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making a meaningful difference

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# Keeping Families Together

An evaluation of the implementation and outcomes  
of a pilot supportive housing model  
for families involved in the child welfare system



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An evaluation of the implementation and outcomes  
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## Executive Summary

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*Keeping Families Together (KFT)* is a pilot initiative of the Corporation for Supportive Housing (CSH) that was designed to test the impact of permanent supportive housing for families who had been involved with the child welfare system and who had been homeless for at least a year. With funding from the Robert Wood Johnson Foundation, the initiative targeted the most vulnerable families, aiming to improve agency collaboration in support of these families and build capacity among providers to serve them.

Although CSH had been working on family supportive housing for almost two decades, the tragic death in New York City of Nixzmary Brown, a little girl who was known to child welfare authorities and whose family had once lived in a shelter, brought a new urgency to identifying ways to serve vulnerable families.

Over the course of the pilot initiative, which began in 2007, CSH worked with city agencies and housing providers in New York City. KFT identified seven strategies:

- Working closely with city agencies and facilitating outreach to nonshelter-based referral sites (Family Court, the Administration for Children’s Services, preventive service agencies) to identify and recruit 25 to 30 homeless families with open child welfare cases who were eligible for housing through NY/NY III (see description below);
- Identifying six housing providers to serve KFT families;
- Convening housing providers, city agencies (child welfare, homeless services, health and mental health, and housing), and other organizations to promote interagency collaboration and problem solving;
- Assisting housing providers in refining their service delivery models and supporting their efforts to serve high-need families;
- Offering clinical consultation through consultants to help assess the capacity of housing provider staff, train, and design an integrated service approach for KFT families;
- Making financial grants available to KFT families (through the housing providers) for activities that promote self-sufficiency (e.g., education, job training) and family cohesion; and
- Evaluating family and system level outcomes.

Those eligible for housing under NY/NY III are “chronically homeless families or [those] at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition or HIV/AIDS.” NY/NY III defines chronic homelessness as “a family which has lived in a homeless shelter for at least 365 days of the last two years, not necessarily consecutively.”<sup>1</sup> Combining the goal of NY/NY III with the goal of preventing child abuse and neglect, CSH planned for KFT to serve families who both met the NY/NY III requirements and had child welfare involvement (i.e., had an open ACS case).

Keeping Families Together became a reality in the fall of 2007 when the first of the vulnerable families moved into supportive housing (SH) provided by two agencies, CAMBA and Women in Need. Subsequently, additional families moved into housing provided by the Lower Eastside Service Center, Palladia, St. John’s House II, and the Lantern Group. Five of the six housing providers were funded by

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<sup>1</sup> New York/New York III Supportive Housing Agreement, retrieved at <http://www.shnny.org/agreements.html>, April 28, 2010.



NY/NY III and one received funding from the U.S. Department of Housing and Urban Development (HUD).

Metis Associates conducted its evaluation of the KFT pilot between September 2009 and May 2010. The evaluation, which was designed to assess the extent to which the initiative met its objectives, built on work begun by Dr. Sylvia Ridlen, the project's first evaluator. It includes a retrospective assessment of the implementation of the pilot initiative and an outcome evaluation that has examined the impact of the initiative on participating KFT families. Metis conducted a review of program documentation, focus group interviews with supportive housing providers (directors and case managers) and families, and interviews with representatives of city agencies, interviews with CSH staff and the project's clinical consultant. Limited data from interviews with KFT families conducted by Dr. Ridlen also were incorporated into this report. Several types of administrative data were analyzed. For consenting families, child welfare data were obtained from the New York City Administration for Children's Services (ACS). Education data on public school students in the KFT families were accessed from a repository maintained by Metis through an agreement with the New York City Department of Education. Data on homelessness for a comparison group of similarly situated families who did not enter supportive housing were provided by the New York City Department of Homeless Services (DHS). Additional data on KFT families were obtained from case managers' records.

The implementation and outcome evaluation findings, challenges, and recommendations are summarized below.

## **KFT Implementation Findings**

**Family Identification and Recruitment.** To identify families eligible to participate in the KFT pilot, CSH had to use several strategies and collaborated with city agencies, including DHS and ACS. These strategies included the matching of administrative data between DHS and ACS records; a review of families accepted for the Children Advantage rental subsidy, which helps families with open ACS cases move out of shelter (for families who were living in a shelter for at least 90 days and had an open ACS case past the investigation stage); outreach to shelters by DHS staff; outreach by CSH staff to shelter staff as well as Family Court, legal, and other agency staff; and direct recruitment by the supportive housing providers.

**The process of identifying and recruiting families for the pilot initiative took about one year and was found to be more difficult than CSH expected.** Although CSH and the city agencies believed that a substantial number of families in the shelter system met the KFT criteria, the ability to identify them depended on the amount of information that the shelter system collected and how much personal information about substance abuse, mental illness, and child welfare involvement the families disclosed to shelter staff.

The most productive strategy was a collaborative approach by DHS, CSH, and ACS-contracted preventive agencies. Use of a screening questionnaire, interviews with families, and direct outreach to shelters by the DHS Deputy Director for Quality Assurance and Program Support produced 22 families for the KFT initiative, and another 15 families became part of the DHS comparison group. The referral efforts of CSH alone resulted in the placement of three families, while the recruitment by housing providers resulted in four families for the KFT pilot. In sum, 29 families were placed in KFT supportive housing.



**Collaboration.** The support, participation, and collaboration of city agencies and private, nonprofit supportive housing partners were instrumental to the development of the KFT initiative. Along with the supportive housing providers, city agencies such as DHS, ACS, the Department of Health and Mental Hygiene (DOHMH), and the Human Resources Administration (HRA) attended meetings that helped to shape the implementation of KFT and drive the interaction and knowledge sharing among stakeholders. CSH acted as a “convener” and promoted and facilitated the collaboration among provider and city agency partners. Child welfare agencies and homeless service providers were brought together to strengthen their communication and ensure the priority of families with child welfare involvement. KFT meetings also served to monitor the implementation of the initiative and created opportunities to offer technical assistance to build the clinical capacity of the providers, especially the case managers.

**Capacity Building.** KFT helped build the capacity of supportive housing providers and case managers, by linking them with experts in the field. Clinical consultants from Mt. Sinai School of Medicine advised the case managers on evidence-based techniques and engagement strategies. KFT also made connections between the supportive housing providers and staff from city and other agencies. These contacts facilitated learning about agency operations and helped to identify information gaps or misinformation. Further, KFT connected the supportive housing providers to other community services; those groups could help all of the families served by the housing providers—not only those participating in KFT.

**Case conferencing remains a goal of KFT, but achieving it requires the collaboration of multiple constituents and this remains an important discussion among KFT stakeholders.** Some families, however, have invited their supportive housing case manager to participate in ACS child safety conferences.

## KFT Family Outcome Findings

**Profile of the Families.** The recruitment process resulted in 29 eligible families, whose characteristics closely paralleled the profile of homeless families found in the research literature: female-headed families with a history of substance abuse, mental illness, domestic violence, or a lack of social support. Most of the participating families were headed by a single female, although a few had two adults in the home or were headed by a single father. The average KFT family had two children living with them in supportive housing. At the time of move-in, the KFT families had a total of 37 open and indicated ACS cases. All but one head of household had a history of substance abuse and over half had been diagnosed with mental illness. Many of the heads of households were reported to have histories of abuse, neglect, and violence, and to have experienced homelessness or foster care placement during their childhoods.

**Service Use.** Upon placement in supportive housing, all families received individual case management services from on-site social workers and had access to additional services through other on-site staff or community providers. Case managers employed by the housing providers met with each family at least twice monthly, to identify services (e.g., substance abuse treatment, medication management, parenting skills training, domestic violence services), as well as to develop intermediate and longer-term service plans. The motivation and receptiveness of families and the relationship with their case managers were important in determining whether or not families accessed services. Case managers were supported by the project’s clinical consultants, who helped them to implement family engagement strategies. A family’s participation in support services other than case

management was not a requirement of the KFT program, and supportive housing providers cannot mandate services to any of their families.

Twelve adults participated in substance abuse treatment programs while living in supportive housing, while seven heads of households were receiving psychiatric treatment to manage their mental illnesses. Nearly all of the families that entered with a substance abuse problem were reported to be clean and sober at the end of the evaluation period.

**Flexible grants.** The KFT initiative provided each family with a grant of up to \$1,000 for each year that the family was housed for the life of the pilot (not to exceed a maximum of \$2,000 per family). These flexible spending funds were to be used for one-time expenses that promoted positive family functioning, and were spent primarily on clothing and household items, as well as items for children. The program encountered some challenges obtaining documentation from the families regarding their purchases.

**Residential Stability.** A total of 29 families moved into their supportive housing apartments between October 2007 and July 2009. At the end of the evaluation period, 26 of the families remained in supportive housing. The other three families, all headed by single women, voluntarily moved out of their supportive housing apartments. Two returned to shelter during the KFT pilot period. Before moving into supportive housing, on average, families had been homeless for about 1,200 days, equivalent to nearly 40 months or more than three years of residential instability.<sup>2</sup>

**The 15 comparison families that met KFT eligibility but were not placed in supportive housing had an average cumulative tenure in shelter during the KFT pilot of 15.3 months, ranging from two to 30 months.** Seven of these families (46.7%) exited shelter after this initial stay. Eight families (53.3%) either remained in shelter without interruption or had episodes of one or two additional shelter stays during the period under study.

**Child Welfare Involvement.** Analyses of data obtained from ACS and additional information from case managers show a decrease in child welfare system involvement for KFT families. More than half (61.1%) of the child welfare cases that were open at the time of the move to supportive housing had been closed. The average duration of the 14 closed cases that were categorized as preventive services cases was 22 months, as compared to the ACS system goal of 12 months for this type of case. However, these KFT families' preventive cases closed an average of 10 months after the family was housed in supportive housing.

**All six of the children who were in placement with a goal of reunification were returned to their families. Sufficient time had elapsed since move-in such that five of the six reunified children met the ACS goal of ensuring that children who have been reunified with their parent do not return to foster care or other placements within one year.** Analyses of the duration of placement, with respect to the family's move-in date, show that the reunified children had spent an average of 680 days in placement before their family moved to supportive housing and only 124 days in placement after the family had stable housing.

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<sup>2</sup> This estimate includes the data for two families that had experienced very long periods of homelessness, 11 and 12 years, respectively.



**KFT families had fewer incidences of repeat maltreatment while living in supportive housing.** KFT families experienced 46 abuse/neglect cases in the three years prior to their move to supportive housing, with an average of 2.1 reports per family. During the families' residence, the number of cases decreased to 13, with an average of 0.6 per family. A majority of the KFT families (63.6%) had no subsequent abuse/neglect cases after moving to supportive housing. In addition, among the group of five families who had lived in supportive housing for more than two years, the number of indicated cases was reduced by half (14 pre-move as compared to six post-move).

**No children were removed from the home and only two ACS cases were reopened during the KFT pilot.** One of these involved a child whose preventive case had closed during the period of residence but who had a new protective case opened by the end of the pilot. The other child did not have an open ACS case at the time of move-in but did have a history of involvement with ACS about four years prior to the family's move to supportive housing.

**Educational Outcomes for Children in KFT Families.** The 10 school-age children housed during the 2007–08 school year showed steady average increases in school attendance over three years, from before move-in to one year after move-in. After the first year of supportive housing, these children were attending an average of 25 more days of school per year than they had attended before moving to supportive housing. In addition to the improvement by the group, as a whole, each of the children who moved in during the 2007–08 school year improved their individual school attendance.

**The academic achievement of children in KFT families on the New York State English Language Arts (ELA) and math tests was mixed.** An analysis of academic achievement was conducted for the children who had moved into supportive housing during the 2007–08 school year. One year after move-in (spring 2009), one child in this cohort of six met the state ELA learning standards and three children met the math learning standards. Longitudinal analyses examined changes in these students' performance from before move-in to the end of move-in year, and from the move-in year to one year after. The results of the analyses found that two of the six children improved their ELA performance and three improved their math performance from move-in to one year after move-in.

**Other Outcomes for KFT Families.** Comments from the families suggest that supportive housing has had a positive effect on their ability to maintain relationships with others and to rebuild their support systems. The adults who participated in focus groups reported that KFT has helped them form supportive relationships with other residents and case managers. They have attended religious services in the community and reconnected with family members.

Focus group participants also felt that supportive housing had a powerful impact on the importance they placed on becoming better parents for their children, and provided the opportunity for them to do so.

About one-third of the families also participated in job readiness/employment skills training. Six adults in KFT families were employed at some point during the project period, although only one head of household was employed at the end of the pilot period.

## Challenges

**For Family Identification and Recruitment.** The availability of housing units challenged KFT's ability to place families with particular providers. Housing providers interviewed the

families and selected them based on their own criteria. But, because the housing units were not all available at the same time, it was not possible to refer families to a different provider if that would mean a better match. Such a strategy would have required a family to wait in shelter until another building opened or a unit was available, which was unrealistic. NY/NY III providers were required to accept one out of every three applications. For the pilot, CSH tapped into newly opening NY/NY III units.

**For Interagency Collaboration.** ACS supported the concept of the KFT initiative at the highest levels and assisted with its development. However, close and ongoing collaboration between CSH and ACS around identifying best practices and procedures for serving the families (whose child welfare involvement had made them eligible for the program) did not occur. At CSH and the supportive housing providers there was concern that some of the ACS frontline case workers were not sufficiently familiar with the concept and operations of supportive housing. In turn, the staff of the housing providers would have benefited from additional training about ACS policies and practices. For example, one policy/practice area that was identified by housing providers as needing clarification concerned the meaning of “mandated (abuse/neglect) reporting” and how to negotiate the role of a mandated reporter with the development and maintenance of a trusting relationship. The absence of a close collaboration between the pilot initiative and ACS may also have impeded the development of case conferences among staff from the supportive housing providers, ACS, and other agencies, or the involvement of supportive housing case managers in ACS case conferences.

**For Providers.** Providers experienced some challenges related to start-up, families’ readiness for independence, and resources available in the community. The KFT initiative was affected by a delayed start for some providers, although this was a likely unavoidable complication of the supportive housing development process and a rolling start-up of the initiative. As a result of these delays, families that were not housed until the summer of 2009 had less time to demonstrate progress than those who moved in at the beginning of the pilot.

**Families expressed a need for balance between intrusiveness and support by housing providers, as some focus group participants equated their experience in single-site supportive housing with the shelter system.** The feelings of these tenants may be similar to what has been described in the literature as a “fishbowl effect,” in that families are monitored closely by staff, which the families feel violates their independence. Some case managers also indicated that they had to negotiate the families’ own desires for independence in light of their professional assessment of the families’ readiness, and learn how best to empower their clients to become self-sufficient. The KFT program took steps to address this by engaging clinical consultants to train case managers on engagement strategies.

Although families clearly benefited from the flexible spending grants, the grants presented challenges in terms of their administration and distribution. Many families perceived a lack of clear rules for how to spend the funds, and some were resentful of having to be accompanied by a staff member when making their purchases.

## Recommendations

Based on these evaluation findings, Metis offers the following recommendations:

- Providers and case managers should continue their efforts to learn the most effective strategies to engage families. Additional training should be provided to supportive housing case managers



and other staff about evidence-based strategies (e.g., intake procedures that focus on overcoming potential barriers to service involvement, interviews that clarify the need for mental health care, and overcoming difficulties keeping appointments) that have been shown to help families build and rebuild relationships and better address the needs of vulnerable children.

- The KFT model should reemphasize the importance of the families having access to high-quality mental health services (e.g., cognitive behavioral therapy, trauma-focused cognitive behavioral therapy, Wellness Self-Management, multiple family group intervention for children with conduct problems, child behavioral management, and integrated family support programs for those parents in contact with child welfare systems). Community-based mental health services are in short supply and may not be sensitive to the unique needs of the KFT families, nevertheless, providers should make efforts to connect families with these services.
- If the KFT model were to be replicated, the initiative should consider adding the services of a consultant who could train the case managers in addiction services and harm reduction strategies. Research indicates that many of these vulnerable families struggle with substance abuse and would benefit from well-trained case managers who are supported by experts.
- Housing provider staff should work to improve their relationships with families so that they are seen as supportive of their independence rather than intrusive in their daily lives. Borrowing from other supportive housing models and one of CSH's own Dimensions of Quality, providers could create tenants' rights boards or tenants' groups to empower tenants in site decision-making. Providers might also consider having tenants staff the front desk of the buildings, which might strengthen the role of front desk staff in providing for tenants' safety rather than monitoring their activities. This issue could be explored by looking at the different ways case managers approach intervention. A future study also could examine whether and how the issue of intrusiveness differs for families residing in single-site or scattered-site units.
- To improve understanding about supportive housing, the child welfare system, and the needs of KFT families, CSH should further engage ACS in discussions that promote an understanding about the role of ACS case workers, their perceptions of the role of the supportive housing case managers, and how the roles of each interact in ACS staff's decisions about a family and support the families' repair and growth. Furthermore, CSH should discuss with ACS how housing provider staff might be involved in case conferences and identify and secure the participation and cooperation of the agencies that need to be involved. The supportive housing providers and other agencies should address the most effective ways to collaborate to identify, recommend, and follow up on services for these needy families.
- With regard to assessing child welfare outcomes, the effect of supportive housing on child welfare cases should be expanded to a larger cohort of families so that the results may be generalized.

The evaluation of the KFT pilot initiative was limited by a number of factors. The sample size, once disaggregated by move-in date, was quite small, which prohibited more advanced statistical analyses that might have been conducted to ascertain differences between providers and between move-in cohorts. There also were some inconsistencies across providers in the records of the families' use of services.

This pilot study has identified a number of areas with potential for future research. With a larger sample size, there could be an examination of the benefits of scattered-site vs. single-site housing models. A study of longer duration would allow for a longitudinal analysis of children's school attendance and



educational achievement, and child welfare outcomes. Information about the effect of services and early interventions on children’s mental, emotional, and general health outcomes also could be explored. Moreover, in a future iteration of KFT, the evaluation could focus on specific substance abuse treatments or addiction services, and other health outcomes for the adults.

In summary, the KFT initiative had a very successful pilot period. The open child welfare cases of many children were closed during the pilot and all of children in placement at the start of the pilot were returned safely to their families and did not return to foster care. There was a large reduction in the number of new child welfare cases for the five families who had been housed for more than two years. Families gained residential stability in supportive housing and were assisted by case managers and other services. Keeping Families Together had city agencies, supportive housing providers, and case managers meeting, collaborating, and participating in training behind the scenes in order to improve outcomes for families.



## I. Introduction

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*Keeping Families Together* (KFT) began in 2006 as a demonstration that permanent supportive housing could create housing stability, and increase family stability, for some of the most vulnerable of the homeless families—families involved in the child welfare system. At the time, New York City was reeling from headlines about the tragedy of seven-year-old Nixzmary Brown, who was abused and murdered by her stepfather and ignored by her mother. The family was known to multiple city agencies as it had once resided in a family shelter monitored by the New York City Department of Homeless Services (DHS) and was under the supervision of the city’s child welfare agency, the Administration for Children’s Services (ACS). Nixzmary’s death resulted in staff supervision reforms at ACS and more severe state penalties for parents, including Nixzmary’s Law, which imposes a life sentence without parole for the murder of a child under age 14 in an “especially cruel and wanton manner.” The Nixzmary case was one of several factors that spurred the Corporation for Supportive Housing (CSH) to target a supportive housing initiative for families with open abuse or neglect child welfare cases. Funded by the Robert Wood Johnson Foundation, the goal of the pilot was to prevent further abuse and neglect and improve outcomes for children through the intervention of permanent supportive housing.

