic segregation patterns impact every one of these issues. To fully comply with the

[1] We encourage you to read the report the Connecticut Fair Housing Center commissioned from the Kirwan Institute for the Study of Race and Ethnicity, *People, Place, and Opportunity: Mapping Communities of Opportunity in Connecticut*, available at http://kirwaninstitute.osu.edu/connecticut-opportunity-mapping-initiative-results-and-resource-materials/.

221 Main Street, 4th Floor • Hartford, CT • 06106
860-247-4400 (Hartford) • 888-247-4401 (Toll Free)
860-247-4236 (fax)
www.ctfairhousing.org

General Assembly's charge, the Council should consider the fair housing and housing discrimination issues which affect each subject area.

In addition, virtually every housing program in the State is under a federal or state obligation to affirmatively further fair housing. HUD has found that the obligation to affirmatively further fair housing means that housing programs must be operated in a manner that intentionally counters the historic and contemporary forces that created or currently perpetuate housing segregation and otherwise marginalize historically disenfranchised groups. In light of these federal obligations and the burdens some of Connecticut's most vulnerable citizens have faced because of long-existing housing practices, we ask that when making a recommendation to the Governor, the recommendation include an analysis of whether creation of such a Department will affirmatively further fair housing and how the Department would help counteract Connecticut's historical segregation patterns.

2. **Affirmatively Furthering Fair Housing:** When moving forward, the Council should urge the State to undertake several steps to effectively further fair housing.

    - **Leadership from the top:** Governor Malloy's leadership on this issue is critical. The Department of Economic and Community Development is currently drafting the Analysis of Impediments to Fair Housing Choice ("AI"), a report mandated by HUD to review current demographics and programs to evaluate barriers to fair housing choice. We encourage Governor Malloy to read this report and make clear that his housing initiatives, including the creation of the Department, if recommended, will be designed to ensure that the fair housing issues raised by the AI will be addressed.

    - **Priority within the Department of Housing:** Oversight of the State's affirmatively furthering obligation should reside with the supervisor of the Department and Department funding should include support for a position dedicated to ensuring fair housing compliance in *all* housing programs in the State. Ideally, this position would be vested with authority to shape the State's housing portfolio to ensure fair housing goals are met.

    - **Fair Housing Goals and Targets:** Using the data produced in the AI report, a new Department of Housing should generate a series of principles to ensure the State's housing policies promote fair housing. These principles should result in very specific goals for housing rehabilitation, development, and placement that result in housing integration.

    - **Fair Housing Reporting Requirements:** The new Department, in collaboration with fair housing advocates, should reassess its statutory demographic and housing need reporting requirements and revise them to allow for the latest improvements in data and mapping capabilities. Accurate and complete data will allow the Department to develop effective and realistic affirmatively furthering policies. Such reporting obligations should apply to all housing programs regardless of the agency in which they reside.

3. **Promoting a Unified Housing Policy:** A single Department of Housing has the potential advantage of unifying housing policy, including interlacing programs and simplifying grant application procedures. While this could theoretically occur by simply bringing all housing programs under the DECD umbrella, we applaud this goal of the Department of Housing proposal and recommend that as many housing programs as possible from other agencies be transferred to the new Department to realize this objective. At least one program, the Low-Income Housing Tax Credit Program, the single biggest generator of affordable housing in the country is not included but should be. There may be other such housing programs.

   To the extent programs are not consolidated, the new Department should be given fair housing oversight authority allowing it to include non-Department housing programs in its evaluation of affirmatively furthering goals.

4. **Bundling State Benefits and Obligations:** By taking housing programs out of DECD, Connecticut decreases the likelihood of effectively "bundling" state benefits and obligations to promote integration. Connecticut towns gain significant benefits from the State. If the Council decides to recommend the creation of a Department of Housing independent of DECD, we ask that receipt of the State's economic largesse be conditioned upon a municipality's willingness to promote integration and incorporate fair housing considerations into its housing policy decisions. Indeed, some New England states have recently combined their housing and economic development programs in order to make just these kinds of funding connections.

5. **Ensuring Appropriate Delivery of Services:** In order to ensure that clients of agencies like the Department of Health and Addiction Services and the Department of Social Services continue to enjoy the benefits of "one-stop-shopping," we encourage meaningful and frequent interagency contact so that those contacts will be able to access benefits administered by the Department. One possibility might involve official exchanges wherein, for example, a DMHAS direct service housing employee is physically located within the new Department, at least on some kind of rotational basis. Proper training of Department employees on issues that arise when assisting vulnerable populations, including fair housing training, is essential.

