Final Report: Connecticut's Intensive Supportive Housing for Families Program

December 2018

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Executive Summary

From 2012-2018, the Connecticut Department of Children and Families (DCF), and its core partners (The Connection, Inc. (TCI), the University of Connecticut, and Chapin Hall at the University of Chicago) planned, developed, implemented, and evaluated a supportive housing (SH) intervention for families in the child welfare system. This federally-funded demonstration project capitalized on a longstanding statewide SH program and synergized a number of emergent practices and partnerships in the state. A Housing and Child Welfare Collaborative co-chaired by state leaders served as the project advisory board; this group informed, oversaw, promoted, and supported project aims and led efforts toward systems integration and sustainability, policy and legislation, and family economic security and well-being.

The demonstration effectively targeted resources to families who were newly involved with the child welfare system, demonstrated high housing instability or homelessness, and evidenced high service needs. In contrast to traditional practice, referrals came from the DCF investigations unit rather than ongoing services, enabling close attention to family housing needs early in child welfare involvement. To aid in triage, the core team developed a universal screening of all new child welfare cases for homelessness/inadequate housing along with an appraisal of service needs. Eligible families were referred for randomization into the program and study.

Using a randomized controlled trial design, we tested experimental contrasts among three groups: (1) the existing statewide SH model that included routine access to housing (voucher) and case management, *Program Supportive Housing for Families* (PSHF); (2) an intensive treatment SH model with a higher dosage of case management, family teaming, and access to a vocational specialist, *Intensive Supportive Housing for Families* (ISHF); and (3) a wait list control group, who received child welfare services in a *business as usual* (BAU) condition. Families enrolled in the ISHF condition had the benefit of assured access to state rental assistance program (RAP) vouchers that were set aside for the demonstration.

The evaluation consisted of three components: process, impact, and economic evaluations. Observations within the process evaluation revealed that planning and implementation activities occurred largely as mapped out in the proposal and implementation plan. Cross-systems collaboration was exhibited across the demonstration and was rated as moderate to high by members of the CT Housing and Child Welfare Collaborative. Looking across the four components of experimental contrast, we observe good to excellent contrast for three components (i.e., casework intensity, vocational services, family teaming). There was a lack of experimental contrast with respect to access to evidence-based interventions, which were intended as a priority for the ISHF condition. Time to lease up with voucher was significantly shorter among families in the ISHF condition than in the PSHF condition.

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Staff reported that both ISHF and PSHF programs helped clients experience support, engagement, and empowerment. Service providers reported that the collaborative process was well developed; however, they reported a need for additional resources and caseload balance to work more effectively. Staff, partner providers, and clients all reported seeing the value in collaboration and felt the benefits of the unique aspects of the project's dedicated focus on improving the quality of client-centered care through inter-agency collaboration.

Results of the impact analysis revealed that access to a service model containing a combination of supportive housing and case management (ISHF, PSHF) was associated with both short- and long-term benefits through two years. Comparing families enrolled in both treatment groups to controls, a greater proportion of children (30% vs. 9%) were reunified with their families (among reunification cases) and a lower proportion of children (9% vs. 40%) were removed from their families or experienced an incident of substantiated maltreatment (among preservation cases). Comparing PSHF and ISHF, we found that the intensity of the service model had minimal impacts on children and families; there was some initial evidence of early benefits to family health, safety, and self-sufficiency in the higher intensity service model, but these effects faded over time.

The economic evaluation complemented and coordinated with a national cost study. Here, we examined the costs of child welfare, shelter, and supportive housing across the three experimental groups. Families in ISHF incurred the highest costs of all experimental groups in child welfare and supportive housing, consistent with the reality that heightened service provision requires a substantial investment. Due to extremely low shelter use, families in ISHF incurred the lowest shelter costs. These high costs in ISHF notwithstanding, results revealed positive findings; although there were not savings associated with PSHF, the standard supportive housing model, the fact that BAU and PSHF incurred equivalent per-child costs means that it is possible to provide services that produce better outcomes for children. Additional sources of data, such as access to Medicaid records and Department of Labor records, are needed to better understand whether SHF programs in CT have true cost-savings benefits.

Ultimately, these findings highlight supportive housing as an essential component of any intervention model to promote child and family well-being, particularly for families involved in the child welfare and at risk of housing instability and homelessness. The implementation of the ISHF program in CT illuminates the potential for multiple interventions to work in concert for the benefit of families and points to the opportunity for future initiatives, such as the Family First Prevention Services Act, to support interventions that take a "housing first" approach and have demonstrated effectiveness. Other lessons from this work that are immediately actionable include the value of an initial screener for housing needs, the emphasis on quickly housing families, and the need for a consistent stream of housing vouchers. Additional research efforts will continue to explore the long-term effects of supportive housing and case management, the mechanisms underlying the early successes of participating families, and the lingering questions around the role of vocational supports for promoting family self-sufficiency.

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1. Overview of the Community and Problem Addressed

1.1 Introduction

In the 1990s, the Connecticut Department of Children and Families (DCF; the state's child welfare agency) and the Department of Mental Health and Addiction Services (DMHAS) collaborated to support the development of a supportive housing (SH) program for women in recovery (from substance use) and their children (Farrell, Britner, Guzzardo, & Goodrich, 2010). Eventually, the two agencies broadened the referral criteria beyond women with addiction, enabling the Supportive Housing for Families (SHF) program to support a larger subset of families in the child welfare system for whom housing was a barrier to family preservation or reunification. CT has consistently been ranked among the most expensive housing corridors in the nation (National Low Income Housing Coalition, 2018), and state child welfare authorities understood that families living in poverty experience a range of housing challenges from affordability to stability, among others. As such, the agencies were mindful of the accumulating risks to children in families who experienced high housing instability and homelessness.

The SHF program model, established in partnership with The Connection, Inc. a statewide nonprofit service provider, included case management, access to scattered-site housing, coordinated mental health and related interventions (e.g., parenting, trauma-focused therapy, addiction treatment), assistance with housing search and procurement, and support for building sustainable community connections. The program leveraged federal Section 8 rental subsidies and CT's state rental assistance program (RAP) to ensure that families who were newly reunified (from foster care) and in receipt of housing vouchers might experience a new, foundational level of stability that would serve as a protective factor in child and family well-being.

Over the past decade, extensive research has documented the relationship between child welfare involvement and housing; in fact, SH programs in CT and elsewhere presaged a range of interventions that would accrue observational research support (Farrell et al., 2010; Corporation for Supportive Housing & Robert Wood Johnson Foundation, n.d.) and eventually contribute momentum toward the federally-funded housing and child welfare demonstration described in this report (ACF's *Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System; SH Partnership;* RFP released in 2012). Momentum came from a number of sources (e.g., Samuels, 2017), including the emerging literature demonstrating the deleterious effects of housing instability and homelessness on child development, case law supporting the provision of basic supports to families at risk of disruption (e.g., foster care placement; Illinois's Norman services), analysis of the effectiveness of the Family Unification Program (Cunningham, Pergamit, Baum, & Luna, 2015; Fowler & Chivira, 2014; Rog, Gilbert-Mongelli, & Lundy, 1998), and the Family Options Study sponsored by the U.S. Department of Housing and Urban Development (Gubits et al., 2015).

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1.2 Context for the Supportive Housing Demonstration: Description of the Community

The State of Connecticut is divided into six DCF regions pictured in Figure 1. We first implemented the demonstration in the eastern region (referred to as Region 3), a relatively large geographic area that encompasses the cities of New London, Norwich, Groton, Middletown, and Willimantic, and the surrounding suburban and rural areas. Region 3 was chosen as the starting place for the demonstration project because of its demographic diversity; combination of urban, suburban and rural areas; existing partnerships with community shelters; and contracts with evidence-based intervention (EBI) providers. The ISHF model was planned and initiated in Region 3 across the first three years of the demonstration and subsequently expanded to Region 4 in in the later years. Region 4 includes the DCF offices in the cities of Hartford and Manchester, which contain larger urban and suburban areas than those in Region 3.

Figure 1. Map of Connecticut State DCF Regions
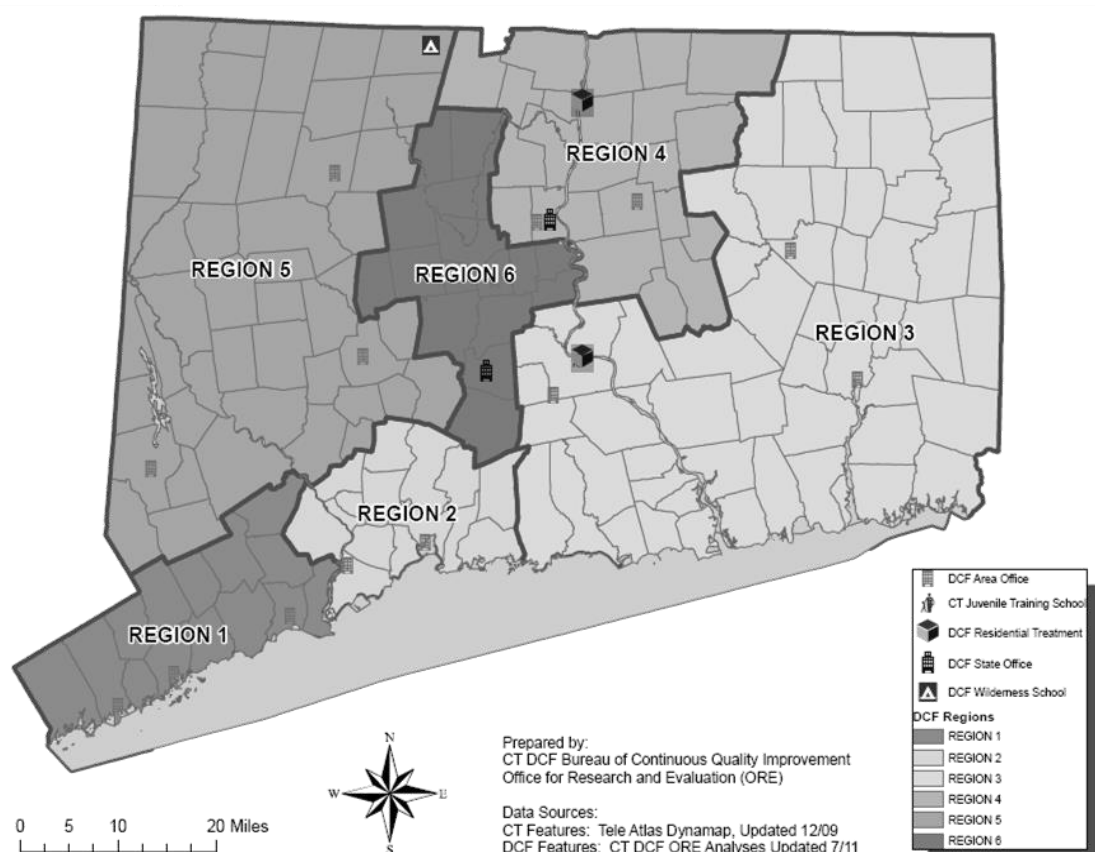
In the more than 10 years prior to the award of the *SH Partnerships* grant in 2012, CT gradually increased its investment in supportive housing for families in the child welfare system. The

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federal award synergized a number of programs and initiatives and helped to solidify existing partnerships and collaborations. Evidence of CT's work in this realm was first published in 2010, when Farrell and colleagues published a descriptive study of client characteristics and their outcomes at discharge from the SHF program. This paper described the findings on 1,720 participating families. The investment, implementation, and ongoing refinement of the SHF program between its inception in the 1990s and the time of the demonstration project enabled CT to augment the federal funding to test new components of the SHF model. The demonstration ultimately entailed a three-group randomized controlled trial and enabled experimental examination of the longstanding SHF program:

1. the federally-funded Intensive Supportive Housing for Families (ISHF) project,
2. the existing (state funded) Supportive Housing for Families program, here called Project Supportive Housing for Families (PSHF), and
3. a business as usual (BAU; control condition).

1.3 Problems Addressed

As outlined in the original grant proposal, CT cities, particularly those in Regions 3 and 4, have relatively high rates of poverty. In 2010, US Census data indicated family poverty rates in these regions ranging from 12% to 26%, well above the state average of approximately 9%. At the time that CT responded to ACF's Funding Opportunity Announcement, the state had the 5th highest cost of living, the 7th highest housing wage in the nation, and was home to two of the most expensive housing areas in the nation based on wage. Its proximity to New York City and combination of urban, suburban, and rural communities is a source of diversity in an otherwise small state. DCF surveys of incoming families indicated disproportionately high rates of trauma, including domestic violence and physical abuse. Homeless shelter use was on the rise. There was a waitlist of more than 500 child welfare-involved families who were likely candidates for the SHF program.

By 2012, the SHF program had been in operation for nearly 15 years, so ample information on client characteristics was available to the grantee and local service providers. These data informed the planning for the demonstration, in particular, the targeting of families with housing instability and homelessness, high parent and child needs, and open child welfare cases. Farrell et al.'s (2010) examination of client characteristics and initial outcomes for SHF across a 10-year period revealed that the average client entered SHF with about $2,000 in debt. Over half (52%) received some form of governmental support/subsidy (e.g., public assistance, disability, unemployment), 31% reported income from employment or pension, 11% had no income, and 4% received support from family or a spouse, including child support. Two-thirds of the families admitted demonstrated moderate barriers to family stability, including housing, environment of care, and mental health. The majority (61%) were unemployed, 36% had recent or current

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employment (19% full time, 18% part time), and 3% had a disability. In short, these findings pointed to income and employability as major barriers to self-sufficiency and housing stability.

Like other jurisdictions, DCF historically made referrals to housing programs when families were judged to be housing ready; that is, caseworkers sometimes "rewarded" families with housing supports when they completed certain steps in their case plans (Cunningham et al., 2015). In many cases, family housing needs might not be considered until close to the time of reunification. In this scenario, a parent applying for a housing voucher might be doing so close to or past the time window for reunification as specified in federal statute. This is just one of the ways that housing instability inadvertently contributes to poor child welfare outcomes. Prior to the current demonstration, it was rare for a "housing lens," meaning an early glimpse into the family's housing stability, to be applied systematically to families entering the child welfare system during the investigation process or very early in case management. The *SHF Partnerships* demonstration codified the application of that housing lens early in the family's child welfare involvement and required a paradigm shift among DCF workers.

Historically, DCF social workers referred families with housing needs to TCI, who conducted extensive screening and assessment with clients at entry and at 6-month intervals until discharge. These measures, which evaluated mental health, parenting, substance abuse, the environment of care, housing, employability, and self-sufficiency, informed client service plans and program evaluation. The screening and assessment data thus served as the basis not only for understanding individual client progress, but also facilitated an ongoing understanding of the population served and the extent to which the program could leverage the core assets and address the central needs of families. Additionally, it prepared the team for the demonstration project.

In sum, at the time the demonstration was awarded, the target community evidenced significant challenges with respect to family poverty. Among the most expensive housing corridors in the nation, CT had shortages of affordable housing and resources out of reach for most child welfare-involved families experiencing vocational challenges, underemployment, unemployment, and housing instability and homelessness. There was a long waitlist for SH for child welfare-involved families. At the same time, the lead agency (CT DCF) had in place a SH infrastructure and highly relevant initiatives that set the stage for implementation.

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2. Overview of the Lead Agency and Collaborative Partnerships

2.1 Collaborative Partnerships

2.1.1 Lead Agency: Connecticut Department of Children and Families (DCF)

The Connecticut Department of Children and Families (DCF) is the state child protective agency tasked with the mandates of child welfare, juvenile justice, and children's behavioral health and prevention. DCF's mission is to protect children, improve child and family well-being, and support and preserve families. Further, DCF aims to advance children's health, safety, and learning both in and out of school, identify and support special talents, provide opportunities for them to both give back to their communities, and to leave the Department with an enduring positive connection to family. In this work, families and communities are valued as full partners. This approach signifies that child safety is paramount, but cannot be the sole focus of DCF involvement with families.

By 2011, DCF implemented a number of initiatives intended specifically to improve practices and outcomes. These included a commitment to collaborative, cross-agency team-based leadership and a Results Based Accountability (RBA) framework. Collaborative leadership goals included movement to more family-centered practices, infusion of trauma-informed policy and practice, improved racial justice, developmentally nested practices, and the promotion of health, safety, and well-being through community partnerships. The RBA framework included nine similar strategic priorities that also focused on reduction of congregate care, increased workforce support, and improved management.

Likewise, within these areas of focus, DCF adopted a Strengthening Families Practice Model to guide its work with families, youth, and providers. This practice model is implemented through eight core strategies: (1) family-centered practice, (2) purposeful visitation, (3) trauma informed practice, (4) family centered assessments, (5) child and family teaming, (6) effective case planning, (7) leadership, management, and (8) supervision to evaluate practice/outcomes and individualized services. DCF uses this approach with the entire family system, including foster and adoptive parents, and enables the agency to support and preserve families by building on their existing strengths and community resources.

In 2012, DCF implemented an alternative response system, the Differential Response System, by which investigative staff began to differentiate responses to reports of child abuse and neglect based on salient family factors. In this system, DCF selects a response (investigation or assessment) based on an initial understanding of family assets and needs, which enables voluntary service participation by some families, promotes streamlined resources and monitoring, and attunes responses to individual family profiles. The practice model considers five protective factors in its assessments: 1) parental resilience, 2) social connections, 3) knowledge of parenting child development, 4) concrete support in times of need, and 5) social

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and emotional competence of children. These protective factors are leveraged in all phases of work with families from intake through ongoing services. The DRS further solidified DCF's commitment to inclusive, family-centered approaches and reflected the organization's learning that the way to improve outcomes for children is through positive engagement of families, providers, and the community, broadly.

2.1.2 Structure of the Collaboration

This section provides an overview of the **core** and **systems-level partners** who collaborated on the demonstration and further delineates how the project leveraged sister agencies and community partners in the work. We distinguish the core partners from the CT Housing and Child Welfare Collaborative. The core partners include the grantee, DCF; the service hub, TCI; the evaluation team, the University of Connecticut (UConn) and Chapin Hall at the University of Chicago (Chapin Hall); and community agencies who provided services to enrolled families. The Housing and Child Welfare Collaborative is the statewide systems-level entity responsible for overseeing and supporting the collective efforts of the initiative. In Section 2.2 below, we review the goals, objectives, major activities, and outcomes for the statewide Collaborative and provide the systems change logic model. Here, we describe the core partners and their roles.

At the time of the grant proposal, the state's housing functions were situated in the Department of Social Services, which was a key planning and funding partner. As noted below, CT's creation of the Department of Housing (DOH) created new opportunities for the CT demonstration, both in the structure of the statewide collaboration and with respect to sustainability. During implementation, the DOH became a critical partner in working to ensure resources and build community capacity. Again, the core members include the team of individuals who designed the initiative, wrote the grant application, and maintained primary responsibility for activities under the grant: the lead agency (CT DCF) the housing and child welfare service hub (TCI), and the local evaluation team (UConn and Chapin Hall).

Core partners. At both the core- and the systems-levels, the partnership undergirding CT's ISHF demonstration included DCF and DOH along with the service hub (TCI). DOH was responsible for administration of housing vouchers and worked with DCF as the lead agency and child welfare partner. The DOH committed 50 housing vouchers for clients enrolled in the ISHF condition. Housing vouchers for families in the SHF condition were furnished through the standard, business as usual means of accessing the state's rental assistance program (RAP) vouchers. TCI served as the community agency partner and provided direct services including intensive case management, vocational services, and housing services to the families enrolled in the project. These core partners worked closely with the local evaluation team to develop the implementation plan and ensure proper monitoring, course correction, evaluation, and reporting. Monthly meetings ensured communication and enabled management of a range of day to day occurrences and challenges, from ensuring case flow to model design modifications such as step-up and step-down in case management intensity.

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As the fiduciary, DCF contracted with TCI to provide the direct services for the project. TCI subcontracted with UConn and (later) Chapin Hall as the project evaluators. For 20 years, DCF has contracted with TCI to provide case management and housing services to DCF-involved families who are homeless and at risk for homelessness. Likewise, the evaluation team had previously been involved in evaluating the effectiveness of various iterations of supportive housing programs in Connecticut. The core team also drew on existing collaborations between partner agencies and local service providers. All of the additional local service providers had existing contracts with DCF prior to the funding of the demonstration project, but per the standard course of business, none of these partnerships were formalized with legal agreements such as a memorandum of understanding.

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Table 1. CT Demonstration: Local Providers and Community Partners

Providers	Service, Purpose, and/or Role
Columbus House United Services	Family homeless shelters, domestic violence shelters: Level 1 triage.
United Community Family Services	EBI: *Trauma-focused Cognitive Behavioral Therapy* (TF-CBT) *Family Enrichment Services:* in-home parenting intervention. *Intensive Family Preservation*: home based. *Triple P* – the IFP providers are in the process of training to become certified Triple P providers. *Family Based Recovery:* intensive in-home clinical treatment program for families with young children. *Functional Family Therapy* multi-component intervention for children with problems ranging from mood to conduct disorders.
	Child FIRST (Child and Family Interagency Resource, Support and Training): program to decrease the serious emotional disturbance, developmental and learning problems, abuse and neglect among young children.
CT Dept. Mental Health and Addiction Services, Wheeler Clinic	EBIs: EMDR, TREM, TARGET, Seeking Safety
Birth to Three CT's Early Intervention Program	Early intervention for children with or at risk for disabilities.
DCF/ Head Start Collaboration	Referrals into Head Start and Early Head Start
Continuum of Care	CT's COC is the statewide entity operating the collaborative effort to locate, triage, refer, and provide services to individuals and families experiencing or at high risk for homelessness. This includes a number of city and regional convenings intended to ensure prevention and promote seamless service entry. Within the demonstration, this included connections with homeless and domestic violence shelters.
SUMSS Meetings	Behavioral health collaborative operating to ensure access to quality services.
Bureau of Rehabilitation Services	Collaborate with BRS to work to ensure employment opportunities and/or benefits to individuals with disabilities.

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Providers	Service, Purpose, and/or Role
Department of Labor	Collaborative relationship with DOL to work in conjunction with high functioning clientele in finding employment.
Social Security	Collaborate with SS to work to ensure employment opportunities and/or benefits to individuals with disabilities.
Department of Housing	Core partner; administers state Rental Assistance Program (RAP) permanent vouchers to families in SHF and ISHF, and beyond.
Advanced Behavioral Health	In home treatment for addictions, additional CM supports.
Thames Valley Council for Community Action, Inc. (TVCCA)	Social services across the eastern region of CT.
Madonna's Place	EBI provider, Fatherhood initiative, Circle of Security
Child & Family Agency of Southeastern CT	EBI for children who have been sexually abused.

2.1.3 Relevant Changes since the Implementation Plan

As noted above, CT created the Department of Housing following the completion of the grant proposal and implementation plan. DOH is a valued core partner in the work and a senior staff member (Karin Motta) co-chairs the Housing and Child Welfare Collaborative. This change enabled the Collaborative to streamline its efforts and resulted in more informed and specialized services statewide related to housing and child welfare. We believe that this structural change had a positive impact on the demonstration and the sustainability of its impacts.

One minor change was that, in January 2016, Dr. Anne Farrell, who was the evaluation Principal Investigator (PI) at the University of Connecticut, assumed the position of Director of Research at Chapin Hall at the University of Chicago. Dr. Farrell, together with Chapin Hall colleagues, assumed the PI role at Chapin Hall and continued as partner in the local evaluation. Dr. Preston Britner, formerly Co-PI, assumed the PI role at UConn. This change had little to no functional impact on the work.

2.2 Collaborative Partnership's Systems-Level Goals

2.2.1 The CT Collaborative

As the grant recipient and lead partner, DCF sought to demonstrate collaboration and engagement, to address and overcome system barriers, and to meet the unique service needs of families for whom housing and related stressors threatened well-being. DCF's general aim was to improve well-being by enhancing protective factors and reduce the need for and length of

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out-of-home placement. The specific goals indicated in the original grant proposal included (1) improve outcomes for the target population of families who come to the attention of the child welfare system due to severe housing issues and high service needs, (2) document and examine planning and implementation processes in order to support success, expansion, and replication, (3) conduct economic evaluation, and relatedly, (4) complete training, technical assistance, and dissemination.

Per Table 1, the core partners (DCF, TCI, evaluation team) had working relationships with service providers, homeless and domestic violence shelters, and related child welfare services. DCF had contractual relationships with a number of providers and did not need to secure additional MOUs. UConn and Chapin Hall obtained study permissions from the cognizant IRBs at their respective institutions and the DCF IRB and established data sharing agreements as needed to complete the evaluation. The evaluation team secured permission to obtain and use HMIS data from the Connecticut Coalition to End Homelessness (CCEH); these data are included in the evaluation.

In procuring federal support, CT's vision was to provide the highest-need families (i.e., with high recidivism, exposure to trauma, and deep housing instability and/or homelessness) priority access to evidence-based services, intensive case management, prompt access to housing supports, family engagement, vocational services, and community involvement (the ISHF program model is described in more detail in Section 3). Together, these components were intended to increase family confidence, motivation, and self-esteem which contribute to healthy children, families, and communities. In short, the ISHF demonstration was designed to align with DCF's mission, vision, and practice model that focuses on engagement of parents as partners and the enhancement of protective factors for families.

From the outset of the grant, CT was focused on systems change, with the intention of better serving vulnerable families across the state and across agencies. Per the project proposal, the core partners, project leadership, and agency leadership worked to convene a larger, systems-level collaborative that participated in the project planning year and met at least twice annually. In addition to the core project partners, the systems-level collaborative contained members from the CT Opening Doors / Reaching Home Campaign (framework to prevent and end homelessness), the Governor's Interagency Council on Supportive Housing, the Three Branch Institute (funded by the National Governor's Association during the first portion of the grant period), DCF Statewide and Regional Advisory Councils (membership from virtually all state agencies), and the DCF Continuum of Care Partnership.

As such, the project advisory board for the demonstration site, called the CT Collaborative for Housing and Child Welfare ("the Collaborative"), was designed and staffed with stakeholders (from an array of state and nonprofit agencies) to improve cross-systems partnerships throughout the state and to help with plans regarding what elements of the ISHF model would be sustained beyond the demonstration in a statewide revision of the existing SHF model. It was

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co-chaired by leaders from the Department of Children and Families (DCF; Administrator Kristina Stevens) and the Department of Housing (DOH; Program Specialist Karin Motta). A complete membership roster for the Collaborative may be found in Appendix A.

Formally, the mission of the Collaborative was to enable the development, quality, and sustainability of collaborative efforts to promote family economic and housing stability in service of child and family well-being. In keeping with state practices, membership in the Collaborative was voluntary; participation was high throughout the demonstration period.

2.2.2 CT Collaborative Activities
Whereas the role of the CT Collaborative as the project advisory board solidified during the implementation period, the full range of stakeholders were convened during the course of the planning year. Once established, the Collaborative met approximately every six months during the demonstration grant, with additional working group meetings, guest speakers, newsletter updates, and such taking place in between meetings.

In early 2014, members met for a lively discussion on their perspectives of the impact of homelessness on the families the represented agencies served. In a later meeting in 2015, Collaborative members debated ways to strengthen and deepen connections to create better, more integrated systems for families and children. Specific topics included: creating systems that are transparent; reducing redundancy; sharing and use data appropriately; bringing missing stakeholders to the table; offering training; and, leveraging resources for families. Members' responses to a question about the characteristics of CT's vulnerable families and obstacles in reaching them yielded some insights and reinforced the need for systems change.

Subsequent meetings between 2015 and 2018 featured: an overview from Connecticut's housing advocates on state policy initiatives and proposed legislation regarding homeless families; program and evaluation updates on the grant's progress; discussions of what practices from the demonstration should be sustained after the grant period; and, workgroup tasks that were focused on system change within specific areas, such as education, employment, and housing, that impact families and their vulnerability to becoming homeless.

2.2.3 State Systems-Level Objectives, Activities, and Outcomes
Three working groups within the Collaborative were active throughout the period of the demonstration; their activities reflected fundamental systems change objectives that were agreed upon in the second year.

The *Systems Integration and Sustainability* working group focused on the objective of developing and maintaining collaborative partners, including leaders from an array of public and private systems that are concerned with economic and housing stability and child and family well-being. The intent was to promote sustainable efforts and programs, strengthen CT's infrastructure for local and regional system change and service integration, support evaluation efforts, assist the

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development of cross-systems data sharing, and enable the design and support of longitudinal evaluation of interventions and collaborations intended to promote child and family well-being. In coordination with the Policy and Outreach working group, the Systems Integration and Sustainability working group sought to ensure the availability of resources in service of the overarching mission of the Collaborative.

The *Policy and Legislative Advocacy* working group had the objective to share information with the public, policymakers, community providers, clients, and others. The intent was to leverage broad and deep support for family well-being through targeted communication efforts, engagement with public officials, dissemination of policy-relevant information to all stakeholders, and an integrated approach to promoting family economic security.

Finally, the *Family Economic Security and Well-Being* working group was tasked with attending to issues related to the overall economic security of families, with a particular emphasis on vulnerable families. This group addressed its attention to cross-systems processes and outcomes such as educational attainment, vocational productivity, housing stability, and support for subpopulations such as very young parents and families with complex needs. Outcomes are further addressed in Section 7: Sustainability.

2.2.4 Systems Change Logic Model
During the preparation period for this grant, the CT team met with a range of stakeholders to discuss the need for cross-systems collaboration and the opportunity for the demonstration to alter systems conditions in sustainable ways, including ensuring a more seamless experience for families, such that housing instability and homelessness, particularly among families with or at risk for child welfare involvement, would be recognized and managed through contact with any of a range of providers and systems. Within the demonstration, the priority was targeting resources to those families who had housing instability and high service needs and had already come to the attention of the child welfare system. The aim was to examine what set of services might best shore up those families with lessons reaching back to the larger composition of supports intended to prevent and end family homelessness in CT. The partners rightly envisioned the demonstration as a set of new resources and opportunities to address well-being more universally, depicted below in Figure 2.