For almost two decades CSH, whose mission is to provide advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing throughout the United States, had worked to foster the growth of supportive housing. During 2006, CSH discussed with the Robert Wood Johnson Foundation funding to “design and implement a ‘family preservation’ supportive housing model specifically designed to prevent family dissolution and chronic neglect among homeless families involved with the child welfare system.” The pilot initiative was designed to serve 25 to 30 families.

*Keeping Families Together* became a reality in the fall of 2007 when the first of the families moved into supportive housing provided by two agencies, CAMBA and Women in Need. Through July 2009, KFT families continued to move into supportive housing provided by Lower Eastside Service Center, Palladia, St. John’s House II, and the Lantern Group. As part of the funding agreement with the Robert Wood Johnson Foundation, the KFT initiative included an external evaluation. This report presents the results of the KFT evaluation.

The findings are organized as follows. Research outlining the need for KFT and the context within which it developed are presented in Section II, followed by a description of the evaluation design (Section III). Section IV discusses the process used to identify and recruit families. Section V presents a profile of those families, and Section VI describes the interagency collaboration among KFT stakeholders. A discussion of the outcomes KFT sought to achieve is presented in Section VII. The final section (VIII) synthesizes the evaluation findings, identifies some of the challenges that were encountered, and offers recommendations.



## II. The Need for the KFT Initiative

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This section of the report begins with a discussion of the need for and development of the initiative, describes the KFT model, and introduces the supportive housing providers.

### Why KFT?

Involvement with child welfare services has often been associated with family homelessness. Using records from New York City DHS and ACS, Park et al. (2004) conducted a study with 8,251 children who entered the NYC shelter system for the first time in 1996 and were under the age of 16 at admission. The researchers found that more than 4 percent of the children had a child welfare case within a year of moving into the shelter, whereas the rate was less than 2 percent before homelessness. They also found that the percentage of children with a child welfare case increased in relation to the number and length of each shelter stay during a homelessness episode. The authors suggest that a higher risk for child welfare involvement may be related to higher frequency and length of the shelter stay, children who are school aged when they enter the shelter system, and families who were homeless due to domestic violence. Furthermore, the age and the number of children in the household were also found to be associated with increased child welfare involvement. Younger heads of households were more likely than older heads of households to have child welfare involvement. An increase in the number of children in a family also increased child welfare involvement.

The depth of research on very vulnerable homeless families has been limited (Bassuk & Geller, 2006) compared to what exists on single adults. Research has identified some characteristics and risk factors that may make families more susceptible to becoming homeless and to entering the shelter system. It is well documented that homeless families are often headed by single females with a history of substance abuse, mental illness, domestic violence, or a lack of social support (Rog and Buckner, 2007; Vostanis, 2002; Task Force on Housing and Services for Families, 2003). Further, projections from a survey by the National Survey of Homeless Assistance Providers and Clients (NSHAPC), conducted in the late 1990s, suggest that “between 900,000 and 1.4 million children are homeless with their families and that almost half of these children are less than six years old” (Burt, Aron, and Lee, 2001 as cited by Bassuk and Geller, 2006, p. 781), making these children one of the largest homeless subgroups (Burt, 1994 as cited by Burt, 1997).

The relationship between child welfare involvement and shelter use may be due to the sense of instability families feel during and after an episode of homelessness and parents’ inability to regain a sense of the strong family unit, the difficulty maintaining parent–child relationships in a shelter due to the strained lifestyle, or the “fishbowl effect” wherein family interactions may be monitored more closely by shelter staff and thus run a higher risk of being reported (Park et al., 2004, p. 433). That families are monitored more closely in a shelter is evidenced by the increased involvement of outside children’s service agencies post-shelter stay as compared to before entering a shelter, and the higher likelihood of mothers in shelters having an open child welfare case compared to housed mothers (Park et al., 2004).

### The KFT Model

With the needs of these families and children in mind, the CSH staff reached out to city agencies, advocates, and supportive housing providers to begin to develop the KFT model at the same time as funding for the development of supportive housing for families was becoming available. In 2005, the city and state entered into the historic New York/New York III (NY/NY III) agreement to create 9,000 units



of supportive housing for disabled homeless people over a 10-year period. NY/NY III expanded on previous agreements by including chronically homeless and at-risk families, as well as youth exiting foster care and psychiatric hospitals, and individuals and families living with substance abuse and/or HIV/AIDS. This influx of new funding to develop supportive housing for families provided a vehicle for CSH to serve child welfare-involved families through the KFT pilot.

Supportive housing is permanent, affordable housing combined with a range of supportive services that help people with special needs live stable and independent lives. The housing may consist of single-site apartments (multiple units in one building) or scattered-site apartments (individual apartments at multiple locations). Supportive services may be provided within the building (as is often seen at single-site dwellings), in tenants' apartments, or off site.

To be eligible for family housing under NY/NY III, families must be “chronically homeless families or at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition or HIV/AIDS.” Chronic homelessness is defined as “a family which has lived in a homeless shelter for at least 365 days of the last two years, not necessarily consecutively.”<sup>3</sup> Combining the goal of NY/NY III with the goal of preventing child abuse and neglect, CSH planned for KFT to serve families who met the NY/NY III requirements and who also had child welfare involvement (i.e., had an open ACS case).

In support of its three objectives (find supportive housing for the most vulnerable families with child welfare involvement, improve interagency collaboration, and build capacity among housing providers to serve KFT families), CSH identified seven strategies:

- Working closely with city agencies and facilitating outreach to nonshelter-based referral sites (Family Court, ACS, preventive service agencies) to identify and recruit 25 to 30 homeless families with open child welfare cases that met the NY/NY III eligibility criteria;
- Identifying six housing providers to serve KFT families;
- Convening housing providers, city agencies (child welfare, homeless services, health and mental health, and housing), and other organizations to promote interagency collaboration and problem solving;
- Helping housing providers refine their service delivery models and supporting their efforts to serve high-need families;
- Making available clinical consultants to help assess the capacity of housing provider staff, train, and design an integrated service approach for KFT families in supportive housing;
- Offering financial grants to KFT families (through the supportive housing providers) for activities that promote self-sufficiency (e.g., education, job training) and family cohesion; and
- Evaluating family and system level outcomes.

Initial planning for KFT occurred during 2006–07 through discussions with city agencies—the New York City Human Resources Administration (HRA), ACS, DHS, and the New York City Departments of Health and Mental Hygiene (DOHMH) and Housing Preservation and Development (HPD)—and housing providers. Eligibility criteria were defined and methods for identifying families who met those criteria were discussed. For housing, CSH decided to use newly opening NY/NY III units. To coordinate the pilot, CSH convened KFT providers meetings, which were attended by the housing providers, DHS staff, and clinical consultants from the Mt. Sinai School of Medicine who were contracted by CSH to provide technical assistance to the staffs of the supportive housing providers.

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<sup>3</sup> New York/New York III Supportive Housing Agreement, retrieved at <http://www.shnny.org/agreements.html>, April 28, 2010.



## The Supportive Housing Providers

The nonprofit housing providers participating in KFT are all established organizations. The five organizations receiving NY/NY III funding were among the first to open family supportive housing under this funding source. The sixth organization received funding from the U.S. Department of Housing and Urban Development (HUD).<sup>4</sup> The KFT housing providers offered one of three types of permanent supportive housing: single site, scattered site, or integrated. *Single-site* supportive housing (four of the six providers) consists of a single building with multiple apartments where families receive on-site case management, some support services, and crisis intervention. In most single-site facilities, provider staff is available 24 hours a day, every day. As their name indicates, *scattered-site* units (one of the six providers) are apartments located in different buildings; for these, case management is conducted by home visit and other services are provided by the agency or coordinated through the community. The *integrated* supportive housing model (one of the six providers) consists of units set aside within a larger, affordable, housing development, usually representing 10 to 30 percent of the total number of units. In this last model, case management is provided on-site but the case manager is not available 24 hours a day. A brief description of each housing provider is presented below.

**CAMBA** provides services to more than 35,000 individuals and families each year in six core areas: economic development; education and youth development; family support services; HIV/AIDS services; housing services and development; and legal services. CAMBA has offered a continuum of housing-related services since 1991, including homelessness prevention, housing relocation, emergency and transitional housing, and permanent and supportive housing.

**Diversity Works** was opened by the **Lower Eastside Service Center (LESC)** in November 2008. The LESK provides substance abuse and mental health treatment and services, as well as vocational services and therapeutic residences.

**Lantern Organization (Jasper Hall)** develops and operates permanent affordable and special needs housing. Founded in 1997, the Lantern Organization has 16 buildings in operation, development, or planning phases. Lantern Community Services, a not-for-profit social services corporation, provides on-site supportive services to tenants living in buildings developed by Lantern Organization.

**Palladia (Fox Point)** serves largely urban, poor individuals and families of color and provides services in the fields of substance abuse, homelessness, HIV, mental illness and trauma, domestic violence, criminal justice services, and family services. Programs include residential, outpatient, and transitional treatment programs; shelters; alternative-to-incarceration programs; and permanent supportive housing. Palladia also provides case management, vocational, educational, and child care services; parenting classes; activities of daily living assistance; HIV/AIDS services; and supportive permanent housing for individuals and families with special needs. The organization was founded in 1970.

**St. John's House II (SJH II)** is a supportive housing program for formerly homeless single adults and families and is part of the St. John's Community, which consists of St. John's I and St. John's II. SJH II houses families in two-bedroom apartments, while single adults have studios and one-bedroom apartments. SJH II provides on-site residential supportive services that foster tenants' independence, empowerment, and personal fulfillment, while it invites tenants to participate in decision-making, and entrusts them with meaningful responsibilities. SJH II offers parenting classes, men's and women's groups, and recreational activities. SJH II also refers tenants to other community-based programs for job

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<sup>4</sup> At this time, all funding for permanent supportive housing for families comes through the homeless system, thus requiring that families be homeless to qualify.

readiness classes, employment placement, Alcoholics and Narcotics Anonymous groups, and domestic violence classes. Parents may also be referred to family-oriented programs that foster parenting skills and socialization for children.

**Women in Need (WIN)** provides shelter, housing, and services to New York City women and their families who are homeless and disadvantaged. Beginning in 1983 with an emergency residence, followed by a scattered-site apartment shelter program, WIN currently operates permanent, supportive housing in the Bronx and Brooklyn for families headed by women with special needs. In addition to housing, the organization’s services include licensed alcohol and substance abuse treatment centers; job readiness preparation and job placement assistance; HIV prevention education; domestic violence prevention and counseling; family support; therapeutic child care; and after-school and summer programs for children.

Table I presents some key characteristics of the KFT supportive housing providers. Most of the KFT sites are single-site apartment buildings. As the table shows, the KFT families represent only a small proportion of families living in these buildings.

**Table I. Characteristics of KFT Supportive Housing Providers**

Characteristics	Supportive Housing Provider					
	CAMBA-Myrtle Avenue	LESC/Diversity Works	Lantern/Jasper Hall	Palladia/Fox Point	St. John’s House II	Women in Need
Borough	Brooklyn	Bronx	Bronx	Bronx	Bronx	Brooklyn
Housing Type	Integrated	Single-site	Single-site	Single-site	Single-site	Scattered-site
Number of Units	33	34	52	48	11	15
Number of Supportive Housing Families	11	34	30	31	11	15
<b>Number of KFT Families</b>	<b>2</b>	<b>10</b>	<b>6</b>	<b>4</b>	<b>2</b>	<b>5</b>
Number of Case Managers	1	2*	4	2	2	1
Family to Case Manager Ratio	11:1	17:1	7:1	15:1	5:1	15:1

\*One position was vacant.



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## III. Evaluation Questions and Methods

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Metis Associates began its evaluation in the fall of 2009 by reviewing project documents and conducting a retrospective assessment of the pilot. The evaluation was designed to assess the degree to which KFT met its three overarching objectives, which were:

- To target supportive housing for the most vulnerable child welfare-involved and homeless families;
- To improve agency collaboration in support of these families; and
- To build capacity among providers to serve KFT families.

Following a review of documents and discussion with CSH, Metis developed as a guide the following evaluation questions:

### ***Program Description***

1. What is the goal of the Keeping Families Together (KFT) family supportive housing program?
2. What is the program model?
3. What are the characteristics and needs of the families in KFT?

### ***Process Questions***

1. How has the model been implemented?
2. Has the model, as implemented, facilitated interagency collaboration? What are the successes and challenges of this collaboration?
3. What challenges were encountered in implementing KFT? How were they resolved?
4. Have all planned activities been implemented? If not, what remains to be done? Were they accomplished on schedule?
5. How have supportive housing services and child welfare preventive services been coordinated? Has this coordination been successful?
6. What recommendations are there for improving the KFT model? Refining the KFT model? Replicating the KFT model?

### ***Outcome Questions***

1. Have the families remained in supportive housing?
2. How has supportive housing impacted families who are chronically homeless and child welfare involved, and their children (job training, employment, substance abuse/mental health treatment, parenting skills, school attendance and achievement)?
3. What kinds of services have these families received?
4. What are the housing providers' perceptions of the effectiveness of KFT overall?
5. What differences are seen among families depending on their housing assignments (scattered site vs. single site; KFT vs. other families in single-site housing)?
6. What differences in shelter use are seen between the families and a comparison sample of similar families?

The evaluation used both quantitative and qualitative evaluation methods and data from a variety of sources to assess the implementation and outcomes of the KFT initiative. Table 2 summarizes these methods and sources; the methods are described in detail following the matrix.



**Table 2. Evaluation Methods by Research Question**

Research Questions	Evaluation Methods												
	Interviews/Focus Groups						Administrative Data			Document Review			
	KFT Staff Interviews	City Agency Staff Interviews	Clinical Consultant Interview	SH Provider Focus Group	SH Case Manager Focus Group	Case Manager Follow-up	Family Focus Groups	Analysis of NYC DOE Data	Analysis of ACS Data	Analysis of DHS Data	Literature Review	Case Manager Review of Records Form	Documentation from SH Providers
<b>Program Description</b>													
1. What is the goal of the Keeping Families Together (KFT)/family supportive housing program?	X												X
2. What is the program model?	X												X
3. What are the characteristics and needs of the families in KFT?		X	X		X	X	X				X		
<b>Process Questions</b>													
1. How has the model been implemented?	X	X	X	X	X							X	X
2. Has the model, as implemented, facilitated interagency collaboration? What are the successes and challenges of this collaboration?	X			X									
3. What challenges were encountered in implementing KFT? How were they resolved?	X			X									X
4. Have all planned activities been implemented? If not, what remains to be done? Were they accomplished on schedule?	X			X									X
5. How have supportive housing services and child welfare preventive services been coordinated? Has this coordination been successful?	X	X		X								X	X
6. What recommendations are there for improving the KFT model? Refining the KFT model? Replicating the KFT model?	X	X	X	X	X							X	X



Research Questions	Evaluation Methods													
	Interviews/Focus Groups						Administrative Data			Document Review				
	KFT Staff Interviews	City Agency Staff Interviews	Clinical Consultant Interview	SH Provider Focus Group	SH Case Manager Focus Group	Case Manager Follow-up	Family Focus Groups	Analysis of NYC DOE Data	Analysis of ACS Data	Analysis of DHS Data	Literature Review	Case Manager Review of Records Form	Documentation from SH Providers	Other Program Documentation
<b>Outcome Questions</b>														
1. Have the families remained in supportive housing?				X	X	X	X					X		
2. How has supportive housing impacted families who are chronically homeless and child welfare involved, and their children (job training, employment, substance abuse/mental health treatment, parenting skills, school attendance and achievement)?			X		X	X	X	X	X		X	X	X	
3. What kinds of services have these families received?	X	X	X	X	X	X	X					X	X	X
4. What are the housing providers' perceptions of the effectiveness of KFT overall?				X	X	X						X	X	
5. What differences are seen among families depending on their housing assignments (scattered site vs. single site; KFT vs. other families in single-site housing)?	X	X	X	X	X	X	X				X	X	X	X
6. What differences in shelter use are seen between the families and a comparison sample of similar families?									X		X			



A process evaluation focused primarily on the implementation of the KFT model, the collaboration of KFT partners, and the coordination of services from various city agencies. An outcomes evaluation examined the effects on KFT families. The following is a description of the study methods.

- **Literature and program documentation review.** Metis reviewed the research literature and KFT’s program documentation in order to understand the needs that the initiative is designed to address, and to identify best practices in the field. In particular, research on the connection between child welfare and homelessness was examined. Results from this review were used to understand the context for the initiative and to situate the findings in relationship to the existing research on the intersection of supportive housing and child welfare.
- **Interviews and focus groups.** Individual interviews and focus groups were conducted to gather perceptions about the program and its impact on families. Open-ended interview protocols were used to guide the interviews and focus groups. A list of the interviews conducted by Metis Associates is presented in Table 3.

**Table 3. Interviews and Focus Groups**

Type	Constituent Group	Organization	Date
FG	Directors	Supportive housing providers	11/17/09
FG	Case managers	Supportive housing providers	11/24/09
FG	Program staff	Corporation for Supportive Housing	12/4/10
I	City agencies	Department of Health and Mental Hygiene	12/1/09
I	City agencies	Department of Homeless Services	12/11/09
I	City agencies	Administration for Children’s Services	1/5/10
I	Program Director	Corporation for Supportive Housing—KFT	1/11/10
I	Clinical consultant	Mt. Sinai School of Medicine	1/12/10
FG	Families	Bronx supportive housing providers	2/17/10
FG	Families	Brooklyn supportive housing providers	2/24/10
FU	Case managers	Supportive housing providers	4/8/10 to 4/12/10

I = Interview, FG = Focus group, FU = Follow-up calls

- **Data from previous evaluation.** At the beginning of the initiative, CSH retained Dr. Sylvia Ridlen to evaluate the KFT pilot. From October 2007 through October 2009, Dr. Ridlen conducted observations of KFT meetings and interviews with agency staff. She also conducted a series of individual interviews with KFT family heads of households or their spouse or partner at the time of their move to supportive housing and at six-month intervals. The limited information that was available from these interviews has been incorporated into Metis’s report.
- **Case manager records.** Metis developed a form for case managers to complete in order to collect, for each family, the following information: demographic information; data on the use of services and discretionary funds; efforts associated with achieving self-sufficiency and stability, effective parenting, recovery from substance use, and treatment of mental illness. Case managers were asked to review their case records to complete the form. Additionally, Metis conducted follow-up phone calls with each of the case managers to clarify and confirm this information.