Thank you for this opportunity to comment on the proposed establishment of the Department of Housing. We welcome the opportunity to discuss these recommendations in greater depth.

Very truly yours,

Erin Kemple

Erin Kemple
Executive Director

Testimony
John Bradley, Executive Director, Liberty Community Services
December 11, 2012
Interagency Council on Affordable Housing

Good Morning, Chair and Members of the Interagency Affordable Housing Council

My name is John Bradley and I am the Executive Director of Liberty Community Services in New Haven. Liberty Community Services has been working in New Haven for 25 years and our mission is to end homelessness and we provide permanent supportive housing and supports to people who are homeless due to HIV/AIDS and mental illness. Liberty has received a grant for many years from Department of Social Services ("DSS") from the Housing Line for AIDS Housing. I would like to talk briefly about our experience with the administration of that grant and hopes for the transition.

Currently, Liberty receives funding from eight separate State and Federal grant programs to administer our various housing and community support programs. So we have a large amount of experience in administering and working with State, Federal, and City agencies with grants and grant compliance. Our experience with DSS and the DSS staff has been excellent. The DSS staff who are the primary contacts for our grant, Cassandra Norfleet-Johnson and Karen Motta, are excellent and we hope they or people of their caliber administer the AIDs Housing Program when it transfers to the Department of Economic and Community Development ("DECD"). Cassandra and Karen and other DSS staff have a full understanding of our program, respond to us on a timely basis when there are questions, and are diligent in ensuring that the grant funds are released on a timely basis. Our grant supports 66 people who were formerly homeless and living with HIV who are now housed in a variety of housing programs. Because we are an agency that is predominantly supported by State and Federal grants, timeliness of payment and communication about the Aids Housing payment is critical to our agency. Housing with people with HIV/AIDs improves the health of the person being housed and the entire community and DSS has always approached this grant with a sense of commitment and importance. We hope that will continue.

I want to share one immediate concern about the transition of housing grants from DSS to DECD. Our Aids Housing grant had a term of October – September. With the upcoming transition, DSS has changed the term of the current contract from one-year to nine months, with an expiration date of June 30, 2013. I am concerned that transition of staff, payments systems, and appropriations on July 1 (close to when we should be receiving a quarterly payment) will result in a delay in a new contract and hence delay in payment. I suggest that DECD create a three month contract extension which can be executed prior to July 1 so that we will be paid early in the quarter beginning on July 1.

Thank you for the opportunity to testify and we look forward to supporting the transition in whatever way we can.

LeadingAge Connecticut
Formerly CANPFA

December 11, 2012

Testimony Submitted to the Interagency Council on Affordable Housing

Re: Proposed Recommendations for Programs to be Transferred to the New Department of Housing

LeadingAge Connecticut is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of long term care including affordable senior housing. Our housing members are sponsored by religious, fraternal, community, and governmental organizations that are committed to providing quality housing, care and services to their residents. Our member organizations, many of which have served their communities for generations, are dedicated to expanding the world of possibilities for aging.

LeadingAge Connecticut appreciates this opportunity to submit testimony regarding the proposed recommendations for which state programs will be transferred into the new Department of Housing.

LeadingAge Connecticut is a strong proponent of the model of linking affordable senior housing with services; a model that enables older adults to remain in their community and to age in place. We believe this model is one of the answers to our state's quest to balance the long term care system. Connecticut has already developed several nationally acclaimed models of housing with services including allowing assisted living services to be delivered within our state congregate and HUD 202 housing sites and the four pilot affordable assisted living demonstration sites. We have excellent models that we would like to see encouraged and replicated to meet the growing needs of our elderly population.

LeadingAge Connecticut supported the creation of a Department of Housing to oversee and coordinate the functions of state government related to senior housing. We continue to be supportive and are hopeful that the recommendations to move the many and varied senior housing and related service programs, included the affordable assisted living programs, into the new department will help to address the fragmented responsibilities, inflexible funding streams, and regulatory constraints that currently impede efforts to develop and coordinate senior housing with health care and other services.

We would encourage the Department of Housing to recognize the unique role and needs of elderly housing sites and to call upon the expertise of elderly housing providers for consultation and advice. On behalf of the not-for-profit senior housing provider members of LeadingAge Connecticut, we offer our assistance to both the Council and the Department of Housing.

Thank you for consideration of these submitted comments.

