



## Housing instability and child welfare: Examining the delivery of innovative services in the context of a randomized controlled trial



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### ABSTRACT

Child welfare-involved homeless families are at greater risk of poor social and economic outcomes compared with homeless families not involved with child welfare, and these negative outcomes reverberate in terms of economic and social costs to society. This study employed a mixed-methods approach to examine process findings from a randomized control trial from the first county-level Pay for Success initiative, Partnering for Family Success. The research compared housing, child welfare and public assistance outcomes for the treatment ( $N = 90$ ) and control ( $N = 73$ ) groups, explored how the program delivered its services, the service pattern over time, and perspectives of child welfare and program staff. We found that during and in the year after exiting the program, treatment group clients were less likely to use homeless services and were more likely to access public assistance benefits as compared with the control group clients, and during and after the program, the treatment and control group clients' child maltreatment reports were not statistically significantly different. There were positive indications from quantitative data showing that the intervention patterns align with those of Critical Time Intervention (CTI), with qualitative interview data indicating shifts over time in case management focus from short-term crisis management and housing stability toward working on longer-term independent living skills. The findings contribute to the literature regarding how best to serve homeless, child welfare-involved families, and suggest the necessity for longer-term interventions and greater attention to non-housing-related needs.

### 1. Introduction

#### 1.1. Housing instability and child welfare involvement

In January 2018, the Point-in-Time homelessness count in the United States indicated that 552,380 people experienced homelessness (Alliance, 2019), and members of families accounted for about one-third of this total (Alliance, 2019). Members of families are considered the fastest expanding homeless subpopulation (Henry, Shivji, de Sousa, & Cohen, 2015). Despite large numbers of persons in families being homeless, literal homelessness (e.g., living in emergency shelter, transitional housing, or places not designed for sleeping accommodation for humans) represents only a small proportion of people experiencing housing instability. Many others do not meet the federal definition of homelessness, experiencing other forms of housing instability, such as moving frequently, and/or doubling-up. These types of housing instability can eventually lead to literal homelessness and are referred to as hidden homelessness (Fowler, Hovmand, Marcal, & Das, 2019).

Housing instability is an important area of focus because it is associated with various adverse outcomes for both parents and children,

including lack of school readiness, poor health, financial hardship, and disruption of family routines (Theodos, McTarnaghan, & Coulton, 2018). Previous literature has also identified associations between housing instability and being involved with the child welfare system (Culhane, Webb, Grim, Metraux, & Culhane, 2003; Dworsky, 2014; Park, Metraux, Broadbar, & Culhane, 2004). As compared with stably housed low-income families, research has found that housing-unstable families are more likely to be investigated by the child welfare system (Rodriguez & Shinn, 2016; Slack et al., 2003; Yang, 2015), and to have their children removed and placed in out-of-home placement (e.g., foster care) (Fowler et al., 2013; Park et al., 2004). Housing instability is associated with less family reunification, and thus inability to procure stable and safe housing can lead to children staying longer in out-of-home placement (Courtney, McMurtry, & Zinn, 2004; Fowler et al., 2013; Rog, Henderson, Lunn, Greer, & Ellis, 2017).

On average, children in out-of-home placement tend to stay for 20 months, with about 28% spending two or more years (U.S. Department of Health and Human Services, 2018). Long stays in out-of-home placement can not only impede healthy development for children but are also quite expensive. Recent data indicate that there are

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approximately 440,000 children in out-of-home placement (U.S. Department of Health and Human Services, 2017), and direct costs associated with it range from \$25,000 to \$30,000 per child per year in some states (Davidson, Tomlinson, Beck, & Bowen, 2019; Hambrick, Oppenheim-Weller, N’zi, & Taussig, 2016). While out-of-home placement is financially costly for governments at both federal and local levels, affected children also face greater economic and social burdens over time. Compared to the general population, children who experience out-of-home placement tend to struggle with high school or post-secondary degree completion, employment, stable housing, and have more mental health problems and substance abuse problems (Biehl & Hill, 2018; Gypen, Vanderfaillie, De Maeyer, Belenger, & Van Holen, 2017). Given the economic and social costs for society of having children in out-of-home placement, it is critical to develop interventions to reduce stays in this type of placement. This research describes one such intervention.

1.2. Housing interventions

Recently, efforts have been made to address the housing needs of child welfare-involved families, and these interventions have shown some positive results regarding child welfare outcomes. The Family Unification Program (FUP), for example, provides Housing Choice Vouchers (HCV, formerly Section-8) for child welfare-involved families whose children are at risk of being placed in out-of-home placement or who cannot reunify due to housing instability (defined as living in substandard housing, being literally homeless, and living doubled-up) (Office of Housing Choice Vouchers, 2012). With HCVs, families choose their desired housing, and pay up to 30% of their income for housing, with payment not exceeding comparable area fair market rents (Rufa & Fowler, 2018). The FUP is the largest and longest-standing program of this type, and partners include the local public housing authority and the child welfare system. An early descriptive evaluation of FUP with 995 families in 31 communities showed promising results: most FUP families remained stably housed after a 12-month follow-up, almost all families avoided out-of-home placement, and approximately 85% of families with children in out-of-home placement were reunified (Rog, Gilbert-Mongelli, & Lundy, 1998). However, an important limitation was the study lacked a comparison group, limiting the ability to conclude that the program produced these outcomes.

Another study examining FUP outcomes used a rigorous quasi-experimental design to examine the program’s impact on child welfare outcomes (Pergamit, Cunningham, & Hanson, 2017). Comparing families who received FUP with eligible families on waitlists, the researchers found FUP participation was associated with family reunification, including faster case closure and decreased probabilities of new child maltreatment reports (Pergamit et al., 2017). In general, however, empirical evidence on housing interventions among child welfare-involved families is limited due to small samples and

nonequivalent or nonexistent comparison groups (Fowler, 2017).

Additional intervention efforts have examined family homelessness outcomes from programs in which the public housing authority and homeless shelters collaborate. The rigorously designed Family Options Study (FOS) randomly assigned homeless families living in shelter to receive different types of housing assistance, including a permanent housing subsidy, short-term rental assistance (rapid re-housing), or transitional housing to examine the impacts of various types of housing interventions on housing stability, family preservation, self-sufficiency, and child welfare outcomes (Fowler, 2017). The study found that families with a permanent housing subsidy had shorter shelter stays, greater housing independence, better success with family preservation, and higher rates of accessing public assistance as compared to families with usual care (Gubits et al., 2015). However, the FOS study showed that housing interventions did not help all homeless families reunify with their children (Fowler, 2017).

Taking the available research together, housing, touted as extremely important for stabilization, may ultimately be insufficient for reunification (Fowler, 2017), and programs’ failures to find dramatic impacts on child welfare outcomes might also reflect the persistent pressures of sustained poverty. Many families who find housing through subsidies remain in low-income neighborhoods, which are marked by concentrated disadvantage and community violence (Fowler & Schoeny, 2017), and many child welfare-involved families continue to struggle with deep poverty, mental health, substance abuse, and domestic violence, even after becoming housed. Thus, continued research is needed on what practices work best in helping housing unstable families with multiple needs.