➤ **Administrative data.** Metis also analyzed the following types of data to assess the KFT families' outcomes:

- **Child welfare.** Metis received Child Care Review Service (CCRS) data from ACS for 23 of the 29 families in the pilot from whom consent was obtained. The data included family-specific records of ACS involvement, the type and length of preventive or other services received through ACS, and the type and dates of any foster care placements. Metis also received data through ACS from CONNECTIONS, the statewide child welfare data system maintained by the New York State Office of Children and Family Services for child protective, preventive, foster care and adoption service information. The data received from CONNECTIONS included the number and type of cases of abuse or neglect.
- **Department of Homeless Services data.** De-identified records of shelter history and demographic characteristics were provided for a random sample of 15 comparison group families, selected by DHS on the basis of having been admitted to a homeless shelter during the period of implementation of the pilot program (August 2007 to February 2010) and meeting the KFT eligibility criteria. The DHS comparison group was based on a list provided by CSH to DHS of NY/NY III applicants who were eligible for and referred to supportive housing but who did not enter housing for reasons unknown.
- **New York City Department of Education student data.** Through an agreement with the NYC Department of Education, Metis maintains a repository containing a wide range of data for NYC public school students. For this evaluation Metis accessed the repository to obtain school attendance and academic performance data for the school-age children of KFT families.

## IV. Family Identification and Recruitment

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The first step in identifying families for KFT was to create a profile of an ACS family that would need supportive housing. CSH collaborated with multiple city agencies in identifying eligible families and recruiting them. HPD coordinated the recruitment efforts with the completion of the NY/NY III units. Several different strategies were used to identify families for KFT, and each strategy met with some challenges. The strategies and challenges are described below.

**Strategy 1—New Data Match.** The first strategy was to match DHS and ACS administrative data to identify a pool of eligible families. DHS maintained a list of about 2,200 chronically homeless families who had been homeless one out of the previous two years, or two out of the previous four years. The DHS list of families was compared to families in the ACS system with open and indicated preventive cases. This data match yielded only five families who met both the chronically homeless requirement and had at least one open and indicated ACS case. However, because none met the disability requirement required for supportive housing, none of these families were accepted into KFT.

Based on these results, CSH suggested that the KFT stakeholders use ACS criteria to find families imminently at risk of losing their children to foster care. Determining how to define “imminently at risk” was the subject of many KFT meetings. Ultimately, the group agreed that it would be defined as families who met one or more of the following criteria: two or more reports from the State Central Registry; repeat investigations within 180 days; and/or families who were under court-ordered supervision. These variables were chosen in part because they were indicators that ACS regularly examined internally to assess risk. CSH proposed that the homelessness criteria together with the ACS criteria would yield the target families. However, ACS determined that it was too difficult to match families with DHS this way because of the incompatibility of their data systems. When a match could not be produced, CSH decided instead that these ACS eligibility criteria would be described to shelter staff, social workers, attorneys, and others working with ACS-involved families, but found the criteria too specific and that most service providers did not have this level of knowledge about the families’ ACS cases.

An ACS staff member also recommended looking at families who were in the “trial discharge” stage at ACS (i.e., children had been discharged to their family temporarily, under supervision, to determine whether or not final discharge was safe) and those who had any history of involvement with ACS. This, it was thought, might yield some results because these families often have repeat occurrences of ACS involvement. In the end, however, ACS could not identify these families. Although CSH/KFT may have admitted into the KFT pilot some families who met these criteria, it is not because they were intentionally targeted.

**Strategy 2—Existing Data Match.** Another strategy used to identify families for KFT was to find families with an existing ACS/DHS data match for the Children Advantage program. Children Advantage is a rental assistance program designed to help families with open ACS cases move out of shelter. The criteria for Children Advantage were that a family had an open ACS case past the investigation stage, had an active public assistance case, and had lived in shelter for at least 90 days. DHS examined 1,673 families among those who were to receive letters of acceptance to Children Advantage. In order to find families who met the chronically homeless criteria, the list was sorted by DHS by length of stay and by shelter. The DHS Deputy Director for Quality Assurance and Program Support then sent each shelter a subset of the master list that included the families residing in their shelter and asked directors to report back on the families’ eligibility for supportive housing. This process, again, yielded very few families. Shelter staff had a difficult time establishing whether a family on the Children Advantage list also met the

disability requirement for supportive housing. CSH/KFT surmised that this was probably because families were fearful of letting shelter staff know about their histories of substance use and mental illness—especially if they were already involved with ACS. During the family identification process, the Children Advantage program provided some competition for KFT since it addressed a similar population of homeless families.

**Strategy 3—Centralized Case Finding.** The DHS Deputy Director for Quality Assurance and Program Support played a direct and crucial role in working with the shelter system and housing providers to identify, assess, and ultimately place families in supportive housing units. She created a questionnaire based on the eligibility criteria for KFT placement, that is, chronic homelessness and ACS involvement with a mental illness or history of substance abuse. Once a shelter director had identified an eligible family, she interviewed the family to determine whether or not they had an open ACS or preventive case and to determine at which site they might be placed, as some providers, such as Palladia and Diversity Works, only served clients with a history of substance abuse. Data to confirm the families' child welfare involvement were also sought from ACS. A total of 37 families were identified through this strategy. Of these, 22 became KFT families and the remaining 15 families became part of the DHS comparison group.

**Strategy 4—Decentralized Case Finding and Referral.** CSH also actively recruited families to the KFT initiative through outreach to shelter staff; to Family Court judges and attorneys as well as attorneys from ACS or those representing parents; to social workers; and to ACS-contracted service providers. To encourage referrals, the contract agencies located in Brooklyn and the Bronx received a letter from the ACS Deputy Commissioner of Family Support Services which explained the KFT pilot and the eligibility criteria, and encouraged them to contact CSH with potentially eligible families. Referrals received by CSH were sent to DHS for an examination of their shelter history and, if the family met the chronic homelessness requirement for NY/NY III, DHS visited the family at the shelter and completed the NY/NY III, or the Human Resources Administration (HRA) 2010(e) application with the family. DHS then confirmed the family's ACS case status with the ACS Housing Unit.

These outreach efforts resulted in approximately 100 referrals, of which 18 were referred for HRA 2010(e) applications. Fourteen were found eligible, but only three were placed in the pilot. Interestingly, some of the 14 eligible families, though approved or nearly approved, never made it into KFT. Two families had children removed before housing placement could occur, one family was too large for the available apartments, two had physical disabilities, several others had serious and persistent mental illness prior to the availability of NY/NY III units for such families, and one head of household was arrested just prior to move-in. In addition, at least three families moved out of shelter with a Children Advantage rental subsidy. Ultimately only three of the 14 eligible families identified through this strategy became KFT participants.

**Strategy 5—Provider-Based Recruitment.** Some housing providers conducted their own recruitment for the KFT pilot. Because Women in Need (WIN) was not a NY/NY III provider, receiving funding from HUD, the organization typically recruited its own families. WIN recruited four of its five KFT families while the DHS Deputy Director for Quality Assurance and Program Support recruited the fifth.

Table 4 displays, by strategy, the number of families who were identified, determined eligible for KFT, and in the end placed into supportive housing apartments.

**Table 4. Number of Families Identified, Eligible, and Placed by Strategy**

Strategy	Number of Families Identified	Number of Families Eligible	Number of Families Placed
1—New data match	5	0	0
2—Existing data match	5	0	0
3—Centralized case finding	37	37	22
4—Decentralized case finding and referral	75 to 100	18	3
5—Provider-based recruitment	5	4	4
<b>Total</b>	<b>127 to 152</b>	<b>59</b>	<b>29</b>

Identifying and recruiting families for KFT supportive housing took about one year and, according to interviews conducted by Metis, was more difficult than expected. Despite the belief that there was a substantial number of families in the shelter system that met the KFT criteria, the ability to identify these families hinged on the data disclosed by the family to shelter staff, ACS case workers, or on the HRA 2010(e) form, the application required for the NY/NY III supportive housing program.

Interviewees from city agencies reported concerns that the HRA 2010(e) application process may not have been inclusive of all eligible families because families were required to have supporting documents for their mental and medical disabilities and a documented history of homelessness. An otherwise eligible family without documentation of a mental illness would not be able to meet NY/NY III criteria for supportive housing. Whether or not families disclosed information about an active ACS case, a history of substance abuse, or mental/medical health issues also affected their eligibility. Moreover, providers had difficulty with the 2010(e) form, the initial screening for consideration for NY/NY III supportive housing. Although training on this form was available to shelter staff, it was not required and poorly attended. In addition, since the 2010(e) only collects information on the head of household of a family, the form may not have reflected the disabilities of a spouse, although, if a spouse has a disability the application should be completed for that person. Thus, the application process may have resulted in an opportunity missed for some families.

It is also possible that the length of time in a shelter required for NY/NY III eligibility was a barrier. Some research has shown that highest need families with child welfare involvement tend to cycle in and out of shelter and thus may not meet the threshold for chronic homelessness. There is also some evidence that long-term or chronically homeless families have been found to be better off than those who have shorter stays but multiple episodes (Culhane et al. 2007).

Ultimately, 29 families who met the KFT eligibility criteria were placed in KFT supportive housing. The fact that CSH had to employ multiple strategies to identify eligible families for KFT speaks to the complexity of these families' needs and the inability of the shelter and child welfare systems to easily identify them. The KFT initiative is a holistic, multifaceted approach to serving families with various vulnerabilities (e.g., chronic, episodic homelessness; mental health issues; and child welfare involvement).

## V. Profile of the KFT Families

According to available research, homeless families are most often female-headed families with a history of substance abuse, mental illness, domestic violence, or a lack of social support (Rog and Buckner,

**Table 5. Characteristics of KFT Heads of Household**

HoH Characteristic	Category	N	% of Total Population
Sex; Single or couple	Female only	23	79.3%
	Male only	2	6.9%
	Couple	4	13.8%
Age (HoH)	20–25	2	6.9%
	26–30	3	10.3%
	31–35	5	17.2%
	36–40	6	20.7%
	41–45	7	24.1%
Race/ ethnicity (HoH)	46+	6	20.7%
	Black	17	58.6%
	Hispanic	9	31.0%
Education (HoH)	White	3	10.3%
	Less than high school	20	69.0%
	High school diploma or GED	7	24.1%
Total	Some college	2	6.9%
		29	100%

2007; Vostanis, 2002; Task Force on Housing and Services for Families, 2003). This profile of homeless families closely parallels the 29 families served by the KFT initiative, who represent some of New York City’s most vulnerable adults and children, and have a large range of needs—from help with substance addiction to basic independent living skills. The 29 families moved into their supportive housing apartments between September 2007 and July 2009. Demographic information about the heads of households for these families is presented in Table 5 and summarized below.

The mean age of the KFT head of household was 38.7 years as of April 2010, with a range of 22 to 52 years. The majority of these families (79.3%) were headed by a single female; only four (13.8%) of the households had two adults in the home. Two families (6.9%) consisted of a single father and his child. The heads of households (HoHs) for these families were predominately Black (58.6%) or Hispanic (31.0%) though some were White (10.3%). Most HoHs had not completed their high school education (69.0%) though about

one-quarter had a high school diploma or GED (24.1%). Two HoHs (6.9%) reported having attended some college courses.

Interviews with the KFT families conducted by Dr. Ridlen, the previous evaluator, revealed considerable histories of trauma and violence: “The parents had very difficult childhood histories, which include a high degree of housing instability, drug use in the household, sexual abuse, and losing a parent at an early age.”<sup>5</sup> As shown in Table 6, nearly half (N=14, 48.3%) reported that one or both of their parents abused drugs or alcohol and about one-third (N=9, 31.0%) faced parental death or abandonment. One-quarter (N=8, 27.6%) were victims of sexual abuse or physical, verbal abuse and neglect. With regard to residential instability, about one of six of the HoHs (N=5, 17.2%) had experienced homelessness or had chronic housing instability as children. More than one-quarter (N=8, 27.6%) of the HoHs had been placed in foster care while one in ten HoHs had themselves lived in another informal setting (N=3, 10.3%).

<sup>5</sup> Ridlen, S. Unpublished draft report.

**Table 6. Trauma Histories for Heads of Household**

	Trauma	N*	% of Total Population
As Children	Parent drug or alcohol abuse	14	48.3%
	Parental death or abandonment	9	31.0%
	Victims of sexual abuse	8	27.6%
	Victims of physical or verbal abuse or neglect	8	27.6%
	Housed in foster care	8	27.6%
	Homelessness	5	17.2%
	Chronic housing instability	5	17.2%
	Housed in another informal setting	3	10.3%
As Adults	Sleep disruptions	26	89.7%
	Depression	22	75.9%
	Victims of domestic violence	21	72.4%
	Anxiety symptoms	18	62.1%
	Suicidal thoughts or actions	11	37.9%
	Victims of rape	8	27.6%
	Victims of assault	7	24.1%
<b>Total</b>		29	100%

\*Includes multiple responses.

HoHs had experienced high levels of trauma and domestic violence as adults. Nearly three-quarters of the HoHs (N=21, 72.4%) were victims of domestic violence, more than one-quarter (N=8, 27.6%) were rape victims, and another one-quarter (N=7, 24.1%) had been victims of other types of assault. Finally, the majority of the HoHs reported mental health concerns such as depression, anxiety, and sleep disruptions.

As a requirement of KFT eligibility, families had to have at least one open ACS case, though in the case of one study participant who had aged out of foster care, the open ACS was on this individual and not the child. Details about the children of the KFT families at the time of move-in were gathered through interviews with the heads of households at the beginning of the study:

- At the time of move-in, the 29 KFT families reported that they had borne 105 children, of whom 16 were adults and 3 were deceased. (One child was born *after* move-in.)<sup>6</sup>
- Of the 86 minor children borne to the families, 43 (50%) moved into supportive housing with their family; 25 (29.1%) were living in foster care; and three (3.5%) were in an informal placement. However, only six children living outside of the family had a goal of reunification with their parent. Parental rights had been terminated sometime in the past for another 15 children (17.5%).
- There were 37 open and indicated ACS cases (among the 43 children who moved into supportive housing with their families) at the time of move-in.

A high rate of foster care placement among homeless families is consistent with the literature, as suggested by Zlotnik (2009, p. 6) who reports that foster care placement among homeless children is 34 times that of children in the general population. Additionally, Zlotnik finds a strong, bidirectional relationship between foster care and homelessness. An intergenerational cycle of child welfare involvement and homelessness is evident for KFT families, as indicated by the histories of the parents (27.6% were once housed in foster care and 17.2% were homeless as children) and the experiences of their children (29.1% were in foster care and all of their families have been homeless).

By the end of the evaluation, all but three of the 29 families (N=26, 89.7%) remained in supportive housing. Three families, all headed by single women, had moved out.<sup>7</sup> The following paragraphs present a

<sup>6</sup> One child was reunited with their KFT family about three months before the move to supportive housing; this child is not included in the count of children in placement at the time of move-in.

<sup>7</sup> Information on their reasons for leaving was not available.

profile of the 26 families who remained in supportive housing through the end of the pilot period (May 31, 2010).

Before moving into supportive housing, on average, families had been homeless for about 1,200 days, equivalent to nearly 40 months or more than three years of residential instability.<sup>8</sup> The median length of homelessness was 20 months, with a range from 10 months to 12 years. DHS data indicate that KFT families spent an average of 507 days in family or single-adult shelters over the two years prior to their move to supportive housing, with a median of 617.5 days. The length of the family’s stay in shelter ranged from 14 days to 730 days. Six families had spent the entire two years in shelter before their move to supportive housing. In fact, these six families had shelter stays longer than two years; one family had been residing in a family shelter for over 2,000 days.

The home provided through KFT may be the first stable environment known to many of the children of the families. These families had an average of two children (1.6) living with them in supportive housing, though this ranged from one child to as many as three children. The average age of the children was 9.2 years as of April 2010, with a range from one to 21 years.

In addition to an open ACS case and a history of chronic homelessness, to be eligible for KFT families were required to have a history of substance abuse or a documented mental illness. The majority of the 26 remaining families (N=25, 96.2%) had a history of substance abuse and over half of the heads of households (N=14, 53.8%) had been diagnosed with mental illness.<sup>9</sup> Table 7 shows that most adults with substance use histories were users of marijuana

**Table 7. Substance Use History or Current Use by Head of Household**

Substance	N*	% of Total Population
Marijuana	11	42.3%
Alcohol	7	26.9%
Cocaine	7	26.9%
Opiates	3	11.5%
Heroin	3	11.5%
Crack	3	11.5%
History indicated without specified substance	2	7.7%
Hallucinogens	1	3.8%
Prescription drugs	1	3.8%
Sedatives	1	3.8%
No history of substance use	1	3.8%
<b>Total</b>	<b>26</b>	<b>100%</b>

\*Includes multiple responses.

and about one-quarter of the families reported past or current abuse of alcohol or cocaine (26.9%, respectively). Only one head of household had no history of substance abuse.

<sup>8</sup> This estimate includes the data for two families that had experienced very long periods of homelessness, 11 and 12 years, respectively.

<sup>9</sup> This information was not available for the three families who had moved out.



## VI. Interagency Collaboration and Resources

The support, participation, and collaboration of city agencies and private supportive housing partners were indispensable to the KFT initiative. This section discusses how KFT worked to facilitate interagency collaboration and share resources among the KFT stakeholders. The Department of Homeless Services (DHS), the Administration for Children’s Services (ACS), the Department of Health and Mental Hygiene (DOHMH), the Human Resources Administration (HRA), the Department of Housing Preservation and Development, along with the supportive housing providers, attended meetings that helped to shape the implementation of KFT. At first, this collaboration was needed to identify and recruit families, and later, to drive the interaction and knowledge sharing among stakeholders.

**Interagency Meetings.** Corporation for Supportive Housing (CSH) promoted and facilitated the collaboration of its provider and city agency partners, convening more than 22 meetings over the project period, as shown in Table 8. In attendance were representatives from the supportive housing providers, DHS, ACS, DOHMH, HPD, and the evaluator, as well as other supportive housing stakeholders. The primary purpose of these meetings was to monitor the implementation of the initiative (e.g., establish eligibility criteria and develop a targeting and recruitment strategy). The KFT meetings also served other purposes—technical assistance for the providers implementing the pilot, strengthening communication among the homeless service organizations and child welfare agencies, ensuring that families with child welfare involvement were being prioritized among those families placed in supportive housing, and that they were receiving necessary preventive child welfare services.

**Table 8. Attendance at KFT Meetings**

Meeting Date	Number of Attendees	Agency Representation									
		Supportive Housing Providers	CSH	HRA	DHS	ACS	DOHMH	HPD	CUCS*	Mt. Sinai Consultants	Evaluator
9/13/07	8		X		X	X	X	X			
10/5/07	10		X		X	X	X	X			
10/15/07	7	X	X						X		
10/25/07	7		X		X		X	X			X
11/16/07	8	X	X		X			X			X
11/19/07	7	X	X					X			X
12/17/07	14	X	X			X					X
12/19/07	9	X	X		X	X	X	X			X
1/23/08	12	X	X	X	X	X					X
1/28/08	7	X	X						X		X
2/25/08	11	X	X	X	X	X		X			X
4/23/08	16	X	X	X	X	X	X	X			X
6/11/08-6/13/08	Peer-to-peer site visit— Minneapolis, MN	X	X		X	X					
7/14/08	12	X	X		X	X					X
9/25/08	11	X	X		X		X				X
1/08/09	12	X	X		X					X	X



Meeting Date	Number of Attendees	Agency Representation										
		Supportive Housing Providers	CSH	HRA	DHS	ACS	DOHMH	HPD	CUCS*	Mt. Sinai Consultants	Evaluator	
2/24/09	7	X	X		X	X					X	
3/31/09	13	X	X		X						X	
7/14/09	12	X						X			X	X
10/6/09	12	X	X									X
12/17/09	14	X	X		X		X				X	X
2/04/10	18	X	X	X	X	X	X				X	X
3/23/10	15	X			X		X					X

\*CUCS=Center for Urban Community Services

In the first year of KFT, CSH worked with government agencies on project planning and determining the necessary steps to identify and recruit families. Later on, in the second year of the initiative, the focus of CSH shifted to building the clinical capacity of the providers and case managers. To do this, CSH and the KFT Project Director increased the number of meetings with the providers in order to identify families' needs and to bring together the necessary services.