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Figure 2. Systems Change Logic Model

Results-based collaborative partnerships

Capitalize on DCF's transformational efforts...
- Change management
- Continuum of care
- Differential response
- Teaming
- Community-based outcomes
- Congregate care rightsizing
- Data collection and monitoring
- State & Regional Advisory Councils
- Trauma-focused services
- Early childhood intervention

Private-public partnerships

Three Branch Institute
- Child welfare, health, behavioral health, and homeless systems

Data integration
- Vehicle for identification, collaboration and integration

Yield more effective, integrated services
- Tailored continuum of supports
- Housing as a platform for family stability
- Prompt, family-centered responses to risk
- Evidence-based interventions (EBIs)
- Expanding regional and local networks
- Coordinated staff training and service delivery models across systems

Address the needs of children, families & the workforce... enabling prompt intervention and expanded prevention
- Ready access to socially valid EBIs
- Access to safe, stable, affordable family housing
- Parental emphasis on self sufficiency, parenting
- Prompt family reunification
- Increased community investment in prevention, health promotion, early intervention and education

Improve child & family well-being

Healthy
Cognitive, physical, behavioral-emotional, social development
Permanent connection with family

Safe
Homes, schools, in community of choice
Positive behavioral and life choices, parenting

Wellness

Smart
Educational and vocational success
Develop interests and talents

Strong
Resilience in the face of adverse experience
Protective factors in the community (support, housing, etc.)

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3. Description of Demonstration Project and Implementation

3.1 Model of Service Provision and Service-Level Goals

As previously described, a primary aim of the initiative was to improve outcomes for the target population of families. This achievement would require prompt and seamless access to housing and needed services for families, provision of family-driven and family-centered case planning and decision making, and promoting family self-sufficiency via vocational supports and training. These goals were accomplished through an intensive model of service provision and access to housing vouchers, among other supports, and documented via the evaluation procedures.

Of note, CT had in place a SH program for approximately 15 years prior to the demonstration. Whereas this brought clear advantages in the form of experience and competence (i.e., with respect to systems management, staff competence, and relations among DCF, TCI, and housing, homelessness, DV and related service providers), it also brought challenges. Specifically, before the demonstration, the existing referral patterns (discussed in Section 1 above) placed the application of the "housing lens" in the hands of the ongoing services social workers at DCF. Within the demonstration, referrals stemmed from the Investigations Unit at DCF, very early in the family's child welfare involvement. This was an important shift; outside of the demonstration, the longstanding Supportive Housing for Families program still existed, such that DCF service workers could continue to make referrals of existing cases to the existing SHF program. Inside the demonstration, families new to the child welfare system were to be triaged for referral to the randomized trial (the demonstration). Accordingly, the core team needed to institute communications efforts to (1) ensure that the Investigations Unit was applying the "housing lens" early in each family's child welfare involvement, in order to make referrals to the demonstration, and (2) continue to message the availability of the longstanding SHF program for "older" cases (families who had been child-welfare involved well beyond the eligibility window for the demonstration).

Figure 3 below depicts the service logic model. Evident in this model is the inherent complexity of both establishing new behavior patterns within the Investigations Unit and ensuring that DCF workers and other services providers understood that the demonstration project was not siphoning scarce resources that would have otherwise been expended elsewhere. Members of the evaluation team and DCF leadership met with DCF staff members to explain the "logic" of the demonstration, explain the randomization process, and ensure that concerns about the ethics of the project were allayed. The team developed a one page summary that emphasized the fact that the demonstration brought new, additional resources rather than supplanting existing capacity, and that the randomization procedures ensured a fair and equitable

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distribution of those resources, that is, each eligible family had an equal chance to participate rather than relying on staff judgment of housing need or readiness.

Figure 3. Service Level Logic Model and Caseflow Diagram
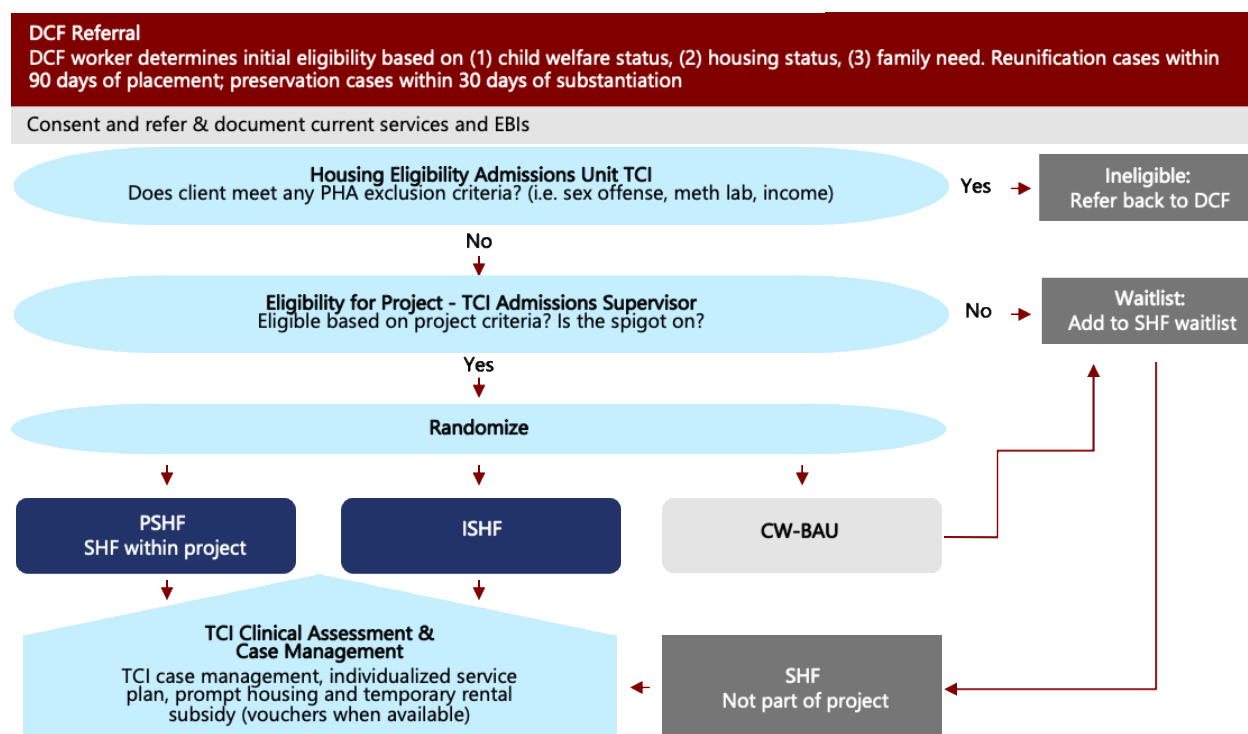
Whereas we discuss fidelity to the model later in this report, it is useful to understand the extent to which there were both overlapping and distinct procedures and services associated with the different experimental groups. All families who were randomized into the demonstration were eligible for participation in the national evaluation conducted by the Urban Institute. Inside the demonstration, there were two levels of treatment, Intensive Supportive Housing for Families (ISHF) and Project Supportive Housing for Families (PSHF). Regardless of their ultimate enrollment in ISHF or PSHF, all families underwent the same triage and referral processes (i.e., from the DCF investigations unit) and participated in initial screening and assessment. Families had similar experiences once enrolled in a SH program at TCI: case management; referral to community providers for specialized services for parenting, trauma, therapeutic support; housing subsidy support until self-sufficiency or voucher availability.

There were four intended aspects of experimental contrast between ISHF and PSHF:

1. Casework intensity: Families in the ISHF condition were to experience casework contacts approximately twice per week versus one contact per week for families in PSHF. (Case managers in ISHF were expected to have caseloads of approximately 7

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families, while case managers in SHF were expected to have a capacity of 12. The BAU condition was expected to have a capacity of 15 to 20 families at DCF.)

2. EBIs: Families in the ISHF condition were to receive priority access to evidence-based interventions (EBIs) available by referral to local service providers.

3. Vocational services: Families in the ISHF condition were to undergo formal vocational assessment and support over the course of their enrollment; no such service was to be provided to families enrolled in the PSHF condition.

4. Family Teaming: Families in the ISHF condition were to experience a specialized form of interdisciplinary family teaming on a regular basis (within two weeks of admission and subsequently every 90 days); this service was to be provided on an as-needed or as-indicated basis (e.g., significant change in conditions or service plan) to families enrolled in the PSHF condition.

Additionally, families enrolled in the ISHF condition had the benefit of assured access to state RAP vouchers that were set aside for the demonstration. In the PSHF condition, families had to await RAP voucher availability on a naturalistic basis, meaning when a voucher became available. There were times when there were no vouchers available and eligible families in the PSHF condition had to wait for access.

In the sections that follow, we describe the target population, provision of housing, and the housing case management and service structure. These components are described mostly with respect to the federally-funded ISHF portion of the demonstration. Families enrolled in the PSHF experimental group had very similar experiences, with the exception of the four experimental contrasts and voucher access differences listed above.

3.1.1 Target Population and Determination of Eligibility and Assessment Process

During the planning year, the core CT team (TCI, DCF, UConn, Chapin Hall) met with the Urban Institute to review referral information from years past and determine targeting goals and procedures, in keeping with the priorities of the demonstration: families with (recent) child welfare involvement, deep housing instability/homelessness, and high service needs. Results of the demonstration (see Section 4) indicate that the targeting procedures were ultimately quite effective. At the onset of the demonstration, however, the referral rate was lower than anticipated. Though a referral form assisted DCF workers to appraise/triage initial eligibility based on child and caregiver needs (and rule out families who would clearly be excluded from housing voucher access), DCF and partners had less experience in appraising housing conditions at the "front end" of the child welfare system. The core team met to discuss this and concluded that this shift in the housing lens required a behavioral shift that might need some initial scaffolding. The team decided to adapt one of the existing screening measures (the Risks and Assets for Family Triage, which already had been in use in SHF) to assist the investigations unit in determining housing instability and homelessness.

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Using a Supportive Housing for Families referral form, all prospectively eligible families were referred to TCI by the social workers at the DCF Investigations Unit. Referral information was entered into an electronic database to generate a report for each family at the time of referral to determine their eligibility for the ISHF demonstration. The report indicated whether the family met the criteria for the program based on the exclusionary criteria, their child welfare involvement, and their housing and service needs. All families were required to have an open DCF case with a substantiation, be homeless or at risk of homelessness, and meet the income guidelines for the project. They also had to meet the criteria for "high need" as determined by a combination of indicators across domains (see Table 2). Exclusionary criteria for the project included previous drug charges, sex offenses, and/or an income that exceeded the maximum standard allowed.

Table 2. Eligibility Criteria for ISHF Demonstration Participation

Domain	Eligibility Criteria
Child Welfare	• DCF-involved: open case, substantiated report of abuse or neglect • The referral needed to be made within the appropriate time period.
Housing Instability or Homelessness	*At least one of the following housing concerns:* • In a place not designated for sleeping (i.e. car, park, abandoned building, campground, transportation station) • In an emergency shelter • Transitional housing (hotel, couch surfing) • Unstably housed (eviction within 7-14 days from the time of referral, exiting a hospital/residential treatment program without access to stable housing) • Three or more moves in the past 12 months • Fleeing domestic violence • Severe risk of homeless (owes the equivalent of 3 months arrears of rent or lacks the resources/natural supports to avoid entry into an emergency shelter)
High Service Needs	*One of the following:* • Primary caregiver has a mental health concern • Primary caregiver has had a substance abuse issue within the last 12 months • Child has a mental health, emotional or behavioral problem • Child has a developmental, learning, or physical disability *And two of the following:* • Two or more incidents of DV in the home in the past 12 months • Primary caregiver has a chronic health condition that impairs daily functioning • Four or more children in the household • Youngest child is under age two

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Domain	Eligibility Criteria
	• Primary caregiver has a criminal arrest history
	• Household has previously received child protective services
	• Primary caregiver has a history of child abuse or neglect as a child

Families who met the targeting criteria and were found eligible for the program were referred to the Quality Improvement Specialist to process the family through the randomization process if the "spigot was open," meaning there were casework openings because the program was not at full capacity. We adjusted randomization blocks for two reasons: one, ensure that casework capacity did not remain unused for extended periods; and two, remove the possibility that case assignment could be guessed. Subsequently, basic family information was input to a secure online randomization platform managed by the Urban Institute, enabling families to be randomly assigned to one of three conditions:

1. ISHF, Intensive Supportive Housing for Families, the enhanced treatment group
2. PSHF, project SHF, the existing treatment group
3. BAU, business as usual waitlist, also referred to as the control group

Those families randomized into the control group (BAU) received no services from TCI but were placed on a wait list. Families randomized to ISHF or PSHF treatment groups were then assigned to a Clinical Assessment Specialist to complete an assessment with the family in preparation for assignment to a Case Manager. The assessment included a comprehensive biopsychosocial assessment and a variety of screening tools (see Table 3). The function of this screening and assessment process was to gather assessment information based on the individual needs of the client and family for the purpose of identifying agreed upon goals for the client's service plan, which was reviewed at the client's initial Family Team Meeting within two weeks of admission and finalized within 30 days of admission. The client's Service Plan was reviewed and updated accordingly at least every 90 days thereafter.

All initial screening and assessments took place face-to-face with the family in the community and took approximately 2.5 hours. Additional assessments were completed by the Case Manager after admission. Findings were used to make any applicable updates to the client's service plan and to integrate any additionally indicated services and supports.

Table 3. Measures for family assessment; outcome/criteria and assessment interval

Measure	Outcome/Criteria Assessed	Assessment Interval
Ages and Stages Questionnaire (ASQ)	Child development (0-2yrs) in communication, gross motor, fine motor, problem solving, and personal social skills	Admission and every six months while the child was in the appropriate age range

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Measure	Outcome/Criteria Assessed	Assessment Interval
Child Behavior Checklist (CBCL/1.5-5 version)	Child's problem behaviors including internalizing and externalizing problems (3-5yrs)	Admission and every six months while the child was in the appropriate age range
Child Behavior Checklist (CBCL/6-18 version)	Child's problem behaviors including internalizing and externalizing problems (6-18yrs)	Admission and every six months while the child was in the appropriate age range
Children with Special Health Care Needs (CSHCN)	The extent to which a child might need health care and related supports beyond what is typical for age	Admission
Child Trauma Screen	Whether a child has experienced traumatic events and the kinds of events experienced	Admission
Risks and Assets for Family Triage (RAFT)	Family assets and the severity of barriers clients face with respect to housing and child welfare	Admission and every six months
Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)	Parental risk for alcohol and other drug abuse	Admission
North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R)	Family functioning in terms of environment, parental capabilities, family interactions, family safety, child well-being, social and community life, self-sufficiency, family health, readiness for reunification, and child/caregiver ambivalence	Admission and every six months
Brief Trauma Questionnaire (BTQ)	Parental exposure to traumatic events in which they experience or perceive threat of harm and/or serious injury	Admission
Hurt-Insult-Threaten-Scream tool (HITS)	Domestic violence exposure for parents currently in a relationship	Admission
Brief Symptom Inventory (BSI)	Parental mental health concerns	Admission and every six months
Parenting Stress Index-Short Form (PSI-SF)	Level of stress in the parent-child relationship	Admission and every six months

3.2 Quick Risks and Assets for Family Triage (QRAFT) Screening

As noted above, the referral process included a triage and referral form developed to assist in determining family eligibility for the ACF-supported housing and child welfare demonstration project. Families who met criteria were referred to TCI, where a determination was made about project eligibility. DCF used the QRAFT to screen for housing problems in all families referred to

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Regions 3 and 4. The QRAFT is an abbreviated version of the RAFT$^©$ that focuses mainly on housing needs. DCF intake workers completed a QRAFT on all new cases that underwent an investigation or removal of a child. A score of 3 or 4 (indicating significant or severe need, on a 0 to 4 scale) on at least one housing item on the QRAFT resulted in a referral. Eligible families were randomized to one of the three experimental conditions: ISHF, PSHF, or BAU.

Framing this occurrence, when cases moved through DCF's investigations unit, they were determined to be unsubstantiated or substantiated, or they could be referred to Family Assessment Response (FAR). Within CT's Differential Response System (DRS) framework, reports of abuse and neglect result in social work consultation with a supervisor which determines whether a traditional investigation is required or if the family can be assigned to a DRS program called Family Assessment Response (FAR). If eligible, e.g., deemed to be low risk, the family is assigned to FAR. According to DCF, the FAR team works together with families to identify strengths and needs and connect them with community resources with the hope of diverting from future DCF involvement. Thus, there are three "decision groups" to be examined among the cases referred. Cases to be referred to the demonstration had to be open DCF cases, either substantiated or unsubstantiated, and not enrolled in the state's FAR initiative.

Of the 6,828 QRAFTS recorded between November 2014 and October 2016 approximately 55% were from Region 3 (Middletown, Norwich, and Willimantic; Eastern Connecticut) and 45% from Region 4 (Hartford and Manchester; Central Connecticut); 43.4% of cases were FAR (n = 2,964), 39.1% were unsubstantiated (n = 2,673), and 16.6% were substantiated (n = 1,136). About 19.3% were transferred to ongoing services (n = 1,316) and, in only 3.2% of cases, there was a child removal (n = 216).

Table 4 below shows the distribution of QRAFT scores for the three housing items. Among all the cases referred, approximately 5.4% were rated as above the referral threshold (i.e., had significant or severe current housing concerns), 5.4% were above the threshold for current housing, 1.7% for housing condition, and 2.6% were above the threshold for housing history. Approximately 3.6% of the sample had scores that indicated that a referral to TCI for further consideration of project eligibility; however, approximately 1.2% were referred. In some cases, there is an explanation for non-referral and in others there is not. Most of these figures are roughly consistent with the smaller sample obtained in the initial earlier three-month pilot (reported in the April 2015 semiannual report).

Table 4. QRAFT Frequencies, Among All Cases Referred

Score/Description	Current Housing		Housing Condition		Housing History	
	n	%	*n*	%	*n*	P%
0 Asset/Not barrier	5,284	77.6%	5,913	86.9	5,787	85.1
1 Mild barrier	864	12.7%	538	7.9	535	7.9

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Score/Description		Current Housing		Housing Condition		Housing History	
		n	%	n	%	n	P%
2	Moderate barrier	289	4.2%	214	3.1	234	3.4
3	Significant barrier	275	4.0%	113	1.7	195	2.9
4	Severe barrier	94	1.4%	27	0.4	47	0.7
Total		6,806	100.0%	6,805	100.0	6,798	100.0

Examining by region, as shown in Table 5, there are some differences among the case determination by percent. For instance, cases were substantiated at rates of 18.3% and 14.6%, which are quite similar, but nearly half (46.5%) of the cases were referred to FAR in Region 3 and 39.7% were in Region 4. The percent of cases above the referral threshold were roughly equivalent by region, as shown in Table 6 below.

Table 5. Case Disposition, by Region

	Region 3		Region 4		Total
	n	%	n	%	
FAR	1,743	46.7%	1,221	40.1%	2,964
Substantiated	686	18.4%	450	14.8%	1,136
Unsubstantiated	1,302	34.9%	1,371	45.1%	2,673
Total	3,731	100.0%	3,042	100.0%	6,773

Table 6. Cases above Referral Threshold, by Region

		Region 3		Region 4		Total
		n	%	n	%	
Above Threshold	No	3,544	94.5%	2,916	94.8%	6,460
	Yes	208	5.5%	160	5.2%	368
Total		3,752	100.0%	3,076	100.0%	6,828

Figures 4, 5, and 6 below depict housing history and current housing by decision. The extent to which case determination (FAR, substantiated, unsubstantiated) relates to the QRAFT items (scores of 3 and 4 are significant and severe) are visible here. FAR cases represent a higher proportion of cases with fewer or less severe housing problems; likewise, more significant housing difficulties are outlined amongst substantiated cases.

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Figure 4. Current Housing Scores on QRAFT, by Region and Case Decision
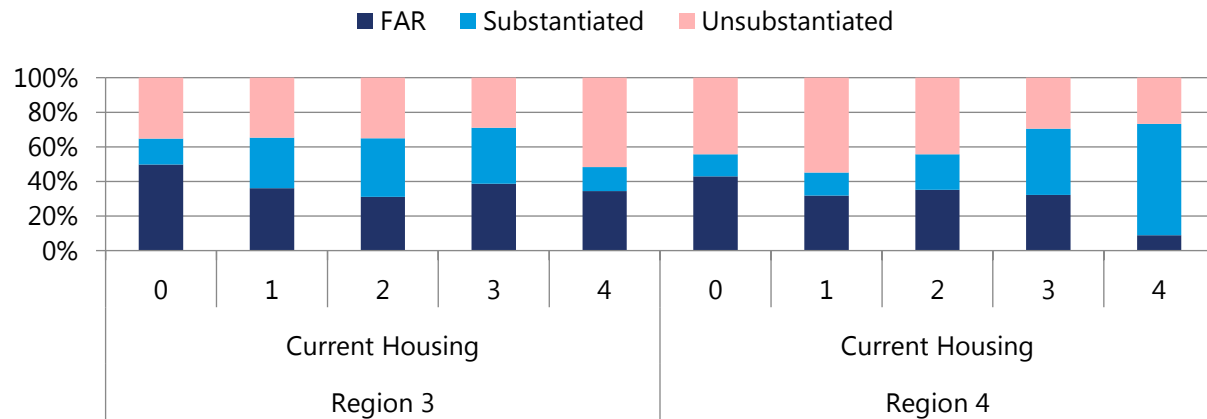
Figure 5. Housing Condition Scores on QRAFT, by Region and Case Decision
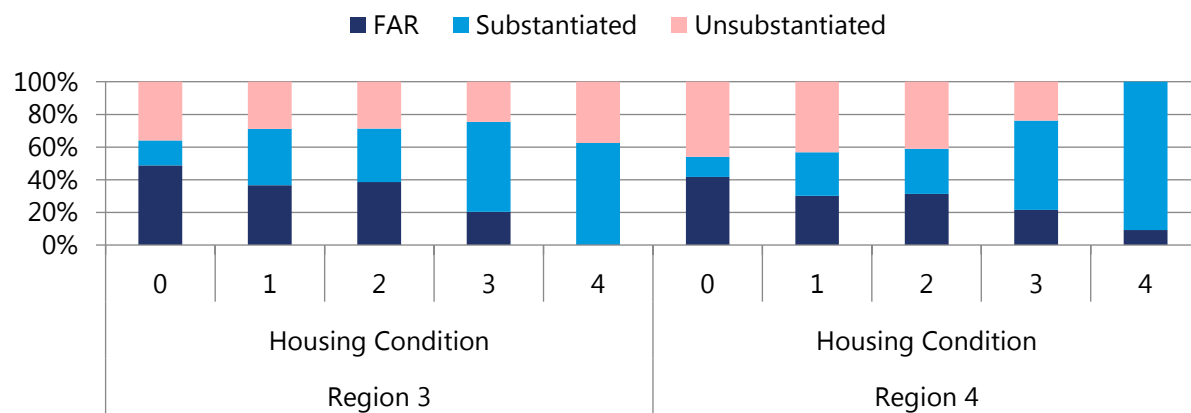
Figure 6. Housing History Scores on QRAFT, by Region and Case Decision

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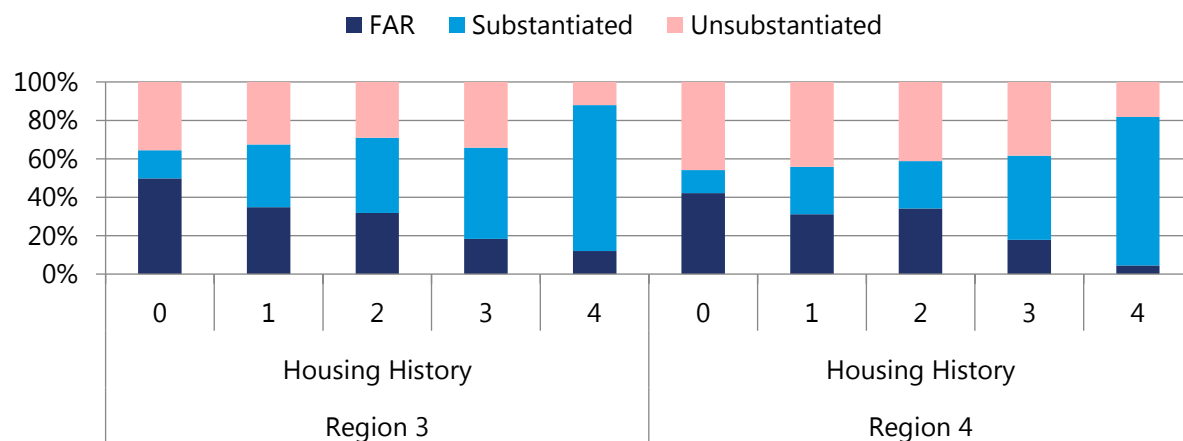
These figures illustrate the intersection between housing concerns – stability, quality, and safety – and the risk for child maltreatment. Families with significant or severe housing risk demonstrated a higher prevalence of substantiated maltreatment, pointing to the deep and multi-faceted needs of these families. In essence, the SHF demonstration in CT targeted these families, and as shown in Section 4, effectively reached and engaged them in the opportunities that SHF offered.

3.3 Provision of Housing

Housing was provided using a scattered site model for PSHF and ISHF. As compared to place-based or housing project models, scattered site models enable clients to select housing within their chosen communities, based upon their support network and individual preferences. That is, program staff help parents to locate housing options within their communities and the set of viable homes and apartments is not restricted to a specific neighborhood, public housing project, or geographic area within the state.

Within this demonstration, the CT Department of Housing (DOH) committed 50 Rental Assistance Program (RAP) certificates—permanent rental vouchers—for ISHF participants. Because the state RAP voucher program requires a 40% income contribution, that threshold was used in the demonstration.[1] A HUD-certified housing inspector examined prospective apartments to ensure safety, security, and suitability within a stable community. Due to small caseloads, frequent client contact, and the streamlined ISHF housing process, the ISHF Case Manager was able to rapidly assess the client and family needs and stabilize the family. An overview of the housing provision process is shown in Figure 7.

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[1] The implementation plan identified that rent would not exceed 30% of family gross income. Because the DOH provided State RAP certificates which require 40% of family gross income, rent for families was 30% of family gross income under our temporary bridge subsidy and 40% of family gross income under the RAP certificates.

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Figure 7. Housing Provision Process

Housing Provision Process

Housing Search
Housing specialist discusses the housing factors that are important to the family (e.g., proximity to schools or natural supports, safe neighborhoods). → Housing specialist uses connections with local landlords to find suitable housing options and present them to the family. → Is the desired unit within the HUD Fair Market Rent (FMR) limits and did it pass inspection of HUD housing standards? No / Yes

Application Process
Client submits housing voucher application, attends briefing at the Public Housing Authority (PHA), and submits the Request for Tenancy Approval. → Housing inspector must review and approve the lease, and the client and landlord must sign it. → Family is provided with a bridge housing subsidy from TCI while waiting to hear about Rental Assistance Program (RAP) certificate approval.

Move-In & Voucher Access
Family can move into chosen housing unit - TCI assists with deposit costs when needed. → Did the client receive a RAP voucher? Yes for 47 families in ISHF* and 20 families in PSHF. *ISHF had priority access* No / Yes → Case manager and housing specialist maintain contact with PHA throughout the duration of the program to ensure client maintenance of the voucher.

3.3.1 Process for Housing Access and Lease-Up

Per the service logic model and caseflow diagram in Figure 3, clients were screened prior to intake to ensure that they met criteria to be eligible for a RAP housing certificate or Section 8 housing voucher. The client had to have a household income that did not exceed the federal "Very Low Income" limits[2] published annually by HUD. Clients also had to meet criteria in regards to criminal backgrounds. No clients were excluded from receiving housing vouchers unless they had charges that made them ineligible for any HUD programs (e.g., certain drug charges or sexual offenses). Housing vouchers have historically been in limited supply in the state; therefore, ISHF families received priority access to these vouchers and a designated Housing Specialist assigned to work directly with them in locating quality housing and assisting them with the lease-up process in order to expedite response time for clients who had immediate housing needs.[3]

After the initial assessments, the family met with the ISHF Case Manager, ISHF Housing Specialist, family members, DCF Worker and relevant service providers at the initial Family Team

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[2] Described at http://www.huduser.org/portal/datasets/il/il12/index_il2012.html
[3] Although CT dedicated the 50 RAP certificates to the ISHF clients, there were eligibility guidelines for obtaining a voucher; anticipating barriers, we built a temporary housing subsidy into the ISHF so families would be housed before the barriers could be adequately addressed.

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Meeting to discuss where they would like to live based on proximity to schools, transportation, and other supports. They developed housing goals that included 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 neighborhood choice was a high priority for dedicated Housing Specialists, who cultivated relationships with landlords and assisted clients in locating housing. Following the Family Team Meeting, the Case Manager worked with the client and the ISHF Housing Specialist to locate a new scattered-site housing unit that met the following requirements: inclusive of the client's preferences and needs; fell within the HUD Fair Market Rent (FMR) amounts (published annually by HUD for major metropolitan areas in each state); and met the HUD standards for safety, physical integrity, functionality, sustainability and maintenance.

The ISHF Case Manager, ISHF Housing Specialist, and client viewed the units identified and met the landlords. The Case Manager and Housing Specialist worked individually with clients and landlords to facilitate the rental agreement. The Case Manager also began to work on the paperwork required to obtain the RAP certificate from the issuing Public Housing Authority (PHA). Some clients required extra support from the Case Manager, such as a letter to verify completion of community service hours or participation in rehabilitative treatment, as a result of a prior conviction, for instance. Addressing these barriers took additional time that could have delayed the housing process. Therefore, the funds for a temporary bridge subsidy were built into the budget in order to quickly house families even before they were able to obtain and utilize the RAP certificate. Under the temporary bridge subsidy, the family paid 30% of gross household income towards the rental payment for the unit. This calculation considered all forms of income, including employment, Social Security Disability payments, TANF Assistance, child support, or any additional sources. Deductions were taken for each child in the household and for any childcare expenses. The Case Manager informed the client about their responsibility to make the monthly rental payments directly to the landlord. The ISHF program paid the remainder of the family's rental amount through provision of the temporary rental subsidy. The Case Manager maintained consistent communication with the family regarding household income and budgets, and changed the family's rental portion as needed, depending on whether the household income increased or decreased.