Respectfully submitted,

Mag Morelli, President
LeadingAge Connecticut (formerly CANPFA)
1340 Worthington Ridge, Berlin, CT 06037
(860) 828-2903 fax (860) 828-8694
www.leadingagect.org

Susan Salters –Independence Unlimited

Interagency Council on Affordable Housing

PUBLIC HEARING NOTICE
Tuesday, December 11, 2012
10:00 a.m. – 11:00 a.m.
Lyceum
227 Lawrence Street
Hartford, Connecticut

I am an advocate for people with severe disabilities at the Center for Independent Living in the Greater Hartford area, Independence Unlimited. I have been the Community Inclusion Specialist with this non-profit agency for over five years. My job is to find ways to have people with all kinds of disabilities included in the daily life of Connecticut communities instead residing in institutions where they are segregated away from family, friends, faith communities and civic engagement. Part of my job is to define and attempt to eliminate barriers to full inclusion as promised in Federal Acts like the ADA and Olmstead Act. One of the biggest obstacles our consumers face is appropriate housing. Like other low income residents of Connecticut who are living on fixed incomes from state and Federal programs, our consumers need affordability in housing. Connecticut's ranking as 6th highest in rental prices leave many who cannot work due to significant disabilities struggling to keep a roof over their heads. Partnership for Strong Communities in their report, Housing in CT 2012 stated that Connecticut's 2-1-1 Infoline expects to respond to nearly 80,000 calls regarding housing. If the caller is disabled many of those calls get referred to us.

We congratulate Governor Malloy's commitment to safe, affordable housing as a vehicle to building strong, healthy communities for people to reside in. The formation of the Department of Housing, which consolidates a vast array of housing programs under one roof, is an exciting, innovative and long overdue instrument towards achieving the Governor's goal. But in order for our communities to be inclusive of people with disabilities they must also be accessible. Accessibility in housing is a just a first step towards creating communities that are truly diverse and equitable. The Rehabilitation Act of 1973, the ADA, Fair Housing Act, and CT P.A 10-56 all encouraged building homes that are accessible to people who use wheelchairs or other mobility devices. Independence Unlimited worked with Rep. Kenneth Green and the General Assembly Housing Committee to get Public Act 10-56, An Act Concerning Visitable Housing

passed in 2010. This act was to encourage builders of single family homes to include the three simple design changes of Visitability to all new home construction. Visitability means all homes should be built with, one no-step entrance, wider hallways and doorways and a bath on the main floor large enough for a person who uses a wheelchair to use. Our initiating this legislation was to bring to light the desperate need in Connecticut for homes that are accessible to everyone. As this new vision by the Department of Housing takes shape to meet the housing needs of Connecticut residents, that vision must include all of Connecticut's residents not just the able bodied.

In The State of Connecticut Analysis of Impediments to Fair Housing Choice (AI) (2006) under "People with Disabilities" the report states, "Much of Connecticut's affordable housing is older housing stock and less likely to be adapted or even adaptable to the needs of this population [the disabled] despite a state law passed in 1990 that requires all newly constructed or substantially renovated apartments to meet new accessibility/adaptability guidelines."

I know today's public hearing held by The Interagency Council on Affordable Housing is to accept public comment on the transfer of programs to the new Department of Housing but I propose that the Council consider the addition of a new program to fall under the jurisdiction of the Department of Housing. My suggestion is to create an Accessibility Task Force or other entity that is a watchdog over housing programs and housing development to insure the people of Connecticut's disability community that their needs are also of concern to the Governor and to the Department of Housing. There are a couple of reasons why I make this suggestion.

1) Most of Connecticut's accessible housing stock is available in elderly and disabled housing projects run by public housing authorities. Housing authorities are making their housing "elderly only" due to the difficulties that arise when both populations live together. This trend eliminates access for people who are younger than 62 and physically disabled to housing that is accessible and affordable.

2) There is an increased demand for accessible housing to fulfill the housing needs of the Baby Boomers who are rapidly joining the ranks of the elderly and the disabled who are moving out of institutions. The DECD 2010-15 Consolidated Plan for Housing and Community Development reports the number of Connecticut residents with physical disabilities younger than 65 years of age as 111,359. This sum does not include people residing in nursing homes that may be transitioning out under the DSS Money Follows the Person or people with disabilities who are already homeless.

3) On page 76 of the 2006 report Analysis of Impediments to Fair Housing Choice, The Office of Protection and Advocacy stated "The agency feels that the availability of accessible housing units for persons with disabilities continues to be a major, chronic

problem."