Throughout the initiative, CSH acted as a “convener.” The organization brought the key stakeholders together and facilitated KFT workgroups that discussed issues regarding problems with families and challenges with ACS. Though not an initial goal, the meetings also served as a forum for participants to discuss and brainstorm solutions to family problems, learn from one another, and hear directly from provider staff about the appropriate measures to take. These meetings gave a voice to the trials and achievements of those invested in family supportive housing, including the providers, case managers, city agencies, and other advocates for this population.

Overall, the meetings were well received by the providers. One participant commended CSH for its efforts, saying,

*All agencies were at the table. These meetings did not occur before KFT. CSH facilitates the meetings and everyone shows up. [We have] monthly meetings with [another supportive housing funder] but city agencies really show up at CSH meetings.*

Another concurred, “We had not worked with ACS until KFT, though we do work closely with ACS Preventive Services. It’s nice to have ACS as part of the conversation. It makes a connection between the agency and the providers.”

Regarding the role of CSH in facilitating collaborations with city agencies, others remarked that “CSH has opened doors” and “We were given the opportunity to have a relationship with the city agencies. KFT got everyone to the table.” All providers agreed that getting the buy in and continued involvement of city agencies was critical to the development and continuation of the KFT model.



Corporation for Supportive Housing staff met with other supportive housing and child welfare audiences in order to present information about the KFT initiative:

- HELP USA Shelter (October 2007);
- Deputy Commissioner of Family Support Services, ACS (November 2007);
- ACS Subcommittee on Domestic Violence (December 2007);
- Family Services Coordinator, Office of the Deputy Mayor for Health and Human Services (February 2008);
- Deputy Commissioner for Family Services, DHS (March 2008);
- The Child Welfare Organizing Project (April 2008);
- Family Court judges and other Brooklyn Family Court representatives (January 2009);
- ACS/Bedford Stuyvesant Field Office (October 2009);
- Deputy Commissioner of Family Services, DHS (April 2010);
- Commissioner, ACS (April 2010).

Though capable of supporting the needs of the families in supportive housing, the case managers had significant training needs, likely related to the newness of the family supportive housing model as well as the multiple agencies with whom they needed to interact. A CSH staff member commented,

*Supportive housing is only as good as the case managers. I was surprised at the lack of training and regulation/guidelines for supportive housing providers. We have made some efforts at improving the quality of case management. The training piece for case managers needs more structure [though]. I would have liked to build a cadre of case managers who have knowledge of all the city's agencies/systems related to child welfare and homelessness.*

To that end, at each of the meetings convened by CSH, the KFT Project Director also invited an outside presenter to discuss relevant topics (e.g., Bronx Defenders on community legal services or HRA on navigating the public assistance process). In this way, KFT worked to introduce and build connections between the supportive housing providers and staff from city and other agencies. A supportive housing director indicated, “Bridges are still being built between the providers and city agencies but we are beginning to have an understanding of one another.”

Exposure to these topics added to the knowledge of providers and case managers, and revealed information gaps or misinformation. For example, a presentation by the HRA/Family Independence Center shed light on the “One-Shot Deal” emergency assistance provided by HRA and the steps case managers should recommend to their families in order to receive this assistance. Other community-based providers that attended the KFT meetings included the Visiting Nurse Service, New York Foundling, the Institute for Community Living, Seedco, Bronx Defenders, Housing + Solutions, St. Vincent’s Services, and the Center for Family Representation.

KFT also connected the supportive housing providers to community services. As one case manager reported, “I was introduced to South Bronx Healthy Families through KFT.... Through KFT, we’ve received information about many new services and programs which case managers can offer to non-KFT families they serve, too.” KFT has made tremendous efforts at building the capacity and skills of providers and case managers. Table 9 lists the trainings provided at the KFT meetings and those facilitated by KFT at other venues.

**Table 9. Trainings Provided at KFT Meetings**

Title of Training	Training Provider	Date of Training
Training for ACS staff about supportive housing	Alison Harte, CSH (ACS Youth Conference)	Spring 2008
Effective Engagement Strategies I (group training)	Dr. Mary McKay, Mt. Sinai	March 2008
ACS Preventive Case Conferencing Model	Raquel Pittman, ACS	April 2008
How to Create Trauma-informed Practice in Supportive Housing Part I (open to ACS, DHS, and KFT providers)	National Center to End Family Homelessness	July 2008
How to Create Trauma-informed Practice in Supportive Housing Part II (open to ACS, DHS, and KFT providers)	National Center to End Family Homelessness	July 2008
Training for KFT providers on adolescent development, parenting, and resources for providers (open to ACS, DHS, and KFT providers)	Melissa Rivera, Independent Consultant	February 2009
Effective Engagement Strategies (Training session and individual follow-ups)	Dr. Mary McKay, Mt. Sinai	April 2009
Family Systems Theory/Multiple Family Groups (Group training and Individual follow-up)	Dr. Mary McKay, Mt. Sinai	May 2009
Wellness Self-Management (group training and Individual follow-up)	Dr. Mary McKay, Mt. Sinai	May 2009
Training for ACS staff about supportive housing II	Alison Harte, CSH (ACS Housing Liaison Meeting)	April 2010
Helping Parents with Challenging Teenagers	Dr. Mary McKay, Mt. Sinai	April 2010

As Table 9 shows, KFT facilitated the capacity building of housing providers and case managers by linking them with experts, including the Mt. Sinai clinical consultants and ACS representatives. Further, the consultants followed up the trainings with individual provider meetings. Participants benefitted from consistent, targeted training as well as one-on-one consultations to help them adopt new practices. Other trainings were recommended to the KFT providers, including a session by Planned Parenthood about safe sex practices for teenagers. The Institute for Community Living also presented its supportive housing model and the training it offers, and discussed its experience with ACS. In addition, trauma-informed services were provided to WIN through a six-month term of bimonthly training sessions with the clinical consultants.

The collective knowledge of the providers and the opportunities to share ideas and procedures was also identified as a benefit of KFT participation. A case manager stated,

*[It is] helpful to be able to attend trainings... Support from other case managers is helpful. We might not have known each other. Hearing everyone's struggles and how it's handled is beneficial, especially if you're the only case manager at your site. It's good to talk and get input [from others].*

The meetings also were a way to identify needed resources and share them across providers and agencies. Table 10 lists the resources that were distributed to the KFT stakeholders. Additionally, the KFT Project Director transmitted information about resources for youth, families, and providers through weekly emails. These communications informed all the KFT partners about current research on supportive housing, policies to address homelessness, services and other opportunities for children and families available in the community (e.g., free legal services, conferences, employment opportunities), and training opportunities.

**Table 10. List of Shared Resources**

Resource
2007 ACS Preventive Service Directory
ACS Community Partnership Initiative coalition meeting schedule
Immigrant Services Directory
List of ACS case workers assigned to each family to discuss service plan
Contact information for ACS staff responsible for homemaking services
Contact information for a mobile crisis team
KFT training list
List of outcomes and data questions for case management software being developed by Foothold Technology for KFT providers to input
Tool to assess children’s mental health needs
Materials to disseminate to ACS/preventive/foster care staff about supportive housing
Materials about supportive housing for referral agencies to distribute to parents and for providers to use during intake

**Clinical Consultants.** CSH also provided key support for the case management staff by retaining the services of consultants from the Mt. Sinai School of Medicine. Dr. Mary McKay, supported by Dr. Carolyn Sicher, worked to build the capacity of the case management staff serving these high-need families with child welfare involvement. The role of the clinical consultants in the KFT initiative was to help raise the staff’s awareness about the adults and children in these families and help the providers learn how best to engage the families. In addition, the consultants helped the providers support families with trauma and mental health issues in a culturally competent manner. The consultant team also identified service delivery strategies, such as Wellness Self-Management and Multiple Family Group Therapy.

Though many of the interactions with Dr. McKay were coordinated by the KFT Project Director, case managers also reached out to her directly. She made technical assistance available to providers and attended staff meetings at Palladia’s Fox Point and WIN every other week. She also made training available directly, when requested, and visited individual providers to help them address their biggest challenges. Dr. McKay provided case managers with training in Wellness Self-Management, a 52-week workbook-based intervention that

**Provider Staff on the Clinical Consultants**

*KFT has supported staff with psychologists. This has helped with case management and peer-to-peer support. They have brought experience and knowledge of the population... [and] knowledge of wellness groups. They’ve provided us with a package of information. We should get the Mt. Sinai consultants involved from the beginning. They have a great background on families like this and this kind of work.*

– Provider director

*Dr. Mary McKay is great. She helps to strategize about how to teach families about wellness, and coping strategies which helps them deal with everyday life so that they [are] not working under crisis anymore. Families get resistant when case workers can’t fix the problems at some point. A Wellness Families group could be great.* – Case manager

*[The training is] very effective. Case workers present family cases to Dr. Mary McKay for her feedback. It is helpful. We look forward to her visits. She is instrumental in getting services.* – Provider director

*We only had one visit [as of November 2009] from Mary McKay but she was instrumental in empowerment, and teaching techniques to use for different groups.* – Provider director

guides participants through addressing families' mental health needs. Wellness Self-Management assists adults with managing serious mental health problems and includes a number of research-informed approaches and tools organized into a comprehensive and coordinated set of practices. The curricula enables case managers to teach their clients to better manage their own mental and physical health problems. In addition, Dr. McKay provided support to case managers in implementing Multiple Family Group Therapy, a 16-week program that includes resources for addressing children's behavior problems. This therapeutic practice also attends to clients' parenting skills, family functioning, involvement in their child(ren)'s mental health care, and parent/child interaction. Feedback from provider agency directors and case managers indicates that they were very satisfied with the clinical consultant services. Many reported that the training was very effective.

**Case Conferencing.** One of the initial goals of KFT was to let case managers interface with each family's preventive services agency. Ideally, the housing case managers would coordinate with ACS or the assigned preventive agency in order to address the immediate factors contributing to child neglect and abuse. The concept was based on New York City's experience with Operation Safe Housing in which parole officers were assigned to specific public housing developments and supervised parolees who lived there.<sup>10</sup> CSH thought this might work with preventive services agencies, assigning one agency to a building. However, because prevention services are contracted out and families come from all over the city, this idea was not feasible.

Another KFT idea was to identify the case manager as the convener and organizer of all of a family's services, with joint case conferencing occurring among ACS and Temporary Assistance for Needy Families (TANF) staff and the provider case managers. A city agency representative recommended,

*Case conferencing with all the players is missing. There needs to be a way to get case managers and ACS workers at the same table to discuss families. We need to be better at following these families. There needs to be one plan including multiple agencies for each family. Currently we meet with the players that are one level above the interaction with the family. We need to bring all the systems together to make one plan [because] plans from different agencies may contradict one another... In addition to contracting with agencies and providers, they should be discussing more about the families. The KFT partners provide an opportunity for case conferencing about specific families. KFT could be a vehicle for [this].*

KFT held a meeting in September 2009 to discuss the possibility of case conferencing and determine the function of KFT case conferences. At the meeting were representatives from CSH and two of KFT's supportive housing providers. The case conference idea, based on a strengths-based model of care, was seen as a means of sharing information among the agencies involved with a family, and empowering families and building a support network for them, thus helping them achieve stability and self-sufficiency.

The group agreed that a case conference should take place within two weeks after a family moved into its supportive housing apartment and that the family's initial service plan should be completed within the first 30 days of tenancy. Participants noted, however, that this standard would be hard to meet if many families were moving in at the same time, such as during an initial program opening. In addition, KFT case conferences would ideally occur biweekly though the frequency of these conferences would decrease to quarterly conferences as the family stabilized. Though some supportive housing providers

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<sup>10</sup> Press Release June 24, 2004. Mayor Michael R. Bloomberg Announces *Operation Safe Housing* to Improve Safety for Residents of Public Housing. Retrieved from: [http://www.nyc.gov/portal/site/nycgov/menuitem.c0935b9a57bb4ef3daf2f1c701c789a0/index.jsp?pageID=mayor\\_press\\_release&catID=1194&doc\\_name=http%3A%2F%2Fwww.nyc.gov%2Fhtml%2Fom%2Fhtml%2F2004a%2Fpr159-04.html&cc=unused1978&rc=1194&ndi=1](http://www.nyc.gov/portal/site/nycgov/menuitem.c0935b9a57bb4ef3daf2f1c701c789a0/index.jsp?pageID=mayor_press_release&catID=1194&doc_name=http%3A%2F%2Fwww.nyc.gov%2Fhtml%2Fom%2Fhtml%2F2004a%2Fpr159-04.html&cc=unused1978&rc=1194&ndi=1)

indicated that they already have standards for the frequency of case conferences with tenants, it was reported that these conferences occurred on an as-needed basis and were most often held regarding a family crisis. Ideally, a KFT case conference would eliminate the need for crisis-based conferences.

The partners identified for involvement in case conferences were the supportive housing providers and case managers, the families themselves, community service providers, ACS, and staff from the referring shelter (for the initial case conference only). In addition, the group recommended that psycho-social evaluations and assessments be completed for all members of the household, especially the children. Finally, it was determined that the case conferences would result in a summary that could be included in the case record of all partner agencies.

Case conferencing remains a goal of KFT, but achieving it requires the collaboration of multiple constituents and this remains an important discussion among KFT stakeholders. Case conferences should value and not be duplicative of the ACS-convened conferences. It is unclear at this point whether or not a specific supportive housing-initiated case conference is necessary if ACS-driven case conferences include supportive housing staff in conferences on a regular basis. However, in order to achieve this goal, education is still needed among child welfare staff so that they understand the role of the supportive housing provider and the importance of their work and relationship to families. While this goal began to be addressed in the early stages of the KFT initiative, as one KFT stakeholder reported,

*We had an idea of a team of DHS staff and ACS workers. This hasn't really happened—especially with the ACS caseworkers. We had hoped we could do organized case conferencing that would involve all of the agencies involved in a family's care. Case conferencing lost momentum. It could be encouraged more. It is not well coordinated.*

Though case conferencing has not been adopted as a practice for the KFT families, at least one family involved its supportive housing case manager in an ACS Child Safety Conference.

## VII. Outcomes for KFT Families

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Keeping Families Together hopes to reduce the adverse effects of abuse and/or neglect, and homelessness, on children, strengthen family resources, and encourage independence in parents. It is well documented that the needs of these vulnerable families are substantial and should be addressed through targeted programs and services. Research suggests that one solution is a combination of services and case management within a subsidized housing program (Rosenheck et al., 2006 as cited by Bassuk and Geller, 2006). A report by the Task Force on Housing and Services for Families (2003) noted that “Service-enriched and supportive housing is by far the most promising strategy currently available” (p. 19). This combination can lead to housing stability and decrease the likelihood that the family will return to the shelter system (Bassuk and Geller, 2006). Subsidized housing models vary, with services available on and/or off site with different requirements for tenants’ use of such services (Task Force on Housing and Services for Families, 2003). As Caton, Wilkins, and Anderson (2007) point out though, retention is highest when housing is combined with services, regardless of the housing model.

Further, research recommends that the range and intensity of services be tailored to the needs of the particular families (Task Force on Housing and Services for Families, 2003). In the case management model, a central person, working with only a small number of families, serves as a primary contact and as a support system, assesses the need for and coordinates services, and monitors progress (Bassuk and Geller, 2006; National Center on Family Homelessness, 2009; Zlotnik, 2009). Case management aside, a review of the literature reveals numerous other service areas targeted toward the specific needs of homeless families and the risk factors that may have originally compromised their housing stability. These recommended services include life skills, financial management, self-advocacy, mental health and/or substance abuse treatment, employment assistance, parenting skills, and recreational or educational activities (Caton, Wilkins, and Anderson, 2007; Cohen et al., 2004; Hart-Shegos, 1999b; National Center on Family Homelessness, 2009). With such services, supportive housing may also offer families the chance to regain their independence and bring their children back into their homes after foster care (Task Force on Housing and Services for Families, 2003).

This section of the report presents information on the families’ use of services and the flexible grants available to them through KFT. It also describes the progress made by KFT families at achieving KFT’s short-term outcomes, including residential stability, interpersonal relationships and support systems, effective parenting, self-sufficiency, family health, and the child welfare and educational outcomes of the children. The data for this section are associated with the 26 pilot families who have remained in supportive housing through the evaluation period.

### Service Use

As a precursor to their supportive housing placement, families met with DHS shelter staff to complete the HRA 2010(e) form. Case workers or other trained staff completed this form with each family and identified recommended services (e.g., case management, medication management, parenting skills training, domestic violence services). The data in this form provided the supportive housing case manager with preliminary information about the history and needs of the applicant. The intake procedures of each provider also gave the case manager information on other services to recommend to the family.

Upon placement in supportive housing, KFT families received individual case management services through the provider’s on-site case managers and had access to additional services through other on-site

staff or community providers (e.g., South Bronx Healthy Families, Bronx Defenders). DOHMH standards required that KFT families meet with the housing case manager at least twice per month, although they were welcome to meet with them more frequently. Housing case managers also worked with families to develop intermediate and longer-term service plans to address underlying troubles that could lead to abuse, neglect, and family instability. Such service plans addressed mental health, substance abuse, parenting, activities of daily living, and employment, and were gradually phased in as the family's immediate crisis defused. However, a family's participation in other support services was not a requirement of the KFT program.

Case managers were asked to review their case records for the 26 families who remained in supportive housing through the end of the pilot period and complete a form indicating which services each family had obtained. Table II displays the services that were referred and obtained by the 26 families, as reported by case managers.

**Table II. Services Referred and Accessed by KFT Families**

Services	% Accessed of Total Population (N=26)	Referred by Case Manager		Accessed of those Referred	
		N	%	N	%
Case management services	100%	26	100%	26	100%
Substance abuse treatment	46.2%	14	53.8%	12	85.7%
Ongoing medical treatment	38.5%	12	46.2%	10	83.3%
Job readiness, employment	34.6%	11	42.3%	9	81.8%
Prevention services	30.8%	9	34.6%	8	88.9%
Money management	30.8%	8	30.8%	8	100%
Ongoing psychiatric treatment	26.9%	8	30.8%	7	87.5%
Family or individual counseling	26.9%	8	30.8%	7	87.5%
Parenting Skills Training	15.4%	4	15.4%	4	100%
Domestic violence services	11.5%	3	11.5%	3	100%
Education	7.7%	4	15.4%	2	50.0%
Daily living skills	7.7%	2	7.7%	2	100%
Group counseling	3.8%	1	3.8%	1	100%
Aftercare program	3.8%	1	3.8%	1	100%

Nearly all of the referred clients accessed the service that was recommended to them. The exception was education, where the number of referrals was very small (four), and only two of the four HoHs accessed this service. It is important to note that case managers may not have had full knowledge of services a family received through an ACS preventive agency if the family did not agree to allow the preventive agency to share that information with their case manager. This situation applied to three of the KFT families. The number of families referred to specific services may seem low, but may point to either incomplete information in case managers' records or that the services/information and resources provided by case managers were sufficient to meet the needs of the families. In addition to regular case management and providing referrals to service, case managers also provided the families with ad hoc crisis intervention and support with problem resolution.