Following the family's selection of a new unit, and if the family used the temporary bridge subsidy, the ISHF Housing Inspector conducted a housing inspection to ensure that the housing unit complied with federal HUD safety, sanitary, physical integrity, functionality, sustainability, and maintenance guidelines, as well as specifications for program housing. If the unit did not meet all of the guidelines mentioned, the landlord had to make the necessary repairs before proceeding to accept rental payments. Once these units passed inspection, the ISHF Housing Inspector reviewed and approved the lease, which the client and landlord both signed. It was made clear that any lease documents were solely between them—independent of subsidy source—and both parties had to uphold the responsibilities set forth in the lease. If necessary, the ISHF program provided a security deposit for the unit on behalf of the client.

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In order to begin the leasing up process to utilize the housing voucher, the ISHF Case Manager assisted the client in meeting HUD guidelines, such as submitting a Housing Voucher Application packet to the issuing Public Housing Authority (PHA) and attending an official briefing at the PHA. Subsequently, the client submitted a document called the Request for Tenancy Approval, signed by the client and the landlord, to the PHA, in order to utilize the RAP certificate. To then lease up with the PHA, the housing unit had to pass a PHA inspection, and the client and landlord had to sign a new lease approved by the PHA. Throughout the leasing-up process, the ISHF Case Manager and Housing Specialist maintained communication with the PHA to ensure that the client continued in the unit without a lapse in subsidy funds, and that all parties were adequately informed of all the necessary steps involved. The ISHF Case Manager communicated as needed with the PHA throughout the time the client was involved with ISHF case management services to ensure compliance with PHA guidelines. The PHA required clients to complete an annual re-certification and re-inspection process, and the Case Manager assisted the clients to ensure that they would successfully maintain their vouchers after graduation from the ISHF program.

Ultimately, in the ISHF condition, 47 families (94%) were housed and leased up on a RAP voucher. Three families were not housed due to two clients requiring higher levels of care for mental health/substance use and one client was incarcerated. In the PSHF condition, 44 families (88%) were housed with 20 of these families leased up and issued a RAP voucher. The six families in PSHF not housed resulted from four clients who required a higher level of care for mental health/substance use, one client chose to live with family, and one client who became incarcerated. The total number of ISHF and PSHF families housed was 91. The total number of families in ISHF to receive a RAP voucher was 47; 20 clients in PSHF received a RAP voucher.

Table 7. Families Housed and Leased-Up by Year

Housing Access	Project Condition	Y1 2013	Y2 2014	Y3 2015	Y4 2016	Y5 2017	Total Housed
Housed	ISHF	0	11	20	16	0	47
	PSHF	0	10	20	14	0	44
Leased-Up (with RAP Voucher)	ISHF	0	11	13	23	0	47
	PSHF	0	3	2	7	8	20

Note. Year 1 was planning only. During the demonstration, 50 RAP vouchers were available to ISHF. 20 RAP vouchers were available to PSHF in keeping with the normal course of business; that is, there was no set aside of housing vouchers for families in the PSHF condition.

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3.4 Integrated Housing Case Management and Service Structure

The project case management model was team-based with an intensive level of engagement, high dosage of family and collateral contact, and reduced case load size. Each family enrolled in ISHF received access to the core internal ISHF team, which consisted of the ISHF Case Manager, the ISHF Vocational Specialist, ISHF Housing Specialist, the ISHF Assessment Specialist and the ISHF Program Manager and Director. The family was expected to receive approximately two home visits per week from the ISHF Case Manager and an additional visit in the home (or community, as applicable) from the ISHF Vocational Specialist. The family also participated in Family Team Meetings (described in further detail below) within the first two weeks and at least every 90 days thereafter that included their support system and providers involved with them and their children. The ISHF Interdisciplinary Team met at least monthly to discuss new cases and provide ongoing staff support in order to ensure a high level of engagement and team-based collaboration.

3.4.1 Development of Case Plan, Ongoing Case Management

Prior to case assignment the primary caregiver participated in a comprehensive intake assessment conducted by an Assessment Specialist who provided a written case summary based on findings from the battery of assessments and assessment interview. This summary was provided to the ISHF team to inform development of the clients' service plan. In addition, an Interdisciplinary Team Meeting, including the ISHF Assessment Specialist, the ISHF Program Manager, the ISHF Case Manager, the ISHF Vocational Specialist, and the ISHF Housing Specialist, was held to inform all members of the team of the family's strengths and needs. The ISHF Assessment Specialist presented the family's history, including their strengths, areas of vulnerability, overall assessment findings, history of trauma, involvement with DCF, housing needs, and any mental health or substance use needs and supports, along with recommendations for initial service plan goals. The group discussed how best to meet the family's needs and gather ideas about the direction and goals for the case.

Subsequently, the Case Manager met with the family to help the client identify its goals for the service plan and work together to determine recommendations for vocational supports and community evidence-based intervention resources. At that time, a date was set for the first Family Team Meeting. In this meeting, the Case Manager worked with the client to identify as many natural and formal supports as possible. This meeting included the core of the ISHF team and the ISHF Housing Specialist. The external team initially included the DCF Social Worker and all relevant community-based care providers and supports. Each family's team differed depending on the family's individual needs. The purpose of this meeting was to have the client determine what their interdisciplinary team will look like and to discuss the goals in their service plan.

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3.4.2 Intensive Case Management

Intensive Case Management in ISHF was available only to families who were randomly assigned to the ISHF treatment group. In addition to case managers and housing and employment specialists, the ISHF team provided skill-building, targeted interventions to help stabilize families in supportive housing; for example, a monthly Health and Safety Home Inspection and a Monthly Budget Management worksheet was completed with each of the families. Both tools were useful in helping families learn new household and financial management skills in order to avoid the issues that may have led to prior homelessness. Case Managers also provided an array of other services, such as: advocacy, crisis intervention, coordination of services for children and the family, access to child care, assistance with cash assistance and entitlement benefits, transportation, access to community resources for items such as furniture, food, clothing, support groups and community involvement, referrals to substance use treatment and mental health and domestic violence support services, assistance with special education and educational supports, attendance at court and provider meetings, training on how to be a good tenant with neighbors and landlords, and myriad other supports and services to support self-efficacy and goal attainment. Figure 8 displays the ISHF service model components.

Figure 8. Core Components of the SHF Service Model

Note. The core SHF service model was consistent across ISHF and PSHF with the exception of the four components of experimental contrast noted above. In other words, families enrolled in PSHF experienced housing and related supports, but at a different level of intensity, and absent vocational specialization.

3.4.2.1 Family Team Meetings

Families assigned to the ISHF treatment condition were provided access to family team meetings, which were conducted with the families according to the Family Centered Teaming model protocol and practices. The initial Family Team Meeting occurred within the first two weeks after being assigned to the ISHF Case Manager, and then, at a minimum, every 90 days

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thereafter in conjunction with the review of the service plan; however, a Family Team Meeting could be called at any time that any member of the team felt it was important to have one. The purpose of the team meeting was to review the client's service plan with their progress on goals, to address barriers to goal attainment or areas that need continued improvement, and to have the ability to alter goals as needed. The family was able to provide feedback during this meeting in regards to services and their strengths and areas of need. It was an opportunity to maintain communication between everyone involved in the client's services and to highlight the family's strengths and progress made and goal achievement. As clients progressed through the ISHF program, many providers closed out their services. Case Managers supported clients in identifying additional family members and/or friends to include at their meetings, so that by the time their case closed, clients felt they had their own team of natural supports who could continue to assist and support them after discharge.

3.4.2.2 Vocational Services

The ISHF Case Manager referred clients to the ISHF Vocational Specialists if the client or the client's child(ren) over age 16 had goals for education or employment. The Vocational Specialist worked with clients who needed vocational support for any reason, including if vocational history was either nonexistent or had been seriously affected by a criminal record, physical or mental health disabilities, layoffs, or terminations. If the client was already employed, the Vocational Specialists helped him or her work on aims related to acquiring higher education or employment that were better aligned with their career goals.

After meeting with the client, and prior to the Vocational Referral, ISHF Case Managers completed the *Job Readiness Checklist* and discussed the findings in the weekly Interdisciplinary Team Meeting. At these meetings, the Vocational Specialist assessed with the team whether the client was ready for vocational services. When the team determined that the client is ready to discuss the possibility of returning to work, the Vocational Specialist contacted the client, scheduled an appointment, and administered several screens to determine the client's abilities with respect to employment the *Employment Service Plan*, *Vocational Data* as well as the *Health Checklist and Physical Capacities Checklist*. Once completed, the Vocational Specialist helped identify goals related to education and employment, which were integrated in the client's service plan and reviewed quarterly at the Family Team Meetings. The Vocational Specialist also utilized vocational assessment tools to help the client better understand his/her strengths/abilities and weaknesses: the *VAK Questionnaire* was used to help clients identify their learning style and the *COPSystem* 4-part assessment in order to identify interests, abilities and work values. Some of the tasks that the Vocational Specialists helped support were assisting clients in seeking jobs that were commensurate with their skills, abilities and education, complete resumes, teaching to write professional cover letters, and preparing clients for job interviews, among other tasks.

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3.4.2.3 Ongoing Assessment

During the course of services, the ISHF team utilized ongoing assessment tools to monitor progress and assess family functioning, parent and child well-being, and child trauma. The ISHF Case Manager administered the Connecticut Trauma Screen on all children in the home over age 6 or who had been in stable placement for more than 30 days to determine whether any children were experiencing trauma-related reactions that required a referral to trauma-focused therapy services. Additional child screening tools given within the first 30 days of case assignment, depending on child age, included: the ASQ administered with the primary caregiver for children ages birth-2; the CBCL Preschool Assessment taken by the primary caregiver for children ages 3-5; and the CBCL School Age Version Assessment completed by the primary caregiver for children and youth ages 6-18. These child assessments were then re-administered and scored every 6 months. The ISHF Case Manager was able to discuss the results of the scores with the parents and any developmental or behavioral health concerns were reported to the Case Manager to make a referral to Birth to Three providers, pediatricians, mental health providers, DCF, or any other relevant resources that could provide support and intervention to address children's needs. The ISHF Case Managers also utilized the screening tools of the BSI, PSI, NCFAS G+R, and RAFT every 6 months to assess parent mental health, parenting stress, and general functioning and well-being in order to determine the need for any additional support services as well as, when indicated, the development of new, applicable service plan goals.

3.4.2.4 Additional Resources

In addition to the aforementioned resources embedded in ISHF's service model, supplementary supports were provided to participating families. These supports included: parent cafés, consistent participant contact, EBIs, and preparation for discharge.

Parent Cafés: a series of structured small group conversations that bring parents together to discuss issues important to them, in building the protective factors needed to prevent maltreatment and promote healthy outcomes for their children.[4]

Consistent participant contact: ISHF Case Managers and the ISHF Vocational Specialist maintained regular contact with other service providers as needed to ensure the continuum of care was uninterrupted, coordinated, and client-driven. Where possible, clients were connected with organizations providing EBIs. Some of the EBI programs had low engagement; primarily the EBI parenting program, Triple P. This may be due to a heavy emphasis on text-based programming with the Triple P curriculum, and many of our participants struggled with literacy issues.

A number of clients had been referred (by DCF or other human services providers) to or participated in EBIs or other services prior to enrollment in the demonstration. Some had had low motivation to engage with those programs, others participated in them, and still others

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[4] http://www.cssp.org/community/constituents-co-invested-in-change/community-and-parent-cafes

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completed such services prior to referral. In some instances, clients stated that they had so many services that they felt overwhelmed. For those instances, ISHF Case Managers, whenever appropriate, requested to overlap home visits with collaborating providers in order to reduce the number of visits that families had to attend per week and to enhance collaboration amongst family service providers.

EBIs: ISHF clients were expected to get direct and increased access to EBI services as a result of their involvement in the program. However, most ISHF clients had already been referred by their DCF workers and were engaged to some extent when referred to the ISHF program; as such, referrals to EBIs by the ISHF Case Managers were not needed. Furthermore, the EBIs that were identified for the project and applicable for families were limited in scope, had limited eligibility criteria, had long waiting lists, or were only available in limited geographical areas that most clients could not access.

Preparation for discharge: The core partners conducted a series of meetings to develop a decision-making process and protocol for determining when case management intervention might be stepped up or down. This process emerged from a recognition that some clients progressed to a point where the intensity of case management was perceived as excessive and in other cases clients needed additional support. To strike a balance between responsiveness at the individual client level and maintaining fidelity, the core team developed a step-up/step-down process (that is more fully documented in Section 4.2 above). The process was recorded so that, for example, reduced case management intensity did not appear as a lack of fidelity to the program model, but rather an appropriate, intentional transition to more client independence when the client was ready and/or preparing for discharge. Therefore, the provision of service dosage based on individual client need and progress demonstrated, rather than on a prescribed frequency. This person-centered approach involved the client in the decision-making process for the step-down/step-up, and preparation for discharge, as well as the decision about who to invite to the Family Team Meeting in which the change was reviewed. Further, DCF and TCI worked together to provide supports to program staff to ensure quality service provision and continuous quality improvement; these resources included supervision, core skill sets, and the development of fidelity indicators.

Supervision: The ISHF Program Manager provided all ISHF Case Managers and the ISHF Vocational Specialist with weekly individual supervision to discuss feedback on job performance, support and guidance on client caseload and model fidelity, a review of all client service plans on a rotating basis or more frequently as needed, a review of client assessments and their integration into service plan goals, review of core skill sets and best practices, client engagement, assessment of skills and ability to execute skills, training needs and training curriculum, continuous quality improvement, review of documentation and data entry relevant to services, research and funder needs, and a review of collaborative relationships with providers.

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Core skill set: Four sets of core skills were emphasized among TCI program staff and reinforced in individual and group supervisions. These skills included: motivational interviewing, trauma-informed care practices, family centered team meeting practices, and awareness of client's cognitive and executive functioning capabilities. A worksheet for monitoring skill set development was used to aid continuous quality improvement and quality of service delivery.

Development of fidelity indicators: Fidelity documentation indicators were embedded within The Connection's electronic chart records, such as the dates for the Family Team Meetings and the frequency of case management activities, among others. These indicators helped to ensure the reduction of case management frequency did not appear as a lack of model fidelity and to also allow the evaluation team to monitor and evaluate practices and outcomes. Through a coordinated referral and assessment process, DCF and TCI worked closely to implement the ISHF program. The overarching goal was to achieve family self-sufficiency and stability through case management, vocational supports, and housing supports.

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4. Evaluation

4.1 Overview of Local Evaluation Design and Implementation

The purpose of the local evaluation was to assess the degree to which a supportive housing model for families in the child welfare system, as implemented in the state of CT, was successful in addressing the following set of overarching questions (specific evaluation questions appear later):

1. To what extent can the SHF planning and implementation process be documented and examined in order to support success, expansion, and replication? Primary outcomes include the documentation of staff insights, interagency collaboration, client engagement, and model fidelity.
2. To what extent does SHF improve outcomes for the target population? Primary outcomes of interest include child welfare involvement, housing stability, child and family functioning, and parental employment.
3. To what extent can an economic evaluation examine the costs and benefits of program implementation?

As above, the project entailed a randomized controlled trial, in which families were randomly assigned to one of three conditions: (1) the existing SHF program, Project Supportive Housing for Families (PSHF); (2) a new, more intensive SHF model, Intensive Supportive Housing for Families (ISHF); or (3) a comparison group comprised of families receiving standard child welfare services, "business as usual" (BAU).

To investigate the three questions above, we used three complementary approaches: a *process evaluation* which documented program inputs and activities as the program was implemented; an *impact evaluation* that documented outcomes, including child welfare and housing, children's well-being, parental employment, parenting skills, and children's development and well-being; and, an *economic evaluation* that assessed the costs and benefits associated with the ISHF and SHF models relative to BAU. A mixed-method approach using both quantitative and qualitative methodologies assesses achievement of the goals and objectives of the project and describes the lessons learned.

The *process evaluation* focused on understanding and documenting: 1) the planning activities conducted prior to the start of the program; 2) the fidelity of implementation of the proposed project strategies and effectiveness of the collaborative process; and 3) key stakeholder views on systems change that could result from the demonstration. This part of the evaluation used a developmental approach to identify barriers to ISHF implementation and provide routine

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feedback on intermediate outcomes, so as to strengthen the implementation and design. The data sources included: direct observations of and participation in planning meetings; participant observation/evaluation; surveys with families; focus groups with staff; surveys with stakeholders on systems change (current practices; barriers to change; opportunities; possible outcomes); secondary analysis of administrative and service utilization data; and review of documentation and archival records.

The *impact evaluation* assesses the effect of participation in a supportive housing program on the target population. To understand the effects of exposure to the treatment we examined two sets of comparisons – one to illuminate the effects of exposure to any treatment (i.e., PSHF or ISHF vs. BAU) and one to understand the effects of different levels of treatment (i.e., PSHF vs. ISHF). For each set of comparisons, we drew on different sources of data, presented in Table 8 (for more information, see Appendices B and C). These data sources included administrative data collected by DCF and from the Homelessness Information Management System (HMIS), program data from TCI, and survey data from the Urban Institute, which coordinated the cross-site evaluation. We obtained access to administrative data through our partnership with the Governor's Office of Policy and Management, which facilitated the execution of Memoranda of Understanding and data sharing-agreements across agencies and evaluation institutions. Families consented to participate in the survey and to release these data to TCI and the evaluation institutions, which adhered to HIPAA standards.

Table 8. Data Sources and Information for Process, Impact, and Economic Evaluations

Data	Source	Type	Description / Contents	Time Frame	Valid Sample	To Inform Analyses
Child welfare (DCF) involvement	DCF database	Admin-istrative	Family child welfare system involvement, such as documented allegations of child maltreatment incidents, system contacts, and child removals, other/related	Ongoing	*N* = 205 families *N* = 418 children	Impact evaluation (SHF vs. BAU; PSHF vs. ISHF); economic evaluation
Housing stability	Urban Institute survey	Survey	Family experiences such as apartment with own lease, number of moves, quality of living situation	Follow-up (1 year from random-ization)	*n* = 116; response rate = 53%	Impact evaluation (SHF vs. BAU; PSHF vs. ISHF)
Family homelessness data	HMIS database	Admin-istrative	Family experiences of homelessness and the dates of their shelter stays	Ongoing	*N* = 205 families	Impact evaluation (SHF vs. BAU; PSHF vs. ISHF); economic evaluation

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Data	Source	Type	Description / Contents	Time Frame	Valid Sample	To Inform Analyses
Family and child well-being	TCI CAMIS database	Assess-ment	Assessments of family trauma, parenting stress, and child functioning, among other indicators of child and family well-being	Intake, every 6 months to discharge	*N* = 205 families *N* = 418 children	Impact evaluation (PSHF vs. ISHF)
Demographics, parental income and employment	TCI CAMIS database	Program	Family characteristics, such as race/ethnicity, household size; family history, such as criminal justice involvement or experiences of domestic violence	Intake, every 6 months to discharge	*N* = 205 families *N* = 418 children	Impact evaluation (PSHF vs. ISHF)
Length of services	TCI CAMIS database	Program	Length of services provided by TCI	Ongoing	*N* = 205 families	Economic evaluation

The overarching objective of the *economic evaluation* is to understand the potential for pecuniary savings to the public system by investing in supportive housing for high-need DCF-involved families who have high housing needs. As a complement to the process and outcomes analysis, it provides a summary measure that can be used to compare supportive housing interventions to other policy options. It answers the question: "how much bang to we get for our buck?" In this domain, the following key research questions are answered:

- What are the per unit transactional costs incurred by government agencies that serve DCF-involved with high needs (including acute housing needs)?
- What are the costs and savings from a government perspective associated with receiving ISHF, PSHF or BAU?
- What is the return on investment for every dollar spent on either ISHF or PSHF services compared to BAU?
- What is the risk or probability associated with achieving this return on investment (i.e., what percent of the time can we expect ISHF or PSHF to produce this level of savings)?
- What are the projected long term costs and savings associated with investing in supportive housing?

Additional information on evaluation methodologies and findings appears below.

4.2 Process Evaluation

The process evaluation examined the planning and implementation of the demonstration, informed by service data and input from collaborative partners, clients, and staff. Without an understanding of the actual conditions for and details of implementation for the ISHF and PSHF

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models, it is impossible to attribute differences in outcome to the intervention itself or to inform future replications and extensions of this work. That is, understanding what happened is needed to determine whether the program is feasible, whether it works (produces the desired effects) when implemented faithfully, and whether there are certain conditions under which its impacts vary. As such, documenting processes, meaning services and supports, dosages, and level of fidelity, was critical for understanding the ability of an intervention to affect change, accommodate modifications, and replicate.

4.2.1 Methods

The process evaluation focused on understanding and documenting:

- *Planning and collaboration*. How was the ISHF model operationalized? Was there satisfactory interagency collaboration in to support the demonstration effort and the new ISHF model?
- *Model fidelity*. What was the fidelity of implementation in the PSHF and ISHF models? Were the intended experimental contrasts between the treatment models achieved?
- *Client engagement and staff insights*. What was the quality and nature of client engagement in the PSHF and ISHF models? What could be gleaned from focus groups with program staff regarding the implementation of the new ISHF model (and its contrast with the existing PSHF model)?

4.2.1.1 Planning and Collaboration

Planning. In the planning year, DCF, TCI, and the evaluation team jointly developed the new ISHF model and developed the implementation plan in part through collaboration with critical partners and stakeholders. The key operational focus was the clear articulation of the new ISHF model and the contrasts that were expected for the three conditions (ISHF, PSHF, BAU) in the evaluation. Tools such as fidelity checklists and training satisfaction survey were used to assess TCI's capacity building and workforce training; the evaluators also provided technical assistance and training effectiveness to ensure that caseworkers were implementing the ISHF model as intended. The evaluation team regularly reviewed program manuals, documented staff hires, and documented staff training and related activities in the transition from the planning year to the phase of client enrollment and service.

Collaboration. Elsewhere in this report, we have detailed the composition and activities of the CT Collaborative on Housing and Child Welfare, which served as the project advisory board for the demonstration. Meetings of the board were routinely used to promote and gauge the success of the demonstration's attempt at collaboration, both for the demo itself and for the implementation of the new ISHF model for clients.

One example of the work done by DCF, TCI, and the evaluation team to facilitate the demonstration is the effort to educate DCF staff about referrals of clients to SHF and the

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importance of – and process for – consenting families into the national evaluation survey of clients across our three experimental conditions. As such, the team delivered a series of trainings at each of the demonstration's DCF regional offices. A member of the evaluation team led each training and was joined (in many cases) by DCF's statewide SHF coordinator, a representative of TCI, and a point person for the national evaluation surveys. Thus, the training consisted of three main topics (and then allowed for questions and discussion): 1) the demonstration grant, key services components of the intervention, and the evaluation design; 2) the procedures for referring clients, confirming their eligibility and consenting them into the national evaluation; and 3) the QRAFT screening measure (for housing/homelessness in child welfare populations), its use, and results to date. Trainings included everyone in the regional offices, from directors to intake staff to caseworkers, so that there was broad awareness of the services, the demonstration, and the importance of the evaluation. These trainings were designed to improve referral rates to the demonstration and rates of consenting into the national evaluation, as well as bring about an awareness of homelessness/housing needs in child welfare across each of these regional DCF offices.

To complement anecdotal observations about collaboration from the CT Collaborative meetings and the DCF staff training events, we asked representatives from four different agencies across the state of CT, ranging from child welfare to counseling and housing services, to participate in a collaboration survey consisting of the Wilder Collaboration Factors Inventory and two additional open-ended questions related to collaboration. Consistent with the systems-level goals for the demonstration (as described earlier in the report), this survey was designed to understand how collaborative partners were succeeding in the mission to focus on the engagement of parents as partners and the enhancement of protective factors for families.

The Wilder Collaboration Factors Inventory (Mattessich, Monsey, & Murray-Close, 2001) is a 41-item instrument that assesses 20 different factors as they related to success. The factors include: history of collaboration or cooperation in the community; collaborative group seen as a legitimate leader in the community; favorable political and social climate; mutual respect, understanding and trust; among others. Respondents were asked to rank their level of agreement to forty different statements on a Likert agreement scale (1 = *Strongly Disagree* to 5 = *Strongly Agree*).

4.2.1.2. Model Fidelity
As described in Section 3, in addition to differences in access to housing subsidy, experimental contrasts were expected between ISHF and PSHF on (1) case management intensity, (2) priority access to evidence-based interventions (EBIs), (3) vocational assessment and support, and (4) the use of family teaming.

To illustrate services that case managers provide in the two experimental conditions that were carried out at TCI, we summarize activity data in Table 9 below, which depicts the number of clients whose case managers logged a particular kind of activity in TCI's CAMIS database. In

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addition to data recorded by case managers, the project director kept track of additional activities for the purposes of ensuring alignment with project plans. The activities recorded by the project director included: completed resume, enrolled in school/college, obtained new employment, and received job training. The evaluation team reviewed activity data recorded for 50 clients in the ISHF condition and 50 clients in the PSHF condition. Of note is the addition of all of the prevocational and vocational service activities for ISHF-enrolled clients, to which PSHF-enrolled clients did not have access. Some activities were recorded both as client achievements (e.g., enrolled in school/college), whereas others were more clearly identified as case manager activities (e.g., apartment search, assessments).

The process data presented in this section tracked the activities that clients engaged in with case managers (including family teaming meetings), the vocational progress made by clients, the evidence-based interventions clients have engaged in, and the process of step-downs and step-ups in service intensity.

Table 9. Process Data Collected

Data Type	Description
Client activity	Case managers recorded every time clients engage in an activity related to their client, including family teaming meetings. The project director independently tracked certain employment and education achievements.
Evidence-based interventions	Client participation in evidence-based interventions was noted at entry into the program, and tracked at six-month intervals for the duration of their time in the program.
Steps-down and steps-up in service intensity	As clients progressed towards discharge, case managers tracked the process of discussing and deciding to change the frequency of case management visits.

4.2.1.3 Client Engagement and Staff Insights
Client engagement. All active clients in the ISHF and PSHF conditions were given the opportunity to participate in an Engagement survey. The purpose was to understand client perceptions of the case management process and related outcomes. Each participant was provided with a paper packet of surveys including the Strengths-Based Practices Inventory (SBPI; Green, McAllister, & Tarte, 2004), the Parent Engagement Measure (PEM; Alpert & Britner, 2009), and an Engagement with Services questionnaire (developed for this purpose) that targets service utilization program perceptions and client participation. In total, 39 clients completed the packet of questionnaires. Clients were asked to complete surveys at the close of a Family Team Meeting without the case manager present in the room. Surveys were completed on paper and given to a Quality Improvement Specialist (not the family's case manager). De-identified data were then shared with the evaluation team, thereby maintaining confidentiality of the clients.

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Strengths-Based Practices Inventory (SBPI). The SBPI (Green et al., 2004) was used to gain insight into clients' thoughts about TCI's strengths based service delivery practice. The SBPI is a 16-tem instrument that was developed to examine how strongly clients agree or disagree with statements oriented toward constructs central to strengths based practices. Respondents are asked to respond to certain statements on a Likert scale range from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. The SBPI demonstrates strong internal consistency across all four of the subscales yielded by the instrument development process: (a) Empowerment approach, α=.92; (b) Cultural Competence, α= .72; (c) Staff Sensitivity-Knowledge, α=.81; and (d) Relationship-Supportive, α=.82 (Green et al., 2004). Reliabilities for these subscales in the current study were .93, .96, .90, and .92, respectively.

Parent Engagement Measure (PEM). In conjunction with the SBPI, respondents were asked to complete the PEM (Alpert & Britner, 2009). The PEM is designed for parents engaging in services leading to reunification facilitated by their caseworker and measures their impressions of case manager engagement. The PEM examines two facets of parents' experiences including: (1) the degree to which parents perceive their caseworkers to be actively doing family focused work; and (2) the degree to which parents feel empowered, respected, understood, and supported (Alpert & Britner). Respondents rate statements on a Likert scale ranging from 1 = *Strongly Agree* to 6 = *Strongly Disagree*. The PEM has strong internal reliability (α = .96) and internal consistency (Farrell et al., 2012). The internal reliability for the scale in the current study was strong (α = .98).

Service Utilization: Engagement with Services Questionnaire. Alongside the SBPI and PEM, clients responded to the Engagement with Services Questionnaire which targets service utilization program perceptions and client participation case management including: frequency of visits; duration of visits; family team meeting attendees (specific focus on cross-agency collaboration); voice in meetings; usefulness of assessments; education around assessment results; vocational specialist meeting; active member in housing search; meeting frequency decrease over duration of program; main decision maker(s); level of comfort in advocating for additional meetings; and major life areas improved.

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Staff insights. Focus groups were held with ISHF and PSHF staff to gain insight into program implementation and staff recommendations for how to best serve future clients. Staff reported on the following prompts in their work setting:

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1. What are your recommendations on "what works" (or doesn't, if there are problems or obstacles) and perhaps "what works, for whom" (if you have ideas about what is helpful for some clients but not others) in the following domains?
   - Accessing evidence-based interventions or other services?
   - Coordinating with DCF or other providers to help your clients?
   - Vocational work (preparedness, placement, etc.)?
   - Case management or supervision?
   - Housing search?
2. How do you make choices about the "sequencing" of services for your clients?
3. When are clients ready to "step down" in service (case management) intensity?
4. If you could write the new SHF (inclusive of ISHF and PSHF) manual for the state, what changes would you propose?

4.2.2 Results

4.2.2.1 Planning and Collaboration

Respondents to the provider collaboration surveys indicated moderate to high levels of agreement on each of the twenty factors, suggesting acceptable levels of collaboration across the agencies involved in the process. Consistently, the area with the lowest level of agreement was sufficient funds (M = 3.05, SD = 1.01), with many respondents indicating "disagree" (mode=2), suggesting that funds and human resources were not sufficient to engage in the cross-agency collaboration necessary to be successful. However, respondents reported agreement with all other 19 factors (e.g., collaborative group seen as a legitimate leader in the community; favorable political and social climate; mutual respect, understanding and trust), suggesting well-developed collaborative factors to further improve work efforts across agencies.

Participants in the study also responded to open-ended questions, including: "What needs improvement in your collaborative?" and "What is working well in your collaborative (i.e., the teaming, for the benefit of clients)?" In terms of improvement, respondents felt that access to sufficient resources was problematic. Resources included money, personnel, and sufficient time to engage in the quality of work necessary to support the clients. In terms of what worked, all respondents commented on the effectiveness of communication and ease of collaboration with other agencies involved in the collaborative.