I hear of the need for accessible housing nearly every day and I am concerned that if, in increasing the numbers of affordable housing units, the problem of accessibility is not addressed the chronically low number of available accessible housing units that are affordable will continue and become an even greater problem. So on this dawn of a new direction in creating affordable housing, the hope of the disability community is that affordable, accessible housing to meet the needs of the thousands of people with physical disabilities is also on the horizon.

Susan Salters
Advocate
Independence Unlimited
151 New Park Ave, Ste. D
Hartford, CT 06106
(860) 523-5021 V/TTY
(860) 523-5603 Fax

PARTNERSHIP
FOR STRONG
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Written Testimony before the Interagency Council on Affordable Housing – December 11, 2012
On behalf of The Partnership for Strong Communities

Respected Members of the Interagency Council,

The Partnership for Strong Communities strongly believes that a new Department of Housing must deal with new realities in the housing market. At the top of that list:

- Mixed-income housing is vital because it is easier to finance, more sustainable and more palatable to the many municipalities in Connecticut that now have little to no affordable housing – and SHOULD. In that way, by opening high resource schools and service-rich communities to low- and moderate-income households, it advances what we believe: that we are not so much in the housing business as we are the opportunity business!
- Housing affordability should no longer be measured in the rental or ownership costs of four walls and a roof. Affordability must be measured in related costs: principally, transportation, but also location-specific costs of healthcare, nutrition, environmental quality and education. Transit-oriented development should therefore be a touchstone for the state's future affordable housing policy.

There are successful examples of mixed-income housing in many municipalities across the state. They were built largely as a result of 8-30g. Now, Connecticut has HOMEConnecticut as another tool for mixed-income housing planning, zoning and development.

The value of mixed-income housing is undeniable. Across the state, mixed-income developments have been shown to vastly increase the array of housing options for residents of a town, and have been embraced by town officials. They have produced none of the negative effects misperceived by too many: crime hasn't gone up, property values haven't gone down (in fact, they've risen!) and hordes of school children have not descended on local school budgets!

With the right configuration, design, unit-mix, affordability level and location, mixed-income housing can be built with internal subsidy, requiring much fewer government subsidies. Sufficient revenue from the market-rate units can permit a developer/builder to make a profit while still absorbing the costs of constructing the affordable units. Valuable subsidy – more valuable today than ever before – can be saved to promote/produce housing for lower-income residents.

That same revenue stream can also be used to more easily maintain the housing, keeping property values high and obviating much of the need for expensive remediation and preservation in later years.

227 LAWRENCE STREET • HARTFORD, CT 06106
TEL: 860.244.0066 • FAX: 860.247.4320
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Perhaps most important, mixed-income housing is more palatable to communities that have little experience with affordability. By making only a minor portion of the units affordable, existing town residents are not provoked into worrying about a new "ghetto" of poor people. Mixed-income developments in such towns as Avon, Simsbury, Kent, Darien, Trumbull, New Canaan and Cheshire have opened new educational, job, recreational, healthcare and social opportunities to families that, like most low- and moderate-income households in the state, were left to choose from among the 29 (of 169) cities and towns with any affordable homes to speak of.

The new Department of Housing must also embrace TOD and a wider definition of housing affordability. It makes little sense, in any era of $4+/gallon gasoline and expensive home heating oil, to try to build larger affordable homes in far-flung locations just because the land can be obtained at low cost.

Average households spend 32% of their income on housing and 19% on transportation. Energy costs are not far behind. But households who can live within a half mile of transit lower their transportation costs to 9%. That extra disposable income can purchase more and better food, healthcare, clothing and other necessities. It can support local merchants and contribute to savings.

When transit proximity can be combined with smaller, denser, more affordable, energy-efficient units, housing and energy costs come down further.

It's rather simple, and that is why the new Department of Housing should be intimately involved in (a) ensuring new affordable housing development near transit, (b) preserving the affordable housing that is already there to avoid the displacement of its residents, and (c) development of transit fares that are affordable and equally affordable and convenient "last-mile" connecting transit service so low- and moderate-residents who cannot live or work near stations can easily use the service and take advantage of the much wider array of job opportunities it can present.