Chronically homeless adults have generally low levels of engagement in outpatient mental health services, substance abuse treatment and health care. Caton, Wilkins, and Anderson (2007) indicate that homeless adults “often find it difficult to maintain participation in outpatient settings... [and] are often unable or unwilling to complete substance abuse programs.” The motivation and receptiveness of families to participate in services, groups, and programs is an important factor that determines whether or not they access services. It became clear in the focus groups with provider directors, case managers, and the families themselves that there were varying degrees of receptiveness among the KFT families. One provider director indicated,

*Families are institutionalized for so long that they mistake interventions as intrusions. We have services offered on site and we refer out to community-based organizations.... Most of our challenges are about getting clients to accept services.*

The work with the clinical consultants helped case managers engage the families. The relationship between the case manager and the family also was important to securing a family’s buy in to using supportive housing services. One provider indicated that it held an initial family interview with a family and all of the housing staff in order to determine what type of case manager a family might need and identify an individual who would work best with the family. Another provider director indicated,

*The effectiveness [of services] depends on what a family makes of the service. The fact that someone is paying attention can make a difference. It depends on whether or not the family is engaged... The negotiation of services has improved relationships with families. It helps them to see the program as on their side. KFT helps families get subsidies and overall improve the quality of their life... Services from other organizations/agencies are negotiated through the on-site case manager. The ease of this depends on how receptive the family is to being coached by the case manager. There is a balance in the role of case manager—protective support versus co-dependency.*

Many families spoke highly of their case managers during the family focus groups. As one parent summed up, “Supportive housing is a blessing. Staff stand up for tenants [and] listen to tenants. Tenants can go to them for anything.”

Some parents had very good relationships with their case managers and looked to this staff person to help them improve their lives. However, there were some differing opinions about the level of intrusiveness of the case managers and the supportive housing staff that seemed to vary by provider. In the focus group, one parent indicated, “The supportive housing staff is nosy.... [The] case manager is located on the first floor.” A parent from another provider disagreed, “[Our] case manager isn’t nosy and doesn’t live in the building. She works 9 to 5 pm.” Other families expressed some dissatisfaction with supportive housing. There were reports of favoritism and uneven enforcement of the rules, and tenants also complained of the large number of rules, such as not being able to put a welcome mat in the hallway or paint the apartment, and restrictions on visitors. One parent asked, “How and why do [case managers] know everything that’s going on? ... Would they ask questions of someone who hadn’t been addicted? Are judgments really for tenants’ safety?” Another stated, “Supportive housing needs to find a happy medium between being supportive and being in people’s business too much. [We] need better guidelines with a balance in their involvement.”

Supportive housing providers cannot mandate services to any of their families. Mandates must come from ACS, usually as part of the services of a preventive agency or Family Court. Further, the ACS-required services come with a large incentive (i.e., maintaining custody of their children). Services that families did indicate having attended or completed, with or without any mandate, included the following:

- GED preparation;
- Men’s/women’s group workshops;
- Substance abuse outpatient programs;
- Counseling;
- Employment training;
- Parenting skills group;
- Anger management.

In their attempts to receive referred services, parents encountered some obstacles. One client reported, “I help myself. I found my own help and found a job. I get help from [my case manager] and she comes through. [She] will fax something if I need her to. I went to training on my own. I got certificates for completing training but they’ve suspended my license because of back child support issues.” Another parent was enrolled in a GED program, but the hours made it difficult for her to attend. She stated, “I could do 9 or 10 am to 1 pm but I have to go pick up my children from school. I live in Bedford-Stuyvesant but the GED course was in East New York.” Some provider’s addressed the transportation issue by offering GED and employment training programs on-site. Table 12 lists the staff that is available at each of the supportive housing sites to provide on-site services.

**Table 12. On-site Supportive Housing Staff**

Staff Position	Number of On-site Support Staff Available*					
	CAMBA	Diversity Works	Jasper Hall	Fox Point	St. John’s House II	Women in Need
Social worker/ case manager	1	2	4	2	2	1
Vocational counselor	0	0.5	1	1	0	1
Education counselor	0	0.5	–	0	0	1
Family specialist	0	1 PT	0**	0	0	0
Substance abuse counselor	0	1 PT	0	0	0	1
Benefit specialist	0	0	0	0	0	0
Clinical supervisor	1	1	0	1	1	0
Youth / child life specialist	0	1 FT, 3 PT	1	1	0	0
Housing coordinator	0	0	1	0	0	0
Recreation specialist	0	0	<i>Pending</i>	0	0	0
Psychiatric nurse practitioner	0	0	0	0	1	0

\* Full-time unless otherwise noted (PT=part time).

\*\* One of the case managers fulfills the role of a family specialist.

Staff availability varied considerably from site to site, however, most had vocational counselors, clinical supervisors, or child life specialists on site. Other examples of on-site services included:

- Case management;
- Children’s after-school services;



- Children’s arts programs ;
- Children’s groups;
- Community empowerment workshops;
- Daily living skills groups;
- Financial management workshops;
- GED preparation (through Kingsborough Community College);
- Health education;
- HIV prevention;
- Legal assistance;
- Mental health education;
- Money management education;
- Recreation for children and adults;
- Vocational rehabilitation.

## Flexible Grants

Every KFT family received a grant of \$1,000 for each year that the family was housed, for the life of the pilot (for a maximum of \$2,000 per family). The expectation was that the money would be used for one-time expenses that promoted positive family functioning. For example, grants could be used for special events, birthday parties, child care, summer camp fees, transportation, clothing, to pay a bill (such as utilities), work-related activities or schooling, and apartment security deposits. The maximum amount of any single flexible spending grant disbursement was \$500.

These funds were used to support a variety of activities and as one director mentioned, “*The [flexible grant funds] are like monies from heaven for these families. [It allows] KFT families to have a little bit of extra money for the things they need to improve their self-sufficiency and family functioning.*”

Families spent the flexible grants primarily on clothing and household items, as described in Figure 1. Records indicate that many of the purchases were for the children, for educational materials, toys and games, and movies. Four of the families spent the funds on family affairs and/or birthday or holiday gifts.

The flexible grants were not without their challenges. During the focus group with case managers, the participants seemed unclear about how the funds could be spent—even though CSH had issued a form with an accompanying instructional memo. There were issues with obtaining receipts and documentation. As one case manager commented, “*I am not sure where all of this client’s money went but he/she said that it was going toward a bill.*” One provider director indicated, “*The biggest challenge with the flexible grants is getting the receipts from the families. There is a missing camera [that was purchased with the funds]. None of the requests were for the child.*”

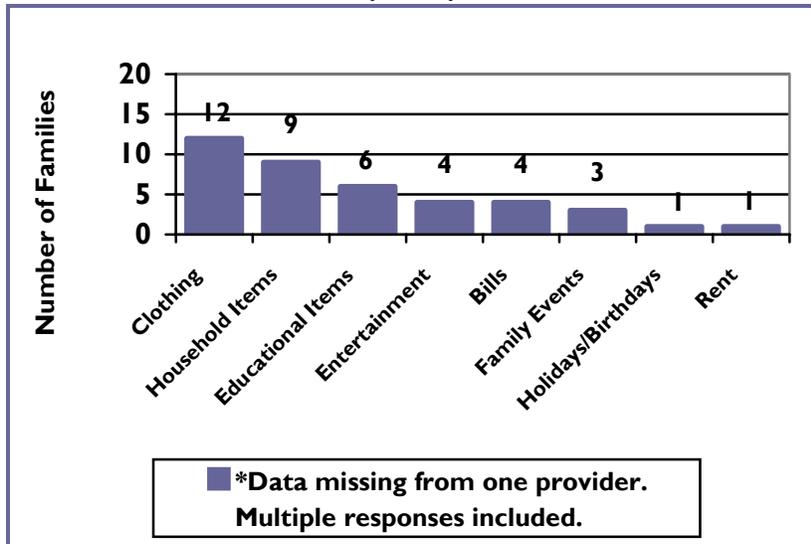
### CSH and Provider Staff on the Flexible Grants

*The families, case managers, and providers feel they’re getting something concrete with the family grants, which is valuable because participation in KFT itself may seem a bit amorphous at times.... CSH feels there is a value in providing poor people with some extra money. [There is] no bureaucracy involved, the money goes right to the case manager for the families. —CSH staff member*

*[KFT families’] needs are more than the average family but not more than the average homeless family. These families have experienced a lot of failure. They need success. KFT flexible monies help the families achieve those successes. It gives them something to build on. The program helps families get subsidies and overall improve the quality of their life. — Provider director*

Case managers would have preferred the funds be used to buy educational materials, toys, etc., for the children, and some providers have implemented their own policies. One provider took KFT families on shopping trips. Another required the program director to decide how the money was used. (At that facility the director allowed the funds to pay for a couple's anniversary celebration and a child's prom.) In addition, families were asked to write holiday wish lists. Another provider recommended that families put the flexible spending money toward child care when the parent needed to attend a job interview.

**Figure 1. Flexible Spending Among Families (N=17)\***



The differences between housing providers with regard to the administration of flexible grants were also evident during the family focus groups. Some buildings let tenants spend money by themselves, while others sent staff with tenants to monitor their shopping and tell them what they could buy. Families were both amazed and annoyed at this variation.

There remains some work to be done in planning and administering the flexible grants. (Though all families seemed to appreciate the extra money and many used it or intended to use it wisely.) Policies were not uniform despite procedures set up by CSH.

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## Residential Stability

Most of the KFT families (26 of 29, 89.6%) achieved residential stability. DHS records indicate that two of the three families who chose to move out have since returned to shelter. One returned in November 2009 and has remained there since that time, while the other family spent three weeks in shelter between January and February 2010.)

### Focus Group Participants on the Flexible Grants

*I'm unclear about the process for getting money. They say we can get \$500 increments but what if you want to buy a computer that costs \$750? I have asked how to go about this and can't get a straight answer, and was told that it would be a big ordeal. Who do I talk to?*

*Scheduling a time to go shopping with staff can be extremely difficult because you have to find a time that's convenient for them to take you. It's not always easy to find a common time.*

*I feel like a child when I have to be accompanied on shopping trips. Why can't we go shopping by ourselves and bring back receipts?*

*I looked forward to getting support but I was not really sure about the program. I understood that money was available to use but then when a tenant wants to do something, it's not available.*

Research indicates that once a family has obtained stable housing, it can begin addressing other problems (Hart-Shegos, 1999b; The National Center on Family Homeless, 2009). Focus groups with the heads of

households suggest that this is the case for the KFT families.<sup>11</sup> Some of the most important insights on the impact of supportive housing come from the families. By and large, focus group participants were thankful for having a permanent place to call home. One family commented, “*I am my own success story. Looking at the past, I am very happy with the present. I like staying home. I am so happy to be here and, when I go out, I can’t wait to get home.*” Another participant echoed this sentiment: “[*Supportive housing has*] made me want to improve my quality of living. I want to be a nicer person. I stay home all day.... [I] don’t want to be tough anymore. I don’t feel so overwhelmed. Stress is more manageable [now].”

As noted in Section III, DHS identified a sample of families who met the KFT criteria and were in shelter during the KFT identification period, but who were not housed in supportive housing. These 15 families make up a comparison group that approximates the trajectories of similarly situated, vulnerable families who did not receive supportive housing. All of the 15 families in the comparison group were NY/NY III applicants, but were not accepted into housing, for reasons unknown. DHS has indicated that the information available to them about ACS case status of the comparison group was incomplete.<sup>12</sup>

The comparison sample consisted mostly of female-headed families (N=14, 93.3%) who were primarily of minority backgrounds—53.3% Black and 40.0% Hispanic. These mothers had from one to four children for an average of about two (mean=1.93). The average age of the children was 9.7 years. Three female-headed families (20.0%) also included a male adult at some point in their shelter history. The average age of the HoH was 39.4 years though they were as young as 22 and as old as 61. Thus, demographically, these families were very similar to the KFT families.

The DHS shelter histories (see Table 13) show that the average cumulative duration of shelter stay for these families was 15.3 months, and ranged from two to 30 months. Seven families (46.7%) exited shelter after this initial stay and did not return during the pilot time period. Eight families (53.3%) either remained in shelter without interruption or had episodes of one or two additional shelter stays during the period under study.

**Table 13. Average Duration of Shelter Stays for Comparison Families**

N Families	Shelter Stay 1		Shelter Stay 2		Shelter Stay 3		Average Cumulative Shelter Stay	
	N	Average Duration	N	Average Duration	N	Average Duration	N	Average Duration
15	15	11.5 months (range = 2 to 30 months)	5	4.5 months (range = 0.5 to 11 months)	4	8.5 months (range = 3 to 20 months)	15	15.3 months (range = 2 to 30 months)

<sup>11</sup> The focus groups were held in the Bronx and Brooklyn and were attended by a total of 15 heads of household (12 in the Bronx and three in Brooklyn).

<sup>12</sup> A field in the DHS client tracking system stipulates whether there is an open ACS case. The field may or may not have been filled in, but provides no other information (e.g., dates, nature of case). Another indicator that was used by DHS, in some instances, was a flag to identify an ACS case in the "personal information" field of the DHS database.

## Child Welfare

Data from the Administration for Children’s Services—rates of case closure, the number of reunifications of children who had been in foster care, and an absence of repeat placements and maltreatment—indicate that KFT families had a decrease in child welfare system involvement.

Child Care Review Service (CCRS) and Connections data were received from ACS in October 2010 for 22 of the 26 families (88.5%), providing information on a total of 77 children.<sup>13 14</sup> Two additional children residing with these families did not have any history with ACS. One of these children was born while the mother was residing in supportive housing. The other child was about one year old at the time his mother moved into supportive housing. As the other children of these two mothers have had at least one ACS case open prior to being housed at one of the providers, the lack of child welfare involvement on behalf of these two young children suggests that these families have been stable since their move-in.

Table 14 displays information on the situations at move-in of the children of the KFT families.

**Table 14. Status of Children of KFT Families**

	N (%)
Families	22
Total number of children for whom ACS data are available	79
Resided in supportive housing at some time during pilot	38 (48.1%)
Moved into supportive housing with parent	32 (84.2%)
In placement with goal of reunification	6 (15.8%)
Never resided in supportive housing	41 (51.9%)
Minors residing elsewhere	12 (29.3%)
In placement with no goal of reunification	10 (24.3%)
Parental rights terminated/adopted prior to move-in	10 (24.3%)
Over age 21 as of October 2010	9 (21.9%)

KFT families had about half of their children (N=38, 48.1%) living with them in supportive housing at some point over the course of the KFT pilot. A majority of these children (N=32, 84.2%) resided with their parent at the time of move-in. The remaining six children (15.8%) were in placement (e.g., foster care, kinship placement) with a goal of being discharged to the parent. The other half of the children (N=41, 51.9%) never lived with their parent during the KFT pilot. Some of them lived elsewhere or were in placement with no goal of reunification, while others were adults or had been adopted.

<sup>13</sup> One family did not meet the criteria for having an open ACS case on a minor child at move-in and ACS data were not available for three other families. Consent forms could not be obtained for two of these families and one family could not be located in the ACS database. These families are not included in the analyses.

<sup>14</sup> In other places in this report, the total number of children borne to the KFT families is reported as 105, a number obtained from interviews with the families. The data in this section reflect the records of ACS on 77 of those children in 22 families.

Information about the 38 children who lived with their parent in supportive housing at some point during the pilot was analyzed to learn more about their ACS history. As displayed in Table 15, 32 of the 38 children had an open ACS case at the beginning of their family’s involvement with KFT. The majority of these cases were for preventive services (75.0%), one was a protective services case, and the remaining cases were in placement in foster care, or in a kinship or out-of-county placement. The other six children in these families did not have an ACS case but at least one of their siblings did.<sup>15</sup>

**Table 15. Children’s ACS Status at Beginning of KFT Pilot**

Status	N (%) of Children
No open ACS case	6 (15.8%)
Open ACS case	32 (84.2%)
Preventive services	24 (75.0%)
Protective services	1 (3.1%)
In foster care placement with goal of return to parent	6 (18.8%)
In placement with a KFT family	1 (3.1%)*

\* One child was placed with a KFT head of household and later reunified with her parent (who did not live in supportive housing).

There were positive outcomes with regard to ACS involvement for many of these families. More than half of the open ACS cases were closed (N=19, 59.3%), including 14 of the 24 preventive cases (58.3%), the one protective case (100%), and four of the six cases (66.7%) where the child was in placement. In addition, based on the ACS data, which were analyzed through May 31, 2010, all six of the children who were placed with a goal of reunification had been returned to their families. These findings are displayed in Table 16.

**Table 16. Disposition of Open ACS Cases by End of KFT Pilot**

	N (%) of Children
Closed	19 (59.3%)
Preventive services	14 (73.7%)
Protective services	1 (5.3%)
Placement	4 (21.0%)
Still open	13 (40.6%)
Total number of children with open ACS cases	32

In addition, the case managers for the three families for whom CCRS data were not available provided anecdotal information indicating that three out of the four ACS cases in these families were closed.<sup>16</sup> Thus, based on data from both sources, 22 of the 36 (61.1%) open ACS cases at the time of the families’ move to supportive housing were reported to be closed by the end of the KFT pilot.