Overall, respondents to the collaboration survey agreed that the collaborative was working well and that there were distinct areas of strength as well as those in need of improvement. Contrasting this are the needs for additional resources. Current staff reported having the

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collaboration resources to complete the work; however, they needed additional funding and human resources to support the clients through their journey toward autonomy.

4.2.2.2 Model Fidelity

In the section on the Target Population, we presented data on the participants in each of the three groups (ISHF, PSHF, and BAU), including key demographics and housing and service needs at enrollment. Here we report on ISHF and PSHF client engagement with program activities and with EBIs, as well as a summary of the contrast in service intensity between ISHF and PSHF (throughout the life of cases, including at the point of a step-down in service intensity toward case closing). In short, the experimental contrasts between ISHF and PSHF models on program activities, caseload, and case management intensity were demonstrated. There was, however, not a clear contrast between ISHF and PSHF on access to and utilization of EBIs.

Case management intensity. One aspect of contrast between the ISHF and PSHF conditions was more frequent meetings between clients and case managers in the ISHF program. Documentation in the CAMIS system confirmed that clients in ISHF did meet with their case managers on a significantly more frequent basis, an average of 1.22 times per week, in comparison to 0.82 times per week in the PSHF condition, $p < .01$. Although casework intensity overall did not quite reach the targeted amounts (once and twice per week, respectively), these differences in casework intensity signify acceptable levels of experimental contrast, e.g., the ISHF group experienced on average about 50% more individual meetings with their case managers. This does not include family teaming meetings and meetings with providers that were intended to be less frequent in the PSHF condition.

As noted in the section on evaluation challenges, the evaluation team was not able to observe family team meetings (due to client confidentiality decisions made by TCI); thus, case records in CAMIS were utilized to document team meeting activities. Furthermore, the evaluation team checked in periodically to ensure that ISHF case managers were maintaining a maximum caseload of seven families (before step-down), in comparison to the 10+ families that made up the PSHF caseloads. This indirect indicator of contrast also suggests acceptable fidelity. If an ISHF case manager had two clients that stepped-down to once-a-week meetings, they were allowed to take on an additional case. CAMIS was also used to document case managers' face-to-face contacts with their clients.

In comparison to child welfare practices across the U.S., PSHF caseloads appear to be within the normal range and ISHF caseloads lower than average. According to the Council on Accreditation (2018), child protection standards for personnel, investigative workers should manage no more than 12 active investigations at once (no more than 8 new investigations per month). The recommendation is for ongoing and preventive services workers to carry no more than 15-18 families (cases), with no more than 10 children who are in out-of-home placement. Data on typical caseloads in child welfare, across states and types of case management, is difficult to find (Child Welfare Information Gateway, 2016). A 2003 survey of 534 child welfare workers reported

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an average of 19 families per caseload, whereas the respondents considered 14.4 families to be a reasonable caseload on average (National Association of Social Workers, 2004).

To ensure that reduced intensity did not appear as a lack of fidelity to the model during the step-down process, the procedures included protocol for chart documentation. The program manual was updated and fidelity indicators were developed and embedded within The Connection's electronic chart records. The electronic records show that data on service intensity decision-making (usually initiated toward the end of cases) was missing for five family team meetings and two interdisciplinary team meetings. In total, six families, or 15%, had some level of missing data regarding changes in service intensity. However, Table 10 below shows that many families did go through the recorded process of changing their service intensity. The step-down process included Family Centered Team Meetings where a change in service intensity was discussed with the family. Then, Interdisciplinary Team Meetings were held to determine whether all parties agreed with the change in service intensity. Finally, a step-down or step-up was recorded with a note of whether the staff or client first initiated the change. A client initiated "indirect" step-down means that the client started disengaging with their case manager without discussing a change in service intensity. These statistics are important because they show that the new protocol for changes in service intensity have been heavily used since implementation, validating the necessity for such a process. The vast majority of changes in service intensity were in the direction of less intensive services, suggesting a natural progression towards discharge as families moved through the program.

Table 10. Service Intensity Data

Team Meeting Activities	Families (*n*)	Instances (*n*)
Family Centered Team Meetings – Service Intensity	37	67
Interdisciplinary Team Meetings in Agreement	33	53
Interdisciplinary Team Meetings Not in Agreement	12	17
Client Initiated Step-Down	20	27
Client Initiated Indirect Step-Down	14	16
Staff Initiated Step-Down	19	27
Staff Initiated Step-Up	1	1

Note. The Families column indicates n of families who were involved in one of those activities. The Instances column is total instances; one family could have multiple instances of step down, etc. (e.g., 2/week to 1/week to 1/month).

Vocational Supports. Figure 9 below shows the differences in the activities in which families in PSHF and ISHF engaged. Additional activities not shown below, such as family centered teaming meeting, job application assistance and attire, and referral to the Department of Labor, among others, were only pursued by families in ISHF. This reflect the intentional experimental contrasts between the two groups. Consistent with the activities described above and the access to a dedicated vocational specialist in the ISHF condition, ISHF clients were more likely than PSHF

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clients to have: received job training (76% vs. 20%); completed a resume (70% vs. 34%); obtained new employment (58% vs. 44%); and, enrolled in school/college (22% vs. 10%). The frequencies of non-vocational activities were more similar between clients in ISHF and clients in PSHF, reflecting similar levels of service in those areas.

Figure 9. Percent of Clients Who Participated in Vocational Activities, by Experimental Group
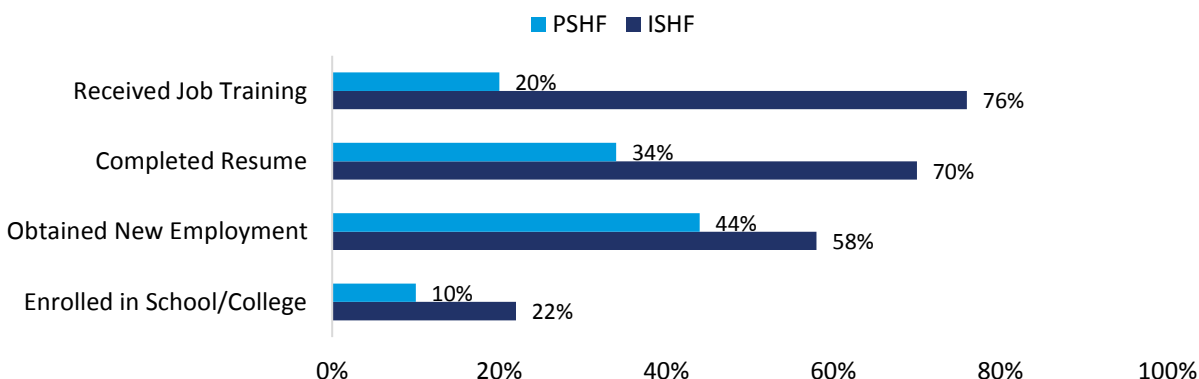
Evidence-based interventions. Table 11 below provides counts and percentages of the number of clients in PSHF and ISHF conditions who participated in various interventions. Intake data were available for 50 clients in ISHF and 50 clients in PSHF. Enrollment in services was available for 49 clients in ISHF and 42 clients in PSHF at the six-month period and beyond. For simplicity, we combined longitudinal data across program enrollment duration; that is, rather than show changes in percent enrollment for each six-month interval, we depict initial and subsequent enrollment.

In the ISHF condition, there were small enrollment increases (from admission) in the percent of clients who attended individual therapy/counseling, trauma-focused CBT, Family Based Recovery, Triple P parenting program, and home visiting during their time in the program (approximately 24%, 15%, 2%, 10%, and 55%, respectively). In the PSHF condition, there were small increases in the percent of clients who attended individual therapy/counseling, trauma-focused CBT, Child FIRST, Family Based Recovery, Triple P parenting program, and home visiting during their time in the program compared to intake (approximately 18%, 10%, 13%, 8%, 8%, and 38%, respectively). There were fewer families with EBI information present at 12 months and beyond due to clients who have been discharged.

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Table 11. n and % of Families in EBIs, by Experimental Group, at Intake and During Enrollment

Intervention	ISHF		PSHF	
	Intake (*n*=50)	During Enrollment (n=49)	Intake (*n*=50)	During Enrollment (n=42)
Multi-Systemic Therapy*	1 (2%)	1 (2%)	1 (2%)	1 (2%)
Individual Therapy/Counseling	30 (60%)	41 (84%)	29 (58%)	32 (76%)
Trauma-Focused CBT*	5 (10%)	12 (25%)	2 (4%)	6 (14%)
Child FIRST*	3 (6%)	3 (6%)	2 (4%)	7 (17%)
Family Based Recovery*	4 (8%)	5 (10%)	2 (4%)	5 (12%)
Triple P*	6 (12%)	11 (22%)	3 (6%)	6 (14%)
Home Visiting	2 (4%)	29 (59%)	5 (10%)	20 (48%)

* Evidence-Based Intervention

Family Teaming. The fourth aspect of experimental contrast was the presence of family teaming as an intervention for ISHF clients. Examination of TCI's CAMIS database, in which case managers record all of their case activities, indicates excellent experimental contrast for this component. There were 384 family centered team meetings" for families in ISHF (7.68/family; range = 2 to 8) and 0 such meetings for families in PSHF.

Looking across the four components of experimental contrast, we observe good to excellent contrast for three. There was a lack of experimental contrast with respect to access to EBIs, which were intended as a priority for the ISHF condition. In section 4.3 below, we discuss time to lease-up and voucher, with serve as proxies for understanding the extent to which families in the ISHF condition experienced shorter waits given the priority access to vouchers. Data support the fidelity of that aspect of the demonstration, such that families in the ISHF condition waited significantly fewer days.

4.2.2.3 Client Engagement:

Client engagement. ISHF and PSHF clients reported strong support from caseworkers, high engagement with services and case management, and many self-reported areas of personal improvement. Client reports of service utilization patterns mirrored the staff-reported data on client activities, including the contrasts between ISHF and PSHF in areas like case management frequency and access to vocational supports.

Strength-based Practices Inventory. Table 12, below, shows descriptive statistics for the respondents to the survey. As evidenced, means are 6 and above, indicating high levels of agreement with the items surveyed. In addition, standard deviations fall between 0.7 and 1.1, demonstrating little variation. In general, clients mostly agreed that their case managers were oriented toward an Empowerment Approach (*M* = 6.6, *SD* = 0.7) and engaged with clients with a

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high degree of cultural competency (*M* = 6.1). In addition, respondents mostly to strongly agreed that their case managers engaged with sensitivity and knowledge to guide their service delivery and engagement (*M* = 6.6). Lastly, respondents reported feeling supported by their case managers (*M* = 6.2). These means are higher (i.e., show more strength-based practices) than those presented by Green et al. (2004).

Table 12. SBPI Descriptive Data

Subscale	*N*	*M*	(*SD*)
Empowerment Approach	38	6.6	0.7
Culture Competence	38	6.1	1.1
Staff Sensitivity-Knowledge	39	6.6	0.8
Relationship-Supportive	37	6.2	1.0

In terms of reported differences across the models of service delivery, ISHF compared with PSHF, there are no statistically significant differences in the mean scores across the four subscales of the SBPI, suggesting that respondents on average mostly agreed with the strengths-based practice statements.

Parent Engagement Measure. Overall, respondents to the PEM were in agreement with the PEM items; the overall mean score for 39 respondents was 1.3 (*SD* = .80), a level of engagement that matches the mean (1.3) in another SHF (Farrell et al., 2012) sample and exceeds the mean (2.3) for a broader child welfare (Alpert & Britner, 2009) sample. The overall mean score suggests that clients who were engaged in the case management process in both PSHF and ISHF conditions experienced case management style and behaviors that fostered an environment of trust; promoted client strengths; encouraged respectful interaction; and, empowered clients to see and utilize their strengths through a collaborative model of service engagement.

Table 13. PEM Items and Descriptives

Item	*M*	(*SD*)
My case manager…		
…focuses on my strengths	1.2	0.5
…makes me feel like an important part of a team.	1.4	1.0
…involves me in meetings about my case	1.2	0.5
…encourages me to share my point of view.	1.2	0.7
…values the knowledge I have about my own child(ren).	1.2	0.8
…values me as a person	1.3	1.0
…is available when I need them	1.4	1.2
…helps me when I ask for help	1.4	1.0
…connects me with the services I need	1.4	1.2
My service plan was developed based on my personal goals	1.2	0.7

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Item	M	(SD)
I have a say in creating the goals of my service plan	1.2	0.9
I have control over whether or not I succeed in the Supportive Housing for Families program	1.2	0.7
I am involved in decisions made about my case	1.1	0.4
When I talk with my case manager about my personal situation, I feel like he/she really listens to me	1.2	0.9
I feel that my opinion is respected by my case manager	1.4	1.0
I trust my case manager	1.4	1.3
I am getting the services I need in order to complete my service plan successfully	1.3	1.1
I can call my case manager if I need help	1.3	1.0
Overall Scale Mean	1.3	0.8

Note. N = 39.

Service Utilization. Of the 38 clients who responded to the survey, 87% reported seeing their case manager between once to twice a week or more with 47% of clients having met with their case manager for an hour; the remaining 53% met for up to one hour. Additionally, 92% of clients reported feeling that they always have a voice in meetings with their case manager. Clients reported that assessments were not only reviewed (84%) but that the assessments had been helpful (84%). Additionally, clients reported talking with or meeting with the vocational specialist (68%) with 57% of those clients meeting between twice a week or more (22%) to once a month (16%). Alongside vocational support, clients reported playing a role in the housing search (90%).

Clients reported improvements in key areas including the following: housing stability (84%); parenting ability (51%); financial stability (38%); employment status (32%); physical health (41%); mental health (54%); substance use (24%); child(ren) well-being (57%); family well-being (68%); personal well-being (76%); feel more self-sufficient (76%); connection to supportive services in the community (76%); personal connections (43%); closed DCF case (27%); budget management (35%); education (31%).

Table 14. Areas of Self-Reported Client Improvement on the Engagement with Services Questionnaire

Area of Improvement	% Identifying Improvement
Housing stability	83.8%
Personal well-being	75.7%
Feeling more self-sufficient	75.7%
Connection to supportive services in the community	75.7%

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Area of Improvement	% Identifying Improvement
Family well-being	67.6%
Children's well-being	56.8%
Parenting ability	51.4%
Personal connections	43.2%
Physical health	40.5%
Financial stability	37.8%
Budget management	35.1%
Employment status	32.4%
Education	30.6%
Closed DCF case	27.0%
Substance use	24.3%

Clients who participated in the surveys reported that they felt empowered and that their case managers practiced with cultural competence and sensitivity while collaborating in the development of supportive relationships. Clients who responded that they felt heard by their case managers within an environment of trust and that their case managers promoted client strengths; encouraged respectful interaction; empowered clients to see and utilize their strengths through a collaborative model of service engagement. Clients who responded to the survey met regularly with their case managers, understood and saw value in assessment(s), felt like a key part of the housing process, and self-reported improvements in areas central to autonomy and reunification.

4.2.3 Summary

Observations within the process evaluation revealed that planning and implementation activities occurred largely as mapped out in the proposal and implementation plan. Cross-systems collaboration was in evidence across the demonstration and was rated as moderate to high by members of the CT Housing and Child Welfare Collaborative. Looking across the four components of experimental contrast, we observe good to excellent contrast for three (casework intensity, vocational services, family teaming). There was a lack of experimental contrast with respect to access to evidence-based interventions, which were intended as a priority for the ISHF condition. Time to lease-up and voucher was significantly shorter among families in the ISHF condition.

In conjunction with the client engagement and collaboration studies, the staff focus groups conveyed a picture of both ISHF and PSHF programs having helped clients feel supported, engaged in the treatment process, and empowered toward better outcomes such as housing stability, personal well-being, independence, and connection to supportive services in the community. Service providers felt that the collaborative process was well developed; however, they reported a need for additional resources and caseload balance to work more effectively.

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Staff, partner providers, and clients all reported seeing the value in collaboration and felt the benefits of the unique aspects of the project's dedicated focus on improving the quality of client-centered care through inter-agency collaboration.

4.3 Impact Evaluation

4.3.1 Methods

4.3.1.1 Overview

As previously described, the impact evaluation aimed to illuminate the effects of exposure to treatment on child and family outcomes among the target population. CT's inclusion of two levels of treatment (ISHF, PSHF) afforded the opportunity to explore multiple experimental contrasts between high intensity wraparound services with a housing voucher or subsidy, lower intensity wraparound services with a housing voucher or subsidy, and business as usual, which functioned as a waitlist comparison group. The *a priori* impact evaluation questions address differences between the business as usual (BAU) condition and both treatment conditions (i.e., we collapsed ISHF and PSHF groups for the first set of questions we explored). This enabled us to focus on the differences between any treatment (services plus housing voucher) and the normal course of child welfare services in CT. These research questions included:

1. Do families who receive supportive housing services (PSHF and ISHF combined) demonstrate improved child welfare outcomes compared to those in the BAU?
    a. Are families assigned to treatment more likely to be reunified (among reunification families)?
    b. Do families assigned to treatment reunify more quickly (among reunification families)?
    c. Are families assigned to treatment less likely to have a child removed (among preservation families)?
    d. Are families assigned to treatment more likely to be fully in tact?
    e. Are families assigned to treatment less likely to experience a maltreatment allegation?
    f. Are families assigned to treatment more likely to have a case closed?
    g. Do families assigned to treatment experience faster case closure?
    h. Are families assigned to treatment less likely to have a case reopened?
    i. Do families who receive supportive housing services (PSHF and ISHF combined) demonstrate improved housing stability compared to those in the BAU?
2. Are families assigned to treatment less likely to experience homelessness?

The second set of research questions focused on the contrast between levels of treatment to investigate whether more intensive wraparound and vocational services are associated with improved family and child well-being outcomes. These research questions included:

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3. Do families who receive higher intensity services in ISHF demonstrate increased self-sufficiency and well-being compared to those in PSHF?
4. Do families who receive higher intensity services in ISHF demonstrate improved parental functioning compared to those in PSHF?
5. Do families who receive higher intensity services in ISHF demonstrate improved child development and well-being compared to those in PSHF?

The impact evaluation exploited the randomized controlled trial design, in which families were randomly assigned to one of three conditions, ISHF, PSHF, or BAU. The process for referral and randomization is described in greater detail elsewhere in this report (Section 3), as are the differences in the services provided to these treatment groups (Section 3). Upon referral (N = 805; see Table 18, Appendix C), all families completed an intake assessment with TCI, which contained information on family demographics and history, such as experiences of domestic violence or family homelessness. This assessment was used to determine eligibility for program participation. Families were determined ineligible if the spigot was off (n = 118), meaning that caseloads had temporarily reached capacity and no more families could be randomized, or if families did not meet the targeting criteria (n = 586). At this point, families also consented to participate in the Urban Institute survey (national or cross-site evaluation).

After randomization (N = 217) and program admission, those families who were randomly assigned to BAU (n = 110) had no further interactions with TCI and volunteered no additional data, though survey and administrative data from DCF and HMIS (and the national evaluation, if the client consented) continued to be collected on these families. Families who were admitted to PSHF (n = 56) or ISHF (n = 51) continued to engage with TCI, in the process of obtaining a voucher and securing a lease, as well as through specialized case management services. These families also participated in a battery of surveys and assessments on family and child well-being at admission and every six months until discharge. Ultimately, data sources could not be linked for 12 families and 20 children, producing an analytic sample of 418 children in 205 families. Within this analytic sample, the results of analysis comparing the SHF treatment (PSHF and ISHF combined) and control (BAU) groups showed evidence of baseline equivalence on a range of family demographic characteristics, family experiences, and family needs (Appendix C, Table 18).

4.3.1.2 Measures
As described above in Table 8, and in more detail in Appendix B, data were drawn from various sources to address the extent to which treatment exposure affected child welfare, housing stability, family self-sufficiency, parental functioning, and child development and well-being:

Table 15. Impact Evaluation Objectives, Research Questions, Measures, and Sources

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Objective	Research Question	Performance Measure/Indicator	Data Source	Agency
Improved child welfare outcomes	*Primary:* Do clients who receive supportive housing services (SHF and ISHF interventions combined) demonstrate improved **child welfare outcomes** compared to those in the BAU? *Secondary:* Are there differential effects by level of intervention for ISHF and PSHF?	Family reunification Child removal New child maltreatment incidents Cases closed and re-opened	DCF database (LINK)	DCF
Improved housing stability	*Primary:* Do clients who receive supportive housing services (SHF and ISHF interventions combined) demonstrate improved **housing stability** compared to those in the Child Welfare (DCF) Business as Usual (BAU) intervention? *Secondary:* Are there differential effects by level of intervention for ISHF and PSHF?	Shelter stay	HMIS	CT Coordinated Access Network (Continuum of Care)
		Have house/apartment with/without own lease, number of moves, quality of living situation, homeless spell, eviction	Urban Institute Survey	n/a
Improved Self-Sufficiency & Well-Being	*Primary:* Do clients who receive any supportive housing services (those in the SHF and ISHF interventions combined) demonstrate increased **self-sufficiency** compared to those in the BAU intervention? *Secondary:* Are there differential effects by level of intervention for ISHF and PSHF?	Self-sufficiency, environment, interactions, family safety, family health	North Carolina Family Assessment Scale (General and Reunification Services; NCFAS-G+R)	TCI Assessment Specialist & Case Manager
Improved Parental Functioning	*Primary Research Question:* Do clients who receive any supportive housing services (those in the SHF and ISHF interventions combined) demonstrate improved **parental**	Caregiver depressive symptoms	Brief Symptom Inventory	TCI Assessment Specialist
		Parental distress	Parenting Stress Index-Short Form	TCI Assessment Specialist

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Objective	Research Question	Performance Measure/Indicator	Data Source	Agency
	well-being compared to those in the BAU? *Secondary:* Are there differential effects by level of intervention for ISHF and PSHF?	Parental capability	NCFAS-G+R	& Case Manager
Improved Child Development & Well-Being	*Primary:* Do clients who receive any supportive housing services (those in the SHF and ISHF interventions combined) demonstrate improved **child development and well-being** compared to those in the Child Welfare Business as Usual intervention? *Secondary:* Are there differential effects by level of intervention for ISHF and PSHF?	Child gross motor skills, fine motor skills, communication skills, personal-social skills, problem solving skills	Ages and Stages Questionnaire	TCI Case Managers
		Child internalizing, externalizing, and total problems	Achenbach Child Behavior Checklist	
		Well-being	NCFAS-G+R	TCI Assessment Specialist & Case Manager

4.3.1.3 Analytic Approach

The analytic approach involved exploiting the experimental contrasts to test whether treatment exposure was associated with improved outcomes for families and children. We conducted an intent-to-treat analysis on all families in the analytic sample (N = 205 families; N = 418 children), given that only three families forfeited their housing vouchers over the course of the analytic time frame. As such, an accompanying treatment-on-treated analysis was not necessary to conduct.

Within the analytic sample, we first explored missing data. Generally, there was very limited missing data on key outcomes of interest. Of course, as families discharged from the PSHF and ISHF programs, attrition of the sample limited the extent to which longitudinal impacts could be measured for those outcomes assessed through program participation, such as parental capabilities and child well-being. Among the model covariates, missing data ranged from 0-8%.

Prior to examining multivariate associations between treatment assignment and outcomes, we first explored bivariate associations. As shown in Table 19 and referenced earlier, we tested for baseline equivalence by comparing families at referral on a set of characteristics including demographics, child welfare status, housing status, and family needs. Using t-tests for

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continuous variables and chi-square tests for binary and categorical variables, we found strong evidence for baseline equivalence, with families assigned to treatment (PSHF and ISHF combined) and control (BAU) differing only on percentage of families with four or more children in the household. Additionally, as presented in Tables 20 and 21, we conducted additional bivariate tests comparing treatment and control groups, with PSHF vs. ISHF comparisons where possible, on housing and child welfare status outcomes.

Our process for building the statistical models to test the effects of the intervention on family and child outcomes adhered to the approach proposed by the Urban Institute, the national cross-site evaluator. As noted above, we aligned our operationalization of child welfare outcomes to facilitate comparisons across sites. Additionally, we incorporated a set of covariates that the Urban Institute recommended including in all statistical models predicting family and child outcomes. The purpose of including these covariates is to increase the specificity of model estimates by controlling for, or holding constant, the influence of confounding observed family and child characteristics, with the outcomes of interest. The covariates in these models included caregiver or child race/ethnicity, categorized as White vs. non-White, caregiver or child age at randomization (in years), and binary indicators capturing two or more experiences of household domestic violence, caregiver criminal justice history, prior family homelessness, and caregiver's childhood abuse history. In models testing differences within subsamples, such as the reunification or preservation cases, covariates that were perfectly correlated with the outcome of interest were dropped from the model to facilitate model convergence.

Further in line with the Urban Institute's recommendations, we predicted outcomes across three time intervals: randomization to 12 months, randomization to 18 months, and randomization to 24 months. We used logistic regression analyses to estimate multivariate associations between treatment assignment and binary (yes/no) outcomes (e.g., child ever reunified, child ever removed, occurrence of a maltreatment allegation), controlling for covariates. We used linear regression analyses to estimate multivariate associations between treatment assignment and continuous outcomes (e.g., days to reunification), controlling for covariates. For models in which children were the unit of analysis, we applied a Huber-White standard error adjustment to cluster shared error variance attributable to family membership amongst siblings in the sample. In other words, this adjusts the model estimates to account for the fact that children within a family may be more similar in their outcomes than other children who are not their siblings. The results of the statistical models were transformed from raw coefficients to marginal effects, which summarize the association between the change in the independent variable – treatment assignment – and the change in the outcome, controlling for covariates. In essence, we present predicted values for the outcomes, including prevalence estimates for binary outcomes, and means for continuous outcomes. Depending on the type of outcome, Chi-square and F tests were used to test for significant differences in the estimates between treatment and control groups and between PSHF and ISHF.

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4.3.2 Results

4.3.2.1 Sample Characteristics

Sample characteristics at referral for the full analytic sample are presented in Appendix C, Table 19. Caregivers in this sample were two-thirds White (67%), 11% Black, 19% Hispanic, and 3% Other, and the majority were female (93%).

Figure 10. Caregiver Race/Ethnicity and Gender

Race/Ethnicity

■ White ■ Black ■ Hispanic ■ Other

3%
19%
11%
67%

Gender

■ Male ■ Female

7%
93%
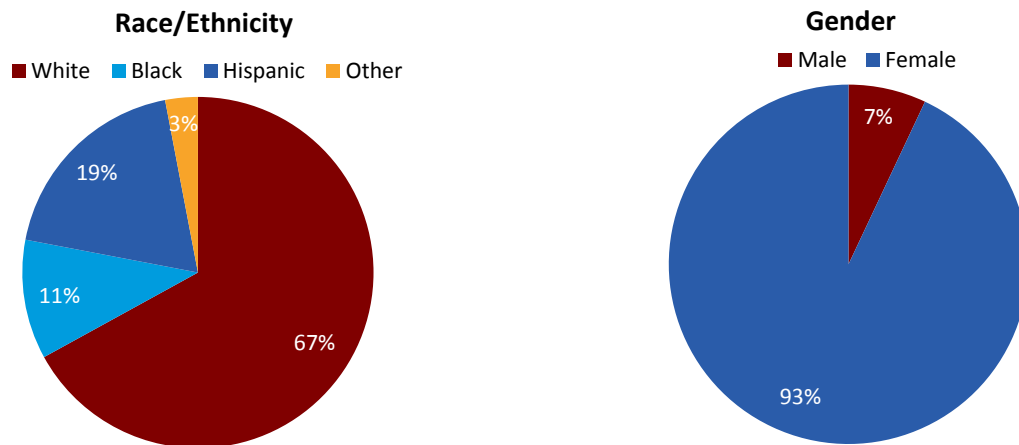
On average, households reported earning $5,411 per year (*SD* = 7,201), or about $450 per month. Twelve percent of families had more than four children in the household and 27% reported having other non-parental adults in the household. This sample was nearly evenly split by child welfare status: 51% were randomized as preservation and 49% were randomized as reunification (Figure 11). As shown in Figure 11, at referral, more than half of families in this sample appeared to be doubled-up Fifty nine percent were living with friends and family and most others were in similarly unsustainable or precarious situations: 11% were in a shelter, 6% were in a hotel or motel, 5% were homeless, 4% were in transitional housing. Only 15% of the sample lived in a private home.

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Figure 11. Family's Child Welfare Case Status and Housing Statuses, at Referral

Child Welfare Case Status

■ Preservation   ■ Reunification

49%   51%

Housing Status

Transitional Housing	4%
Homeless	5%
In Hotel/Motel	6%
In Shelter	11%
Private Home	15%
With Friends/Relatives	59%

0%   20%   40%   60%   80%
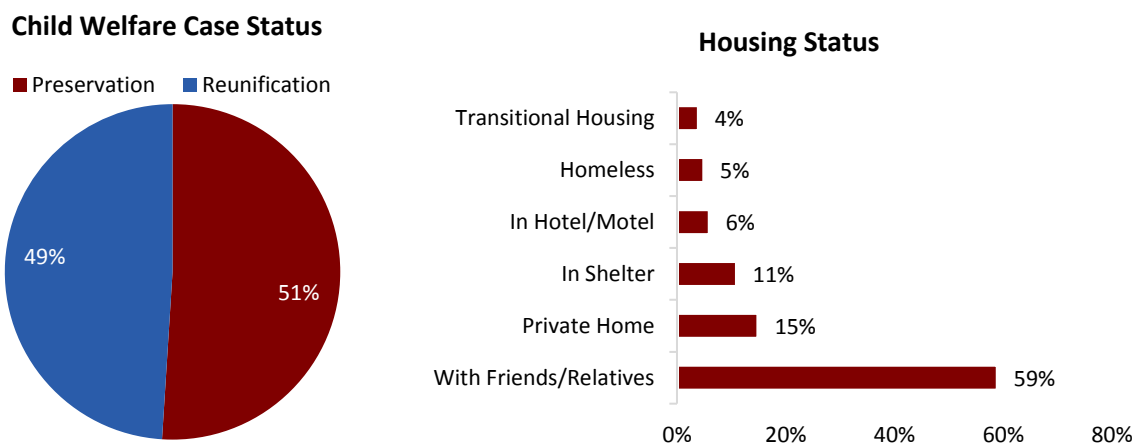
4.3.2.2 Child Welfare Involvement

Within each of the outcome domains, the first set of research questions addressed whether families assigned to treatment (either PSHF or ISHF) demonstrated improved child welfare outcomes as compared with a waitlist control group (BAU).