1.3. Program description

Efficient, interagency collaboration approaches are increasingly being suggested as necessary to decrease service silos, reduce service fragmentation, and best serve families who are experiencing both housing instability and child welfare involvement (Bai, Collins, Fischer, & Crampton, 2019). Such collaborative approaches have the potential to bridge gaps between the needs of these families and available resources. To better serve housing unstable child welfare-involved homeless families, Cuyahoga County, Ohio, launched Partnering for Family Success (referred to from here on as “the program”), a randomized controlled trial Pay for Success initiative in January of 2015. Fig. 1 displays the program design. Partnering with the local child welfare system, public housing services, jobs and families services, and a local university, the program’s primary goal was to house homeless and housing-unstable families as quickly as possible and then work towards safely transitioning children out of out-of-home placement. The program’s ultimate goal and payment metric was a 25% reduction in days in out-of-home placement for the treatment group children as compared to the control group. As the trial is ongoing and outcome

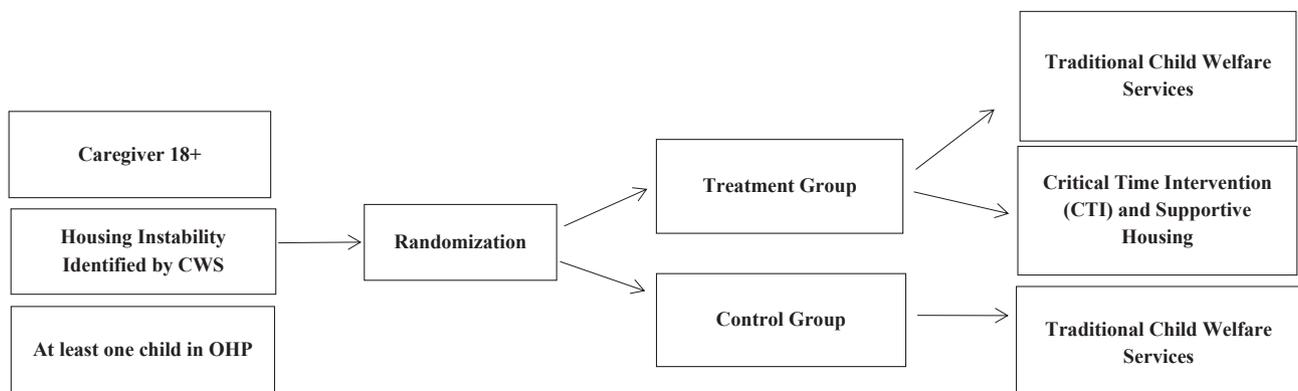


Fig. 1. PFS program model.

metrics have not yet been calculated, this paper focuses on the non-payment-related program implementation outcomes.

The program adopted the Housing First philosophy in which stable housing was assumed to be a critical first step for families to work on their child welfare case plan and other issues (e.g., mental health, substance abuse). Treatment group clients were assigned a case manager from a local service agency that helped them obtain housing and offered intensive case management and tailored supportive services using a trauma-informed approach. The collaborative partnership allowed clients to access housing relatively quickly (within three months), as treatment group families were prioritized for public housing units. The program was unique in part because it provided resources for relationship-building between child welfare, public housing providers and other governmental and local service providers, did not have stringent productivity requirements for service providers, and offered flexible funding allowing program workers to access funds for client needs that were not covered by other funding sources. The partnership allowed diverse service providers to work together toward providing housing for treatment group families as a first step toward family reunification or a permanent custody arrangement.

The program’s case managers employed Critical Time Intervention (CTI) (Herman, Conover, Felix, Nakagawa, & Mills, 2007) a promising trauma-informed approach for addressing housing and mental health issues for homeless single adults (Herman et al., 2011; Kaspro & Rosenheck, 2007). CTI was intended to help vulnerable housing-unstable families connect to community support networks, settle successfully in newly attained housing, and maintain that housing. After reunification, the program offered families the option to continue services and receive Trauma Adapted-Family Connections (TA-FC), a six-month, manualized trauma-focused therapeutic intervention. TA-FC is focused on helping address service gaps for underserved populations, supporting families, and reducing risk factors for child maltreatment through reductions of trauma symptoms and parenting stress (Collins et al., 2011; Collins, Freeman, Strieder, Reinicker, & Baldwin, 2015).

#### 1.4. Study aims and research questions

This study, which took place as part of a larger, five-year program, focused on examining the extent to which treatment group families gained greater stability in the first two years of the program. Though the larger study focused on understanding the final outcome of interest (differences in days in out-of-home placement) this study examined how participating in the program might be associated with changes in ancillary outcomes (measured quantitatively), contextualizing those findings using qualitative data. The study sought to answer three quantitative questions comparing outcomes associated with housing, income (via public assistance) and child welfare involvement between treatment and control group clients. We asked, after being enrolled in the program, (1) were treatment as compared to control group clients less likely to be involved with homeless services? (2) were treatment as compared to control group clients more likely to enroll in public assistance benefits? (3) were treatment as compared to control group clients less likely to have new child maltreatment reports? Two

exploratory qualitative questions examined for treatment group clients only included: How were program services carried out, and what was the service pattern over time? and (2) What did child welfare and program staff perceive were important client challenges and how did the program address those challenges?

## 2. Methods

### 2.1. Study design

A convergent parallel mixed method design (Creswell & Plano Clark, 2017) was employed in this study to address the research questions. This design is characterized by collecting quantitative and qualitative data at about the same time, analyzing the two data sets separately, and combining findings at the interpretation stage (Creswell & Plano Clark, 2017). Quantitative data compared treatment and control group outcomes including interactions with homeless, child welfare and public assistance systems before, during and after program enrollment. The qualitative data included staff interviews examining perspectives on the program, client challenges, and service delivery, and client progress notes documented case management interactions.

### 2.2. Sample

Clients eligible for inclusion in the program were caregivers over the age of 18 who had a child in out-of-home placement who was not in permanent custody at the intake and who also had housing issues. Housing issues were defined as having a record in the Homeless Management Information System (HMIS), spending at least one day in a domestic violence shelter with housing instability, or being housing unstable based on the child welfare supervisor’s review of case files. Housing instability included living temporarily with family members or others and not having permanent housing. Because of the partnership with the public housing authority, we excluded people with characteristics that would keep them from being able to receive a unit in public housing (i.e., being a registered sex offender, being convicted of methamphetamine production on the premises of a federally-assisted/insured housing project, committing fraud in connection with any Housing and Urban Development (HUD)-funded program, or being unable to certify US citizenship or documentation of eligible alien status) and thus the housing aspect of the intervention would not benefit them. The service population, therefore, generalizes only to those for whom public housing was an option. Participants were recruited through the county child welfare agency after meeting the eligibility criteria. The child welfare agency program supervisor created a list of eligible clients and submitted them to the research team, which then randomized clients into the treatment and control groups.