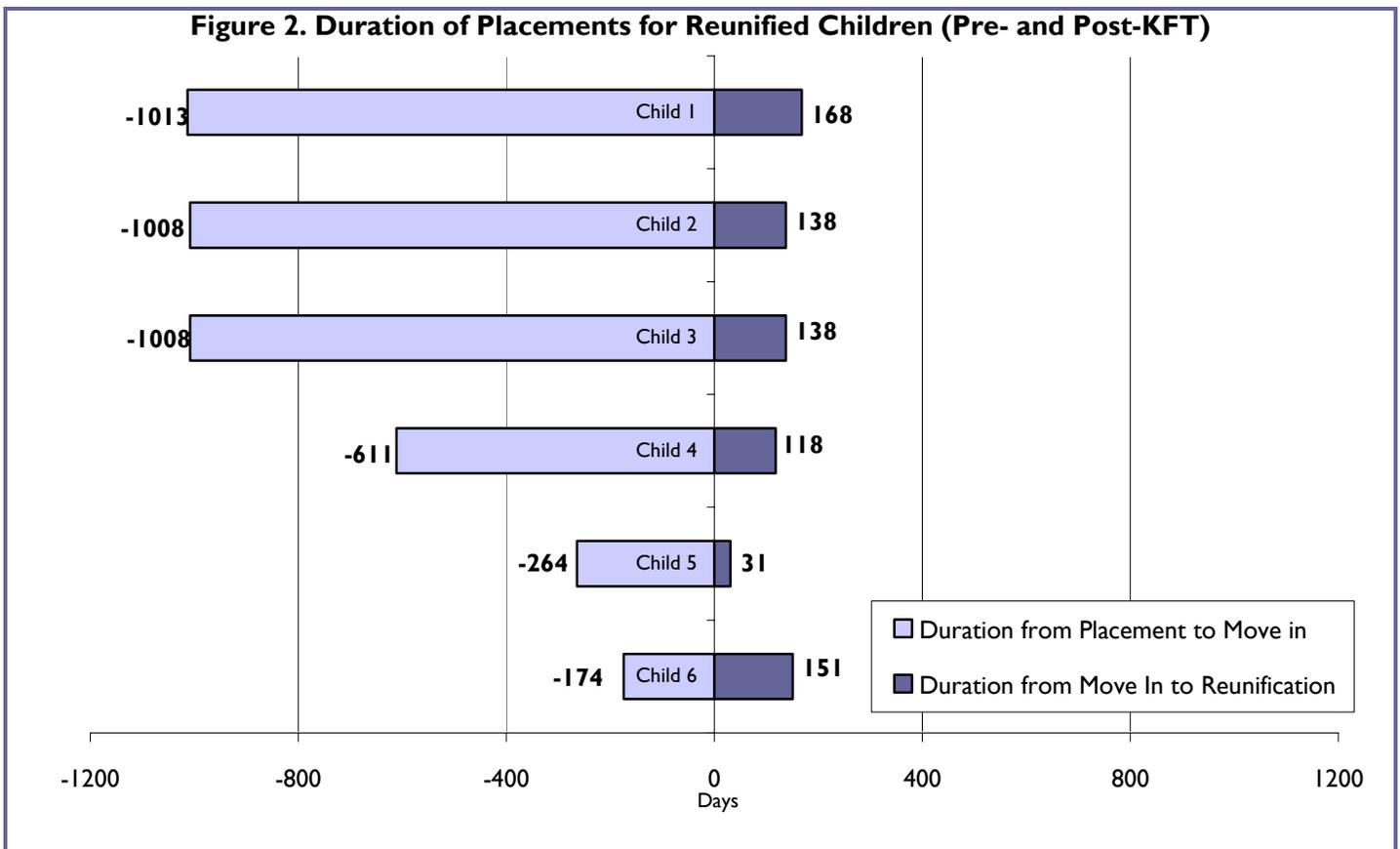
<sup>15</sup> A family needed only to have an open ACS case on at least one of the children in their custody in order to be eligible for KFT.

<sup>16</sup> As of April 2010.

KFT parents perceived the closing of an ACS case as a great accomplishment. One parent remarked concerning the child’s ACS case, “Another success was getting rid of ACS. ACS doesn’t say anything anymore. [My child] is doing well in school. [Two of my children] graduated and one got into college.”

**Foster Care Recidivism and Permanency.** One of ACS’s goals is to ensure that children who have been reunified with their parent do not return to foster care or other placements. ACS measures this outcome by the “rate at which children discharged to reunification return to care within one year.”<sup>17</sup> Although at the time of this study a year had not passed for all of these KFT families, none of the six KFT children who had a goal of reunification had returned to placement. As of May 31, 2010, the 12-month goal had been met for five of the six (83.3%) reunified children. At the end of the pilot, reunified KFT children had been living with their families for an average of 15 months, with a range of from six to 26 months.

The relationship between gaining stable housing and the reunification of children in placement is illustrated in Figure 2, which shows the length of placement for each of the six children that were reunified with their families. The light blue bar shows the number of days each child spent in placement before the family’s move to supportive housing (pre) while the dark blue bar shows the number of days the child spent in placement after stable housing was attained (post). The zero line indicates the point at which the family moved to supportive housing.

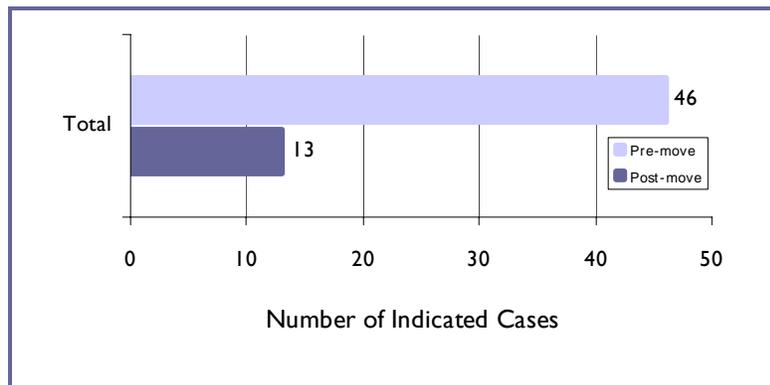


<sup>17</sup> Retrieved October 2010 from: [http://www.nyc.gov/html/acs/html/statistics/top12\\_out4.shtml](http://www.nyc.gov/html/acs/html/statistics/top12_out4.shtml).

The reunified children had spent an average of 680 days in placement before their family moved to supportive housing and only 124 days in placement after the family had stable housing. Although the small number of children does not allow for generalization, these data may help support the idea that obtaining stable housing, gaining access to supportive services, and receiving assistance from case managers helps to stabilize families, in that there was a shorter period of placement once stable housing was achieved.

**Indicated Abuse/Neglect Reports Before and After KFT.** Another ACS outcome assesses the extent to which children who had been the subject of an indicated abuse/neglect report are victims of subsequent substantiated maltreatment. The ACS data were analyzed to examine the number of indicated abuse/neglect cases that occurred three years prior to the families move to supportive housing (pre-move) and the number of indicated cases during the family’s residence in supportive housing (post-move), through May 31, 2010. There were a total of 46 indicated cases pre-move as compared to 13 indicated cases post-move, as shown in Figure 3.

**Figure 3. Total Indicated Cases from 3 Years Before Move in (Pre-move) and during Supportive Housing (Post-move)**



All but one family had at least one indicated case three years prior to move-in. However, after moving into supportive housing, 14 of the 22 families (63.6%) had no subsequent indicated abuse/neglect cases. These findings, shown for each family in Figure 4, indicate a statistically significant ( $p=.000$ )<sup>18</sup> reduction in the number of indicated repeat abuse/neglect cases—from an average of 2.1 reports prior to move-in to an average of 0.6 after move-in.

<sup>18</sup> Based on the Wilcoxon Signed Ranks Test.

**Figure 4: Number of Indicated Abuse/Neglect Cases from 3 Years Before Move in (Pre-move) and during Supportive Housing (Post-move)**

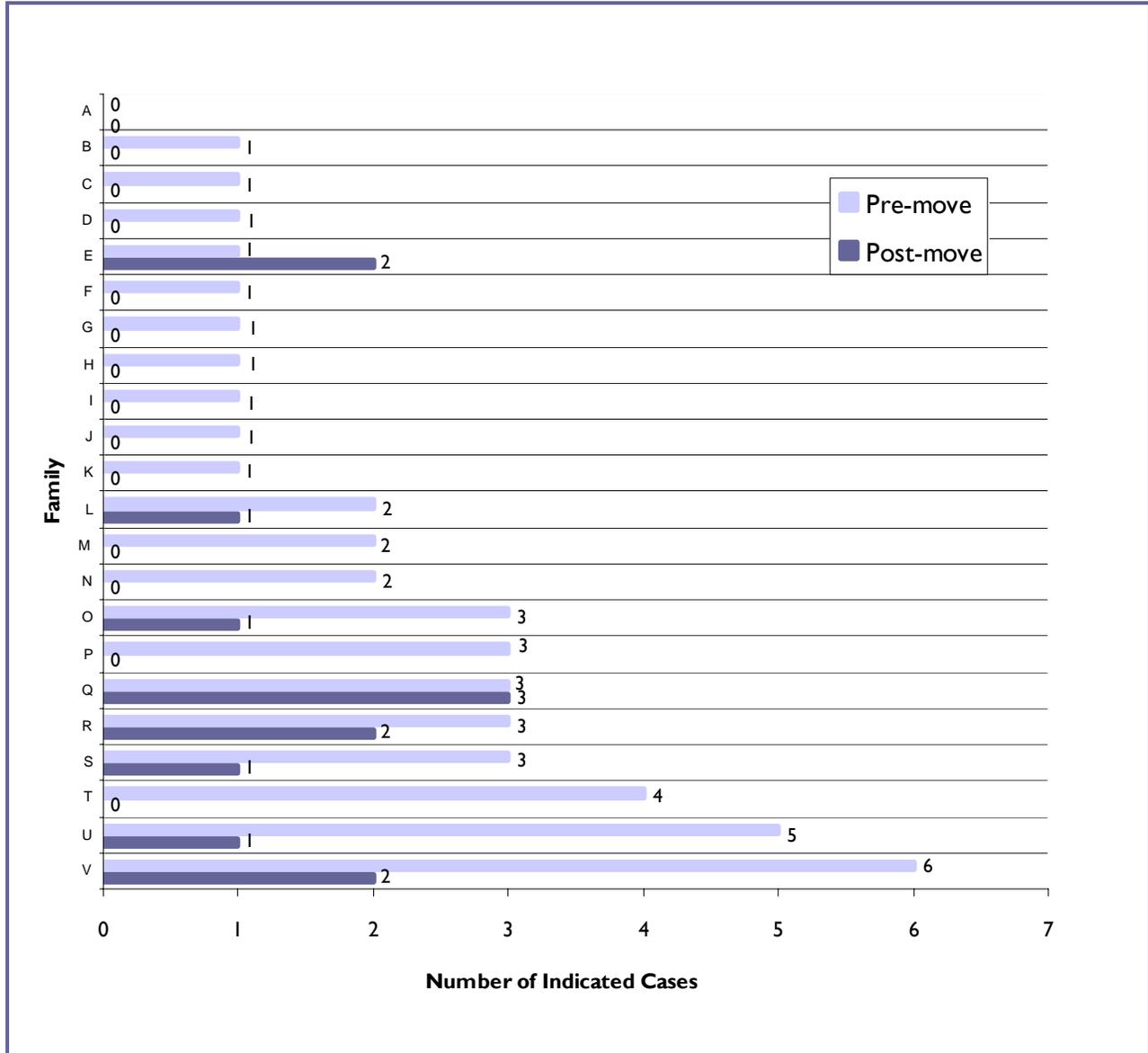
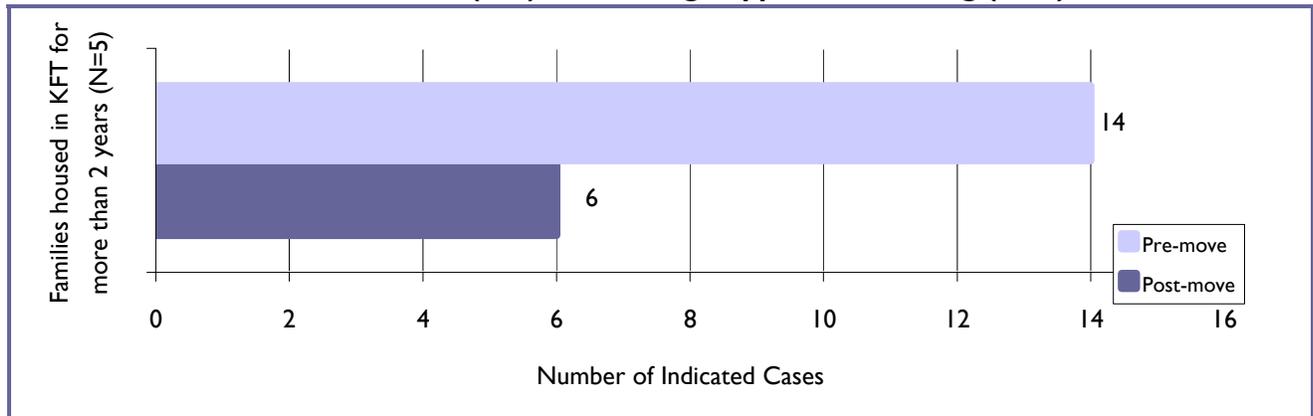


Figure 4 does not take into account the different lengths of time in supportive housing. Nor are the pre-move and post-move periods equivalent, as the pre-move period is three years while the post-move period could be from 10 to 31 months. For the analysis in Figure 5 the families were divided into groups, based on their move-in date, to account for the “dosage” of supportive housing received by each family. Figure 5 displays the total number of indicated cases before and during supportive housing for the five families that spent more than two years in it.

**Figure 5: Number of Indicated Abuse/Neglect Cases From 3 Years Before Move in (Pre) and During Supportive Housing (Post)**

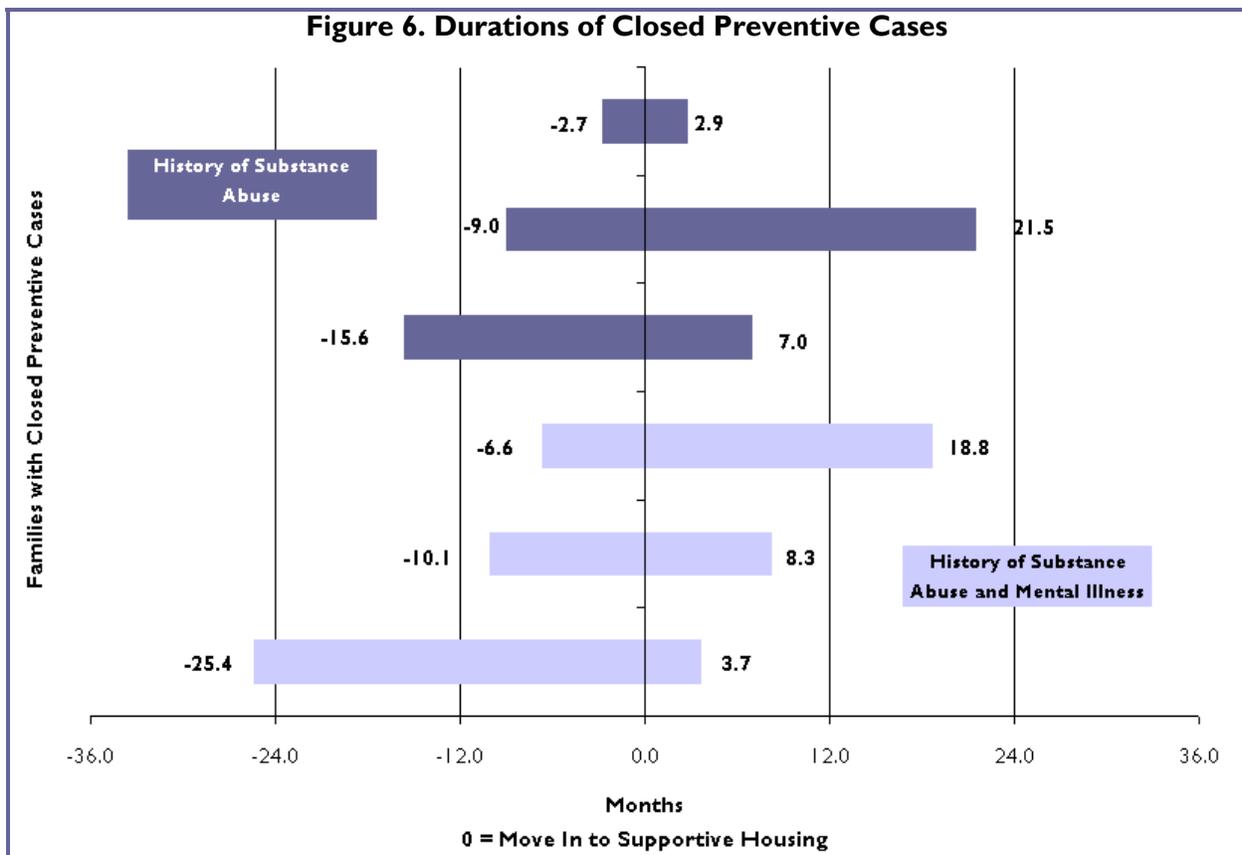


There was a large reduction in the number of indicated cases from before (pre) supportive housing to after (post) housing for families who had been housed for more than two years. However, because of the small number of cases, these data should not be assumed to be indicative of a relationship between the duration the family spent in supportive housing and the number of indicated cases occurring after families obtained supportive housing.

**Preventive Case Closure Rates among KFT Families.** In October 2010, ACS Commissioner John Mattingly reported that the average length of service for a preventive case had typically been 15 to 18 months, though the goal is 12 months.<sup>19</sup> The data show that for the 14 preventive services cases (representing six families) that had been closed, the case average duration was 22 months (from opening to closure), with a range from 6 to 31 months. In addition, the 14 cases were analyzed according to the family’s move-in date. This analysis indicates that, on average, a KFT child’s ACS case was closed within 10 months of the family’s move to supportive housing, with a range from 3 to 22 months. These findings suggest that once the family received stable housing the subsequent duration of the preventive case was somewhat shorter than the average preventive services case. It is important to note, however, that a preventive case must stay open in order for families to receive an ACS housing subsidy. It is possible that leaving a case open could have been a factor in the family’s pre-KFT case duration.

The case duration for each of these six families is displayed in Figure 6. In this chart each line represents from one to three children. In addition, the families were categorized into two groups based on their presenting eligibility criteria—a history of substance abuse, mental illness, or both. All of these families had a history of substance abuse and three of them also had a diagnosed mental illness. There seems to be little relationship between the presenting substance abuse and mental health problems, and ACS case duration.

<sup>19</sup> New York City Council Hearing Testimony by ACS Commissioner John B. Mattingly; October 5, 2010.



**New ACS Activity among Families during the Pilot.** No children were removed from the home during the KFT pilot; however, ACS data indicate that two cases were reopened. One of these cases involved a child whose preventive case had closed during the period of residence but who had a new protective case opened by the end of the pilot. The other child did not have an open ACS case at move-in but did have a history of involvement with ACS about four years prior to the family’s move to supportive housing.

## Interpersonal Relationships and Support Systems

Beyond providing a roof over their heads, supportive housing has had an effect on residents’ ability to maintain positive relationships with others and to rebuild the support systems that may have been challenged by homelessness. As reported by Ridlen,

*[KFT] parents have very little social support from friends and family. One-third of the parents have no contact with their family of origin, one-quarter have lost both parents, and 60% report no or only one close friend(s). Parents also have little connection to the labor market—only 20% have had any employment in the last three years.*

In focus group conversations held in February 2010, multiple adults reported that KFT has helped them form supportive relationships with other residents or case managers. They have joined religious services in the community and reconnected with long-lost family members. One tenant commented, “Supportive housing is really great. In the shelter, you were on your own but the supportive housing [provides] welcomed help and support.”

In addition, KFT has encouraged the reunification of parents and their children in six cases and the maintenance of a stable address has facilitated contact between parents and their adult children. One parent indicated, “I have been reunited with my children and mother (who used to all live together elsewhere without me).” Another reported, “In the shelter, I wasn’t allowed to have [my] daughter stay with me when she visited. I am proud and excited that, when my daughter comes to visit now, she’s allowed to stay with me in my apartment.”

## Effective Parenting

Focus group participants felt that supportive housing had a powerful impact on them becoming better parents for their children and provided the opportunity for them to do so. Three HoHs completed parenting skills courses and eight HoHs also received preventive services. One parent mentioned, “My daughter has her own room now.” To families that have spent many nights sleeping in shelters or on the couches and floors of friends’ living rooms, the ability to provide their children with their own room is a tremendous accomplishment. Further, KFT facilitates parents’ ability to achieve small victories like being able to adequately provide for their children (e.g., buying a winter coat, purchasing school supplies, being able to cook dinner in their own apartment).