Are families assigned to treatment more likely to be reunified? Are they reunified more quickly?
Treatment vs. Control. Among families in the reunification group, a statistically significantly higher proportion of families in treatment than in control were reunited with at least one child within 18 and 24 months from randomization. Within 18 months, 38% of families in the treatment group and 16% of families in the control group were reunited with a child. At 24 months, 41% of families in the treatment and 16% of families in the control group were reunited with a child.

Analyses at the child level reflected this pattern, shown in Figure 12. Within 18 months of randomization, 29% of children in the treatment group and 9% of children in the control group were reunified, a statistically significant difference. Likewise, at 24 months, 30% of children in the treatment and 9% of children in the control group were reunited with their parents.

There were no statistically significant differences in time to reunification among children who were reunified with their families, which on average took about 633 days in the full sample. In Figure 13, we depict reunification findings across *PSHF* and *ISHF*; there were no significant differences in rates of reunification between families or children.

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Figure 12. Prevalence of Child Reunification (Among Reunification Cases) at 12, 18, and 24 Months, by Experimental Group
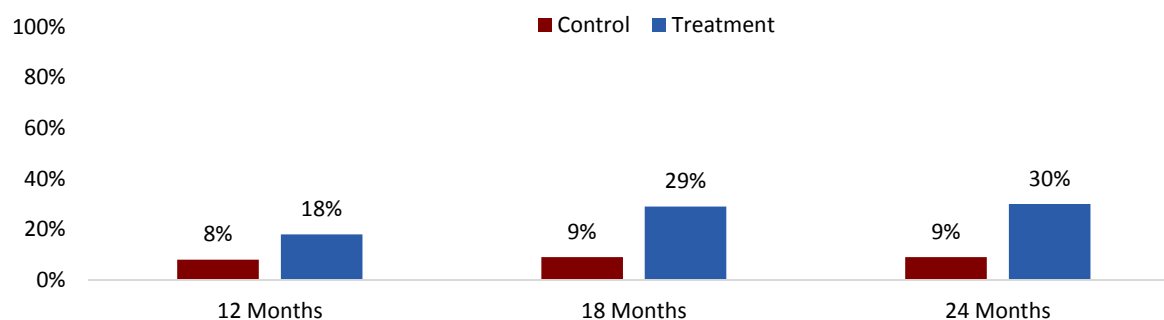
Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

Figure 13. Prevalence of Children Reunification (Among Reunification Cases) at 12, 18, and 24 Months, by Experimental Group
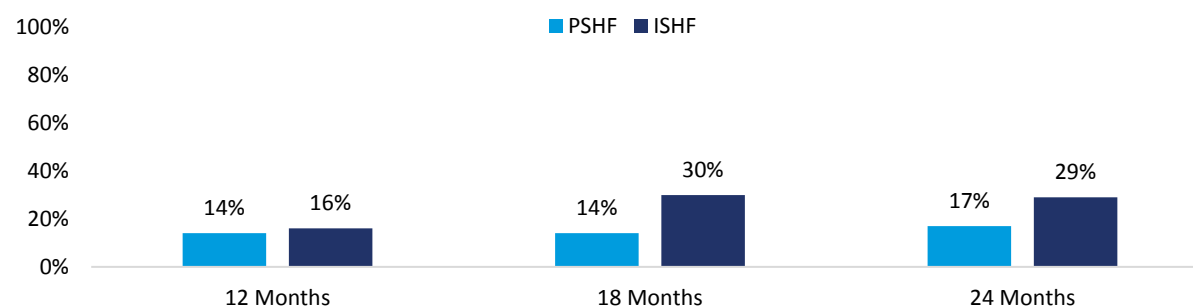
Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

Are families assigned to treatment less likely to have a child removed?

Treatment vs. Control. At the family level, among families in the preservation group, a higher proportion of families in the control group had at least one child removed as compared with families in the treatment group. Within 12 months, 28% of families in the control group and 6% of families in the treatment group had a child removed from the home. Within 18 months, 41% of families in the control group and 9% of families in the treatment group had a child removed. By 24 months, 40% of families in the control and 11% of families in the treatment group had a child removed.

Differences at the child level were even more striking, as shown in Figure 14. Within the first year, the rate of children in the control group who were removed from their families was more than five times the rate of the treatment group (33% vs. 6%). Within 18 months, 40% of children in the control group and 7% of children in the treatment group were. At 24 months, 40% of children in the control and 9% of children in the treatment group were removed from their homes.

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Figure 14. Prevalence of Child Removal (Among Preservation Cases) at 12, 18, and 24 Months, by Experimental Group

Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

PSHF vs. ISHF. Among families randomized to the preservation group, there were no differences between PSHF and ISHF within 12 months from randomization. By 18 and 24 months, children randomized to PSHF experienced a lower prevalence of removal than children in ISHF (4% vs. 15% by 18 months; 3% vs. 21% by 24 months).

Figure 15. Prevalence of Child Removal (Among Preservation Cases) at 12, 18, and 24 Months, by Experimental Group
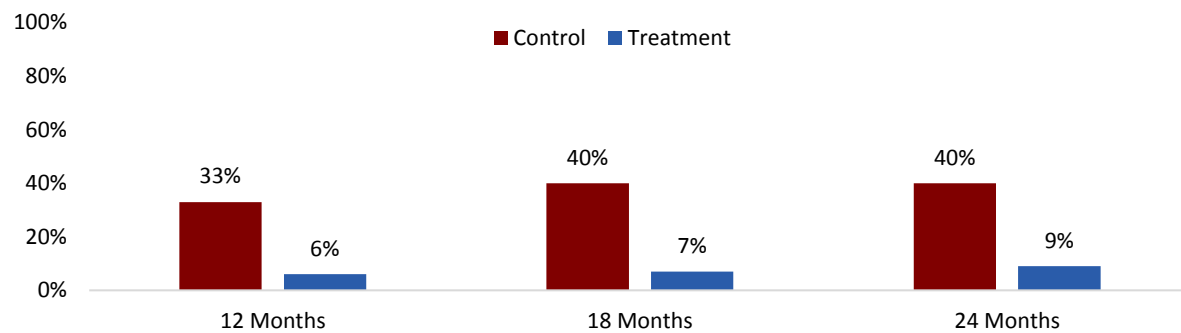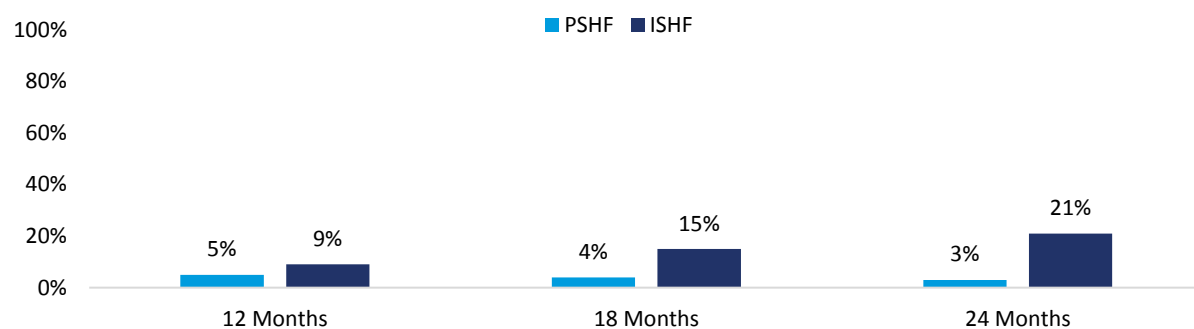

Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

Are families assigned to treatment more likely to be fully intact?

Treatment vs. Control. There were no differences in the likelihood of living with one's family within 12 months of randomization, but by 18 months, a significantly higher proportion of children in the treatment group were living with family (60%) than were children in the control group (47%). By 24 months, estimates were similar, but were only marginally significant.

PSHF vs. ISHF. Children in ISHF were no more likely that children in PSHF to be living with their family at any time point – 12, 18, or 24 months – since randomization.

Are families assigned to treatment less likely to experience a maltreatment allegation?

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Treatment vs. Control. Children in the treatment and control groups were equally likely to experience a maltreatment report or referral within 12-, 18-, and 24-month time frames. However, children in the control group had a higher prevalence of substantiated maltreatment than children in the treatment group at 12 months (19% vs. 5%) and 18 months (26% vs. 8%). The trend continued at 24 months but was only marginally significant at the *p* < 0.10 level.

Figure 16. Prevalence of Substantiated Maltreatment Reports (Among Children in Preservation Cases) at 12, 18, and 24 Months, by Experimental Group
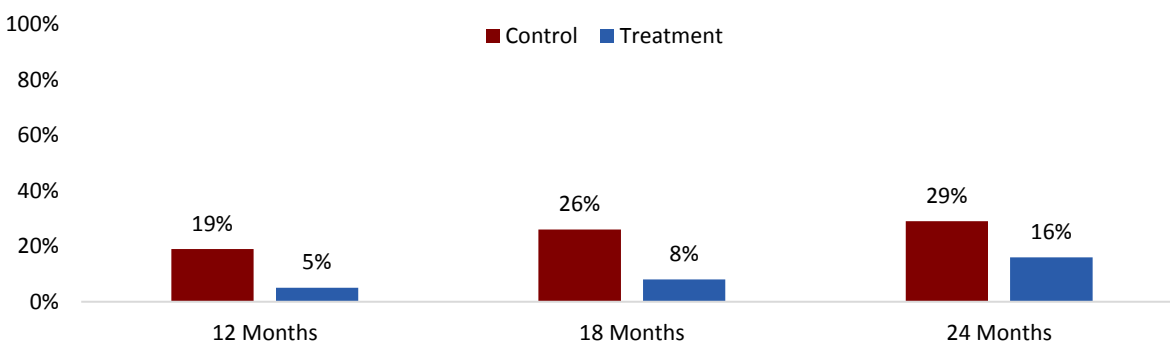
Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

PSHF vs. ISHF. There were also no differences between children in PSHF and ISHF on the prevalence of experiencing either any maltreatment report or a substantiated maltreatment report.

Are families assigned to treatment more likely to have a case closed? Do they experience faster case closure? Are they less likely to have a case re-opened?
Treatment vs. Control. There were no differences in whether cases were closed or re-opened, or the speed with which they were closed, between children in the treatment and control groups.

PSHF vs. ISHF. Similarly, there were no differences in whether cases were closed or re-opened, or the speed with which they were closed, between children in PSHF and ISHF.

4.3.2.3 Housing Stability
With regard to housing stability, we asked: *are families assigned to treatment less likely to become homeless?* Generally, we had few measures of housing stability that we could use to test differences between treatment and control groups, so we present findings from the CT's HMIS system in addition to descriptive differences drawn from the Urban Institute survey.

Treatment vs. Control. With regard to shelter stays, there was no difference in likelihood of entering the state's Coordinated Access Network (also known as the Continuum of Care) between the treatment and control groups.

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Figure 17. Prevalence of Families with a Shelter Stay at 12, 18, and 24 Months, by Experimental Group
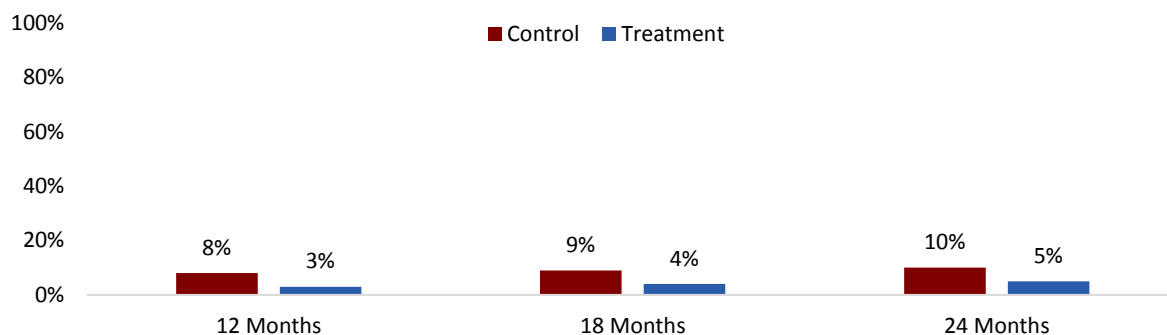
Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

Although it was not possible at this time to investigate multivariate associations using the Urban Institute survey data, we explored bivariate differences between treatment and control on a variety of indicators of housing stability. We examined number of moves since randomization, the self-reported quality of the living situation, housing quality issues (e.g., presence of rodents, non-working utilities), self-reported spells of homelessness and experiences of eviction, the number of people living in the household, and the attainment of a home with or without a lease. Across these indicators, the only significant differences between treatment and control was the attainment of a home with or without a lease within a year since randomization. Families in the control group were less likely to have a house or apartment with their own lease, whereas families in the treatment were more likely to have a house or apartment with their own lease.

Figure 18. Prevalence of Families Who Having a House/Apartment with a Lease One Year from Randomization, by Experimental Group
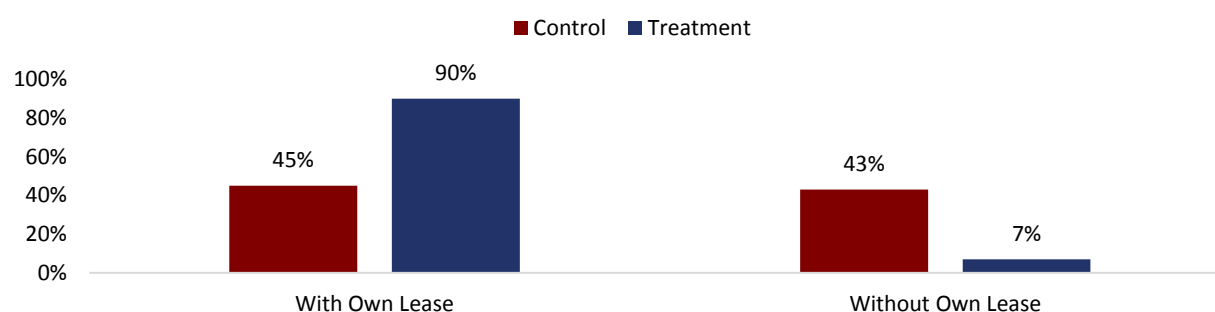
Note. These prevalence estimates shown in this figure are predicted from statistical models that control for family demographics and prior experiences.

PSHF vs. ISHF. On average, families waited about 97 days (*SD* = 59) from admission before they obtained housing, which was considered a bridge subsidy that housed families temporarily until

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they obtained their RAP voucher. The difference in wait time between families enrolled in PSHF and ISHF was marginally significant different ($p < 0.10$).

On average, families waited about 8 months (241 days; $SD = 167$) to obtain a RAP voucher. By nature of the program structure, families in the ISHF condition received their vouchers significantly faster than did families in PSHF. Families in ISHF waited an average of 160 days ($SD = 72$) whereas families in PSHF waited 427 days ($SD = 176$), more than 14 months, to transition from a bridge subsidy to a RAP voucher ($p < 0.01$).

Figure 19. Mean Time to Housing and Lease Up (With Voucher) from Randomization, by Experimental Group
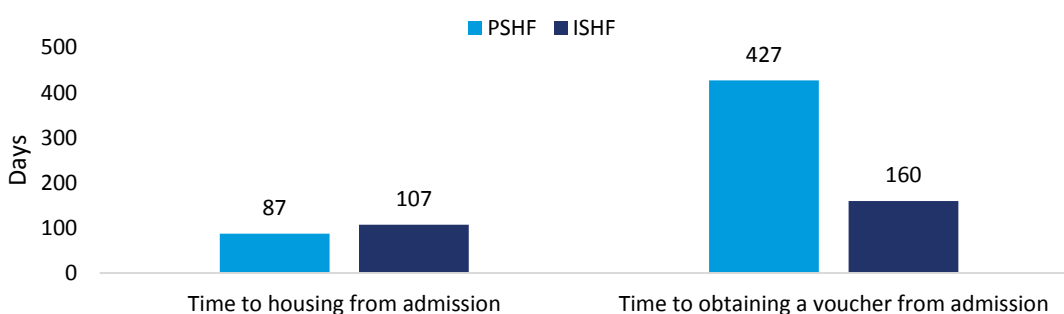
With regard to experiences of homelessness, using shelter stay as a proxy, we could not test for significant differences between groups because no families in ISHF had entered the HMIS system within two years of randomization. Among families in PSHF, 6% had entered within 12 months, 8% entered within 18 months, and 12% had entered within 24 months, pointing to increasing housing insecurity over time.

In the Urban Institute survey data, we were able run multivariate models testing the impact of treatment assignment on a number of housing stability indicators, including number of moves since randomization, the self-reported quality of the living situation, housing quality issues (e.g., presence of rodents, non-working utilities), self-reported spells of homelessness and experiences of eviction, and the number of people living in the household. Across these measures, there were no significant differences between families assigned to PSHF and ISHF.

4.3.2.4 Family Self-Sufficiency and Well-Being
In a series of targeted comparisons focused on the level of service intensity we asked: do families who received higher intensity services in ISHF demonstrate increased self-sufficiency and well-being?

PSHF vs. ISHF. Across most of the family well-being outcomes – family self-sufficiency, environment, safety, and health – families in ISHF showed an initial improvement at 6 months

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from randomization. By 12 months, the differences between families in ISHF and PSHF had largely faded; families in ISHF continued to show significant improvements over families in PSHF only in the domain of family health.

Figure 20. Mean Client Scores on the Self-Sufficiency and Family Health Subscales of the NCFAS-G+R at 6 and 12 Months, by Experimental Group
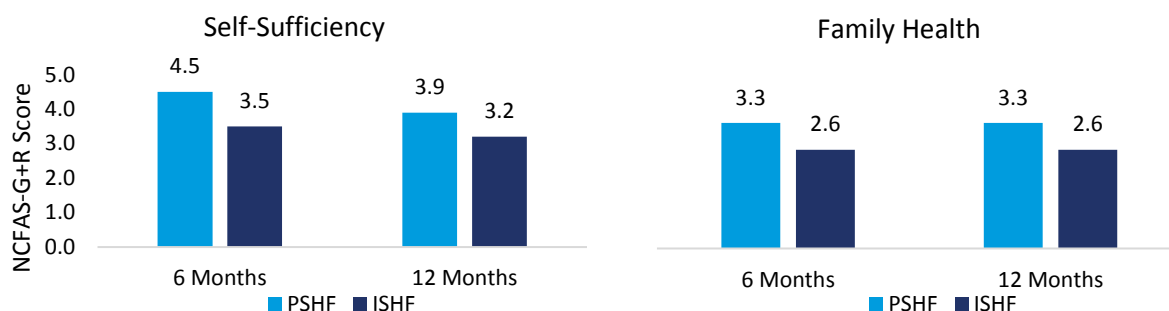
Further investigation of family trajectories in these domains indicate that families in both ISHF and PSHF appear to stabilize between 6 and 12 months since randomization.

4.3.2.5 Parental Functioning
Do families who received higher intensity services in ISHF demonstrate improved parental functioning?

PSHF vs. ISHF. We examined three indicators of parent functioning – parent depressive symptoms, parental stress, and parental capabilities – all of which were drawn from the TCI assessment data, and we examined differences between PSHF and ISHF at 6 and 12 months post admission. There were no significant differences between the groups on any of these measures at any time point. Examination of family trajectories on these measures over time reveals somewhat similar trajectories. For instance, average trajectories are shown below for caregiver depressive symptoms, measured using the Global Severity Index.

Figure 21. Mean Client Scores on the BSI at Intake, 6 and 12 Months, by Experimental Group

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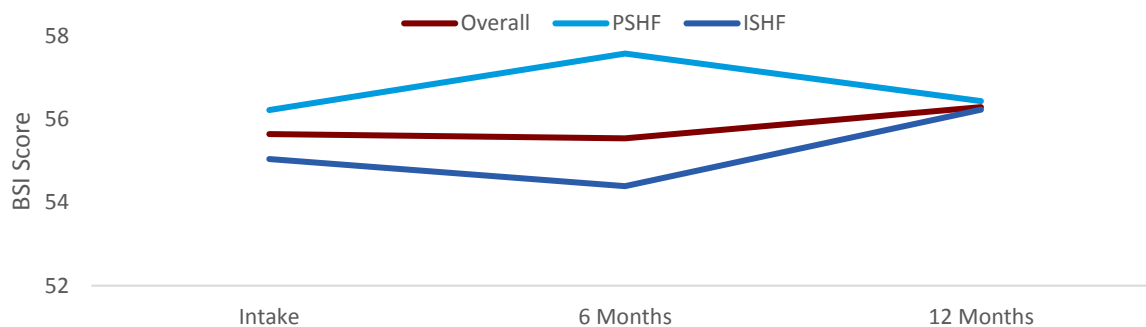
Figure 22. Mean Client Scores on Parental Capabilities Subscale of the NCFAS-G+R at Intake, 6 and 12 Months, by Experimental Group
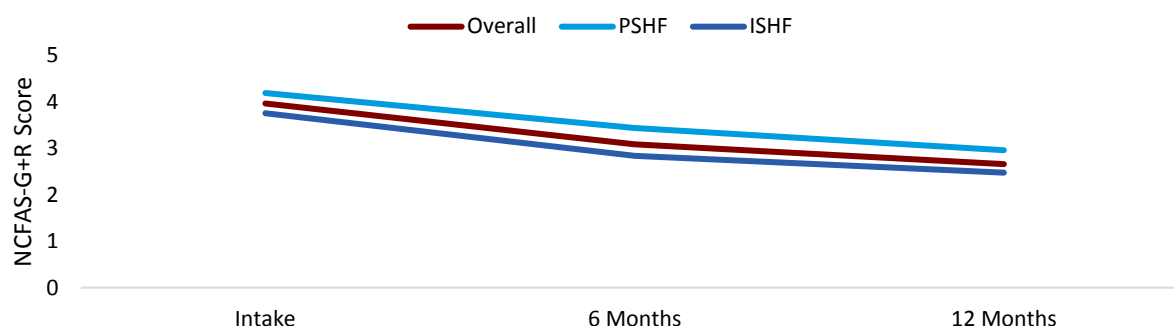
4.3.2.6 Child Development and Well-Being

Do families who received higher intensity services in ISHF demonstrate improved child development and well-being?

PSHF vs. ISHF. We tested for differences between PSHF and ISHF in nine domains. One of these domains captured child well-being broadly, a subscale drawn from the NCFAS-G+R; five of these domains captured infant and toddler physical, cognitive, and socio-emotional development; and three of these domains captured child and youth socio-emotional functioning. Again, differences on outcomes were explored at 6 and 12 months post admission, and among 18 contrasts, only one was found to be statistically significant at the $p < 0.05$ level, suggesting no notable differences in child functioning between the children whose families were assigned to PSHF and ISHF.

4.3.2.7 Family Exits

PSHF vs. ISHF. In addition to our primary research questions, we also examined family discharge status and family anecdotes on their experiences in CT's supportive housing model. Overall, all families were discharged from the ISHF or SHF program over the course of the demonstration (Figure 23). In the full sample, 52% completed the program, and the remaining families were discharged: 23% for administrative reasons, 10% for clinical reasons, 3% because the client became incarcerated and 12% because the family opted to discontinue participation. Nearly 70% of families in the preservation group completed the program, compared to 37% of reunification families. Families in the reunification group were slightly more likely than those in the preservation group to be discontinued for administrative or clinical reasons, or due to incarceration. Across both groups, families were about equally as likely to choose to discontinue.

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Figure 23. Family Exit from Program by Reason and Cases Status
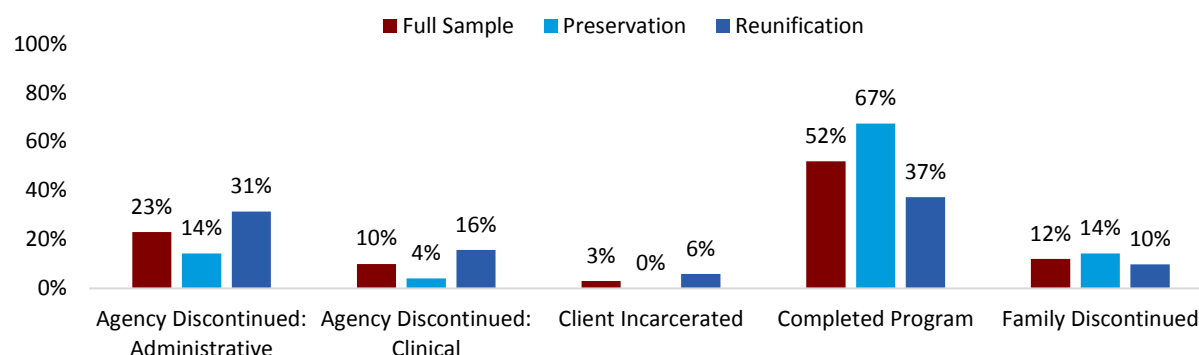
4.3.3 Summary

In sum, using a randomized controlled trial design, we tested experimental contrasts among three groups (1) the current SH model that includes routine access to housing (voucher) and case management; (2) an intensive treatment SH model with a higher dosage of case management, family teaming, and access to a vocational specialist; and (3) a wait list control group. We first tested the extent to which access to *any* supportive housing and case management services improved child welfare and housing stability outcomes in comparison to the wait list control group. Subsequently, we investigated the extent to which *intensity* of services improved not only child welfare and housing stability outcomes, but also family and child functioning. The second contrast permitted us to test whether more concentrated vocational resources and supports promoted family stability and well-being over and above the existing state model.

Results revealed that access to a service model containing a combination of supportive housing and case management was associated with both short and long-term benefits through two years. Among families enrolled in the treatment groups, greater proportion of children were reunified with their families (among reunification cases) and a lower proportion of children were removed from their families or experienced an incident of substantiated maltreatment (among preservation cases). The intensity of the service model had minimal impacts on children and families; there was some initial evidence of early benefits to family health, safety, and self-sufficiency in the higher intensity service model, but these effects appeared to fade over time.

4.4 Economic Evaluation

The Connecticut site-specific cost analysis sought to examine the costs associated with the three conditions that Connecticut included in its demonstration: control (BAU), treatment (PSHF), and enhanced treatment (ISHF). This analysis reviews the cost of the program and the impacts on the shelter system and child welfare. Originally, the planned analysis included a number of other governmental systems that the high need families in this study touched. Unfortunately, those

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data were not available as anticipated. This more limited analysis reduced the likelihood of finding cost savings that would inform a cost-benefit analysis.

4.4.1 Methods

The Connecticut cost-analysis assessed costs for a 24-month period following randomization. This period allowed the Connecticut analysis to capture subsequent re-entries into the child welfare system, which may be missed with a shorter time horizon. The analysis takes the perspective of the agencies offering services rather than the broader social perspective. It employed a micro-costing approach looking at each facet of the programs. Cost data were collected by online survey, focus groups, program budgets, and actual case expenditures. Costs excluded capital investments and all but program specific overhead. Costs were imputed on an intent-to-treat basis. Details are provided below.

4.4.1.1 Child Welfare Costs

In CT, DCF has three main streams of funds. Case worker time is the first type of funding. In the CT system, every time a case worker interacts with a case they are required to document the activity in narrative. These narratives are classified by functional type. For the cost study, each of these types was assessed to understand who is involved in the activity and how long the activity takes. These data were collected for a previous study of child welfare costs using a series of focus groups which was triangulated with a DCF time study. Estimates of staff time were based on SFY16 average wages by worker type with an overhead share and retirement benefits. The narrative types, number, and timing were extracted from the DCF database and multiplied by the appropriate cost estimate.

The second type of funding relates to contract programs that the state provides. These include in-home programs, parenting programs, and reunification readiness programs. These programs were per costed at the per month average cost excluding capital investments. Length of time in these programs was assessed for each enrollee during the 24-month window.[5]

The final type of funding includes out-of-home placement cost and other ad hoc expenses. These costs were estimated based on direct expenses based on DCF's billings database and adjusted for inflation to $2016. The sum of these three types of payments represents the full accounting of the child welfare costs.[6]

4.4.1.2 Homelessness Costs

To estimate the cost of a shelter night, an online survey was conducted. Thirteen of 18 potential family shelters participated or provided their annual financial reports.[7] Per night costs were estimated by summing non-capital budgetary costs divided by the number of families served in

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[5] These costs were excluded from the cross-site evaluation.

[6] These costs are fully articulated than in the cross-site evaluation that assessed readily available costs for all sites.

[7] This is a larger sample than what is included in the cross-site analysis.

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CY15. These per night estimates were then adjusted to $2016 for consistency; for a per night rate of $57.

4.4.1.3 Supportive Housing Program Costs
In CT, the supportive housing program served 51 clients in ISHF and 56 clients in PSHF. Costs were estimated separately for each program using budgets less capital costs. In addition, 47 families in ISHF received housing vouchers compared to 20 families in PSHF. Per month costs were estimated using the program costs and housing vouchers on a per month per family basis. Including the costs of housing vouchers for the proportion served, the ISHF program cost $2,697 per month per family and the PSHF program cost $1,727 in $2016.

4.4.2 Results
There was a total of 214 families with 428 children included in this economic analysis, a slightly larger sample than for the impact analysis (which excluded a few cases due to an inability to match child and parent child welfare cases). Because of the highly skewed nature of the cases and costs, a focus was placed on medians and non-parametric tests rather than reports representing standard normal distribution.

The median length of child welfare cases ranged from 16.6 months with the PSHF model to 17 months for BAU. These differences were not statistically significant based on a Kruskall-Wallis H test ($\chi^2 = 0.025$, $df = 2$, $p = 0.99$). The median length of the supportive housing services was 14.7 months in PSHF and 19.7 months in ISHF. This represents a statistically significant difference at $p \leq 0.05$ using independent samples median test.