### 2.3. Data sources

Table 1 details the key data sources used in this study. Quantitative data were procured through data use agreements (DUAs) between the university researchers and: (1) The program agency, a provider of

**Table 1**  
Data sources and focus areas.

Data Source	Data Type & Focus
(1) <i>HMIS data</i> : Continuum of Care data on contacts with homeless service providers	(Quantitative) Demographic data, pre and post-program entry, shelter entry/exit stays
(2) <i>Client progress notes</i> : Case management notes on individual client contacts	(Quantitative & Qualitative) Types, frequency, lengths of service contacts, common service themes
(3) <i>Interviews with staff</i> : PFS, child welfare and CMHA staff-in-depth, semi-structured interviews on experiences with PFS	(Qualitative) Perspectives on the PFS experience from staff perspectives, and impacts of program
(4) <i>Public assistance and child welfare data</i> : JFS public assistance and DCFS data	(Quantitative) TANF and SNAP benefits, child welfare involvement (child maltreatment, foster care)

homeless and mental health services (for Homeless Management Information System (HMIS) and progress note data); (2) County Jobs and Family Services (for public assistance data) and (3) County Department of Children and Family Services (for child welfare reports). Qualitative data were obtained through interviews and focus groups with staff members at the child welfare agency and the homeless services agency. All study activities were approved by a university-based institutional review board. All client data with identifiable information were stored in a secure research environment and accessed for analysis purposes only.

### 2.3.1. HMIS data

HMIS data were used to gather descriptive data on clients, including demographic characteristics, homelessness history, chronic homelessness, being a victim of domestic violence, and disability status, all data elements program participants self-reported. HMIS also contains data on clients' use of homeless services, including emergency shelter, coordinated assessment, and rapid re-housing. We examined the use of these services one year before program entry, 12 months after entry and 24 months after entry as an indicator of housing stability. Housing instability was indicated by clients' using homeless services.

### 2.3.2. Public assistance and child welfare data

Public assistance data included Temporary Assistance for Needy Families (TANF) benefits and Supplemental Nutrition Assistance Program (SNAP). Data were acquired from Cuyahoga Job and Family Services (JFS). Enrollment in these services indicated greater financial stability. Child welfare data were obtained from the Cuyahoga County Division of Children and Family Services (DCFS). These data provided information about clients' involvement with the child welfare system (as measured by substantiated child maltreatment cases and any child maltreatment reports). Clients had multiple children and some gave birth during the program, and data on child welfare involvement reflected any involvement, not just involvement of the child or children in out-of-home placement for the purposes of the study. To examine change over time, the public assistance and child welfare data were examined at three time points: one year before the clients entered the program, 12 months after the program entry date, and two years (24 months) after the program entry date. Public assistance data were unavailable after September 2018, and DCFS data were unavailable after December 2017, so we were unable to track public assistance data beyond September 30, 2016 (for 13 clients), and child welfare involvement beyond December 31, 2016 (for 80 clients).

### 2.3.3. Client progress notes

Client progress notes were obtained from the program agency's electronic medical records (EMR) and were examined on clients entering the program during 2015 (the first year of the program) and tracked through their first full year (i.e., through December 2016 for clients entering in December 2015). Qualitative and quantitative program implementation data on case management, service themes, and service dosage were collected and coded. Each progress note entry was defined as a contact. For each contact, the notes were coded quantitatively for dosage information (date, duration of the contact, and type of contact (phone or in-person) to examine the extent, timing, and intensity of program services, and compare those to what would be expected in the CTI phases. The qualitative issues addressed in each contact were coded categorically to prepare for content analysis.

### 2.3.4. Staff interviews

Interviews were conducted over two years with a total of 23 unique staff members; only one participant was interviewed more than once. Interview data were collected from seven participants in the first year (three program workers and four child welfare workers), and 16 in the second year (six program workers and 10 child welfare workers). Participants were asked 18 questions about their perceptions of the

program. This study analyzed a subset of questions asking about the program's goals, what steps they followed in working with clients, clients' challenges and strengths, the impact they felt the program made, recommendations for improving the program, and overall experiences with the program. The question on program clients was: "we'd like you to tell us a little about your Partnering for Family Success clients. Who are they? What are their major challenges? What are their strengths?" A question about the service delivery was, "please talk a bit about how your Partnering for Family Success cases are different or similar to the cases that did not end up in the program. In what ways are the clients different? In what ways are the services they receive the same or similar or different?" The question on program impacts was "from your experience, to what extent has Partnering for Family Success had an impact on your clients—positive and/or negative? How so?" A general question asked, "Is there anything else you would like to share about your experience with Partnering for Family Success?"

## 2.4. Procedures

County public assistance and child welfare data required that probabilistic data matching techniques in SAS be used to match program clients with HMIS data. At the program service organization, the first author came to a staff meeting to introduce herself to the staff and explain the purpose of the interviews. Program staff members were given a sheet of paper in which they could choose opt-out of the interview altogether, or to participate in a group or individual interview. All invited staff chose to participate and be interviewed as part of a group. The interview was conducted during the time set aside for scheduled staff meetings. At the child welfare agency, two possible interview times were proposed, and workers who had clients participating in the program were notified by a supervisor and encouraged to attend (however, the supervisor did not follow up to check if the workers attended and there were no consequences for not attending).

At all interviews, the interviewer explained the purpose of the interviews, obtained a signed informed consent document, assured participants that they could end the interview at any time or skip questions, and that their responses were confidential. Interviews were conducted by three research team members with workers in conference rooms at their respective organizations. Supervisors were interviewed separately from caseworkers. The interview times ranged from 45 min to one and a half hours. A digital recording device was used to record the interviews and a professional transcriptionist transcribed the interviews.

## 2.5. Analysis

Chi-square tests for categorical data and t-tests for continuous data were performed to examine differences between the treatment and control groups on demographic and background variables at intake. In examining outcomes for housing instability, HMIS data were analyzed. On the bivariate level, chi-square analyses were performed to examine differences in the proportion of treatment and control group participants becoming involved in the homeless system before, during (12 months) and after (24 months) of program enrollment. On the multivariate level, binary logistic regression analyses were performed to predict homeless system involvement within 12 and 24 months of program entry. Similar analyses were conducted with the public assistance and child welfare data. Preliminary analyses were conducted to make sure assumptions of binary logistic regression were met. We are not able to conduct the logistic regression on rapid re-housing outcomes at 24 months of program entry due to the sparseness of data. Because there were significant differences between treatment and control groups in homeless services use before program entry, we controlled for those differences in the logistic regressions.