Families remarked that their children were successful and safe now that they lived in supportive housing. They were appreciative of all the extra activities that are available for their children such as summer camps, tickets and trips to Broadway shows, and family retreats. One parent remarked that, “The case managers are big advocates for kids. We had a camping family reunification trip that was really great. We worked on strengths and weaknesses as a family.”

A comment from a case manager echoed the achievements of families at becoming better parents: “One mother has renewed concern for her son and put drugs aside. She has become more involved with her son’s school.”

### Quotations from Family Focus Group Participants

*Watching [my] family repair and prosper is a success. I am watching children adjust. Despite my complaints, I am still happy in supportive housing. Now, I have support and an extended family.*

*I didn’t like having my kids in a shelter. I could make do by myself but, since I have kids, I had to do better for them and go to supportive housing.... [Now], I don’t worry anymore. I sleep well.... I couldn’t sleep at the shelter. I had to worry about my kids and our possessions [at night].*

*Tenants want to do whatever they can for their children. I am learning to be responsible even though little things get in the way. My daughter is the reason to stay clean, and not go and hang out on the street.*

*My daughter comes first now. She is a happy child and I feel that I must be doing something right to have a great child.*

*I am learning how to be a good parent. I take everything day by day.*



## Maintaining Recovery

Dr. Ridlen, the previous evaluator, also reported that, at baseline, “the presence of mental health and addiction issues among parents is extremely high. Almost all the parents interviewed have struggled with addiction in one way or another. Over half reported having tried treatment one to five times. Two-thirds indicated they are presently in treatment or are being tested regularly.”

Many parents reported in the focus group that their greatest success and biggest challenge was maintaining their sobriety, although nearly all of the families who entered with a substance abuse problem were now clean and sober. Twelve adults participated in substance abuse treatment programs while in supportive housing (Table 11) and parents mentioned recovery from substance abuse as a frequent success of KFT. Many pointed to the support of housing staff as being instrumental in their ability to stay clean. One tenant reported, “I have celebrated two anniversaries of being clean while in supportive housing. I have been ambitious—got a job. The staff has been supportive in staying clean and say they’re proud I have stayed clean.” Another concurred, “I don’t need to get high anymore and that’s a good feeling.”

Parents also identified obstacles to staying clean, even in supportive housing. Among these obstacles was the recurring presence of visitors to the building. One tenant worried that other tenants’ guests may compromise the sober environment of the building. Another openly remarked that maintaining her sobriety was a daily challenge. She said, “Sobriety means a lot and I worry about relapse, especially with stress of children. I have a good support network [in supportive housing] but sometimes I think they are too involved and that if I’m going to relapse, it’s going to happen no matter what.” Further, conversations with provider directors and case managers indicate that at least three adults were suspected to have relapsed. One of the supporting housing directors indicated, “About 80 to 85 percent of adults have maintained their recovery. The remaining 15 percent have not maintained recovery but are willing to work on it.”

## Self-Sufficiency

Stable housing gave participating families some breathing room to focus on other needs, since they no longer had to worry about a place to live. About one-third of the parents (N=9, 34.6%) participated in job readiness or employment classes and nearly this many (N=8, 30.8%) attended money management workshops. A few parents (N=2, 7.8%) were

### Comments from Case Managers

*Client pays bills on time and hopes to attain employment in the future.*

*Client has worked and is linked with VESID. Client continues to pay bills in a timely manner. Tenant worked temporarily for the Parks Department.*

*Client has been responsible in handling finances and will soon be participating in GED classes at FEGS.*

*Client is participating in a Back-to-Work program at public assistance and is currently looking for full-time employment.*

*Client has goals on returning to school and obtaining employment. Client is making efforts toward becoming independent by attending job readiness trainings and making goals toward an education.*

*Client is currently in the public assistance Back-to-Work program and the domestic partner is working with the vocational instructor for placement in vocational services in culinary arts.*

*Client has completed the public assistance Back-to-Work program but did not receive compensation. Client does not receive these services on-site but at FEGS.*

attending programs to help them prepare for the GED test. One parent said, “I attend workshops and am going back to school. I appreciate things a lot more because I have to work for it.” In addition, one of the KFT adults was employed as of April 2010, while another six adults were employed at some point during their residence in supportive housing. It is important to note that achieving employment was not a goal for all families. Those families with disabling medical conditions, such as severe and persistent mental illness, would not be expected to attain employment.

## Family Health

Health, behavioral, and emotional problems are often prevalent among homeless children, possibly due to instability and stress (Alperstein, Rappaport, and Flanigan, 1988; Miller and Lin, 1988; Wood et al., 1990, all as cited by Rog and Buckner, 2007; Task Force on Housing and Services for Families, 2003). Health problems may begin even before birth as homeless mothers may have limited access to health care and, as Hart-Shegos (1999a) discusses, behavioral studies have found that the rates of mental disorders, aggressive behavior, and anger are higher among homeless children as compared to housed children.

Parents were appreciative of the medical treatment that their children were receiving. One parent reported,

*I had three kids when I went into the shelter. We lived in the Bronx but their school was in Brooklyn<sup>20</sup>... Children’s medical records are all over. Now that we are in supportive housing, the children have one doctor and have been in the same school for a few years.*

Seven families or HoHs had received ongoing psychiatric treatment to manage their mental illness (see Table 11). And as already mentioned, the clinical consultants worked with case managers to help families self-manage their mental health needs. The assistance from case managers and the resources of the consultants also helped parents obtain needed services for their children, such as psychiatric exams or school-based assessments, which has led to revised Individual Educational Plans (IEPs) for special education services. Two parents commented on their children’s health as follows:

*My child got a new IEP and changed schools. Was able to put child on medication. It is hard to see any changes in child yet but education has improved.*

*I am working with my case manager to get my child a new IEP and into a self-contained classroom. Supportive housing is available to support the child and mother. I can go to my son’s school and say things are going well when they are.*

Finally, parents indicated that they would like to see services or courses for their teenage children on topics such as substance use/abuse prevention and safe sex practices.

## Children’s School Attendance and Achievement

The short-term and long-term impacts of poverty and homelessness during childhood have been examined in various areas of development and functioning, including mental and physical health and school performance. However, studies have struggled to separate the effects of homelessness specifically from the effect of growing up in an economically disadvantaged household. For example, children from

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<sup>20</sup> This family’s recollection of its shelter experience may not be typical; DHS reports that the vast majority of students are placed in shelters near their school.

both poor and homeless families may face such developmental risk factors as hunger and exposure to violence (Rog and Buckner, 2007), but it is difficult to determine which of these circumstances (poverty or homelessness) have contributed more to the developmental risk. Keeping this in mind, the academic achievement of homeless children could be challenged by their lack of exposure to early childhood education, unstable home environments, and frequent relocation. Irregular schooling may also remove a sense of stability and peer relationships that could support a child's educational achievement (Vostanis, 2002; Hart-Shegos, 1999a). It is also suggested, however, that the impact of these detrimental factors may fade after stable housing is restored (Rog and Buckner, 2007), pointing to the importance of eliminating such factors in a child's life, and limiting their experience in such transient living situations.

In keeping with the points made by Rog and Buckner, it is expected that with housing through KFT, children should show improvements in their school attendance and academic achievement. Anecdotally, case managers have reported that the children have improved in school. For example, one case manager reported, "[Since supportive housing,] *the children's education has improved. I went to one family's apartment every morning to make sure the kids were headed to school. They have improved their attendance.*" Another mentioned, "*The children have stability. They have spent most of their lives in a shelter. Now, they have a school in the neighborhood and can graduate because they are staying in one school and not moving around so much.*"<sup>21</sup>

The public school records of the KFT families' school-age children were examined to assess the relationship between improved residential stability and children's school attendance and academic achievement. Metis analyzed the children's average daily school attendance (ADA) as well as English Language Arts and mathematics standardized test scores. Data were matched by the child's name, address, and birth date and were obtained for 28 of 30 (93.3%) of the families' school-age children.

As the first families were housed in October 2007, data from the 2006–07 school year (SY) are considered *baseline* (before supportive housing). Three groups were defined according to move-in date (2007–08, 2008–09, or 2009–10). The move-in date served as a means to disaggregate the data because it was expected that the duration of residential stability would affect the results. Achievement test scores and average daily attendance (ADA) data were not available for the eight children who moved into supportive housing during the 2009–10 school year.

As shown in Table 17, of the 28 children for whom data were available, slightly more than half are female (57.1%), most are in the elementary grades (64.3%), about one-third are considered special education students, and all are from a minority ethnic group (85.7% Black and 14.3% Hispanic). In addition, the children were fairly evenly distributed among move-in groups, with one-third of the children in each group. Statistical analyses to measure changes in children's attendance and academic achievement from pre-housing to post-housing test scores could not be calculated because there were fewer than 10 students in two of the move-in groups.

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<sup>21</sup> It should be noted that it is much more likely that residential instability occurred prior to shelter entry, rather than in the shelter system. DHS works closely with the New York City Department of Education to maintain a student's school enrollment and attendance for the children living in emergency shelter.

**Table 17. Demographic Characteristics of School-Age Children**

Category		N	% of Total Population
Gender	Female	16	57.1%
	Male	12	42.9%
Race/ethnicity	Black	24	85.7%
	Hispanic	4	14.3%
School level	Elementary	18	64.3%
	Middle	6	21.4%
	High	4	14.3%
English Language Learner status (ELL)	ELL	1*	3.6%
	Not ELL	27	96.4%
Special Education status (SPED)	SPED	10	35.7%
	Not SPED	18	64.3%
Move-in group	2007–08 (10/07 to 3/08)	11	39.3%
	2008–09 (6/08 to 1/09)	10	35.7%
	2009–10 (6/09 to 7/09)	7	25.0%
<b>Total</b>		<b>28</b>	<b>100%</b>

\* Student was identified as ELL in 2005–06.

**School Attendance.** Data on children’s average daily attendance (ADA) were analyzed to obtain the mean ADA for the year before, during (year of move-in), and one year after housing. These data are disaggregated by move-in group (see Table 18).

**Table 18. Average Daily School Attendance Before, During, and One Year after Housing**

Move-in Group	Average Daily Attendance						
	Matched N	Before		Year of Move-In		One Year After	
		Mean	Range	Mean	Range	Mean	Range
2007–08	10*	65.8%	45.7% - 83.5%	80.7%	64.3% - 92.4%	84.0%	53.3% - 99.5%
2008–09	10	71.7%	24.3% - 96.2%	68.4%	6.0%-91.7%	Not available	
2009–10	7	70.7%	32.6% - 81.8%				
<b>Total</b>	<b>27</b>	<b>69.4%</b>	<b>24.3% - 96.2%</b>				

\*Represents one less child than is included in this move-in group in Table 17 because this child was not of school age until the 2008–09 school year.

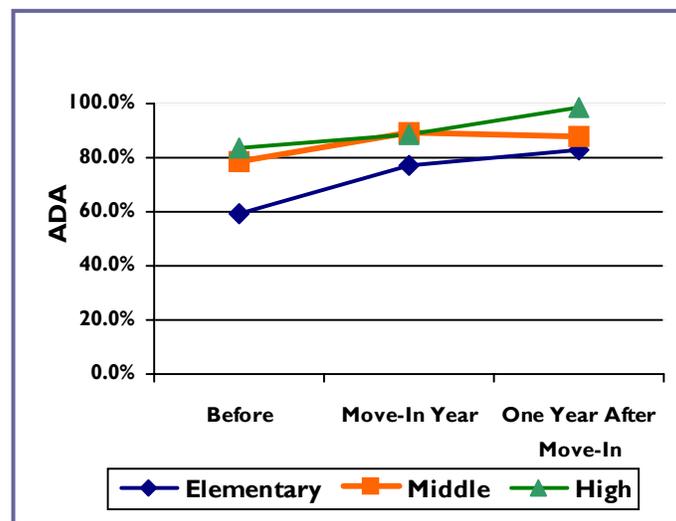
Children at all grade levels averaged a relatively low ADA (0.70) before supportive housing, which means that children had attended 126 of the 180 days in the school year, or 70 percent of the school days. In other words, students had missed on average 54 days of school. One would expect that missing this many days of school would adversely affect student academic performance.

Two children in the 2007–08 move-in group achieved 99 percent attendance during the 2008–09 school year, meaning that they had missed only six or fewer days of school during the year after move-in. These two students, who are siblings, have improved their attendance by 17 percentage points from the baseline year (before move-in). Both have steadily improved their average daily attendance since they were housed. The mother of these children proudly announced, “My son wanted to drop out but now he’s in the 12<sup>th</sup> grade and on the honor roll. [My other child] hasn’t missed one day of school.... [The] kids have less fights. My children have been in the same schools for three years and everyone knows each other.” This parent does not want the family’s residential stability to take the credit for her children’s success in school, however. She explains, “My son’s improvement in school has nothing to do with being in supportive housing. I told him that I wouldn’t settle for a GED from him and that he needed a diploma. I won’t give supportive housing credit. It is all due to my work with my son...no one else’s.” Not reflected in the data presented in Table 18

is a kindergarten student who attended school for the first time during the 2008–09 school year (one year after move-in) and achieved 97 percent attendance, which suggests that his parent was bringing him to school regularly.

For the 10 children who moved into supportive housing during the 2007–08 school year, multiple years of data—before, during, and one year after housing—could be compared. For this group, steady average increases were seen over the three years of analysis, as shown in Figure 7. After the first year of supportive housing, this group averaged an ADA of 84 percent—meaning that they were attending an average of 25 *more* days of school than they had attended before supportive housing.

**Figure 7. Average Change in ADA for the 2007-08 Move-In Group (N=10)**



The 2008–09 move-in group did not show as many positive gains in attendance as the 2007–08 move-in group (see Table 18). This group averaged 72 percent attendance before move-in and 68 percent during the move-in year.

The attendance data were also analyzed to examine changes in individual students' attendance. Tables 19 and 20 show these changes for the 2007–08 and 2008–09 move-in groups from before move-in to the end of the move-in year, as well as from the move-in to one year after move-in, respectively.

**Table 19. Change in ADA from Before Move-in Year to End of Move-in Year**

Move-in Group	Change in ADA (Before move-in to end of move-in year)				
	Total	Improvement		Decline	
	N	N	%	N	%
2007–08	10*	10	100%	0	0%
2008–09	9	3	33.3%	6	66.7%
<b>Total</b>	<b>19</b>	<b>13</b>	<b>68.4%</b>	<b>6</b>	<b>31.6%</b>

\*This number represents one less child than is included in the 2007–08 move-in group from Table 17 because this child was not of school age until the 2008–09 school year.

Among the children who moved into supportive housing with their families before June 2009, over two-thirds (N=13 of 19, 68.4%) showed an increase in their average daily school attendance from the year before move-in to the end of move-in year (see Table 19). All (N=10, 100%) of the children who moved in during 2007–08 had improved their ADA during this time period. One-third of the children (N=3 of 9, 33.3%) in the 2008–09 move-in group had improved their ADA by the end of the move-in year.

**Table 20. Change in ADA from the Move-in Year to One Year After Move-in**

Move-in Group	Change in ADA (Move-in year to one year after move-in)				
	Total	Improvement		Decline	
	N	N	%	N	%
2007–08	10	8	80.0%	2	20.0%

Table 20 shows that there may be a positive relationship between the length of residence in supportive housing and children’s school attendance. Attendance data for the children who moved into supportive housing during the 2007–08 school year (N=10) were compared from before move-in to one year after move-in: 80 percent (N=8) of these children had improved their school attendance over this time period.

**Educational Achievement.** It would be expected that attaining residential stability would lead to increased school attendance and, thereby, also impact student achievement. Metis examined the children’s achievement on the standardized NYS English Language Arts (ELA) and mathematics (math) exams. Before describing the results of these analyses, it should be noted that the extremely small number of subjects precludes generalization. These results are merely suggestive, but, if the pilot were expanded, the techniques could be applied to larger numbers of students, with inferential statistics, in order to yield reliable findings.

The NYS ELA and Math exams are criterion-referenced tests that are directly aligned with state standards, administered each year to students in grades 3 to 8, and are proven to be valid and reliable measures of student achievement. For each grade, scores are categorized into one of four performance levels: Level 1 (not meeting learning standards); Level 2 (partially meeting learning standards); Level 3 (meeting learning standards); and Level 4 (meeting learning standards with distinction).

An analysis of academic achievement was conducted for the 2007–08 move-in group, which had test scores for three years. One child in this cohort met the ELA standards (Level 3) and three children met the math standards in spring 2009 (one year after move-in).

Longitudinal analyses were conducted to examine changes in performance levels on the NYS ELA test. These analyses were conducted for children who moved into supportive housing during the 2007–08

school year (SY) and who had scores for all of the test administrations. Table 21 presents changes over two different time frames— from before move-in (SY 2006–07) to the end of move-in year (SY 2007–08), and from the move-in year (SY 2007–08) to one year after (SY 2008–09), respectively. The number of tested students increases because more children were in tested grades during the second time period.

**Table 21. Change in ELA Performance Level, 2007–08 Cohort**

Time Period	Change in NYS ELA Performance Level						
	Total N	No change		Improvement		Decline	
		N	%	N	%	N	%
Before move-in to end of move-in year	3	3	100%	0	0%	0	0%
Move-in year to one year after move-in	6	3	50.0%	2	33.3%	1	16.7%

As shown in Table 21, all of the tested students (N=3; 100%) who moved into supportive housing during 2007–08 had no change in their ELA performance levels from before move-in to the end of move-in year. By one year after move-in, two out of the six children who moved into supportive housing during 2007–08 (33.3%) had improved their ELA performance by one level and half of the group (N=3) had no change in their performance level, while one student declined in performance. Constancy in students’ performance levels should not be interpreted negatively because most students maintain their test performance levels from year to year without substantial academic intervention.

Similar analyses were performed to analyze these same students’ achievement on the NYS math test. These analyses, shown in Table 22, were conducted for children who moved into supportive housing during 2007–08 and who had scores for all of the test administrations.

**Table 22. Change in Math Performance Level, 2007–08 Cohort**

Time Period	Change in NYS Math Performance Level						
	Total N	No change		Improvement		Decline	
		N	%	N	%	N	%
Before move-in to end of move-in year	3	0	0%	1	33.3%	2	66.7%
Move-in year to one year after move-in	6	0	0%	3	50.0%	3	50.0%

Two of the three tested students (66.7%) who moved into supportive housing during 2007–08 declined in math performance while the remaining student improved. One year after move-in, half of the tested children who moved into supportive housing during 2007–08 (N=3, 50%) improved their math performance by one level from the move-in year while the other half of the group (N=3, 50%) declined in performance.

In summary, children’s daily school attendance improved. The 10 children housed during the 2007–08 school year showed steady average increases in school attendance over three years, from before move-in to one year after move-in. After the first year of supportive housing, this group was attending an average of 25 more days of school per year than they had attended before supportive housing. In addition to improvement by the group as a whole, each of the children who moved in during the 2007–08 school year improved their own individual school attendance. The academic achievement of children in KFT families on the New York State (NYS) English Language Arts (ELA) and math tests was mixed, however. Two of the six children improved their ELA performance and three improved their math performance from move-in to one year after move-in.