Sincerely,

David Fink
Policy Director

227 LAWRENCE STREET • HARTFORD, CT 06106
TEL: 860.244.0066 • FAX: 860.247.4320
WWW.PSCHOUSING.ORG

PARTNERSHIP FOR STRONG COMMUNITIES

Written Testimony before the Interagency Council on Affordable Housing – December 11, 2012
On behalf of The Partnership for Strong Communities

Respected Members of the Interagency Council,

The Partnership for Strong Communities strongly believes that a new Department of Housing must deal with new realities in the housing market. At the top of that list:

- Mixed-income housing is vital because it is easier to finance, more sustainable and more palatable to the many municipalities in Connecticut that now have little to no affordable housing – and SHOULD. In that way, by opening high resource schools and service-rich communities to low- and moderate-income households, it advances what we believe: that we are not so much in the housing business as we are the opportunity business!
- Housing affordability should no longer be measured in the rental or ownership costs of four walls and a roof. Affordability must be measured in related costs: principally, transportation, but also location-specific costs of healthcare, nutrition, environmental quality and education. Transit-oriented development should therefore be a touchstone for the state's future affordable housing policy.

There are successful examples of mixed-income housing in many municipalities across the state. They were built largely as a result of 8-30g. Now, Connecticut has HOMEConnecticut as another tool for mixed-income housing planning, zoning and development.

The value of mixed-income housing is undeniable. Across the state, mixed-income developments have been shown to vastly increase the array of housing options for residents of a town, and have been embraced by town officials. They have produced none of the negative effects misperceived by too many: crime hasn't gone up, property values haven't gone down (in fact, they've risen!) and hordes of school children have not descended on local school budgets!

With the right configuration, design, unit-mix, affordability level and location, mixed-income housing can be built with internal subsidy, requiring much fewer government subsidies. Sufficient revenue from the market-rate units can permit a developer/builder to make a profit while still absorbing the costs of constructing the affordable units. Valuable subsidy – more valuable today than ever before – can be saved to promote/produce housing for lower-income residents.

That same revenue stream can also be used to more easily maintain the housing, keeping property values high and obviating much of the need for expensive remediation and preservation in later years.

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Perhaps most important, mixed-income housing is more palatable to communities that have little experience with affordability. By making only a minor portion of the units affordable, existing town residents are not provoked into worrying about a new "ghetto" of poor people. Mixed-income developments in such towns as Avon, Simsbury, Kent, Darien, Trumbull, New Canaan and Cheshire have opened new educational, job, recreational, healthcare and social opportunities to families that, like most low- and moderate-income households in the state, were left to choose from among the 29 (of 169) cities and towns with any affordable homes to speak of.

The new Department of Housing must also embrace TOD and a wider definition of housing affordability. It makes little sense, in any era of $4+/gallon gasoline and expensive home heating oil, to try to build larger affordable homes in far-flung locations just because the land can be obtained at low cost.

Average households spend 32% of their income on housing and 19% on transportation. Energy costs are not far behind. But households who can live within a half mile of transit lower their transportation costs to 9%. That extra disposable income can purchase more and better food, healthcare, clothing and other necessities. It can support local merchants and contribute to savings.

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Sincerely,

David Fink
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December 10, 2012

Anne Foley – Chair
Interagency Council on Affordable Housing
450 Capitol Avenue
Hartford, CT 06106-1379

Dear Ms. Foley:

RE: **Comments from Reaching Home Affordable and Supportive Housing Workgroup** to the Recommendations for Implementation of the Department of Housing.

As you are aware, Connecticut's statewide initiative to end homelessness – Reaching Home – has been broadening its approach through Opening Doors-CT, a blueprint for preventing and ending homelessness in Connecticut. Opening Doors represents a comprehensive collaboration among public and private partners across many systems and settings, and significant recommendations have been advanced by each of the five Work Groups.

I have served as Chair of the Affordable and Supportive Housing workgroup, and have been asked to submit comments to the draft "Recommendations for Implementation of the Department of Housing" to ensure that the consensus position of the Workgroup is considered by the Interagency Council. These comments are meant to supplement and expand upon the testimony submitted by Alicia Woodsby on behalf of the Reaching Home Campaign.

Comments:

The Reaching Home Housing Workgroup applauds the Interagency Council's "Rationale for Creation of the New Department" of housing and the importance of the new Department providing leadership for the state's housing policy issues and facilitating a coordinated implementation of the state's housing agenda. The affordable housing industry in Connecticut is on the threshold of potentially significant changes with new resource investment that has not been seen in some 20 years. To meet this new opportunity, the new Department of Housing and the Connecticut Housing Finance Authority must rise to the challenge of leveraging scarce resources and being responsive to local needs. Resources are critical; the efficiency and effectiveness of the housing delivery system is just as critical to producing and preserving our affordable housing stock.