Analyses of progress note dosage information examined the total number of contacts, the average number of contacts per client, the total

number of minutes spent across all clients, the average and the median number of minutes per contact, and the type of contact (in-person, phone). These data were analyzed by time in the program to explore how time in the program was related to contact dosage and to test the hypothesis that, over time, the number of contacts and/or time spent in contacts would decrease (according to CTI phases). Content analysis was conducted on topics discussed during case management contacts. The general structure, methodology, and description of these codes are described in detail in Collins et al. (2018).

Interview analysis proceeded by members of the research team (authors one through four) reading through the interview transcripts individually first, and then reviewing the transcripts as a team to identify and discuss common and important themes within and across interviews and summarizing the results. Inductive open coding of specific quotes, grounded in the participants' own words (Patton, 1990) that the team agreed were important were categorized together based on their similarities and themes were developed. For this study, themes focused on clients' challenges and workers' relationships were examined to help contextualize and inform the quantitative findings on the program, housing, public assistance, and child welfare service use. We used a realist framework in exploring staff perspectives on housing and how it contributed to client stability, one of the program's main primary goals. Credibility was established in two ways: using member checks and prolonged engagement (Lincoln & Guba, 1985). Member checks were conducted by consulting representatives of the different organizations to check the accuracy of interpretations, and the report was shared with the full collaborative team to ensure the perspectives and experiences of the partner organizations were represented with fidelity. Prolonged engagement was established by one author's extensive experience working with the child welfare agency and being a critical member of the qualitative analysis team. Confirmability was established using an audit trail through careful notes about our process, as well as triangulation of both data sources and analysts (Patton, 1999).

### 3. Results

#### 3.1. Client Demographics

During the first two years of the program, a total of 163 participants were randomized into the treatment ( $n = 90$ ) and control ( $n = 73$ ) groups. The rolling randomization was not balanced 50/50 throughout, rather, the proportion randomly assigned to the treatment was dependent on program capacity at each assignment point, this is, the space that was available in the treatment group. Table 2 displays the demographic characteristics of the sample. Gender was the only statistically significant difference between the treatment and control groups at intake, with the control group including a significantly greater proportion of men than women ( $\chi^2(1) = 7.78, p < .01$ ). Overall, more than two-thirds of the total sample identified as non-Hispanic Black and more than 90% were women. The average age of participants was approximately 32, the average number of children per household was just over one and the average household size was two people. Numbers with disabilities, health conditions, chronic homelessness were similar for the treatment and control groups. Regarding clients' disability statuses, the most common disabling condition for both groups was a mental health diagnosis, with more than half having mental health issues. Drug abuse and chronic health conditions were the next most commonly reported disabilities, followed by alcohol abuse. Participants in the control group were more likely to report alcohol or drug abuse than the treatment group. Being a domestic violence survivor was reported by more than three-quarters of the treatment group but less than two-thirds of the control group. A total of 17 clients in the control group and 23 clients in the control group were in foster care themselves as children, and eight clients in the treatment and eight in the control group aged out of foster care, differences that were not statistically significant.

**Table 2**  
Client demographics at intake.

	Treatment ( $n = 90$ )	Control ( $n = 73$ )	Total ( $N = 163$ )
Ethnicity/Race (%)			
Non-Hispanic Black	70.0	71.2	70.6
Non-Hispanic White	23.3	19.2	21.5
Hispanic	6.7	9.6	8.0
Gender (% female)	97.8	86.3*	92.6
Age: M (SD)	31.5 (8.4)	32.2 (9.2)	31.8 (8.8)
#Kids: M (SD)	1.2 (1.5)	1.2 (1.5)	1.2 (1.5)
Household size M (SD)	2.3 (1.4)	2.2 (1.5)	2.3 (1.5)
Chronically Homeless (% yes)	12.2	11.0	11.7
DV survivor (% yes)	76.7	60.3	69.3
Disabilities (% yes)			
Mental health	56.7	58.9	57.7
Alcohol abuse	8.9	15.1	11.7
Drug abuse	13.3	23.3	17.8
Alcohol and drug abuse	4.4	8.2	6.1
Chronic health condition (% yes)	18.9	16.4	17.8
Physical health condition (% yes)	10.0	16.4	12.9
Developmental (% yes)	8.9	8.2	8.6
HIV/AIDS (% yes)	3.3	1.4	2.5
Client was in foster care as a child (%)	23.3	25.6	24.5
Client aged out of foster care	8.9	10.9	9.8

Note. Data source: HMIS from Jan 2014 to Dec 2018. DCFS from Jan 2014 to Dec 2017.

\* $p < .05$ .

\*\* $p < .01$ .

\*\*\* $p < .001$ .

#### 3.2. Case management: topics covered, type of contact and time spent

Qualitative content analysis of progress note data explored the content and frequency of CTI case management services and type of contact. A total of 15 higher-order codes were developed representing groupings of 61 lower-order codes. Examples of issues for which codes were developed included Housing (e.g., eviction, dealing with landlords), Independent Living Skills (e.g., cleaning, budgeting, education), Alcohol and Drug Abuse, Domestic Violence, Mental Health, Child (e.g., children's material, educational, childcare needs), Financial, Social Environment (e.g., family, friends, other relationships), System (e.g., child welfare, legal system), Program Support (e.g., program-specific services delivered). Table 3 displays the top 10 most frequently covered topics and their rankings. The frequency of codes was analyzed by time in the program, that is, being in the first six months or second six months in the program. The most commonly cited topics over the full year measured in the progress notes included child-related topics, independent living skills, system issues, housing, and program support. Domestic violence was the least frequently mentioned topic. During the first six months, child-related issues were the most frequently covered topics, while independent living skills were second, and system and housing issues were third and fourth. Mental health and alcohol and drug issues, while still in the top 10 of issues covered, appeared lower in the ranking.

Fig. 2 displays the pattern of service dosage over time, measured by the number of contacts, separated by type of contact (in-person or by phone) and displayed according to CTI phase. Initially, in the pre-CTI period, the contacts were quite high for both phone and in-person, reflecting the period during which clients and their program workers were building rapport and working on attaining housing. In CTI Phase 1, there was a drop in the number of contacts, which continued to decline over the next two phases, reflective of the CTI model. The pattern of contacts also switched from in-person to phone during Phase

**Table 3**  
Top 10 Most Frequent Case Management Topics.

One year (n = 9437)			First 6 months (n = 5663)			Second 6 months (n = 3774)		
Rank	Topic	%	Rank	Topic	%	Rank	Topic	%
1	Child	16.4	1	Child	17.0	1	System	15.7
2	Independent Living Skills	15.4	2	Independent Living Skills	15.6	2	Child	15.5
3	System	15.2	3	System	14.8	3	Independent Living Skills	15.0
4	Housing	12.9	4	Housing	13.8	4	Housing	11.4
5	PFS Support	7.9	5	PFS Support	8.2	5	PFS Support	7.4
6	Transportation	6.3	6	Transportation	5.7	6	Resources	7.3
7	Resources	5.5	7	Mental Health	5.5	7	Transportation	7.1
8	Mental Health	5.2	8	Social Environment	4.7	8	Mental Health	4.8
9	Social Environment	4.1	9	Resources	4.4	9	Alcohol and Drug Abuse	3.7
10	Alcohol and Drug Abuse	3.0	10	Financial	2.8	10	Social Environment	3.2

2, and the contacts decreased for both contact types in Phase 3, suggesting a decrease in the intensity of service delivery.