Table 16. Mean and Median Program Costs, by Service Type and Experimental Group

Treatment Assignment	Child Welfare		Shelter*		Supportive Housing	
	Mean	Median	Mean	Median	Mean	Median
BAU	$62,940	$56,021	$9,606	$8,750	$0	$0
PSHF	$68,577	$47,880	$2,861	$1,981	$24,860	$25,391
ISHF	$75,851	$59,123	$536	$536	$50,937	$53,120

Note. * For only those families who experienced shelter stays

Child welfare costs were the largest costs across all three cost types. Of the three treatment conditions, PSHF had the lowest median value and ISHF had the highest median value. For those cases with one or more shelter stays, BAU had the highest costs per child. Only one ISHF case had a shelter stay during the 24-month window. Supportive housing costs were significantly different between the families assigned to PSHF and ISHF. This is consistent with the broader array of services and longer stay for the enhanced treatment cases ($p \leq 0.01$).

Aggregating the costs across the different groups did not result in a net savings for either the PSHF or ISHF groups. This suggests that the improved outcomes such as increased reunification,

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increased preservation and fewer shelter stays, in fact, cost more than services as usual. The median, 24-month, per child costs ranged from $56,021 for the BAU group to $99,518 for the ISHF group. The difference between the three groups was statistically significant (χ^2 = 16.7, *df* = 2, *p* ≤ 0.01). However, the difference between the BAU group and the PSHF group ($59,199) was not significant at *p* ≤ 0.05 (Mann-Whitney U test, *z* = -10877, *p* = 0.06).

4.4.3 Summary

Results revealed substantial costs per family for all services of interest – child welfare, shelter, and supportive housing. Families in ISHF, who received the highest intensity services, incurred the highest costs of all experimental groups in child welfare and supportive housing, suggesting that heightened service intensity required a substantial investment. Due to extremely low shelter use, families in ISHF incurred the lowest costs in this domain. These high costs in ISHF notwithstanding, results revealed positive findings; although there may not be savings associated with PSHF, the standard supportive housing model, the fact that BAU and PSHF incurred equivalent per-child costs means that it is possible to provide the services that provide better outcomes for children. Additional sources of data, such as access to Medicaid records and Department of Labor records, will be needed to better understand whether SHF programs in CT have true cost-savings benefits.

4.5 Evaluation Challenges

There were several challenges that affected the execution of the evaluation plan over the course of the demonstration.

In prior studies of Supportive Housing for Families in CT, the evaluation team had direct access to clients and to clients' identified data. At the outset of this grant, however, TCI made some changes to agency policies that restricted such access. Thus, TCI and DCF staff had to do additional work to collect and link data before sharing de-identified data with the evaluators for analysis. This also meant that the evaluators did not have access to a crucial source of data needed for the process evaluation – the observations of family teaming – and instead drew on TCI's reporting on the occurrence of family meetings, which lent insight into the quantity but not the quality of families' experiences with this service.

ISHF families were expected to get direct and increased access to evidence-based interventions as a result of their involvement in the program. However, most ISHF clients had already been referred by their DCF workers and were engaged to some extent when referred to the ISHF program; as such, referrals to EBIs by the ISHF Case Managers were not needed. Furthermore, the EBIs that were identified for the project and applicable for families were restrictive in scope, had limited eligibility criteria, had long waiting lists, or were only available in certain geographical areas that most clients could not access. Thus, access to EBIs was not a clear experimental contrast between treatment conditions, as had been planned. Other planned

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experimental contrasts, however, were supported by the process data collected, allowing for meaningful ISHF-PSHF-BAU comparisons.

As part of the impact and economic evaluations, we planned to examine Medicaid claims and costs (as possible averted costs in our comparisons of treatment vs. control (BAU). However, DCF did not secure a data sharing agreement with the Department of Social Services (DSS) for those data. CT's Office of Policy and Management (OPM) had committed, in the form of a letter of support included by DCF in the grant application, to support such data sharing; however, OPM's capacity to compel such data sharing was, in reality, extremely limited. Despite this, we did have robust data on programs costs, child welfare costs, and family shelters costs which we shared for the national cross-site cost study and used in our own local analyses.

In addition to these challenges, there were other limitations to the evaluation. The evaluation was powered to contrast SHF (ISHF and PSHF) with BAU, but small sample sizes (about 50 families in each of the treatment groups) yield less statistical power for comparisons between the these conditions. Rolling admission of clients into the study over the period of several years meant that some families were followed for only about two years since randomization. Thus, conclusions about longer term effects on key child welfare and housing outcomes and possible averted costs over time will require additional longitudinal evaluation.

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5. Dissemination

5.1 Dissemination Activities

The CT team prioritized dissemination of findings and "lessons learned" throughout the demonstration. Facilitators of this goal included strong pre-existing administrative and clinical relationships among CT service providers, DCF and TCI, and evaluators, the University of Connecticut and Chapin Hall. Newer partnerships built across the five demonstration sites, with the Children's Bureau and its Resource Center, and national technical assistance and cross-site evaluation partners, James Bell Associates and the Urban Institute, have further enhanced our program delivery, evaluation, and dissemination. Within the state, the CT Collaborative for Housing and Child Welfare convened stakeholders from a variety of state agencies and service providers to improve cross-systems coordination and provide a mechanism for disseminating findings from the demonstration to these partners.

5.2 Products

A listing of over 40 dissemination products related to the CT site team's involvement in the demonstration may be found in Appendix D. Those products include: articles in refereed journals, testimony at state and national levels, technical reports, invited talks, and conference presentations.

One highlight was the team's participation in a Congressional Briefing at the U.S. Capitol on *Escaping Homelessness: Helping Families Reach their Full Potential*. Evaluators Preston Britner (UConn) and Anne Farrell (Chapin Hall) spoke on housing and child welfare, the SHF model, and the evidence base for its effectiveness. [8]

Program expertise was routinely shared on national webinars and at national meetings (e.g., CSH Summit; Child Welfare League of America) by Kim Somaroo-Rodriguez (DCF) and Debra Struzinski and Betsy Cronin (TCI), among others.

In 2017, core team members contributed to three different special issues of journals of relevance to the demonstration. Farrell co-edited a special section of the *American Journal of Community Psychology* on housing and child well-being, which also involved colleagues from the Urban Institute (national, cross-site evaluators) and other demonstration sites. That issue included an article on the CT site's housing screen for all new child welfare cases (Farrell, Dibble, Randall, & Britner, 2017), an editorial co-authored by Farrell and Fowler (2017), and an additional co-

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[8] Video: https://www.youtube.com/watch?v=9RQlYJySpMQ&feature=youtu.be

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authored paper (Fowler, Farrell, Marcal, Chung, & Hovmand, 2017) on scaling up services in housing and child welfare. Britner and Farrell also contributed a policy implications article to an issue (devoted to family homelessness) of *Advances in Child and Family Policy and Practice* (2017), the journal of the American Psychological Association's Division 37. Finally, DCF, TCI, UConn, and Chapin Hall colleagues from the CT site jointly authored a paper on the SHF model and outcomes in a special issue of *Child Welfare* (2017) devoted to housing, homelessness, and economic security.

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6. Sustainability

6.1 Sustainability Activities

The sustainability team consisted of the program team (DCF, The Connection), the evaluation team (UConn, Chapin Hall), and the two Board co-chairs (representing the Department of Housing and the Department of Children and Families in the state, respectively). The team coordinated with the larger project advisory board (i.e., the CT Collaborative for Housing and Child Welfare; "the Collaborative") on cross-systems partnerships throughout the state and on plans regarding what elements of the ISHF model would be sustained beyond the demonstration in a statewide revision of the existing SHF model. The activities of the Collaborative and its three working groups (Systems Integration and Sustainability; Policy and Legislative Advocacy; Family Economic Security and Well-Being) are described in Section 2.2.

Utilizing a planning worksheet provided by the Children's Bureau and its Resource Center, the sustainability team updated its answers every six months to key questions about what to sustain, why to sustain it, how to sustain it, who can help, managing the transition, and dissemination and communication.

TCI and the evaluation team have for many years been good about bringing client voices to the table in improving services (e.g., Farrell et al., 2012) and sharing program successes with stakeholders around the state (e.g., testimony at the legislature). During the demonstration, the resources and expertise of the national evaluators and foundation sponsors helped bring client stories into photo essay[9] and video[10] formats for wider dissemination.

Working with the national partners (Children's Bureau, Urban Institute, James Bell Associates, foundations) experts and the other four demonstration sites, we helped to develop promising practices highlighted by ACYF[11] and shared with the United States Interagency Council on Homelessness.[12]

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[9] How Housing Matters (MacArthur Foundation and Urban Institute),"Protecting Families: A Photo Story About Supportive Housing" https://howhousingmatters.org/articles/protecting-families-photo-story-supportive-housing/
[10] Robert Wood Johnson Foundation, "How Supportive Housing Uplifts Families in Crisis" https://www.rwjf.org/en/blog/2017/10/supportive-housing-for-families.html; direct link to video: https://www.youtube.com/watch?time_continue=12&v=KpGcRpEamMM
[11] https://www.acf.hhs.gov/archive/blog/2016/10/supportive-housing-can-help-keep-families-together
[12] https://www.usich.gov/resources/uploads/asset_library/Supportive-Housing-Families-Case-Study-Connecticut-November-2017.pdf

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6.2 What Will Be Sustained

A number of accomplishments are in evidence as a consequence of this demonstration, the resources it provided and stimulated in CT, the collaborative partnerships it convened, program and practice innovations, and critically important research findings on the effectiveness of SH. Supportive Housing for Families (SHF) will continue to operate statewide throughout CT, serving existing clients and taking on new clients. SHF has expanded considerably in CT, from a small program in 1997 to a large initiative serving over 500 families annually statewide (and having served thousands of families over the past decade).

The Intensive Supportive Housing for Families (ISHF) model, funded by the Children's Bureau, was contrasted with both the control group, BAU within DCF, and the existing SHF model, PSHF, in this demonstration. Although the evaluation was designed and powered to contrast ISHF/PSHF with BAU, additional contrasts between ISHF and PSHF have informed decisions about what elements of ISHF should be brought into the statewide SHF model after the demonstration. All of the current TCI practices within SHF (e.g., services, training, infrastructure, CQI, fidelity monitoring, and broader evaluation) will be sustained, with continued funding from DCF. Some practices developed in the ISHF condition, including dedicated vocational specialists and family teaming approaches, will be embedded in SHF practice beyond the demonstration. These and others are noted by Burt (2018) in her summary of sustainability and systems change in SH.

Screening for Housing Instability and Homelessness in Child Welfare. The building of relationships with regional DCF offices facilitated the pilot of the universal housing screen (Quick Risks and Assets for Family Triage; QRAFT) of new child welfare cases in two of the state's six DCF regions. That universal screen helped with: making sure that eligible cases were referred; getting DCF workers to think "housing first"; and, documenting the large numbers of families with child welfare *and* housing needs as assessed at intake into the child welfare system. The evaluation team and DCF leadership are working now to embed the QRAFT screening questions statewide when DCF completes the updates to its SACWIS in 2022.

Screening for Housing Instability and Homelessness in Early Childhood. In 2017, with the urging of the Partnership for Strong Communities and the Office of Early Childhood, Farrell, Karter, and Kull (2017) adapted the QRAFT used in this demonstration for use in a sample (N ≈ 1,000) of families enrolled in Early Start and Head Start in the Bridgeport, CT area. This practice has been formally adopted across all Early Start and Head Start programs across all early childhood sites run by Action for Bridgeport Community Development (ABCD).

Step-Up/Step-Down Procedures in SHF. The step up/step down procedures established to modify casework intensity in keeping with family engagement and progress is an innovation that will be sustained. TCI has formally adopted this suite of practices statewide and trained all of its case management staff accordingly.

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Targeting and Tailoring. Beyond 2018, the vision is to have a statewide Supportive Housing for Families model that serves families with varying levels of risks and assets, with appropriate services and supports tailored to family needs. That is, we see the likelihood of serving a broader range of families than we served and evaluated under the strict (i.e., very high risk) targeting criteria of this demonstration grant, with several "levels" of services tied to intake assessments. Going forward, SHF will prioritize its vocational resources to families who are appraised to be likely candidates for substantial gainful employment; the intention here is to ensure that housing vouchers, which remain scarce, are available to those families for whom continuing economic support is most likely.

Partnerships. Enduring partnerships have been formed with the CT Coalition to End Homelessness (CCEH) and the Partnership for Strong Communities (PSC) in discussions of systems and services (for homeless youth and families) and especially around studying the costs of homelessness for families in CT. The evaluation team conducted a statewide survey of family shelter costs that was helpful to those organizations. In turn, CCEH and PSC greatly facilitated the evaluation team's work with shelters to obtain cost estimates and in linking HMIS and child welfare data.

Child welfare emphasis statewide. In February of 2018, the CT Interagency Council on Supportive Housing and Homelessness announced that child welfare-involved families would be a new priority. Reportedly, this emerged from advocacy from members who were familiar with the demonstration (Burt, 2018).

Ultimately, DCF has expressed firm commitment to SHF funding, but statewide service capacity over the past decade has been constrained by ebbs and flows in the availability of housing vouchers. The recent commitment of vouchers by the state (both DCF and the Department of Housing), however, is promising. We hope that the findings of this demonstration will also complement state and national advocacy for the targeting of scarce housing vouchers. In fact, recent efforts in the advocacy domain point to major opportunities for the state. In February 2018, the Connecticut Interagency Council on Supportive Housing and Homelessness established a preference for child welfare-involved families for access to supportive housing. Then, in November 2018, the U.S. Department of Housing and Urban Development (HUD) awarded $30 million in Family Unification Program (FUP) vouchers to public housing authorities nationwide. CT received a disproportionately high $2.3 million in funding.[13]

6.3 Lessons Learned

By reviewing the sustainability plan semiannually, even in the early phases of the demonstration, the sustainability team was constantly thinking ahead about "what to sustain" and "how to do

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[13] https://www.hud.gov/press/press_releases_media_advisories/HUD_No_18_139

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it." This long-term planning has aided in the transition from the demonstration grant period to the post-demonstration Supportive Housing for Families model that CT is scaling to statewide implementation. For example, the dedicated vocational specialist and the family teaming approaches from the ISHF model in the demonstration are now being phased into statewide practice within the revised SHF model.

The focus on rigorous evaluation and dissemination of findings from this demonstration has had a positive effect on sustained funding and commitment to a model of supportive housing for families, which has grown from 1997 to the present. Publications of findings in peer reviewed journals and involvement in a Congressional Briefing and national conferences help validate the program to local policymakers. Direct testimony to executive and legislative officials, combining both empirical findings and client stories, is also vital to demonstrate client needs and the effectiveness of SHF in meeting those needs.

The effort to partner with the state child welfare agency to do a brief screening for homelessness/housing risk on all new cases resulted in effective targeting for the demonstration. More broadly, this screening also raised valuable awareness of housing needs for child welfare professionals and resulted in population-level data on the types of housing risks facing child welfare-involved families.

Following interviews across the demonstration sites, Marti Burt and colleagues at the Urban Institute (Burt, 2018; Burt, Gearing, & McDaniel, 2016) expand on some of these lessons learned with respect to screening child welfare cases for housing needs, incorporating family teaming approaches, and utilizing data for program decisions. They further highlighted the integration of a vocational specialist at the Connecticut site as a promising practice. Burt (2018) also discussed the importance having the child welfare agency be fully engaged with the supportive housing program (as is the case in Connecticut) in order to maximize the likelihood of sustaining services.

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7. Conclusion and Discussion

7.1 Accomplishments

7.1.1   Design, Planning, Implementation

From 2012-2018, the Connecticut Department of Children and Families, and its core partners (The Connection, Inc., the University of Connecticut, and Chapin Hall at the University of Chicago) planned, developed, implemented, and evaluated a supportive housing (SH) intervention for families in the child welfare system. This federally-funded demonstration project capitalized on a longstanding statewide SH program and synergized a number of emergent practices and partnerships in the state. A Housing and Child Welfare Collaborative co-chaired by state leaders served as the project advisory board; this group informed, oversaw, promoted, and supported project efforts and led efforts toward systems integration and sustainability, policy and legislation, and family economic security and well-being.

The project *effectively targeted* a subset of families who were relatively new to the child welfare system, demonstrated deep housing instability and/or experienced homelessness, and evidenced substantial service needs. Each family in the treatment conditions received case management services, housing supports, and related services. Implementation went largely according to plan and the CT site met its minimum numerical targets for both the SHF and ISHF conditions. Process evaluation findings suggest effective cross systems collaboration and high levels of staff and client engagement. Three of four aspects of experimental contrast (casework intensity, vocational services, family teaming) were appraised as good to excellent; contrast was not achieved with respect to evidence-based interventions. Reasons for this include family exposure to such interventions prior to the demonstration and limited community accessibility and capacity. In sum, *fidelity of implementation* is appraised as good to excellent.

State RAP vouchers were set aside for families in the ISHF condition and as a consequence, they received vouchers and leased up more quickly than their counterparts in the PSHF condition who awaited vouchers along with other applicants in child welfare and beyond. Because voucher access fluctuates significantly based on policy and funding priorities, length of stay can be significantly longer in PSHF. Across the recent history of the SHF program, TCI has served a minimum of 500 families per year and in some years, because of a relative surfeit of vouchers, has been able to support, lease up, and discharge more than 700 families per year.

7.1.2   Impacts

At a high level, the impact analysis indicates a number of *significant effects on child welfare outcomes* as indicated by administrative data. Among families with children in foster care, a greater proportion of children were reunified within the treatment conditions, ISHF and PSHF.

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Among families receiving preservation services, fewer families in the treatment groups experienced out of home care or substantiated re-allegations of maltreatment. There were no significant differences in case closure rates. There were no statistically significant differences in time to reunification among children who were reunified with their families, which on average took about 633 days in the full sample.

Table 17. Summary of Child Welfare Outcomes (Family and Child Levels, 24 Months Beyond Randomization)

	ISHF & PSHF	BAU
	%	%
Families with all children successfully preserved	89%	60%
Children successfully preserved	91%	60%
Families with at least one child reunified	41%	16%
Children reunified	30%	9%

More specifically, among families in the *reunification group*, a statistically significantly higher proportion of families in the treatment groups were reunited with at least one child within 18 and 24 months from randomization. By 18 months, 38% of families in the treatment group and 16% of families in the control group were reunited; by 24 months, reunification occurred among 41% and 16% of treatment and control group member families (respectively). Findings are similar at the child level. Within 18 months of randomization, 29% of children in the treatment group and 9% of children in the control group were reunified, a statistically significant difference. Likewise, at 24 months, 30% of children in the treatment and 9% of children in the control group were reunited with their parents.

Among families in the *preservation group*, a higher proportion of families in the control group had at least one child removed as compared with families in the treatment group. By 12 months, 28% of families in the control group and 6% of families in the treatment group had a child removed from the home. By 18 months, removal proportions were 41% in the control group and 9% in the treatment group. By 24 months, 40% of families in the control and 11% of families in the treatment group had a child removed. (The percentages alter in these ways because admission to the program was "rolling"; families were accepted into the program across three years based on availability of case management. As such, the divisor changed across the course of the project.) Again, differences at the child level are striking. Within the first year, the proportion of children in the control group experiencing removal was *more than five times* the rate of the treatment group (33% vs. 6%). Within 18 months, 40% of children in the control group and 7% of children in the treatment group were removed. At 24 months, the rate of

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removal in the control group was stable (40%) and 9% of children in the treatment group were removed.

Children in the treatment and control groups were equally likely to experience a maltreatment report or referral within 12, 18, and 24-month time frames. Children in the control group, however, had a higher prevalence of substantiated maltreatment than children in the treatment group at 12 months (19% vs. 5%) and 18 months (26% vs. 8%). The trend continued at 24 months but was only marginally significant.

To facilitate interpretation of re-occurrence of maltreatment, foster care placement, and reunification rates of families in ISHF, PSHF, and BAU within the broader context of Connecticut and U.S. samples, we examined multiple national resources. Rates of reoccurrence of substantiated maltreatment within six months of a prior substantiation were 6.3% in Connecticut (and 5.0% throughout the U.S.). Most families with substantiated cases are preserved; in contrast, approximately 17.3% of child victims in CT (and 22.6% nationally) received foster care as a response to a child welfare investigation in 2016 (Children's Bureau, 2018a). The percent of children discharged from foster care due to reunification in 2015 was 36.2% in CT (and 51% throughout the U.S.) (Children's Bureau, 2018b).

Examining these comparative figures, it is important to bear in mind that this project was intended to and succeeded in targeting families experiencing homelessness, along with high acuity with respect to service needs. The cost to support families with multi-systems involvement during spells of homelessness was estimated at $35,000 in 2007 dollars (Samuels, 2012); this only includes service dollars spent during episodes in shelter. The current demonstration targeted families at the "deep end" of the child welfare system. Whereas we have provided some comparable figures for child welfare in general, they do not provide a proper comparison group as they represent a mix of child welfare cases instead of those who experience higher acuity across the board.

We also made *within-treatment group comparisons.* There were few differences in outcome across the two treatment groups, PSHF and ISHF; that is, on measures of parent and child well-being, families in both treatment groups tended to stabilize across a 6- to 12-month period, ultimately experiencing equivalent outcomes in these domains. The demonstration did not achieve the intended experimental contrast across PSHF and ISHF with respect to EBI access; it is plausible that prompt access to EBIs for trauma, parenting, and related concerns might have resulted in improved well-being, however, the absence of fidelity on this component would attenuate such impacts. It is also possible that the effects of stable housing on adaptive function and well-being do not emerge within the time window of the demonstration.

We did not find significant differences in income (a proxy for vocational achievement) across the ISHF and PSHF conditions. The only experimental contrast that relates logically to this component is the vocational assessment and support that was provided to all families enrolled

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in the ISHF condition. Once again, it is possible that the effects of this intervention on education, vocational preparation, and employment outcomes are visible only within a longer time horizon of observation. Additionally, TCI notes that its case managers have not historically been asked to monitor income carefully and express some doubt that the income data are highly reliable for this sample.

With respect to *housing outcomes*, no families enrolled in the ISHF condition used homeless shelter during the demonstration. The only significant differences we observed between treatment and control groups was the attainment of a home (with or without a lease), with treatment groups more likely to do so. There was no difference in access to the state's Coordinated Access Network, but the rates of access were small across the board, suppressing the ability to detect differences across experimental groups.

7.1.3   Understanding Cost
Unsurprisingly, the ISHF condition was the most expensive of the experimental groups from the standpoint of cost. Of note, the BAU and PSHF groups incurred equivalent per-child costs in spite of the fact that the PSHF group (together with ISHF) experienced superior outcomes with respect to housing and child welfare. This is a critical finding and suggests that the lower case management intensity of the PSHF model is likely to be significantly more effective than child welfare business as usual and costs about the same. We will conduct additional analysis to confirm and further explore this initial finding; if borne out, has important potential to shape child welfare practice. Of course, longer term follow up of families in this demonstration would shed additional light on the child welfare, housing, and cost impacts.

7.2 Facilitators and Barriers

7.2.1 Facilitators
Among the facilitators identified as contributing to the achievements of the demonstration are the longstanding SH capacity in the state (preexisting condition), the close partnership and collaboration among the core team (DCF, TCI, evaluation team), the successful utilization of CQI within The Connection, Inc., and the extent to which the demonstration was implemented with rigor. In the CT human services community, supportive housing (specifically, voucher access + case management + related supports) was already seen as part of a continuum of resources available to families in the child welfare system. There was a relatively long tradition of service, a financial commitment from DCF, and non-experimental evidence on the effectiveness of SHF. This all led to a level of competence and confidence in the intervention.

This demonstration achieved a relatively high level of client engagement which is attributable to the quality of case management at The Connection, Inc. Whereas we did not study client engagement carefully from a process standpoint, this is indeed worthy of additional investigation. We hypothesize that one element of the effectiveness of engagement is the

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observation that TCI case managers are seen by clients as a bit "removed" from their child welfare case decision making, potentially diminishing some elements of perceived coercion or aspects of distrust that are common among families experiencing child welfare services. A separate consideration is whether the quality of case management in the SH program produces a distinctly high level of engagement among clients. Given that casework is the core service element in the child welfare system and there is virtually no evidence of its effectiveness, closer empirical examination of the elements and processes associated with client engagement and outcomes is warranted.

As mentioned above, early in the demonstration, the referral rate was lower than expected, prompting the core team to create a screening tool for housing that became a critical element of investigations practice and part of the larger triage processes for the demonstration and beyond. At first, however, we experienced resistance regarding the presence of a randomized trial and the need for the appraisal of family housing needs to establish eligibility. The core team managed this barrier by creating a one-page communication that outlined the goals of the demonstration, made plain that these were new, additional SH resources afforded by the federal demonstration, and underscored that randomization made the process fair, since every eligible family had an equal chance of accessing the resource. In this sense, an initial barrier became a facilitator to project management and of systems change.

7.2.2 Barriers

Whereas we are pleased with the accomplishments of the demonstration, there were some barriers to full implementation and to data analysis. First, as mentioned earlier, there was limited and nonsystematic access to EBIs. Second, families waited on average approximately three months between randomization to housing. Families in ISHF and PSHF waited 160 and 427 days from randomization, respectively, to transition from a bridge housing subsidy to a RAP voucher. Given the highly precarious nature of family housing circumstances, the wait between referral and housing is potentially concerning. That said, these waits are much lower than those experienced by families without access to SHF services. We make the point here simply because these are exigent circumstances that imperil child safety, family stability, and child well-being, so clearly additional work is warranted. Third, we were unable to secure the complete compliment of wage and cost data that was originally planned and this affected the extent to which we could fully explore the impact of the project on income and related labor outcomes.

Impact on partner organizations/local systems. As suggested earlier, this demonstration capitalized on and extended existing partnerships in the state, while synergizing a range of housing-related and child welfare-related collaborations. Importantly, the core team and the CT Housing and Child Welfare Collaborative assisted in moving the application of the "housing lens" to the front end of the child welfare system while also helping the range of public and private housing provider to see the extent to which DCF's commitment to SH adds additional capacity in the state.

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Impact in the child welfare community system. Again, there was ample commitment to supportive housing for families in the child welfare system ahead of the demonstration. This project expanded the collective expertise of the child welfare community system and elevated the understanding of housing as a child welfare intervention.

Impact in the supportive housing community. As discussed above and below, a major impact on the SH community was a reframing of SH for families in the child welfare system. Historically, the aim of SHF is to supply child welfare-involved families experiencing housing instability and homelessness with access to housing + services, with the intention to keep families intact and hasten family reunification. Whereas there are various definitions of homelessness, the definition of homelessness that CT has historically applied for these child welfare-involved families is one that is more akin to the McKinney-Vento Act[14] than to the HUD definition of homelessness. As a matter of policy and practice, DCF targets not only those families who are experiencing literal homelessness or are living in shelter (HUD definition), but also those families whose current and recent housing picture is one of instability or clear unsustainability. In practice, this distinction means that DCF's commitment to providing (and resourcing) SH services to families in the child welfare system provides additional, otherwise unavailable capacity to the state's COC. The majority of families targeted by SHF, then, are unlikely to qualify for federal housing benefits unless/until they meet the HUD definition of homelessness, which is more restrictive than that used historically in the SHF program and also within this demonstration. The CT RAP vouchers do require tenants to contribute a higher proportion of their income (40% versus 30%) than has historically been the case for federal Section 8 (Housing Choice) vouchers.

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[14] The McKinney-Vento Homeless Assistance Act, codified as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, *Federal Register, 77*(147), 45421-45467.

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8. Recommendations

The five year-long implementation and evaluation of the Intensive Supportive Housing for Families program has yielded valuable lessons for a range of stakeholders. As state and local governments look towards multi-dimensional solutions to prevent and end family homelessness, some emerging findings from CT may shed light on the most efficient way forward.

8.1 Administrators of Future, Similar Projects

One of the central recommendations to emerge from this work is the *need to identify and operationalize the essential intervention components*. This demonstration showed that the ISHF, as a universal intervention for very high need families, cost more than PSHF without notable additional benefit. Whereas both ISHF and PSHF produced significant, positive impacts for families, the ISHF features of 50% higher casework intensity combined with family teaming did not produce superior child welfare outcomes over PSHF. We also saw that there was not a true experimental contrast on access to EBIs; as such, administrators should carefully consider the proposed components of an intervention to ensure that there can be true experimental contrasts that will yield insight onto which components have the greatest impact on promoting family and child well-being.

CT's findings indicate that vouchers + case management produce significantly superior outcomes over child welfare business as usual. We have a clear understanding of how vouchers worked in the demonstration, e.g., CT used bridge subsidies ahead of vouchers as needed to provide prompt access to scattered-site housing. State RAP vouchers enabled families to lease up at a very high rate. We have a fairly specific description of the dosage and fundamentals of case management used at TCI (program manual, client activities database). In a subsample of families, we measured both client engagement and client perceptions of strength-based casework to be high. At the same time, the operation of "critical components" of case management with respect to outcomes is not clear and needs to be studied.

Additionally, in this demonstration, access to EBIs was not systematically different across the two treatment groups and without additional administrative data, we are unable to discern the level of EBI access among the BAU group. It is possible that EBIs would have contributed to even more robust treatment effects. Future studies of SH might use methods such as propensity scoring to examine effects of different dosages or to employ research designs intended to isolate the effects of various treatment components. For example, Multiphase Optimization Strategy (MOST; Collins et al., 2013; Wyrick et al., 2013) entails selecting and applying particular intervention components and measuring effects. Sequential Multiple Assignment Randomized Trials (SMART; Allmiral et al., 2013) entail sequencing interventions. These trials test the optimal

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sequencing of intervention components as well as decision rules for changing dosage, when one intervention should be augmented with another, and/or when an intervention or component should be terminated due to lack of progress.

The CT demonstration's *screening and targeting processes* were crucial for identifying families with high service needs who were also homeless or at serious risk of homelessness. The QRAFT allowed DCF to identify families with severe housing needs that ranged from previous evictions, living in places not fit for human habitation, and doubling up, among other extreme conditions. Targeting, triage, and screening enabled CT to recruit families whose characteristics matched the demonstration priorities. Small caseloads and intensive services produced high engagement that, combined with voucher access, enabled families to experience a range of benefits. CT should continue with screening with the QRAFT across systems that interact with families (including education, early childcare, etc.) to ensure that families and children have access to necessary resources and supports. (Indeed, this is under way as we write this report.)