We are all well-aware that the current systems for funding housing and community development are fragmented and bureaucratic. Improving the systems that administer housing programs is as important as increasing the total resources available. Connecticut must develop policies that transform our housing delivery system to focus on comprehensive solutions and outcomes and that bring together all available resources to solve our state's housing needs.

The Housing Workgroup agrees that consolidation of housing production, operation and financing will enhance our productivity and will ensure a comprehensive approach to housing initiatives. Our specific recommendations include the following, for your consideration:

1. Implement a unified approach to accessing state financing for affordable housing that brings together all housing resources in the state that could include, but not be limited to, CHFA, DECD, Office of Policy and Management, Departments of Social Services, Children and Families, Mental Health and Addiction Services, Banking, Education, Transportation, and Environmental Protection. Such approach could operate through an Interagency Workgroup model (which could be similar to the one used for Supportive Housing Initiatives).
2. Implement a true one-stop application process that enables projects to receive funding from a variety of appropriate resource "pots" rather than chase after isolated programs. This would allow for housing for homeless and at-risk populations to be embedded within affordable housing projects and for the Department to meet the financing needs of the deal.
3. Transform staff from a regulatory mentality to a focus on development, program administration and production, with a clear focus on streamlined investment and incentives to:
    a. Establish greater predictability of funding rounds;
    b. Be pro-active in identifying and bringing projects to fruition;
    c. Work collaboratively with developers throughout the process;
    d. Make decisions and take risks;
    e. Finance and close on projects more quickly;
    f. Coordinate with agencies at the underwriting level;
    g. Identify new and creative financing and packaging approaches;
    h. Assess the pros and cons of rounds vs. pipeline;
    i. Reduce the time and costs during predevelopment and construction.
4. Invest in capacity-building activities that will result in high quality, "ready-to-go" proposals that meet local needs and state priorities by:
    a. Providing access to predevelopment funding for high-performing developers;
    b. Providing or funding technical assistance in deal structuring, particularly when using resources from multiple agencies;
    c. Develop financing tools that support a range of housing types, including both large and small projects, and those that are mixed income and those that have deep income-targeting; and
    d. Fund Community Development Financial Institutions (CDFI's) to manage financing activities.

With leadership from the Administration and a Department of Housing that is able to coordinate the resources at hand, the development community stands ready to be a full partner in the business of creating, managing and preserving affordable housing in Connecticut. Thank for you this opportunity.

Very truly yours,

Betsy Crum
Chair – Reaching Home Housing Workgroup

Reaching Home Housing Workgroup Members

Cathy Branch Stebbins, *CONN-NAHRO*
Lawrence Davis, *Webster Bank*
Maria DeMarco, *DeMarco, Miles & Murphy*
Steve DiLella, *CT Dept. of Mental Health and Addiction Services*
Kelly Doran, *Robert Wood Johnson Foundation*
Karen Dubois-Walton, *Housing Authority of the City of New Haven*
John Dunne, *Corp. for Supportive Housing Southern New England Program*
Heather Gates, *Community Health Resources*
Amanda Girardin, *Journey Home*
Peter Hance, *Bridgeport Housing Authority*
Tracy Helin, *CT Coalition to End Homelessness*
Dara Kovel, *CT Housing Finance Authority*
Nick Lundgren, *CT Dept. of Economic and Community Development*
Tony Lyons, *National Equity Fund*
Carol Martin, *Konover Residential Corporation*
Alice Minervino, *CT Dept. of Mental Health and Addiction Services*
Michelle Molina, *John D'Amelia & Associates*
Nancy O'Brien, *CT Housing Finance Authority*
Diane Paige-Blondet, *My Sisters' Place*
Andrea Pereira, *Local Initiatives Support Corporation*
Chris Peterson, *Columbus House*
David Rich, *Supportive Housing WORKS*
Christina Rubenstein, *Partnership for Strong Communities*
Michael Santoro, *CT Dept. of Economic and Community Development*
Lisa Sementilli, *CT Coalition to End Homelessness*
Elizabeth Torres, *Bridgeport Neighborhood Trust*
Vincent Tufo, *Charter Oak Communities*
Carla Weil, *Greater New Haven Community Loan Fund*
Mollye Wolahan, *Women's Institute for Housing and Economic Development*