3.3. Qualitative interviews: staff perspectives on clients and the program

3.3.1. Program strengths

The interviews explored child welfare and program workers' perceptions of clients' challenges and the extent to which housing was effective at stabilizing clients. Child welfare workers overall viewed program workers as strong assets, noting that clients felt more relaxed and confident with program workers offering help, support, and advocacy, attending visitations, child welfare appointments, and court dates, and providing transportation to appointments. When asked about what best supported clients' stability, strengths mentioned included the program workers themselves, the program's access to flexible funding, resources, and therapeutic services. Program workers' abilities to tailor services and address specific issues and needs through flexible discretionary funds and thereby meet clients' basic needs, including housing, furniture, utility bills, clothing, and food, were assets child welfare workers said they typically did not have due to productivity, time and/or resource limitations and high caseloads. Funding flexibility was also important to program workers in that they talked about having more freedom to do what is needed for the client, and when to do it because they didn't have to worry about productivity levels. One program worker expressed how helpful the funding flexibility was:

So for the clients, I love that we have the ability for a client to say "Hey, my gas is gonna be turned off and I might lose my housing. Can

you guys help?" It is like unheard of to be able to say "We can help." So that is huge.

Participants overall expressed that they were positive and hopeful about the program's potential for increasing the safe reunification of children and their families. When asked about the benefits of the program as compared to the usual child welfare practice, child welfare staff emphasized the importance of multiple stakeholders being invested in the program and collaboration across agencies which increased the program's accountability.

3.3.2. Client challenges

Child welfare workers saw a clients' poverty (for many, a complete lack of income), mental health, drug abuse, and domestic violence as important challenges to case progress and clients attaining self-sufficiency. One child welfare worker said: "The domestic violence, mental health, and substance abuse is a big key nowadays." While both child welfare and program workers mentioned lack of employment and poverty as key barriers to self-sufficiency and overall stability, in contrast to child welfare workers, program workers tended to mention transportation issues, chronic trauma, and lack of social support as important challenges. Program workers were also more likely to mention important structural barriers related to systems, including prejudice against their clients from child welfare workers and court-related personnel (magistrates and guardians ad litem in particular). One program worker said child welfare workers' expectations were unrealistic, saying they "want [clients] to be self-sufficient before they reunite ...[but] they have no cash. A lot of them don't have jobs, so they

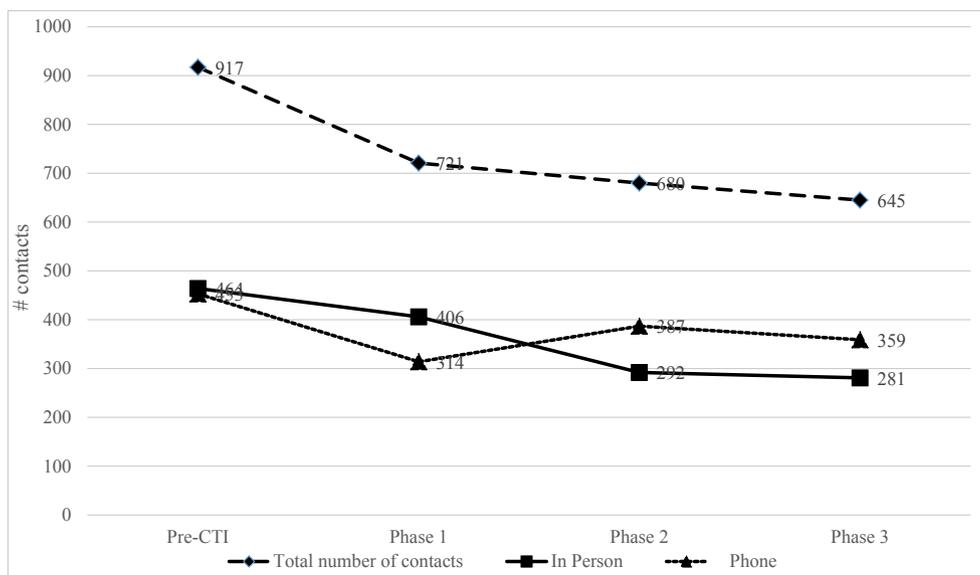


Fig. 2. Client contacts by CTI phase.

aren't self-sufficient." The worker went on to note that the systems were not set up to help clients become stably employed and reduce their poverty.

In addition to limited economic support, program workers also stressed the challenges of their clients' limited social support systems. One worker said: "I would say close to 100% of my people have been in foster care." While this estimate that was not borne out by the data, the worker's perception of her clients was important since it likely shaped her approach to her clients, including her assessment, choice of intervention, and beliefs about the efficacy of the intervention, given most clients' experiences with trauma and understanding clients' available social support. The limited availability of support was a common theme, whether or not the client had been in foster care. Both instrumental and emotional support and resources were described as limited. One worker said "It's such a cycle of the family at large not being able to provide supports, and it's something that we see with homeless families all the time" going on to explain that it wasn't just that the client herself didn't have a job, but other family members also were unemployed, or for other reasons could not assist the client and her family. "Family members are going through their own life cycle transitions and are sometimes really combative with our parents, and so the whole system is unable to support the family." Thus, even if extended family members were available, they were not always emotionally unresponsive.

In addition to family overall, fathers who were "not really providing" and "not really that great of a support" were mentioned specifically as challenging, and workers talked about issues that arise in domestic violence cases: "so you decide for you and your family that you no longer want him involved, and you tell him he can no longer come over. So now she has two new hotline calls [to child welfare], because he's pissed." Cases with situations like this one, workers noted, are a threat to families' being able to stabilize and lead to continued child welfare involvement.

In domestic violence cases, both program and child welfare worker interviewees agreed that domestic violence was a major stumbling block for clients, and this could be difficult especially when the client was not ready to share the domestic violence relationship with the worker. One welfare worker said, "Mom [is] engaged in a volatile relationship, which has always been Mom's downfall, and she kind of kept the relationship a secret, so that [program worker] couldn't even begin to address it, 'cause no one even knew of the involvement." A program worker described she and other workers address cases like this.

We have therapy in there and then case management's in there too, and really we're providing education to Mom around like, "Hey. We have some shelter resources if you're interested." ...Laying the groundwork, really building the trust up around "Does she want to tell us?" 'cause she hasn't. When we talk to her about her bruises, they're always about like "Oh, my kids are playing really rough with me," like that kind of thing. So she's not ready to tell us what exactly is going on in the home, so continuing to build a trusting relationship and add in pieces of education to her along the way. Like hopefully that lays the groundwork for if she chooses to say "Hey, that shelter you talked to me about six months ago, are you ready?" "I think I might be ready." That kind of thing.