Unfortunately, we had limited *data* by which to judge the effectiveness of vocational supports, but participation in PSHF or ISHF was not systematically associated with higher income. Consistent with earlier observations in this report, it could be that the vocational supports have sleeper effects that emerge much later (beyond the scope of this evaluation). Alternatively, and consistent with the observations of TCI SH staff (and current, post-demo practice), the application of vocational supports, which are an expensive and scarce resource, may need to be applied more judiciously to the highest need families, such as through screening, triage, and assessment. Further, more longitudinal and comprehensive tracking of self-sufficiency indicators, including income and employment, may help to illuminate whether access to supportive housing and case management supports promote well-being in these domains.

As such, our initial recommendations for administrators include:

8.1.1 ***Additional Study***: Conduct/embed additional research to define, operationalize, and investigate the necessary bounds of fidelity necessary to produce impacts in SH for child welfare-involved families. Future studies of SH might consider innovative designs that combine targeting, phased optimization, and/or sequenced interventions in order to better identify effective elements of intervention that can be replicated.

8.1.2 ***Data***: Ensure the availability of administrative data and enable longitudinal follow up to ensure that "sleeper effects" of components such as vocational training can be gleaned.

8.1.3 ***Facilitators and Barriers***: Per the conclusion and discussion section above, a number of preexisting conditions likely influenced the success of this demonstration. The core team's efforts to address barriers, attention to fidelity and CQI throughout the implementation, and fairly prompt attention to problems identified are all considered to be critical to the success noted here.

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8.2   Project Funders.

The results of this demonstration constitute a successful test of SH as an intervention for families in the child welfare system. Whereas past studies of housing programs such as FUP have produced mixed results (Cunningham et al., 2015; Fowler & Chivira, 2014; Rog et al., 1998), it appears that the benefits derived here may accrue from the combination of housing vouchers and responsive case management that produced high levels of client engagement. As such, pending the findings of the other demonstrations, we believe that these results essentially endorse the methods used in the CT SH study.

For future funders of such demonstration projects, it is important to recognize the detrimental impact that *waiting for resources* can have on families. In this demonstration, families in ISHF were placed into housing much faster than families in PSHF, and families in ISHF showed some improvements in child welfare outcomes. Essentially, such projects need to build in the resources to ensure that families are quickly shepherded into housing and are not left to sort out crisis situations on their own despite enrollment in such a program. We are limited in the extent to which we can understand the effects of intervention components (e.g., case management, family teaming) because participation may have suffered while families awaited housing; it took families in PSHF on average 87 days to get housed and 427 days to acquire a voucher, where as it took families in ISHF 107 days to get housed and 160 days to acquire a voucher.

This demonstration achieved positive impacts and included measurement strategies that were embedded in the ongoing practices of the implementation partners. TCI has in place data collection systems and practices that required little alteration in casework practices from a behavioral standpoint.

As such, our initial recommendations for funders include:

8.2.1 *Child Welfare Policy and Funding*: The results of this study indicate that both SH interventions produced significantly better outcomes at the child and family levels. The PSHF condition achieved this cost no more than child welfare business as usual. This argues for funding supportive housing (case management + voucher + related supports) as a core child welfare intervention, however, this should be done in ways that support continued and more nuanced evaluation.

8.2.2 *Additional Study*: Per section 8.1 above, we recommend additional study of SH models and components. CT's demonstration used a unique model that, while designed and engineered for this demonstration, capitalized on a range of ecological factors that we see as instrumental to our success. As such, we offer that future replications need to not only study impacts, but should benefit from the knowledge and experience gained through this (and the other four) housing and child welfare demonstrations with respect to planning, implementation, and understanding of cost. Evaluation can be conducted

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efficiently, be supportive of fidelity, and support understanding of cost and impact, but it too requires resources. We recommend longitudinal study of families with housing instability and homelessness.

8.2.3 *Wait Times*: In this demonstration families acquired access to housing within relatively short windows of time as compared to business as usual in child welfare and (as we understand it) the likely wait time for housing vouchers more broadly. Nevertheless, we have yet to measure the full effect of the time that families spend in shelter, doubled up, homeless, and in otherwise precarious and perilous circumstances. Enabling families to move more quickly into a SH pipeline would require a flow of vouchers and a nimble set of services, but it may have significant human impact and potentially reduce costs. Clearly, moving families into and through SH programs efficiently relies on the availability of housing vouchers (and bridge subsidies).

8.3   Child Welfare and Housing Fields

One of the challenges that arises with interventions spread across different systems or agencies is the lack of agreement about where to place or how to fund a particular program or initiative; this sometimes leads to "wrong pocket problems" whereby expenditures in one system produce savings in others, reducing the will to fund initiatives. In this case, DCF and DOH worked together, along with the support of TCI and the evaluators, to ensure that families screened in through DCF received the necessary resources based on their assignment to treatment group. CT DCF dedicated agency resources to ensure that housing vouchers would be available to families in the child welfare system. The CT DCF has a staff person whose role is dedicated in part to housing concerns within and outside of child welfare. Similar concerns have emerged with regard to Family Unification Program vouchers, which provide resources to families involved in the child welfare system. Interventions that target such specific populations should be sure to incorporate the guidance, feedback, and support of partner agencies who have the deepest insights into the target families. As Fowler and colleagues (2017) point out, no evidence guides decision-making about how to best allocate relatively scarce housing vouchers. In CT, one practice implication of the scarcity of vouchers is to triage parent vocational potential. That is, based on the scarcity of vouchers and the indeterminate effects of vocational support on parent employment and family self-sufficiency, DCF and TCI have decided to let case managers triage families in SH. Those who appear relatively well prepared for employment will be given priority access to vocational supports and job preparation, even as they may still qualify for housing vouchers and be able to contribute 40% to housing (CT RAP certificate requirement).

Similarly, cross systems partnerships can help agencies focus on putting the necessary resources into place to affect certain outcomes. Historically, housing agencies have not prioritized child and family functioning outcomes, such as mental and physical health, and for children, school mobility and engagement. Early childhood systems appear ill-prepared to understand and

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manage the housing needs of families. Perlman, Shaw, Kieffer, Whitney, and Bires (2017) combined results from a survey of early childhood professionals and findings from HUD's Family Options Study (e.g., Gubits et al., 2015). Their findings indicated that families were often unaware of services and early childhood programs, and programs were often unaware of housing needs.

Among child welfare programs, deep commitment to housing is rare but perhaps it is growing. CT committed child welfare resources to a housing intervention and perhaps the five demonstrations and other SH work nationally will prompt additional commitment. As the Families First Prevention and Services Act becomes more visible and influential, it is critical to consider how child welfare services themselves are construed. In other words, as evidence-based parenting interventions can be seen both as generic services and as specifically helpful to families in the child welfare system; the same may be true of supportive housing. Yet, as SH itself might enfold a range of EBIs for parents and children, it becomes important to understand both the separate and combined effect of EBIs.

Among housing programs, some require families to meet the definition of homelessness as determined by the McKinney Vento Homeless Assistance Act, which find families and children to be homeless when they "lack a fixed, regular, and adequate nighttime residence." For families and children who are living in unsafe and unsustainable housing or are doubled-up, this definition may not afford access to supportive housing resources, despite the extensive body of literature on the negative repercussions of housing instability on family and child well-being (Fowler & Farrell, 2017). Given that the funding necessary to support a supportive housing program (PSHF) is equivalent to the business-as-usual approach, it is worthwhile for agencies to continue work together to provide such resources to high-need families and to prevent these families from not only overburdening the shelter system but also from experiencing greater trauma in the process.

Recent evidence suggests a high general prevalence of youth homelessness (Morton, Dworsky, Matjasko, et al., 2017) and a very high rate of homelessness among former foster youth. In a related study (Morton, Dworsky, & Samuels, 2017), the majority of young adults (ages 18-25) had first experiences of homelessness or housing instability childhood or adolescence, part of family homelessness. Nearly a quarter of young people ages 13-25 had unaccompanied experiences in the context of family homelessness. It appears that the overlap between housing instability/homelessness and child welfare involvement may be deeper than the well-known connection between housing and child welfare at the family level (e.g., contributing to judgements of maltreatment, elongating the time to reunification). That is, given the emerging understanding of homelessness as an intergenerational prospect, it is all the more compelling that we identify the core aspects of SH that are responsible for positive family impacts and begin to examine how to affect child well being across time.

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As such, our initial recommendations for the fields of child welfare and supportive housing include:

8.3.1 *Cross Systems Collaborations:* The results of this study support the critical need for cross-systems and cross-agency collaboration in order to effectively identify and support families with housing instability and homelessness who are also in the child welfare system. In an era of scarce resources, it is critical to ensure that resources are targeted and matched appropriately to subgroups of the population. Further cross-systems support will likely be needed to both explore and study the effectiveness of braided funding and integrated SH programs.

8.3.2 *Intergenerational Focus:* Given the intergenerational nature of involvement in child welfare and other systems, and some emerging evidence about the intergenerational nature of housing instability and homelessness, it is important for housing and child welfare programs alike, and in particular supportive housing programs, pay close attention to the prospect of child and family well being. It is of encouraging to see child welfare impacts at the family and child level; extending those impacts into well being and self-sufficiency require continuing diligence and long term study.

8.3.3 *Sustainability*: In the sustainability section of this report, we detail a number of practices, routines, and procedures that we see as sustainable elements established as part of this demonstration. In these are several lessons with applicability to housing and child welfare systems.

In short, the findings of this study support the effectiveness of supportive housing as an intervention for families in the child welfare system; additionally, there are extensive opportunities to immediately apply these lessons to enhance the lives of children and families in CT and beyond.

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References

Abidin, R. (1995). *Parenting Stress Index: Professional manual (3rd ed.)*. Lutz, FL: Psychological Assessment Resources.

Achenbach, T. M. (1991). *Integrative guide to the 1991 CBCL/ 4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychology.

Almirall, D., Nahum-Shani, I., Sherwood, N. E., & Murphy, S. A. (2014). Introduction to SMART designs for the development of adaptive interventions: With application to weight loss research. *Translational Behavioral Medicine, 4*(3), 260-274.

Alpert, L. T., & Britner, P. A. (2009). Measuring parent engagement in foster care. *Social Work Research, 33,* 135-145.

Bricker, D., & Squires, J. (1999). *Ages & Stages Questionnaires (ASQ): A parent-completed child-monitoring system* (2nd ed.). Baltimore: Paul H. Brookes Publishing Co.

Britner, P. A., & Farrell, A. F. (2017). A safe, stable place to call home: Policy implications and next steps to address family homelessness. Special issue: Child and family well-being and homelessness: Integrating research into practice and policy. *Advances in Child and Family Policy and Practice*, 101-112.

Burt, M. R. (2018). *Sustainability and system change in partnership communities offering supportive housing to child welfare-involved families: Services integration and systems change as the demonstration ends*. Washington, DC: Urban Institute.

Burt, M. R., Gearing, M. E., & McDaniel, M. (2016). *Evolution in programs offering supportive housing to child welfare-involved families: Services integration and systems change at the half-way point*. Washington, DC: Urban Institute.

Children's Bureau. (2018a). *Child maltreatment 2016*. Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Children's Bureau. (2018b). *Child welfare outcomes 2015: Report to Congress*. Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Child Welfare Information Gateway (2016). *Caseload and workload management. Issue brief*. Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Collins, L. M., Trail, J. B., Kugler, K. C., Baker, T. B., Piper, M. E., & Mermelstein, R. J. (2013). Evaluating individual intervention components: Making decisions based on the results of a factorial screening experiment. *Translational Behavioral Medicine, 4*(3), 238-251

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Connecticut State Department of Public Safety. (2007). *Family violence: Detailed report*. Hartford, CT: Author.

Council on Accreditation. (2018). *Personnel. Child protective service standards.* New York: Author. Retrieved December 18, 2018, from http://coanet.org/standard/cps/14/

Crusto, C. A., Lowell, D., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S.R., & Kaufman, J. S. (2008). Evaluation of wraparound services for children exposed to violence. *Best Practices in Mental Health: An International Journal, 4*, 1-18.

Corporation for Supportive Housing (CSH) & Robert Wood Johnson Foundation (RWJF). (nd). *Keeping Families Together brochure.* New York: Corporation for Supportive Housing.

Cunningham, M., Pergamit, M., Baum, A., & Luna, J. (2015). *Helping families involved in the child welfare system achieve housing stability: Implementation of the Family Unification Program in eight sites.* Washington, DC: Urban Institute.

Derogatis, L. R., & Spencer, P. M. (1982). *The Brief Symptom Inventory (BSI) administration, scoring and procedures manual*. Baltimore, MD: John Hopkins University School of Medicine, Clinical Psychometrics Research Unit.

Green, B. L., McAllister, C. L., & Tarte, J. M. (2004). The Strengths-Based Practices Inventory: A tool for measuring strengths-based service delivery in early childhood and family support programs. *Families in Society*, *85*(3), 326–334.

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,*145-154.

Farrell, A. F., Dibble, K. E., Randall, K. G., & Britner, P. A. (2017). Screening for housing instability and homelessness among families undergoing child maltreatment investigation. *American Journal of Community Psychology, 60*, 25-32.

Farrell, A. F., Karter, C., & Kull, M. (2017, November). *QRAFT-EC: Screening for housing instability in early childhood service provision*. Technical report prepared under contract with The Connection, Inc. Chicago, IL: Chapin Hall at the University of Chicago.

Farrell, A. F., Lujan, M.L., Britner, P. A., Randall, K. G., & Goodrich, S. A. (2012). "I am part of every decision": Client perceptions of engagement within a supportive housing child welfare program. Special issue: Parental engagement with services when children may be at risk. *Child and Family Social Work, 17*(2*),* 254-264.

Farrell, A. F., Randall, K. G., Britner, P. A., Cronin, B., Somaroo-Rodriguez, S. K., & Hansen, L. (2017). Integrated solutions for intertwined challenges. *Child Welfare, 94*(1), 141-165

Farrell, A. F., Randall, K. G., Britner, P. A., & Reynolds, J. A. (2015). *Universal housing screening of families undergoing child welfare investigation: Technical report on CT's pilot of the QRAFT.* Technical report prepared under Grant HHS-2012-ACF-ACYF-CA-0538, Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System.

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Fowler, P. J., & Chivira, D. (2014). Family Unification Program: Housing services for homeless child welfare-involved families. *Housing Policy Debate, 24,* 802-814.

Fowler, P. J., & Farrell, A. F. (2017). Housing and child well-being: Implications for research, policy, and practice. *American Journal of Community Psychology, 60*, 1-6.

Fowler, P. J., Farrell, A. F., Marcal, K. E., Chung, S., & Hovmand, P. S. (2017). Housing and child welfare: Emerging evidence and implications for scaling up services. *American Journal of Community Psychology, 60*(1-2), 134-144.

Green, B. L., McAllister, C. L., & Tarte, J. M. (2004). The Strengths-Based Practices Inventory: A tool for measuring strengths-based service delivery in early childhood and family support programs. *Families in Society: The Journal of Contemporary Social Services, 85*(3), 326-334.

Gubits, D., Shinn, M., Bell, S., Wood, M., Dastrup, S., Solari, C. D., ... Spellman, B. E. (2015). *Family Options Study: Short-term impacts of housing and services interventions for homeless families.* Technical report prepared for the U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Mattessich, P., Murray-Close, M., & Monsey, B. (2001). *Wilder Collaboration Factors Inventory*. St. Paul, MN: Wilder Research.

Morton, M. H., Dworsky, A., Matjasko, J. L., Curry, S. R., Schlueter, D., Chavez, M. A., & Farrell, A. F. (2017). Prevalence and correlates of youth homelessness in the United States. *Journal of Adolescent Health*, 14-21.

Morton, M. H., Dworsky, A., & Samuels, G. M. (2017). *Missed opportunities: Youth homelessness in America. National estimates*. Chicago, IL: Chapin Hall at the University of Chicago.

National Association of Social Workers. (2004). *"If you're right for the job, it's the best in the world": The National Association of Social Workers' child welfare specialty practice section members describe their experiences in child welfare*. Washington, DC: Author.

National Low Income Housing Coalition. (2018). *The GAP: A shortage of affordable homes*. Washington, DC: Author.

Perlman, S. M., Shaw, S. H., Kieffer, C. H., Whitney, G. A. C., & Bires, C. (2017). Access to early childhood services for young children experiencing homelessness. Special issue: Child and family well-being and homelessness: Integrating research into practice and policy. *Advances in Child and Family Policy and Practice*, 65-82.

Reed-Ashcraft, K., Kirk, R. S., & Fraser, M. W. (2001). The reliability and validity of the North Carolina Family Assessment Scale. *Research on Social Work Practice, 11*, 503-520.

Rog, D. J., Gilbert-Mongelli, A. M., & Lundy, E. (1998). *The Family Unification Program: Final evaluation report*. Washington, DC: CWLA Press.

Samuels, B. (2017). Pathways to housing policy: Translating research to policy to achieve impact on well being. *American Journal of Community Psychology, 60*, 9-16.

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Squires, J., Bricker, D., & Potter, L. (1997). Revision of a parent-completed developmental screening tool: Ages and Stages Questionnaire. *Journal of Pediatric Psychology, 22*(3), 313-328.

Wyrick, D. L., Rulison, K. L., Fearnow-Kenney, M., Milroy, J. J., & Collins, L. M. (2014). Moving beyond the treatment package approach to developing behavioral interventions: addressing questions that arose during an application of the Multiphase Optimization Strategy (MOST). *Translational Behavioral Medicine,* 4(3), 252-259.

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Appendices

Appendix A. CT Collaborative for Housing and Child Welfare (CCHCW)

Person	Organization	Title
Joette Katz	Department of Children and Families (DCF)/ 3 Branch Chair	DCF Commissioner
Richard Dyer	Judicial/ 3 Branch Member	Superior Court Judge for Juvenile Matters at Willimantic
Susan Reilly	Casey Family / 3 Branch Member	Technical Assistance
Dante Bartolomeo	Judicial/ 3 Branch Member	State Senator (Meriden, Middletown, Cheshire, Middlefield)
Sarah Eagan Mickey Kramer	Office of the Child Advocate/ 3 Branch Member	Connecticut's Child Advocate
Jewel Mullen Rosa Biaggi	Department of Public Heath / 3 Branch Member	Commissioner of Public Health
Evonne Klein Karin Motta Steve DiLella Leigh Sheilds-Church	Department of Housing (DOH)/ 3 Branch Member	Commissioner
Kate McEvoy	Department of Social Services (DSS)/ 3 Branch Member	Director of Health Services for DSS
Bernadette Conway	Judicial/ 3 Branch Member	Chief Administrative judge, juvenile matters
Nancy DiMauro	DCF/ 3 Branch Member	Clinical Program Director
Elizabeth Duryea	DCF/ 3 Branch Member	Chief of Staff
Allon Kalisher	DCF/ 3 Branch Member	Regional Administrator (DCF Region 3)
Kristina Stevens	DCF/ 3 Branch Member	Deputy Commissioner
Non-Three Branch Members		
Grace Whitney	Head Start State Collaboration Office	Director
Anne Foley	Office of Policy and Management (OPM)	Senior Policy Advisor

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Person	Organization	Title
Kelly Sinko		
Lisa Tepper-Bates	Connecticut Coalition to End Homelessness	Executive Director (until 2018)
Richard Cho		Executive Director (starting 2018)
Mimi Haley		
Sarah Fox		
Alicia Woodsby	Partnership for Strong Communities	Executive Director
Terry Nowkowski		
Carline Charmelus		
Sarah Gallagher	CSH	Managing Director, Eastern Region
Nichole Guerra		
Alison Harte		
Christi Staples		
Ruth White	National Center for Housing and Child Welfare	Executive Director
Sarah Morrison	Center for the Study of Social Policy	Director, Learning and Evidence
Susan Palmer	Department of Labor (DOL)	Commissioner
Lisa Arends		
Ram Aberasturia		
Mike Bartley		
Christine Flammia		
Jason Lang	The Child Health and Development Institute (CHDI) of Connecticut	Assoc. Dir. For the Center of Effective Practice
Larry Butler	City of Waterbury	State Representative
Gallo Rodriguez	The Village for Children and Families	Exec. Director
Yvette Young		
Catherine Corto-Mergins		
Liz Bryden		
Robert Plant	Value Options	Director
Terry Nash	CHFA	Executive Director
Lisa DeMatteis-Lepore	The Connection, Inc. (TCI)	Chief Executive Officer

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Person	Organization	Title
Betsy Cronin		Director of Housing Development
Lisa Hansen		QI Specialist
Debra Struzinski		Program Director, Supportive Housing
Chelsea Humphrey		Associate Director, Eastern Region, Center for Behavioral Health
Anne Ventimiglia		Program Director, Supportive Housing for Families
Debra Borzellino		Service Area Director, Family Support Services
		Chief Program Officer
Kathy Savino		Program Director
Helen McAlinden		Project Manager
Beth Hogan		Director of Housing Assessment, SHF
Yesy Rivera		
Sheila Kristofak		Director of Housing Certification, SHF
Joseph Sisk		Director of Assessment & Intake, SHF
Louis Tallarita	Department of Education	Director of Homeless Services
Suzanne Piacentini	HUD Hartford Field Office	Director
Jennifer Gottlieb Elazhari,		
Preston Britner	University of Connecticut	Professor (Evaluator)
Carmen Britton		
Samantha Goodrich		
Kathryn Parr		
Kellie Randall		
Christopher Rhoads		
Lindsay Westberg		
Anne Farrell	Chapin Hall at the University of Chicago	Director of Research (Evaluator)
Melissa Kull		

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Person	Organization	Title
Kim Somaroo-Rodriguez	DCF	Program Supervisor
Christine Lau		Regional Administrator
Donna Maitland-Ward		Office Director
Fred North		
Kyle Parkinson		Program Supervisor
David Silva		Office Director
Kim Nilson		Office Director
Rosmary Wieworka		Director of Child Welfare
Lisa Sedlock		Systems Director Region 4
		Office Director
Sen. Chris Murphy	U.S. Senator	U.S. Senator
Ben Florsheim		Outreach Assistant
David Wilkenson	OEC	Commissioner
Laura Dunlevy		
Maggie Adair		
Eileen McMurrer		
Betsy Ritter		
Stacey Violante-Cote	Center for Children's Advocacy	Attorney
Lisa Quach	Journey Home	
Niya Solomon		
Kellyann Day	New Reach	Executive Director
Nicole Barnofski		
Meredith Damboise		
Alaina Crawford	Intercommunity CT	
Steven Hernandez	Commission on Women, Children and Seniors	Executive Director
Rick Porth	United Way of Connecticut	President/CEO
Tanya Barrett		Senior Vice President
Sherry Linton-Massiah	Child First	Communications Director

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Person	Organization	Title
Marilyn Caleron	CT Parent Power	
Kim Karanda	Department of Mental Health and	
Alice Minervino	Addiction Services	
Kathy Allen	Thames River Community Service	Director
Rebecca Allen	Melville Charitable Trust	
Karen Jarmoc	CT Coalition Against Domestic Violence	Executive Director
Kelly Annelli		
Bonita Grubbs	Christian Community Action	Executive Director
Shellina Toure		

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Appendix B. Impact Evaluation Measures

Child Welfare Outcomes

Child welfare outcomes were drawn from the DCF State Automated Child Welfare Information System database to address Research Question 1. Data included case start and end dates, case placement episode dates and dispositions, and dates of maltreatment investigations, among other indicators of child welfare system involvement. We analyzed data on child welfare outcomes to capture three windows of time: between randomization and 12 months, between randomization and 18 months, and between randomization and 24 months. Specific child welfare outcomes captured:

- *Reunification*: We measured reunification at both the family and child level among the reunification group. For reunification families, we captured whether at least one child was living with the family within the analytic timeframe, and for children, we captured whether individual children were reunified with that timeframe. We also computed the number of days between child's removal and reunification.
- *Removal*: Again, we measured removal at both the family and child level among the preservation group. For preservation families, we captured whether at least one child was removed from the household within the analytic timeframe, and for children, we captured whether individual children were removed with that timeframe.
- *Intact families*: To assess whether families were intact, we captured whether children were living with their families at each time point.
- *Maltreatment referrals/reports*: Among children in preservation families, we examined both the incidence of any maltreatment referrals/reports within the analytic timeframe, as well as substantiated maltreatment referrals reports.
- *Cases closed and reopened*: Using the date of randomization and the date of case closure, we measured whether cases were close or re-opened within the analytic timeframe. We also computed the number of days between randomization and case closure.

Family Housing Stability

In order to answer Research Question 2, whether families had experienced homelessness during the analytic period, we drew on administrative data from the state HMIS. We use a shelter stay as a proxy for homelessness, though we recognize that this data source likely produces a conservative estimate, because many families experiencing homelessness may not enter the state's Continuum of Care, known in CT as the Coordinated Access Network. We analyzed data on shelter use to capture three windows of time: between randomization and 12 months, between randomization and 18 months, and between randomization and 24 months. In lieu of additional information on housing stability, we draw on data from the Urban Institute survey, in which families self-reported on their experiences of housing instability and homelessness at

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follow-up, which was 12 months from randomization. These items included caregiver self-reports of number of moves since randomization, the quality of the living situation, housing problems (e.g., presence of rodents, non-working utilities), spells of homelessness and experiences of eviction since randomization, the number of people living in the household, and the attainment of a home with or without a lease within a year since randomization.

Family Self-Sufficiency and Well-Being

Measures of family self-sufficiency and well-being to address Research Question 3 were captured using The North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R), a measure of family functioning intended for use with child welfare populations. It is completed by the services worker based on their overall knowledge of and work with the client. There are 10 scales, and items are scored on a -3 to +2 scale, which we transformed to a 1 (clear strength) to 6 (serious problem) scale, where 3 indicates adequate. The following subscales were used to assess family self-sufficiency and well-being:

- *Family self-sufficiency* indicates the extent to which families have a caregiver with stable employment, reliable and sufficient family income, and financial management skills.
- *Environment* includes items on neighborhood safety or violence, housing stability, and the structural quality of the housing.
- *Interactions* captured the extent to which parents are bonded and communicate with children and have appropriates expectations for children.
- *Family safety* includes items that pertain to the incidence of family conflict and physical abuse within the household.
- *Family health* reflects whether the families have good physical and mental health and lack any disabilities.

Parental Functioning

In order to address Research Question 4, we measured caregiver depressive symptoms, parental distress, and parental capabilities:

- *Caregiver depression* was measured using the Brief Symptoms Inventory (BSI), which is a 53-item screen of mental health concerns. Items ask about problems (e.g., feeling nervous or shakiness inside) and are rated on a 0 = *Not at All* to 4 = *Extremely* scale of how distressing that item has been over the past 7 days. We draw on the Global Severity Index (GSI), calculated as a simple average across all items.
- *Parental distress* was measured using the Parenting Stress Index-Short Form (PSI-SF), consisting of three subscales and a Total Stress score. The Parental Distress subscale captures parental competence, conflict, support, and stress in regarding to parenting.

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- *Parental capabilities* was drawn from the NCFAS G+R and reflected parent's inadequate supervision of children, disciplinary practices, and provision of activities and resources for enrichment.

Child Development and Well-Being

For Research Question 5, child development and well-being were assessed using three measures:

- *Child development*, specifically the presence of developmental delays among infants and toddlers (ages 0-2), was assessed using the Ages and Stages Questionnaire. The ASQ is a 30-item self-report questionnaire that consists of five developmental areas: communication, gross motor, fine motor, problem solving and personal social. The ASQ is a screen for developmental delays in children ages 1 month to three years old. The answer options range from "*yes*", "*sometimes*" or "*not yet*." Each yes response is assigned 10 points; each sometimes is assigned 5 points; and each not yet is assigned 0 points.
- *Child well-being*, broadly, was measured using the NCFAS-G+R subscale on Child Well-being, which indicates whether there are issues related to child behavior, school performance, or relationship with the child's caregiver.
- *Children's socio-emotional well-being* was measured using two versions of the Child Behavior Checklist. The CBCL/1.5-5 version is a short, caregiver-completed questionnaire used to identify problem behaviors in children ages 3-5 years. It has 100 problem items, which include seven syndrome scales: emotional reactivity, sleep problems, anxiety/depression, somatic complaints, withdrawal, attention problems, aggression and other problems. Similarly, the CBCL/6-18 version is used to identify problem behaviors in children ages 6-18 years using 118 items, which include eight syndrome scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-breaking Behavior, Aggressive Behavior, and Other Problems. Within each version, the syndrome scales are used to calculate the internalizing and externalizing symptom scores. Answer options include: 0 = *Not True*; 1 = *Somewhat/Sometimes True*; or 2 = *Very True or Often True*.

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Appendix C. Additional Results Tables

Table 18. Family/Child Enrollment and Participation in Program and Evaluation

Participant Status	Household *n*
Referred	805
Ineligible for study	2
Income too high	1
Sex offender in household	1
Eligible for study	803
Ineligible for randomization	704
Spigot off [1]	118
Did not meet targeting criteria [2]	586
Families not housing unstable/homeless	105
Service needs not high	141
Insufficient child welfare involvement	354
Families deemed ineligible/denied voucher at referral [1]	553
Families randomized	217
Randomized families who declined participation in housing/program [1, 2, 3]	2
Families housed [2, 3, 4]	91
Families who forfeited housing voucher [2, 3, 4]	3
Lost or gave up voucher	2
Moved out of state	1

Random Assignment	Families		Children	
	n	%	*n*	%
Randomized	217	100%	443	100%
Treatment: ISHF	51	24%	118	27%
Preservation	21	10%	58	13%
Reunification	30	14%	60	14%
Both (if relevant)	0	0%	0	0%
Treatment: PSHF	56	26%	123	28%
Preservation	32	15%	74	17%
Reunification	24	11%	49	11%
Both (if relevant)	0	0%	0	0%
Control: Business as Usual	110	51%	202	46%
Preservation	56	26%	114	26%
Reunification	54	25%	88	20%
Both (if relevant)	0	0%	0	0%

[1] The spigot would be turned off due to full ISHF caseload capacity. The project served clients in two of the DCF state regions. Region 3 had a max caseload capacity of 28 clients (4 Case Managers with caseload of 7 clients per Case Manager). Region 4 had a caseload capacity of 21 clients (3 Case Managers with caseload of 7 clients per Case Manager). Exception: If a Case Manager had clients in step-down they could take additional clients. For every 2 clients in step-down they could take another.