## VIII. Discussion, Challenges, and Recommendations

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*[Supportive housing has meant that] I am getting help. I am learning new things like how to get a job. Everything is there [for you]...you just need to ask for it. You need to take action. It is hard to stay motivated once you have a place. You can get lazy but you still have to get a job and save money... [Since supportive housing], I get along with everyone. I am trying not to be lonely. I reach out to other people [and] give trust to people around the building and everywhere. I am staying strong and am being a good parent. I am willing to ask for help. I am learning to be responsible even though I didn't used to be. Moving to supportive housing has helped me to think and learn about what is right. I see other people doing good and want to, too. – A Supportive Housing Resident*

### Discussion

Keeping Families Together worked to facilitate relationships between supportive housing providers and city agencies and build the capacity of housing providers and case managers. Because its goal was to better support some of the city's most vulnerable families, it was targeted at those who were chronically homeless, entangled with the child welfare system, and with histories of substance abuse or mental illness. Permanent, supportive housing was provided to 29 families, 26 (89.6%) of whom remained housed at the end of the pilot period. These families shared characteristics with other high-need families—most were headed by a single female with a history of substance abuse, mental illness, domestic violence, or a lack of social support.

Some of these families stayed in permanent supportive housing as long as 31 months (from October 2007 to May 2010). Three families chose to move out of supportive housing and two of these families returned to shelters.

The KFT initiative was implemented through a collaborative made up of housing providers, city agencies, and other social service organizations taking an approach designed to promote interagency collaboration and problem solving. To help housing providers better serve high-need families, KFT offered assistance and resources to refine their service delivery models. Clinical consultation with experts from the Mt. Sinai School of Medicine was available to help train and build the capacity of housing provider staff and design an integrated service approach for KFT families. Financial grants were available to KFT families (through the housing providers) for activities that promote self-sufficiency and family cohesion.

**Family Identification/Recruitment.** In the end, the KFT initiative successfully identified a sufficient number of families for the pilot. Since the participation of the DHS Deputy Director for Quality Assurance and Program Support seemed to produce the largest number of eligible families, if this initiative were to be replicated, it would be advantageous to identify a staff member, as in the KFT project, who could work with DHS and ACS-contracted providers, to identify families and evaluate their eligibility for KFT, and recommend an appropriate supportive housing provider.

The Deputy Director's success was due, in part, to collaboration with CSH and ACS preventive provider staff. CSH's helping to bridge the gap in information available through ACS and DHS data systems was crucial; neither system was able to easily identify the most vulnerable families. KFT's outreach to shelters and shelter staff, legal services entities, social workers, domestic violence consultants, as well as ACS-contracted service providers, also proved to be fruitful at identifying potential KFT families.

The limitations of the HRA 2010(e) form, which provided the initial screening for KFT, should be addressed if this form is to be used in the future. Other limitations were inadequate training of shelter and child welfare agency staff in the completion of the application, and a focus on the needs of the head of household rather than on the entire family. Further, KFT may want to specify the type of ACS cases (e.g., educational neglect, physical abuse, neglect) in order to better target vulnerable families with specific problems.

**Interagency Collaboration.** KFT has served as a convener of those invested in supportive housing for needy families, including supportive housing providers and city agencies. More than 22 meetings were convened over the project period. These meetings provided a forum to discuss issues such as individual problems with families, challenges in working with ACS, and how to negotiate services and identify community-based services. The meetings were an opportunity for the participants to identify and recommend training opportunities and share resources to further aid and build the capacity of staff.

**Clinical Consultants.** The consultants from Mt. Sinai School of Medicine were instrumental in helping the KFT initiative support and build the capacity of housing provider staff to serve high-need families. Dr. McKay had direct relationships with most of the providers, furnished technical assistance and trainings to case managers, supported implementation of the Wellness Self-Management intervention curriculum and Multiple Family Groups, and both she and Dr. Sicher attended provider staff meetings.

**Case Conferencing.** Case conferencing between supportive housing staff and other city agencies, notably ACS, has not yet been implemented. As noted in the discussion about the role of ACS, case conferencing is still desired by the case managers and would be a means to streamline the management of a family's needs. Perhaps with the support of ACS and the involvement of supervisors and line case workers, joint case conferences could be implemented.

**Outcomes for Families.** KFT families achieved a number of successes during their participation in the KFT pilot. These achievements are summarized in the paragraphs below.

**Residential stability.** Residential stability was achieved for nearly all of the KFT chronically homeless families; 26 of the 29 pilot families (89.6%) have remained in supportive housing for as long as 31 months. (The remaining three families voluntarily moved out of their supportive housing apartments; two of these families returned to shelter). In contrast, during the project period, the DHS comparison families' shelter histories show average cumulative shelter duration of 15.3 months, ranging from two to 30 months. Seven families (46.7%) exited shelter after this initial stay. Eight families (53.3%) either remained in shelter without interruption or had episodes of one or two additional shelter stays during the period under study.

**Services.** All KFT families had regular interactions with a supportive housing case manager who negotiated other needed services for them through on-site resources and community-based providers. These services included substance abuse treatment, ongoing medical treatment, job readiness, employment, and prevention services.

Research indicates that homeless families benefit from case management services as well as other services targeted to their specific needs, such as life skills, financial management, self-advocacy, mental health and/or substance abuse treatment, employment assistance, parenting skills, and recreational or educational activities. Although chronically homeless adults have generally low levels of engagement in outpatient mental health services, substance abuse treatment and health care, many KFT families took

advantage of the services available to them. Six adults (23.1%) found employment at some point during the project period, although only one HoH was employed as of April 2010.

Participants' feedback about the program and its impact were very positive. KFT families stated that supportive housing services such as parenting courses have helped them improve their relationships with their children and that other services facilitated their ability to form supportive relationships with other residents, case managers, community members, and long-lost family members. In addition, these families reported that supportive housing helped them to become better parents. Nearly all of the families who entered with a substance abuse problem were reported to be clean and sober. The reunification of families has much to do with the parent's willingness to stay free of drugs.

**Child welfare.** An analysis of child welfare administrative data reveals many successful child welfare outcomes for KFT families. The rate of case closure, the number of reunifications of children who had been in foster care, and an absence of repeat placements and maltreatment show a decrease in child welfare system involvement for KFT families. More than half (61.1%) of the child welfare cases that were open at the time of placement had been closed.<sup>22</sup> For the 14 closed preventive-status ACS cases, the average duration was 22 months, as compared to the ACS system average preventive service goal of 12 months. However, KFT families' preventive cases closed an average of 10 months after the family was housed in supportive housing. These findings suggest that once the family received stable housing the subsequent duration of the preventive case was somewhat shorter than the ACS standard for preventive services cases.

All six children who were placed with a goal of reunification were returned to their families by the end of the pilot. Five of the six reunified children met the ACS goal of ensuring that children who have been reunified with their parent do not return to foster care or other placements within one year. At the end of the pilot, the reunified KFT children had been back with their families for an average of 15 months, with a range of six to 26 months. Analyses of the duration of placement, with respect to the family's move-in date, show that the reunified children had spent an average of 680 days in placement before their family moved to supportive housing and only 124 days in placement after the family had stable housing. Although the small number of children does not allow generalization, these data may help support the idea that a lack of permanent housing is an obstacle to reunifying a family, in that there was a shorter period of placement once stable housing was achieved.

Further, KFT families had fewer incidences of repeat maltreatment. ACS data on the number of indicated abuse/neglect reports were analyzed for each family to examine the number of substantiated cases that occurred three years prior to the families move to supportive housing (pre-move) and the number of indicated cases during the family's residence in supportive housing (post-move), through May 31, 2010. There were a total of 46 indicated cases pre-move, with an average of 2.1 reports per family. This compares to 13 indicated cases post-move, with an average of 0.6 per family. Importantly, after moving into supportive housing, 14 of the 22 families (63.6%) had no subsequent indicated abuse/neglect cases. Comparative analyses indicate a statistically significant reduction in the number of indicated repeat abuse/neglect cases. In order to take into account the impact of supportive housing "dosage," the number of reports pre-move and post-move was examined for a group of five families who had spent more than two years in supportive housing. These data indicate that the number of indicated cases was reduced by half (14 pre-move as compared to six post-move) for these five families.

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<sup>22</sup> This includes information from case managers on three families who were not included in the ACS CCRS database.

No children were removed from the home during the KFT pilot and only two ACS cases were reopened. One of these cases involved a child whose preventive case had closed during the period of residence but who had a new protective case opened by the end of the pilot. The other child did not have an open ACS case at move-in but did have a history of involvement with ACS about four years prior to the family's move to supportive housing.

**Children's school attendance and academic achievement.** While these findings cannot be generalized because of the small numbers involved, public school children from the 2007–08 move-in group improved their school attendance by 18 percentage points from one year before their move-in to one year after move-in. Two out of the six children who moved into supportive housing during 2007–08 (33.3%) improved their performance on the New York State English Language Arts test by one level from the move-in year to one year after move-in. Half of the children who moved into supportive housing during 2007–08 (N=3, 50%) improved their math performance by one level from the move-in year to one year after move-in.

**Flexible grants.** While there were some difficulties and inconsistencies administering the flexible grants, the monies were greatly appreciated by families. Parents purchased clothing, educational materials, toys, and holiday and birthday gifts. A few parents also used the funds for family events such as a trip to an out-of-state graduation and birthday parties.

## Challenges

**For Family Identification and Recruitment.** A notable drawback of the HRA 2010(e) form, which was used for the identification of families who might be eligible for KFT, is that it only collects information on the head of household, so the needs of a spouse and the applicant's children are not reflected. As mentioned earlier, this could have impacted the identification of families eligible for KFT.

CSH was also challenged by the fact that family supportive housing was a relatively new way of addressing the multiple needs of vulnerable families and had never been focused on the specific needs of child welfare-involved families in New York City. In the context of NY/NY III, the expansion of services from single adults to families had also never been done. The eligibility criteria tried to target families in need but the chronic homeless criterion alone was not useful in identifying the most vulnerable, child welfare-involved families. In addition, there was little understanding at the time about the types of families that might be better served in scattered-site or single-site housing models. There also was a need to place families as they were identified as eligible.

In addition, one stakeholder felt the KFT eligibility criteria were too restrictive—*“It is really important that the model expand. You cannot directly apply an adult model to a family. There is lots more work to be done...Different models are needed to focus on strengthening family functioning and for addressing children's needs.”*

**For Interagency Collaboration.** With regard to the cooperation and collaboration of city agencies and the providers, ACS was less involved than other agencies in the ongoing implementation of KFT. High-level staff from the agency were involved in the initial envisioning and development of KFT and there was ACS presence at many of the interagency meetings in the first year of the pilot. Supportive housing's traditional focus on homelessness may have been seen as less central to the mission of ACS. A greater involvement in the ongoing work of the initiative could have helped to identify best practices and procedures, and facilitated policy changes, to better serve KFT families. As a CSH staff member stated, *“The current arrangement unfortunately requires families to rack up time in homelessness in order to be eligible*

*for certain state programs or for supportive housing...We don't have a hook to get ACS involved. They're not talking about housing as a preventive strategy [for their families], only as it relates to reunification."*

One concern that came out of conversations with CSH and supportive housing staff is the belief that there is a lack of understanding among ACS case workers what supportive housing is and what it is not. For example, a staff member said, "ACS doesn't respect or understand 'permanent supportive housing.' They don't understand this idea, how it differs from a shelter, and the role of the different people working in housing." Although ACS case workers were not interviewed as part of the evaluation, it would seem that there need to be discussions to help promote an understanding about the role of ACS case workers, how they perceive the supportive housing case manager, and how the presence of a supportive housing case manager fits into the ACS staff's decisions about a family's ACS case. In the perspective of one housing case manager, "[The families'] ACS case has been closed but I don't know if it's because of this project [or that they are legitimately not a concern anymore]. It depends on the attitude of the ACS worker. Sometimes, when ACS sees another agency is involved, they think that they don't have to worry about that family because there's a case manager on site visiting the family."

In general, supportive housing case managers felt that the appropriate level of ACS staff were not involved with the KFT initiative. As one staff person reported, "[we] need the ACS people who are knocking on people's doors involved and not just the higher level staff. This won't help.... Supportive housing workers and case managers could be so helpful to ACS workers. We see the families, know their problems, and could be a great asset to ACS." Supportive housing providers and case managers also might benefit from training about what "mandated reporting" means and how to negotiate this task with the need to maintain a trusting relationship with the family.

One provider offered an example of a training that was being held with substance abuse counseling staff and ACS case workers who met monthly in order to facilitate an understanding about each other's roles and sympathy about each other's work. He recommended that KFT link supportive housing case managers and ACS line workers using a similar training.

**For Providers.** The number of families living in scattered-site compared to single-site housing was too small to ascertain whether these models resulted in any differences in outcomes, but case managers at both types of housing had to grapple with the families' desires versus readiness for independence, and learn how best to empower their clients to become more self-sufficient. Having a case manager on site may make families more dependent on this staff person. One supportive housing director shared his opinion on scattered-site versus single-site models for supportive housing:

*Scattered-site families are more independent because there is no case manager on site. They advocate and take more action for themselves. But, families benefit differently from the scattered-site model. Some families can't handle the independence that comes along with a scattered-site location and need services on site. So, it depends. [A] scattered site [facility] forces family to take care of themselves because they can't run downstairs to their case manager, as families in congregate housing can, whenever there's a problem.*

The KFT initiative was also challenged by a delayed start for some providers, although this was likely an unavoidable complication of the supportive housing development process, as well as a rolling start-up. CSH intended for all providers to begin serving families at the same time (January 2008), however, there were some setbacks, including construction delays and obtaining certificates of occupancy. As a result, families that were not housed until the summer of 2009 have had much less time to demonstrate progress than have those who moved in during the fall of 2007.

A shortage of and inadequate community-based mental health services has affected families' access to and use of these services. Dr. McKay indicated, "The model needs embedded mental health services. National data suggest that community mental health care is inadequate; in the case of these families, it is also not what they need.... The trouble with community services is that they are not as intense as the families need. Services in the community are ineffective. They are not evidence based, programs are at capacity, and there are waiting lists... The model needs on-site, embedded, voluntary mental health services. There needs to be more reliance on evidence-based practices."

One of the key lessons from the focus groups with KFT residents is the importance of balancing the intrusiveness of supportive housing staff and the adults' desires to be independent. Some focus group participants equated single-site supportive housing to being in the shelter system. The feelings of the tenants may be similar to the "fishbowl effect," in that families are monitored closely by staff (Park et al., 2004, p. 433), which families feel is an invasion of their independence. KFT families provided the following comments about the intrusiveness of staff:

*I would change [about supportive housing] that everyone knows everything. There is no confidentiality. I can hear workers talking about us and our lives.*

*Tenants were told that the building security was there to monitor guests and not the tenants. But, I feel that the guard is passing judgment. She writes down when tenants leave and return, and pass[es] this information along. Judgment travels around staff. If the building security is there to monitor tenants, then they should say that and not say they're only looking at guests.*

*I have a great apartment and supportive housing is a great improvement from the shelter but I still feel very judged—especially because all guests must be logged in. I think that staff look at certain tenants more closely and monitor their guests and how long they stay for. We wonder how they can be judged and have staff be so nosy when tenants pay rent?*

Another challenge was the degree of a family's receptiveness to services and intervention. Notably, few adults took advantage of all of the services that were available to them. This reluctance has been well documented by research, and the KFT program has taken steps to address this by involving the clinical consultants in the resource sharing and training of case managers on engagement strategies. It is possible that this reluctance could have stemmed from a family's past negative experiences with case management and services. Case managers might also benefit from training on how to build and sustain positive relationships with families who have multiple needs.

Though families clearly benefited from the flexible spending grants, the grants also presented challenges in terms of their administration and distribution, which should be uniformly handled across providers. Further, many families perceived a lack of clear rules for how to spend the funds and some were resentful of having to be taken shopping by a staff member.

## Recommendations

Metis offers the following recommendations:

- Providers and case managers should continue their efforts to learn the most effective strategies to engage families. Additional training should be provided to supportive housing case managers and other staff about evidence-based strategies (e.g., intake procedures that focus on overcoming potential barriers to service involvement, interviews that clarify the need for mental

health care, and overcoming difficulties keeping appointments) that have been shown to help families build and rebuild relationships and better address the needs of vulnerable children.

- The KFT model should reemphasize the importance of the families having access to high-quality mental health services (e.g., cognitive behavioral therapy, trauma-focused cognitive behavioral therapy, Wellness Self-Management, multiple family group intervention for children with conduct problems, child behavioral management, and integrated family support programs for those parents in contact with child welfare systems). Community-based mental health services are in short supply and may not be sensitive to the unique needs of the KFT families, nevertheless, providers should make efforts to connect families with these services.
- If the KFT model were to be replicated, the initiative should consider adding the services of a consultant who could train the case managers in addiction services and harm reduction strategies. Research indicates that many of these vulnerable families struggle with substance abuse and would benefit from well-trained case managers who are supported by experts.
- Housing provider staff should work to improve their relationships with families so that they are seen as supportive of their independence rather than intrusive in their daily lives. Borrowing from other supportive housing models and one of CSH's own Dimensions of Quality, providers could create tenants' rights boards or tenants' groups to empower tenants in site decision-making. Providers might also consider having tenants staff the front desk of the buildings, which might strengthen the role of front desk staff in providing for tenants' safety rather than monitoring their activities. This issue could be explored by looking at the different ways case managers approach intervention. A future study also could examine whether and how the issue of intrusiveness differs for families residing in single-site or scattered-site units.
- To improve understanding about supportive housing, the child welfare system, and the needs of KFT families, CSH should further engage ACS in discussions that promote an understanding about the role of ACS case workers, their perceptions of the role of the supportive housing case managers, and how the roles of each interact in ACS staff's decisions about a family and support the families' repair and growth. Furthermore, CSH should discuss with ACS how housing provider staff might be involved in case conferences and identify and secure the participation and cooperation of the agencies that need to be involved. The supportive housing providers and other agencies should address the most effective ways to collaborate to identify, recommend, and follow up on services for these needy families.
- With regard to assessing child welfare outcomes, the effect of supportive housing on child welfare cases should be expanded to a larger cohort of families so that the results may be generalized.

The evaluation of the KFT pilot initiative was limited by a number of factors. The sample size, once disaggregated by move-in date, was quite small, which prohibited more advanced statistical analyses that might have ascertained differences between providers and between move-in cohorts. There also were some inconsistencies in case managers' records of families' service use.

This pilot study has identified a number of areas for future research. For example, with a larger sample size there could be an examination of the benefits of scattered-site vs. single-site housing. A longer study would allow for a longitudinal analysis of children's school attendance and educational achievement, and child welfare outcomes. This study could be expanded to collect information about the effect of services and early interventions on children's mental, emotional, and general health outcomes. Moreover, in a

future iteration of KFT, the evaluation could focus on specific substance abuse treatments or addiction services and other health outcomes for the adults.

The KFT initiative was a very successful pilot. There was a large reduction in the number of new child welfare cases for the five families who had been housed for more than two years. This was seen in the number of new (post-move) ACS cases compared to the number of pre-move cases (up to three years prior to KFT). The open child welfare cases of many children (N=19, 59.3%) were closed during the pilot and all of children (N=6) in placement at the start of the pilot were returned safely to their families and did not return to foster care. Twenty-six of the 29 families gained residential stability in supportive housing and were assisted by case managers and other services. Keeping Families Together had city agencies, supportive housing providers, and case managers meeting, collaborating, and participating in training behind the scenes in order to improve outcomes for families.



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