This quote demonstrates the workers' recognition of the need for a long-term approach in domestic violence cases, as well as the importance of a strong relationship between case managers and clients and the laying of groundwork for clients' acceptance of services.

### 3.3.3. Benefits of housing

The program was widely praised in all interviews for the quickness with which clients were able to secure housing (typically within three months). The quick housing the program facilitated through its collaboration with the public housing authority were acknowledged by both child welfare and program staff as helpful for clients to build housing

stability. This was the first thing workers mentioned about the program and the most positive aspect of the program. One program worker said:

We've had several cases where children have been removed in the past. The families have worked their case plan for everything, except housing, and now they're re-referred for a new child and we get them housing and they tell us "I would never have been able to keep this child if it hadn't been for your program."

A child welfare worker agreed with the assessment that housing was essential for clients to begin building a stable foundation for the rest of their lives.

Again, if you can't meet the need, you see a lot of other things that's declining, whereas the need of housing for the clients that's in the program has been met, so you see a lot of improvement in their life and their readiness to want to engage in services.

Another child welfare worker, however, felt that just providing housing was insufficient, and not first directly addressing client issues such as mental health, substance abuse, and trauma would ultimately keep clients from being able to move forward. The worker said:

If you do not address your mental health, your substance abuse, then trying to be a good parent...we see it every day. We appreciate [program workers] but [the program agency] really needs to understand and see what is really going on with the clients that we have and what's going on in the lives of these children. The children suffer because... parents have suffered and basically they just grow up and they're still age 3 or 6 or 10 and they've had kids. So finding housing and getting them not to be homeless again, housing cannot be the top priority, because they have not addressed the main issues. It cannot be.

This quote indicated a contrast from previous quotes with this worker feeling that parents who have experienced trauma might not be prepared to stabilize without addressing mental health and substance abuse issues first.

Although the quick housing was praised overall, both child welfare and program workers expressed concern that housing clients in public housing was only a short-term remedy because parents did not ultimately want to raise their children, particularly young boys, in public housing. In the long term, they said, parents did not see public housing as a safe environment or a long-term solution to their housing issues. One child welfare worker said, "I think people are glad to have a house, but it is not what their first choice would be living in the [public housing] property." Other workers, however, saw housing as some clients' main issue and wished other clients could qualify, feeling the program was very valuable. One program worker said: "So is there a possibility, instead of the families being selected, that it's like an actual application that we could fill out?" She went on to ask if there could be a way workers could "sign an application and say 'This is a family that I can advocate for, I can support. They're working their services and they are truly worthy.'" This worker's quote reflects a frustration with the random selection criteria for the randomized control trial and also her belief that the program would be beneficial for particular clients.

## 3.4. Quantitative findings

### 3.4.1. Housing instability

Housing instability was explored by examining differences between the treatment and control group before, during and after program entry using HMIS data. Table 4 displays client homeless service involvement a year before program entry, 12 months and 24 months after program entry, and Table 5 displays a summary of logistic regression analyses. The findings indicate that in the year before program entry, the treatment group had proportionally more contact with rapid rehousing and a reduced likelihood of entering emergency shelter than the control group, however, these differences did not reach statistical significance.

**Table 4**

HMIS involvement, public assistance and child welfare involvement for treatment (n = 90) and control (n = 73) clients (total N = 163).

	Before Program		During Program		After Program	
	Treatment	Control	Treatment	Control	Treatment	Control
<b>HMIS (% yes)</b>	(n = 90)	(n = 73)	(n = 90)	(n = 73)	(n = 90)	(n = 73)
Emergency shelter entry	59.6	69.4	12.4	22.5	3.3	14.5*
Rapid-re-housing	29.2	19.4	6.7	16.1	0.0	1.6
Coordinated assessment	67.4	83.9*	14.6	19.4	4.4	16.1*
Any homeless system involvement	75.3	90.3*	23.6	35.3	5.6	17.7*
<b>Public assistance (% yes)</b>	(n = 90)	(n = 73)	(n = 90)	(n = 73)	(n = 86)	(n = 64)
SNAP	80.0	72.6	82.2	72.6	75.6	67.2
TANF-Cash assistance	12.2	16.4	13.3	5.5	9.3	9.4
<b>Child welfare involvement</b>	(n = 90)	(n = 73)	(n = 90)	(n = 73)	(n = 48)	(n = 35)
Substantiated reports	52.2	61.6	13.3	9.6	22.9	17.1
All reports	75.6	79.4	40.0	35.6	45.8	40.0

Note. Data source: HMIS from Jan 2014 to Dec 2018. DCFS from Jan 2014 to Dec 2017.

Thus, we were not able to track public assistance for 13 clients and DCFS involvement for 80 clients after 24 months of program entry.

\* $p < .05$ .

\*\* $p < .01$ .

\*\*\* $p < .001$ .

**Table 5**

Summary of Logistic Regression Analyses (N = 163).

	B	SE	OR	CI
<b>During Program (12 months after program entry)</b>				
<b>HMIS</b>				
Coordinated assessment	-0.2	0.4	0.8	[0.3, 2.0]
Emergency shelter	-0.7	0.4	0.5	[0.2, 1.2]
Rapid re-housing	-1.0	0.5	0.4	[0.1, 1.1]
Any homeless system involvement	-0.4	0.4	0.6	[0.3, 1.3]
<b>Public assistance</b>				
SNAP	0.6	0.4	1.7	[0.8, 3.7]
TANF-Cash assistance	1.0	0.6	2.6	[0.8, 8.6]
<b>Child welfare involvement</b>				
Substantiated reports	0.2	0.3	1.2	[0.6, 2.3]
All reports	0.4	0.5	1.4	[0.5, 3.9]
<b>After Program (24 months after program entry)</b>				
<b>HMIS</b>				
Coordinated assessment	-1.4	0.6	0.2*	[0.1, 0.8]
Emergency shelter	-1.6	0.7	0.2*	[0.1, 0.8]
Rapid re-housing	-	-	-	-
Any homeless system involvement	-1.5	0.6	0.2*	[0.1, 0.7]
<b>Public assistance</b>				
SNAP	0.4	0.4	1.5	[0.7, 3.1]
TANF-Cash assistance	0	0.5	1.0	[0.3, 3.0]
<b>Child welfare involvement</b>				
Substantiated reports	0.4	0.6	1.4	[0.5, 4.3]
All reports	0.2	0.4	1.3	[0.5, 3.1]

Note. CI = confidence interval for odds ratio (OR).

\* $p < .05$ .

\*\* $p < .01$ .

\*\*\* $p < .001$ .