[2] Did not meet project eligibility criteria in these domains

Table 19. Characteristics of Families at Baseline

	Full Sample		Control		Treatment		Chi-Square or *t* Value	*p*-value
	n	% / *M (SD)*	*n*	% / *M (SD)*	*n*	% / *M (SD)*		
Caregiver Race/Ethnicity								
White	138	67%	69	64%	69	70%		
Black	22	11%	12	11%	10	10%	1.3	ns
Hispanic	39	19%	23	22%	16	16%		
Other	7	3%	3	3%	4	4%		
Caregiver Gender								
Male	14	7%	7	7%	7	7%	< 0.1	ns
Female	192	93%	100	93%	92	93%		
Household Income (Annual)	205	5,411 (7,201)	107	5,460 (7,216)	99	5,359 (7,221)	0.1	ns
Four+ Children in Household	25	12%	7	7%	18	18%	6.5	$p < 0.05$
Non-parental Adults in the Household	55	27%	32	30%	23	23%	1.4	ns
Child Welfare Status								
Preservation	106	51%	54	50%	52	53%	0.1	ns
Reunification	100	49%	53	50%	47	47%		
Housing Status								
Private Home	29	15%	16	16%	13	14%		
With Friends/Relatives	112	59%	56	57%	56	61%		
Homeless	10	5%	6	6%	4	4%	1.5	ns
In Shelter	21	11%	12	12%	9	10%		
Transitional Housing	8	4%	3	3%	5	5%		
In Hotel/Motel	11	6%	6	6%	5	5%		
Household Service Needs								
Caregiver Chronic Health Problem	35	18%	19	19%	16	17%	0.1	ns
Caregiver Mental Health Problem	138	73%	70	71%	68	74%	0.1	ns

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	Full Sample		Control		Treatment		Chi-Square or *t* Value	*p*-value
	n	% / *M (SD)*	*n*	% / *M (SD)*	*n*	% / *M (SD)*		
Caregiver Substance Abuse Issue	124	64%	67	66%	57	61%	0.4	ns
Child Mental, Emotional, Behavioral Problem	81	42%	38	38%	43	47%	1.6	ns
Child Developmental, Learning, Physical Disability	53	29%	24	25%	29	33%	1.2	ns
Domestic Violence Incidents (2+ past year)	62	33%	31	32%	31	34%	0.1	ns
Caregiver Criminal Justice History	103	51%	57	54%	46	48%	0.8	ns
Caregiver History of Childhood Maltreatment	125	63%	61	59%	64	68%	1.7	ns
Caregiver Foster Care History	62	31%	28	27%	34	36%	1.9	ns
Family Ever Homeless	114	59%	55	55%	59	63%	1.4	ns

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Table 20. Housing Status and Outcomes: Control vs. Treatment

	Full Sample		Control		Treatment		Mean difference or chi square	*p-value*
	n	*M* (SD) / %	*n*	*M* (SD*)* / %	*n*	*M* (SD*)* / %		
Families housed [1, 2, 3]	91	-	-	-	91	-	-	-
Time to housing from randomization [2, 4]	-	-	-	-	89	97 (59)	-	-
Time to obtaining a voucher from randomization (days) [2, 4]	-	-	-	-	66	241 (167)	-	-
Have house/apartment with own lease [5]	82	71%	22	45%	60	90%	27.2	*p* < 0.01
Have house/apartment without own lease [5]	26	22%	21	43%	5	7%	20.4	*p* < 0.01
Number of moves since randomization [5]	116	1.5 (1.2)	49	1.7 (1.3)	67	1.3 (1.0)	0.4	ns
Excellent, very good, or good quality of living situation [5]	95	82%	40	82%	55	82%	< 0.1	ns
One or more housing quality problems [5]	37	32	14	29%	23	34	0.4	ns
Ever homeless spell since randomization [5]	17	15%	10	20%	7	10%	2.2	ns
Evicted since randomization [5]	9	8%	6	67%	3	33%	2.5	ns
Number of people living in home currently [5]	108	3.4 (1.6)	43	3.7 (1.5)	65	3.1 (1.7)	0.6	*p* < 0.10
Families who entered shelter between randomization and timepoint								
12 Months	11	5%	8%	(0.02, 0.14)	3%	(-0.00, 0.07)	1.8	ns
18 Months	13	6%	9%	(0.03, 0.16)	4%	(0.00, 0.08)	1.7	ns
24 Months	16	8%	10%	(0.04, 0.17)	5%	(0.01, 0.10)	1.4	ns

[1] Percentage of sample not presented because there is no valid denominator for the "referred" sample or the control group. Percentage presented for the PSHF vs. ISHF comparison includes the sample randomized to either PSHF or ISHF as the denominator (n = 99)

[2] Only relevant among treatment group (PSHF and ISHF)

[3] Cannot compute chi square test for PSHF-ISHF comparison because these data were reported in aggregate

[4] These are results from bivariate tests - t-test or Chi-square tests - because the control group could not be linked across data sources.

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Table 21. Housing Status and Outcomes: PSHF vs. ISHF

	Treatment		PSHF		ISHF		Mean difference or chi square	p-value
	n	M (SD) / %	n	M (SD) / %	n	M (SD) / %		
Families housed [1]	91	-	44	88%	47	96%	-	-
Time to housing from admission	89	97 (59)	43	87 (51)	46	107 (65)	30	p < 0.10
Time to obtaining a voucher from admission (days)	66	241 (167)	20	427 (176)	46	160 (72)	267	p < 0.01
Have house/apartment with own lease [2,3]	42	95%	-	-	-	-	-	-
Have house/apartment without own lease [2,3]	1	2%	-	-	-	-	-	-
Number of moves since randomization [2]	44	1.3 (0.8)	1.1	(0.52, 1.75)	1.2	(0.91, 1.44)	< 0.1	ns
Excellent, very good, or good quality of living situation [2]	36	82%	58%	(0.18, 0.97)	84%	(0.73, 0.96)	1.5	ns
One or more housing quality problems [2]	44	34%	61%	(0.27, 0.95)	27%	(0.13, 0.42)	3.1	p < 0.10
Ever homeless spell since randomization [2]	6	14%	22%	(-0.24, 0.58)	22%	(0.01, 0.43)	< 0.1	ns
Evicted since randomization [2,3]	3	7%	-	-	-	-	-	-
Number of people living in home currently [2]	43	3.0 (1.7)	3.8	(2.46, 5.18)	3.1	(2.56, 3.63)	1.0	ns
Families who entered shelter between randomization and timepoint [2,3]								
12 Months	3	3%	-	-	-	-	-	-
18 Months	4	4%	-	-	-	-	-	-
24 Months	6	6%	-	-	-	-	-	-

[1] Cannot compute chi square test for PSHF-ISHF comparison because these data were reported in aggregate

[2] Covariates include child race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. In models where covariates perfectly predicted the dependent variable, covariates were removed.

[3] Models could not be estimated due to perfect prediction in the treatment assignment variable.

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Table 22. Child Welfare Outcomes: Control vs. Treatment

	Control		Treatment		Chi-Square or *F* Value	*p*-value
	M/%	**(95% CI)**	**M/%**	**(95% CI)**		
Families with a child reunified between randomization and timepoint (reunification)						
12 Months	12%	(0.02, 0.22)	24%	(0.10, 0.37)	0.2	ns
18 Months	16%	(0.05, 0.27)	38%	(0.23, 0.54)	5.2	*p* < 0.05
24 Months	16%	(0.05, 0.27)	41%	(0.25, 0.57)	6.1	*p* < 0.05
Families with a child removed between randomization and timepoint (preservation)						
12 Months	28%	(0.16, 0.41)	6%	(0.01, 0.11)	10.4	*p* < 0.01
18 Months	41%	(0.27, 0.56)	9%	(0.02, 0.16)	15.1	*p* < 0.01
24 Months	40%	(0.26, 0.55)	11%	(0.03, 0.19)	11.5	*p* < 0.01
Children reunified between randomization and timepoint (reunification)						
12 Months	8%	(0.01, 0.14)	18%	(0.07, 0.29)	2.8	ns
18 Months	9%	(0.02, 0.16)	29%	(0.17, 0.40)	7.9	*p* < 0.01
24 Months	9%	(0.03, 0.16)	30%	(0.18, 0.42)	8.9	*p* < 0.01
Days to reunification (reunification)	580	(494, 666)	589	(507, 673)	< 0.1	ns
Child removed from family between randomization and timepoint (preservation)						
12 Months	33%	(0.19, 0.47)	6%	(0.02, 0.11)	14.7	*p* < 0.01
18 Months	40%	(0.27, 0.54)	7%	(0.02, 0.13)	21.9	*p* < 0.01
24 Months	40%	(0.26, 0.54)	9%	(0.02, 0.16)	17.1	*p* < 0.01
Children who were living with family by timepoint (all)						
12 Months	56%	(0.46, 0.66)	63%	(0.55, 0.71)	1.0	ns
18 Months	47%	(0.37, 0.57)	60%	(0.52, 0.68)	3.9	*p* < 0.05
24 Months	46%	(0.35, 0.56)	59%	(0.51, 0.67)	3.6	*p* < 0.10
Children with maltreatment referrals/reports between randomization and timepoint (preservation)						
12 Months	33%	(0.21, 0.46)	19%	(0.09, 0.29)	2.5	ns
18 Months	40%	(0.27, 0.53)	28%	(0.17, 0.40)	1.5	ns
24 Months	46%	(0.33, 0.60)	44%	(0.31, 0.57)	0.1	ns

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	Control		Treatment		Chi-Square or *F* Value	*p*-value
	M/%	(95% CI)	*M/%*	(95% CI)		
Children with substantiated allegation between randomization and timepoint (preservation)						
12 Months	19%	(0.07, 0.32)	5%	(0.01, 0.10)	5.1	*p* < 0.05
18 Months	26%	(0.13, 0.40)	8%	(0.02, 0.13)	7.1	*p* < 0.01
24 Months	29%	(0.17, 0.41)	16%	(0.08, 0.25)	3.0	*p* < 0.10
Families with closed case between randomization and timepoint (all)						
12 Months	40%	(0.30, 50)	41%	(0.30, 0.51)	< 0.1	ns
18 Months	54%	(0.43, 0.64)	62%	(0.52, 0.72)	1.2	ns
24 Months	66%	(0.56, 0.76)	74%	(0.65, 0.84)	1.3	ns
Days to case closure (all)	343	(263, 422)	285	(207, 363)	1.0	ns
Families with re-opened case between randomization and timepoint (all)						
12 Months [1]	4%	(-0.0, 0.08)	1%	(-0.01, 0.04)	0.9	ns
18 Months	8%	(0.02, 0.13)	6%	(0.01, 0.12)	0.1	ns
24 Months	11%	(0.05, 0.18)	11%	(0.04, 0.19)	< 0.1	ns
Families with shelther use between randomization and timepoint (all)						
12 Months [2]	8%	(0.02, 0.14)	3%	(-0.0, 0.07)	1.8	ns
18 Months	9%	(0.03, 0.16)	4%	(0.0, 0.08)	1.7	ns
24 Months	10%	(0.04, 0.17)	5%	(0.01, 0.10)	1.4	ns

[1] Model did not converge for PSHF vs. ISHF comparison due to small cell size
[2] No ISHF families entered the HMIS system in the two years since randomization

Note. In models predicting child outcomes, covariates include child race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. Models predicting family outcomes control for caregiver race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness.

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Table 23. Child Welfare Outcomes: PSHF vs. ISHF

	PSHF		ISHF		Chi-Square or F Value	p-value
	M/%	(95% CI)	M/%	(95% CI)		
Families with a child reunified between randomization and timepoint (reunification)						
12 Months	22%	(0.02, 0.42)	23%	(0.05, 0.40)	< 0.1	ns
18 Months	22%	(0.03, 0.42)	45%	(0.25, 0.64)	2.2	ns
24 Months	28%	(0.07, 0.50)	44%	(0.24, 0.64)	1.0	ns
Families with a child removed between randomization and timepoint (preservation)						
12 Months	8%	(-0.02, 0.18)	9%	(-0.03, 0.21)	< 0.1	ns
18 Months	9%	(-0.02, 0.21)	14%	(0.00, 0.28)	0.3	ns
24 Months	7%	(-0.02, 0.17)	21%	(0.07, 0.35)	2.1	ns
Children reunified between randomization and timepoint (reunification)						
12 Months	14%	(0.03, 0.26)	16%	(0.02, 0.31)	< 0.1	ns
18 Months	14%	(0.03, 0.25)	30%	(0.13, 0.47)	2.0	ns
24 Months	17%	(0.05, 0.30)	29%	(0.13, 0.45)	1.1	ns
Days to reunification (reunification)	646	(513, 779)	575.2	(446, 704)	0.6	ns
Child removed from family between randomization and timepoint (preservation)						
12 Months	5%	(-0.00, 0.10)	9%	(0.01, 0.17)	1.2	ns
18 Months	4%	(-0.01, 0.08)	15%	(0.04, 0.25)	4.2	$p < 0.05$
24 Months	3%	(-0.01, 0.07)	21%	(0.09, 0.32)	9.5	$p < 0.01$
Children who were living with family by timepoint (all)						
12 Months	63%	(0.51, 0.74)	57%	(0.45, 0.69)	0.4	ns
18 Months	60%	(0.49, 0.71)	55%	(0.43, 0.67)	0.4	ns
24 Months	60%	(0.48, 0.71)	52%	(0.40, 0.65)	0.6	ns
Children with maltreatment referrals/reports between randomization and timepoint (preservation)						
12 Months	18%	(0.08, 0.27)	30%	(0.17, 0.42)	2.1	ns
18 Months	23%	(0.12, 0.34)	38%	(0.24, 0.51)	2.7	ns
24 Months	37%	(0.26, 0.48)	51%	(0.39, 0.64)	2.5	ns

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	PSHF		ISHF		Chi-Square or F Value	p-value
	M/%	(95% CI)	M/%	(95% CI)		
Children with substantiated allegation between randomization and timepoint (preservation)						
12 Months	4%	(-0.01, 0.10)	8%	(0.01, 0.15)	0.6	ns
18 Months	7%	(0.01, 0.13)	10%	(0.02, 0.18)	0.3	ns
24 Months	16%	(0.07, 0.26)	17%	(0.07, 0.28)	< 0.1	ns
Families with closed case between randomization and timepoint (all)						
12 Months	40%	(0.25, 0.55)	42%	(0.27, 0.56)	< 0.1	ns
18 Months	59%	(0.44, 0.74)	64%	(0.50, 0.78)	0.3	ns
24 Months	71%	(0.58, 0.85)	76%	(0.63, 0.88)	0.2	ns
Days to case closure (all)	235	(115, 354)	357	(242, 472)	2.1	ns
Families with re-opened case between randomization and timepoint (all)						
12 Months [1]	-	-	-	-	-	-
18 Months	5%	(-0.02, 0.12)	7%	(-0.01, 0.14)	0.1	ns
24 Months	14%	(0.04, 0.24)	7%	(-0.00, 0.15	1.1	ns

[1] Model did not converge due to small cell size

Note. In models predicting child outcomes, covariates include child race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. Models predicting family outcomes control for caregiver race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. In some models, covariates that perfectly predicted the outcome were dropped to facilitate model convergence.

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Table 24. Well-Being Outcomes: PSHF vs. ISHF

	PSHF		ISHF		Chi-Square or F Value	p-value
	M/%	(95% CI)	M/%	(95% CI)		
Family Self-Sufficiency & Well-Being						
Self-Sufficiency						
6 Months	4.5	(3.9, 5.0)	3.5	(3.1, 3.9)	7.5	$p < 0.01$
12 Months	3.9	(3.3, 4.6)	3.2	(2.8, 3.7)	3.5	$p < 0.10$
Environment						
6 Months	3.2	(2.7, 3.7)	2.5	(2.1, 2.8)	5.1	$p < 0.05$
12 Months	2.9	(2.4, 3.4)	2.3	(2.0, 2.7)	3.2	$p < 0.10$
Interactions						
6 Months	3.0	(2.5, 3.4)	2.9	(2.6, 3.2)	0.1	ns
12 Months	3.3	(2.7, 3.8)	2.7	(2.3, 3.0)	3.2	$p < 0.10$
Family Safety						
6 Months	3.1	(2.7, 3.5)	2.3	(2.0, 2.7)	7.9	$p < 0.01$
12 Months	3.1	(2.5, 3.7)	2.5	(2.1, 2.9)	3.3	$p < 0.10$
Family Health						
6 Months	3.3	(2.8, 3.8)	2.6	(2.3, 3.0)	4.0	$p = 0.05$
12 Months	3.3	(2.8, 3.9)	2.6	(2.2, 2.9)	5.4	$p < 0.05$
Parental Functioning						
Caregiver Depressive Symptoms						
6 Months	55.3	(49.1, 61.5)	55.6	(51.6, 59.7)	< 0.1	ns
12 Months	56.2	(50.0, 62.4)	56.4	(52.7, 60.1)	< 0.1	ns
Parental Distress						
6 Months	26.2	(22.8, 29.5)	28.1	(25.2, 31.0)	0.7	ns
12 Months	24.9	(20.9, 28.9)	28.2	(24.6, 31.8)	1.4	ns
Parental Capabilities						
6 Months	3.4	(2.8, 3.9)	2.9	(2.5, 3.3)	2.0	ns
12 Months	3.1	(2.5, 3.7)	2.6	(2.2, 3.0)	1.8	ns
Child Development & Well-Being						
Child Well-Being						
6 Months	2.9	(2.4, 3.4)	2.6	(2.2, 3.0)	0.8	ns
12 Months	3.0	(2.4, 3.5)	2.2	(1.9, 2.6)	5.5	$p < 0.05$
Gross Motor Skills						
6 Months	57.0	(52.0, 62.0)	49.9	(44.6, 55.2)	3.6	$p < 0.10$
12 Months	48.8	(43.0, 54.7)	55.6	(51.1, 60.2)	2.5	ns
Fine Motor Skills						

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	PSHF		ISHF		Chi-Square or F Value	p-value
	M/%	(95% CI)	M/%	(95% CI)		
6 Months	50.8	(44.3, 57.2)	50.4	(46.4, 54.4)	< 0.1	ns
12 Months	41.6	(33.3, 49.9)	51.1	(41.7, 60.6)	1.8	ns
Communication Skills						
6 Months	49.6	(40.3, 58.9)	46.9	(40.1, 53.6)	0.2	ns
12 Months	38.4	(26.4, 50.3)	50.0	(41.4, 58.5)	2.5	ns
Personal Social Skills						
6 Months	50.7	(45.8, 55.6)	49.0	(45.9, 52.1)	0.3	ns
12 Months	47.6	(38.2, 56.9)	45.3	(39.3, 51.3)	0.1	ns
Problem Solving Skills						
6 Months	49.3	(43.3, 55.3)	47.5	(43.6, 51.4)	0.3	ns
12 Months	40.5	(28.4, 52.6)	47.1	(37.4, 56.8)	0.6	ns
Internalizing Problems						
6 Months	48.6	(42.6, 54.7)	48.1	(44.0, 52.2)	< 0.1	ns
12 Months	45.3	(38.2, 52.6)	49.7	(46.5, 53.0)	1.1	ns
Externalizing Problems						
6 Months	53.5	(47.5, 59.4)	48.3	(43.9, 52.7)	1.7	ns
12 Months	52.7	(44.3, 61.1)	52.0	(47.3, 56.8)	< 0.1	ns
Total Problems						
6 Months	49.7	(42.5, 56.8)	47.4	(42.4, 52.5)	0.2	ns
12 Months	49.9	(40.9, 58.9)	50.8	(46.5, 55.1)	< 0.1	ns

Note. Caregiver and family well-being models control for caregiver race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. Child development and socioemotional well-being models control for child race/ethnicity, age, family domestic violence, household size, caregiver criminal justice history, caregiver abuse history, and prior family homelessness. In some models, covariates that perfectly predicted the outcome were dropped to facilitate model convergence.

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Appendix D. Dissemination Products

Articles in Refereed Journals

Britner, P. A., & Farrell, A. F. (2017). A safe, stable place to call home: Policy implications and next steps to address family homelessness. Special issue: Child and family well-being and homelessness: Integrating research into practice and policy. *Advances in Child and Family Policy and Practice*, 101-112. [DOI 10.1007/978-3-319-50886-3_7].

Farrell, A. F., Dibble, K. E., Randall, K. G., & Britner, P. A. (2017). Screening for housing instability and homelessness among families undergoing child maltreatment investigation. Special section: Child welfare and housing: Implications for policy and practice. *American Journal of Community Psychology, 60*(1-2), 25-32.

Farrell, A. F., Randall, K. G., Britner, P. A., Cronin, B., Somaroo-Rodriguez, S. K., & Hansen, L. (2017). Integrated solutions for intertwined challenges: A statewide collaboration in supportive housing for child welfare-involved families. Special issue: Housing, homelessness, and economic security. *Child Welfare, 94*(1), 141-165.

Fowler, P. J., & Farrell, A. F. (2017). Housing and child well being: Implications for research, policy, and practice. Special section: Child welfare and housing: Implications for policy and practice. *American Journal of Community Psychology, 60*(1-2), 3-8.

Fowler, P. J., Farrell, A. F., Marcal, K. E., Chung, S., & Hovmand, P. S. (2017). Housing and child welfare: Emerging evidence and implications for scaling up services. Special section: Child welfare and housing: Implications for policy and practice. *American Journal of Community Psychology, 60*(1-2), 134-144.

Testimony

Britner, P. A., & Farrell, A. F. (2017, June). Supportive housing for families involved in child welfare. Invited talk delivered as part of a Congressional Briefing on *Escaping homelessness: Helping families reach their full potential*. Washington, DC: U.S. Capitol Visitor Center. [Video: https://www.youtube.com/watch?v=9RQlYJySpMQ&feature=youtu.be]

Farrell, A. F. (2015, March). Testimony before the CT General Assembly, Joint Committee on Government Administration and Elections, in support of Governor's Bill No. 949: An Act Concerning Data Security and Agency Effectiveness.

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Kull, M., & Farrell, A. F. (2018, March). *Reducing barriers to child care for children experiencing homelessness*. Written testimony submitted to the Committee on Children public hearing related to H.B. 5330. Connecticut General Assembly, Hartford, CT.

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Technical Reports

Bryce, K., Farrell, A. F., Britner, P. A., & Racine, L. (2015, March). *Client perceptions of engagement in child welfare and housing services: A pilot study*. Technical report prepared under Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System, U.S. Department of Health and Human Services, Administration for Children and Families, HHS-2012-ACF-ACYF-CA-0538.

Farrell, A. F., Britner, P. A., & Dibble, K. E. (2016, July). *Research to practice brief: Results from Connecticut's universal housing screen in child welfare*. Storrs, CT: Center for Applied Research in Human Development, University of Connecticut. [http://appliedresearch.uconn.edu/project-acf-grant/]

Farrell, A. F., Randall, K. G., Britner, P. A., & Reynolds, J. A. (2015). *Universal housing screening of families undergoing child welfare investigation: Technical report on CT's pilot of the QRAFT*. Technical report prepared under Grant HHS-2012-ACF-ACYF-CA-0538, Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System.

Somaroo-Rodriguez, S. K. (2018, January). *Housing solutions for vulnerable families learning community*. Presentation as part of a webinar moderated by A. Harte and hosted by the Corporation for Supportive Housing, 2018 National Webinar Series.

Somaroo-Rodriguez, S. K. (2017, September). *Inspiring systems collaboration: Child welfare and housing partnering for strengthening families*. Presentation as part of a webinar hosted by the Child Welfare League of America and Corporation for Supportive Housing, 2017 National Webinar Series.

Somaroo-Rodriguez, S. K., & Struzinski, D. (2017, November). Interview cited in *Partnerships to demonstrate the effectiveness of Supportive Housing for Families in the child welfare system: Lessons from the State of Connecticut*. Washington, DC: United States Interagency Council on Homelessness.

Westberg, L. M., & Britner, P. A. (2017, June). *Peer mentorship in a child welfare setting: Components and barriers to an effective program*. Technical report prepared for The Connection, Inc., Middletown, CT.

Westberg, L. M., & Britner, P. A. (2017, June). *Permanent supportive housing for families in the child welfare system: Potential benefits of a scattered-site approach*. Technical report prepared for The Connection, Inc., Middletown, CT.

Invited Talks

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Britner, P. A. (2015, October). *How do we keep the momentum going? Sustainability planning across systems*. Connecticut Housing and Child Welfare Collaborative, New Haven, CT.

Britner, P. A. (2015, September). *Vision for the Connecticut demonstration*. Invited talk delivered as part of a panel presentation on sustainability. 2015 Supportive Housing Grantees Convening, Washington, DC.

Farrell, A. F. (2015, November). *Screening for housing instability among vulnerable populations*. Presentation offered at the National Association for the Education of Homeless Children and Youth, Annual Conference, Phoenix, AZ.

Farrell, A. F., & Britner, P. A. (2014, June). *Housing as a platform for child welfare intervention: Evaluating a new paradigm*. Invited colloquium delivered at the Division of Prevention and Community Research, Department of Psychiatry, Yale University, New Haven, CT.

Farrell, A. F., Britner, P. A., & Randall, K. G. (2015, April). *Supportive housing for families in child welfare: A research perspective*. Joint meeting of the Corporation for Supporting Housing (CSH) and the Departments of Children and Families (DCF), Connecticut and New Jersey, hosted by The Connection, Middletown, CT.

Conference Presentations

Britner, P. A. (2015, June). Case example: Integrating housing and child welfare. Invited talk delivered as part of a workshop on *Community psychology in the policy arena: Policy influence skills, strategies, and vantage points*. Professional Development Committee Summer Institute, Biennial Meeting of the Society for Community Research and Action, Lowell, MA.

Britner, P. A. (2014, August). Housing and child welfare. In J. W. Kaminski (Chair), *Contextual and environmental approaches to preventing child maltreatment*. Symposium presented at the annual convention of the American Psychological Association, Washington, DC.

Britner, P. A., & Farrell, A. F. (2017, August). Family homelessness and housing instability within a child welfare population. In M. Haskett (Chair), *Child and family well-being and homelessness: Integrating research into practice and policy*. Symposium presented at the annual convention of the American Psychological Association, Washington, DC.

Cronin, B., & Ferguson, M. (2017, October). *A head start on housing stability*. Presentation at the National Association to Educate Homeless Children and Youth (NAEHCY) Early Childhood Pre-Conference, Chicago, IL.

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Cronin, B., & LaRegina, E. (2018, March). *Why employment matters: How to create a culture of employment and resources available to clients.* Corporation for Supportive Housing and the CT Balance of State (CoC), Employment Learning Institute, Hartford, CT.

Cronin, B., & Struzinski, D. (2018, April). *The hard work to bring housing and child welfare systems together.* Presentation at the Housing First Partners Conference, Denver, CO.

Cronin, B., White, R. A., & Ferguson, M. (2017, June). *A head start on housing stability for child welfare families*. Presentation at One Child, Many Hands: A multidisciplinary Conference on Child Welfare, University of Pennsylvania, Philadelphia, PA.

Farrell, A. F. (2018, January). *No place like home: Housing as a platform for child development.* Keynote address. Finding home: Connecting multiple systems to create a safe space for family recovery. CT Department of Mental Health and Addiction Services, Hamden, CT.

Farrell, A. F. (2017, March). *What do we know about supportive housing for families?* In A. Johnson (Facilitator), super session on housing and homelessness in child welfare: Housing interventions for prevention, permanency & family success. Child Welfare League of America, 2017 National Conference, Washington, DC.

Farrell, A.F. (2015, July). *A cross-systems approach to addressing family homelessness.* Invited presentation, Connecticut Early Childhood Cabinet, Hartford, CT.

Farrell, A. F., & Britner, P. A. (2017, June). *Matching support to client needs and assets*. Invited talk delivered at the 2017 Corporation for Supportive Housing (CSH) Supportive Housing Summit, Denver, CO.

Farrell, A. F., Britner, P. A., & Randall, K. G. (2015, April). *Supportive housing for families in child welfare: A research perspective*. Joint meeting of the Corporation for Supporting Housing (CSH) and the Departments of Children and Families (DCF), Connecticut and New Jersey, hosted by The Connection, Middletown, CT.

Farrell, A. F., & Cronin, E. (2017, March). *Assessing housing and related needs of families in early childhood programs.* Presentation at Action for Bridgeport Community Development, Bridgeport, CT.

Farrell, A. F., Goodrich, S. A., Randall, K. G., Britton, C., & Britner, P. A. (2014, November). Patterns of family characteristics in child welfare: A configural frequency analysis. In P. J. Fowler (Discussant), *No place like home: Family mobility, stability, and resilience*. Paper symposium presented at the annual meeting of the National Council on Family Relations, Baltimore, MD.

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Goodrich, S. A., Farrell, A. F., Maxwell, M. L., Randall, K. G., Robinson, J. L., & Britner, P. A. (2014, October). *Patterns among families enrolled in human service programs: Moving away from a variable-centered to person centered approaches.* Presentation at the annual conference of the American Evaluation Association, Denver, CO.

Parr, K. E., Farrell, A. F., Britner, P. A. Leopold, J., & Howell, B. (2016, April). *CECHI: Connecticut Estimating Costs of Child Homelessness Initiative*. Invited talk delivered as part of the Partnership for Strong Communities (PSC) Policy IForum, Hartford, CT.

Somaroo-Rodriguez, S. K. (2017, May). *One family, one plan: Cross system collaboration.* Break out session at the 2017 Corporation for Supportive Housing (CSH) Supportive Housing Summit, Denver, CO.

Somaroo-Rodriguez, S. K., & Struzinski, D. (2017, May). *Roadmap to child welfare and supportive housing partnerships*. Panel presentation at the 2017 Corporation for Supportive Housing (CSH) Supportive Housing Summit, Denver, CO.

Westberg, L. M., Dibble, K. E., Farrell, A. F., & Britner, P. A. (2016, November). *Risks, assets, and typologies among child welfare involved families*. Poster presented at the annual meeting of the National Council on Family Relations, Minneapolis, MN.

White, R. A., Cronin, B., & Farrell, A. F. (2015, April). *Housing solutions for child welfare-involved families and youth.* Symposium presented at the Annual Meeting of the Child Welfare League of America. Arlington, VA.

Whitney, G., Ferguson, M., & Kull, M. (2018, April). *Safe and stable housing: Tools and strategies for understanding and addressing the housing needs of Head Start families*. Workshop presented at the New England Head Start Association, Falmouth, MA.

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