However, a statistically significantly smaller proportion of clients in the treatment group received coordinated assessment (centralized homelessness assessment) as compared to the control group ( $X^2(1) = 5.16$ ,  $p < .05$ ). A statistically significant larger proportion of clients in the control group had any homeless service contact as compared to the treatment group ( $X^2(1) = 5.47$ ,  $p < .05$ ). During the program year (12 months after program entry), treatment group clients were less likely than the control group to have accessed any homeless services, however, the differences between treatment and control were not statistically significant. After 24 months of program entry, however, treatment group clients were significantly less likely than the control group to enter emergency shelter ( $X^2(1) = 6.20$ ,  $p < .05$ ), receive coordinated assessment ( $X^2(1) = 5.88$ ,  $p < .05$ ), or access services in

any of these categories (emergency shelter, rapid re-housing or coordinated assessment) ( $X^2(1) = 5.67$ ,  $p < .05$ ). Additionally, logistic regression results indicated that after 24 months of program entry, the odds of receiving coordinated assessment, entering emergency shelter, and having any homeless service contact were statistically significant, with the risk of having contact with homeless services being reduced by 80% for the treatment group as compared to the control group, controlling for group differences before program entry.

### 3.4.2. Public assistance and child welfare involvement

Examining clients' receipt of public assistance one year before, the year during the program and two years after program entry revealed that clients in the treatment group were somewhat more likely than clients in the control group to receive SNAP assistance, however, the differences were not statistically significant. The proportion of clients in the treatment group receiving TANF increased slightly over time while the proportion in the control group remained about the same. The difference between the two groups was not statistically significant on either bivariate or multivariate levels.

Data on the number of substantiated maltreatment reports were analyzed for the year before the program entry date, the year in the program, and up to 24 months from program entry. The analysis focused on the parent, rather than the child level, and thus the denominator reflects all parents in the study rather than only parents who had their children in their care. More than half of clients in both the treatment and control groups had substantiated child maltreatment incidents one year before the program, but after program entry, incidents for both groups dropped dramatically. The treatment group's decline was not statistically significant compared to that of the control group. After 24 months of program entry, more clients in the treatment group (n = 48) had substantiated maltreatment cases as compared to the control group (n = 35), but those differences were not statistically significant at either bivariate or multivariate levels. Examination of data on participants' children as a victim of any maltreatment report (substantiated or unsubstantiated) a year before the program found both groups had similar rates. After entering the program and at follow-up, treatment group clients had a higher proportion of reports as compared to the control group, but the differences were not statistically significant.

## 4. Discussion

This mixed-methods study explored implementation findings of treatment and control group clients participating in a randomized

control trial of housing-unstable clients with children in out-of-home placement. Quantitative housing, public assistance, and child welfare administrative data findings, measured over three years were contextualized by qualitative content analyses of case management contacts, examinations of service patterns based on progress notes, and qualitative interviews with program and child welfare staff. Assuming unstable housing was a primary obstacle for clients, the program focused on quickly housing clients and providing supportive services. The findings suggest positive trends in housing stability with treatment group clients being less likely to use homeless services after entering the program as compared with control group clients, suggesting more housing stability amongst treatment group clients. Regarding obtaining greater financial stability, as measured by accessing public assistance benefits (among this high poverty sample), treatment groups were somewhat more likely to access these benefits. Child welfare findings indicated that overall, both treatment and control group clients' child welfare involvement decreased, but treatment group clients were somewhat more likely to have child welfare reports (both substantiated and unsubstantiated). Differences between treatment and control groups in both public assistance and child welfare involvement were nonsignificant. Though the direction of the trend was positive regarding greater financial stability, the child welfare trend did not suggest greater stability. Qualitative data indicated the program model mirrored CTI stages and suggested that it successfully affected clients' housing situations, but there were some caveats regarding housing quality and some disagreement amongst workers regarding the wisdom of following Housing First principles with this population.

Housing is an important foundation for families, and the program's success in this area is notable. Reducing both the societal and economic costs associated with homeless system involvement is worthy, and the benefits of effective programs for avoiding homelessness far outweigh the costs (Evans, Sullivan, & Wallskog, 2016). Our findings that treatment group clients had less contact with homeless services than the control group at both the period after program enrollment and the following year provide support for the idea that interventions following Housing First principles can help reduce the use of homeless services. This finding contributes to the field as we continue to learn how Housing First service models can be adapted and applied to homeless subpopulations such as families, part of the Ending Homelessness Grand Challenge for Social Work (Henwood et al., 2015). The qualitative findings support other research that has found that Housing First provides an important foundation on which to build for chronically homeless families with substance abuse or mental health issues (Collins et al., 2018) and work that is informing us of the relationship between housing and child welfare outcomes (Fowler, 2017; Pergamit et al., 2017; Shinn, Brown, & Gubits, 2017).

Regarding financial stability, while treatment group clients were becoming somewhat more financially stable, the change was not dramatic, and overall, despite their poverty status, very few clients accessed TANF. Reasons for this are not clear, however, they may reflect the benefit's low levels of support which have eroded over time (Burnside & Floyd, 2019). SNAP benefits were used at a higher rate, however, suggesting that at least families had some measure of food security. Some measure of stabilization was suggested by progress notes and interview data findings that staff worked intensively with clients by coaching and guiding them toward strengthening independent living skills, helping clients communicate, assisting clients in accessing housing, and helping clients navigate the social service system. These findings suggested program workers were important guides for vulnerable treatment group families.

Despite the encouraging findings on housing, and somewhat, public assistance, clearly, treatment group clients' child welfare outcomes were not ideal, as any new child welfare reports warrant attention, and any child experiencing maltreatment is cause for concern. Qualitative interview data suggested some reasons for these findings, including that program families have at least one person very close to them in their

program worker—a person who might be intimately familiar with the families' strengths as well as their challenges. Thus, families in the treatment group may experience a "fishbowl effect" or particular scrutiny, as they have frequent contact with program staff who are mandated child abuse reporters. As a result, parenting behaviors—which might normally be unobserved due to child welfare workers' limited time and resources—were under closer observation by program staff and would be reported if there was any suggestion of child maltreatment (Dworsky, 2014; Park et al., 2004).

Additionally, taken together, the quantitative and qualitative data indicated that domestic violence was a real concern amongst treatment group families. The HMIS data indicated much of the sample were "domestic violence survivors" at intake, but we did not have strong data on which clients were currently experiencing domestic violence or how that evolved over time in the program. While the interview data suggested it was a very common problem and was responsible for additional child welfare reports and subsequent removals of children, we also learned that the issue was not always actively discussed with program workers, making it difficult to address directly. Our progress note data supported this idea, indicating that domestic violence was the least frequently explicitly addressed issue. Non-disclosure is an important issue and a significant impediment to effective service provision (Francis, Loxton, & James, 2017). It might be that the timeframe of this study was too short to detect longer-term changes in domestic violence situations which could in turn point toward improved child welfare outcomes. This idea is consistent with research on domestic violence suggesting that exiting a domestic violence relationship can be a long process, characterized by leave/return cycles in which women leave and then return to the violent relationship, cycles which are common and can threaten housing stability (Anderson & Saunders, 2003), and lead to future child welfare involvement.

Past research has indicated findings consistent with ours. Families with children in out-of-home placement experiencing housing instability have significant challenges, and a stable housing intervention equipped with intensive case management does not necessarily translate to reduced caregiver distress (Gubits et al., 2016). Many families continue to struggle with poverty, mental health issues, and substance abuse. Our interviews indicated that the treatment families had extremely complex needs, extensive trauma histories, and crises were common, suggesting that while housing was important, it was simply not enough to fully stabilize them. Additionally, while program staff in our study worked with parents on improving stress levels and parenting skills, we do not have strong measures in this study of the efficacy of that work.

While our findings contribute to the knowledge base in the field around the importance of housing, given our qualitative findings from providers, it might be that housing is not enough to address the complex needs of these families (Fowler, 2017), and sustainable income generation strategies and additional services that target specific needs of families with multiple problems (Marsh, Ryan, Choi, & Testa, 2006) must be considered for supporting families' long-term stability. The uniqueness of the program, however, should be noted, because funding flexibility and decreased emphasis on worker productivity allows for tailored services, cited as key to serving families with complex needs.

Finally, the knowledge base is continuing to develop regarding serving families using CTI. Progress note data on case management dosage indicated that as the clients' time in the program increased, program workers spent less time overall, with clients, reflecting the expected pattern for CTI (Herman et al., 2007). However, examining families' progress as aligned with CTI stages is challenging since the CTI time frame varies based on clients' different needs (Harder + Company Community Research, 2014). As noted earlier regarding domestic violence, some clients need more time to move on to the next CTI stage while others move more quickly and crises can push client clients back to earlier stages. Thus, it might be appropriate to consider varied time frames based on client needs for future CTI applications.

#### 4.1. Limitations

Any conclusions that can be drawn from this study should be done carefully and while considering its limitations. The total sample size is small ( $N = 163$ ), and might be insufficiently powered to detect desired differences between the treatment and control groups. Falsely negative findings from this study may lead to a Type II error. The HMIS data also have limitations. For instance, while the county's coordinated assessment team and shelter staff are well-trained on entering HMS data, the data for other programs such as permanent supportive housing were not collected reliably, thus we could not report on the number of clients who received other sorts of program services. Although program-served families increase their receipt of SNAP and TANF after being in the program, our data do not allow us to know if they were pursuing work-generated income, therefore we cannot draw conclusions about long-term self-sufficiency in this area. Moreover, public assistance and child welfare data were not available for some program clients at the follow-up period, thus, we have a limited window in which to observe long-term changes. Also, as mentioned earlier, the service population generalizes only to those for whom public housing was an option. We did not track and do not know the proportion of families who had housing issues with children in foster care but who were excluded, thus our sample might be biased in favor of clients with less extreme cases.

#### 4.2. Implications

##### 4.2.1. Policy

Our findings that fewer treatment families than control families accessed homeless services after becoming involved in the program is important, and suggests the program is associated with reduced homelessness. The social and economic benefits of reduced homelessness are important. Given research that finds supporting families through housing has various positive impacts on families and children (Hong & Piescher, 2012), we join other researchers in urging policymakers to consider increasing funding for supportive housing services, subsidized housing, and increase cross-system collaboration efforts to serve dual-system-involved populations (Dworsky, 2014) and help them avoid further homeless spells. While housing is critical, future policies and programs should also aim to help stabilize families' economic resources and prevent or compensate for economic crises, as well as improve access to needed resources such as mental health, domestic violence, and substance abuse treatments to help families avoid homelessness. These supports might be more successful than focusing on helping families avoid housing instability and providing supportive services without addressing other underlying economic needs and stressors (Berger et al., 2015). Providing such vulnerable families with strong foundations (e.g., teaching them skills with which to increase self-sufficiency, maintain housing, increase parenting skills, and link to community resources to support them) is likely to be a public policy investment that will pay off in the long-term.

##### 4.2.2. Practice

One important issue highlighted in this study was that the program provides an innovative approach in addressing social problems through a unique funding mechanism. Traditionally, the capacity of many programs is limited by grants and/or contracts and other restrictions. The program model focuses on a particular issue and allows us to better help vulnerable groups without such constraints and/or productivity requirements. Additionally, the flexible discretionary funds to which program service providers had access allowed workers to assist clients in many ways, in line with CTI guidelines, including groceries, utility bills, and other basic needs. Thus, the model leverages the strengths of different agencies involved and provides needed flexibility, allowing service providers to focus on the real-time needs of at-risk families, and giving workers more freedom and autonomy to deliver high-quality

services to clients in need, truly tailored to each family's specific needs (Henwood et al., 2015).

In addition to flexibility and tailoring, collaborative practice is increasingly being considered critical to effective service provision, particularly for clients with multiple and complex needs (Bai et al., 2019). One key strength of the program model has been that it has worked to build bridges between government, private funders, and service providers. Successful collaborations between service providers, including housing providers, suggest that different sectors can work together to effectively improve services for families and children. While child welfare workers with high caseloads cannot be expected to provide intensive, individualized services to highly needy families, with collaboration, other service sectors can step in and help families obtain housing and other support and work toward better outcomes for families.

##### 4.2.3. Research

Additional research is necessary as we continue to learn how to best serve dually involved families with multiple risk factors and service needs. Research with large samples and utilizing high-quality designs that incorporate mixed methods, such as this one, can help us more fully understand the factors that predict positive outcomes such as housing stability and child welfare involvement (quantitatively) among housing unstable and child welfare-involved families. Further exploration of the reasons for such outcomes from the perspectives of both service providers and families themselves (qualitatively) will do much to increase the knowledge base. Longitudinal research is also essential; families' needs do not become complex overnight, or even over a relatively short amount of time (e.g., one year), thus research on interventions is necessary to determine the timeline(s) necessary to see significant differences through interventions. Both the process and outcome data are needed to inform the field and are essential in moving the knowledge base forward, as well as improving practice with housing unstable, child welfare-involved families.

## 5. Conclusion

Determining what interventions are most effective for stabilizing housing-unstable, child welfare-involved families is a challenge that is increasingly being prioritized as society recognizes the high social and economic costs of both housing these families in emergency shelter and funding out of home placement for their children. Though our findings were mixed regarding quantitative indicators of client's housing, public assistance receipt, and child welfare outcomes, there was more reason for hope in examining quantitative and qualitative progress note data that suggested families were on their way to stabilizing. Qualitative interview data also indicated mixed findings that while housing was essential for long-term self-sufficiency, families with complex needs may need more time to fully stabilize and move their lives forward. Together with the extant literature, our findings suggest that additional work is needed to fully understand how to produce positive outcomes for multiply service-involved families' homeless service use, child welfare involvement, and public assistance receipt.

### Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.chidyouth.2019.104578>.

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