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Supportive Housing for Families in Child Welfare:

Client Characteristics and Risk Factors at Intake

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Supportive Housing for Families in Child Welfare:
Client Characteristics and Risk Factors at Intake

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Abstract

Many families involved in the child welfare system also face housing difficulties. Housing problems can disrupt family preservation efforts and delay reunifications from foster care. Supportive housing programs work with families who have dual vulnerabilities in housing and child welfare to integrate services and improve outcomes. Families in these programs might face barriers in addition to their housing and child welfare needs, but little is known about other risk factors in this population. This study uses a sample of 80 clients referred to a supportive housing for families program in order to examine the rate and prevalence of other risk factors: mental health needs, parenting stress, and substance abuse. Overall, 34.2% of clients had mental health needs, 46.0% showed elevated levels of parenting stress in at least one dimension, and 31.3% were identified as being at a moderate to high risk for substance abuse. For many of these clients, these risks were co-occurring. Additionally, after meeting with clients, Assessment Specialists completed a comprehensive measure of family functioning; high levels of barriers were reflected for families across multiple domains. A better understanding of risk at intake can help inform case management, match services to client needs, and guide the use of limited program resources more effectively.

Supportive Housing for Families in Child Welfare:

Client Characteristics and Risk Factors at Intake

Family housing problems and family child welfare needs are often thought of, and treated as, separate problems. However, for some families, these problems are intertwined: inadequate housing can trigger a child welfare investigation and, alternatively, housing problems discovered due to involvement with child protective services can cause children to be removed or reunification to be delayed (Shdaimah, 2009). One potential way to address the intertwined nature of the problems for families with dual vulnerabilities is to offer supportive housing programs. Supportive housing is a broad term that is used in this paper to refer to programs that offer housing services plus supportive services. The supportive housing model as been used with homeless individuals (e.g., Culhane, Metraux, & Hadley, 2002), and to some extent families (Burt, 2006; Matulef, Crosse, & Dietz, 1995), but little research exists on supportive housing programs for families with child welfare system involvement. One exception to this is a paper that presented a supportive housing model for families and looked at how outcomes at discharge related to service utilization and select client characteristics (Farrell, Britner, Guzzardo, & Goodrich, 2010). The current paper builds on the Farrell et al. work by providing an assessment of client risks at intake in the same program. These programs tend to be intensive as they attempt to address multiple client needs; a better understanding of this population's risk characteristics can enable programs to tailor their services better and use limited resources more efficiently.

Links between Homeless Families and Child Welfare Concerns

On any given night in the United States, 238,110 people in families are experiencing homelessness (U.S. Conference of Mayors, 2010). Homeless families account for 37% of the homeless population. Over the past decade, there has been an increase in family homelessness (Burt, Aron, Lee, & Valentin, 2001). In the period from 2009 to 2012, there was a nine percent increase in homeless families (U.S. Conference of Mayors). The top reasons given for family homelessness were unemployment (79%) and lack of affordable housing (72%) (U.S. Conference of Mayors). Homeless families tend to be much more similar to other poor families than they are to homeless individuals; the majority of the differences between homeless and domiciled families have to do with life stage and availability of resource (Shinn, Rog, & Culhane, 2005). Experiences of homelessness, however, can put children at an increased risk for negative outcomes.

Studies of families living in shelters show children experience significantly worse outcomes such as hunger, multiple school placements, exposure to violence and maltreatment (Anooshian, 2005; Gerwitz & Edleson, 2007; Vostanis, Grattan, Cumella, & Winchester, 1997). Housing problems for families do not have to reach the extreme of homelessness for children to be negatively affected; in one study housing instability, measured by moving at least three times, was associated with increased behavioral, emotional, and school problems for children (Shinn & Weitzman, 1996). Interestingly, this relationship held regardless of income suggesting the lack of stable housing was the driving factor in the observed negative outcomes.

Families who have a history of homelessness are more likely to come into contact with child welfare services. One study found that women with homelessness episodes were seven times more likely to have had contact with child welfare services than

mothers in a comparable situation but without a homelessness history (Culhane, Webb, Grim, Metraux, & Culhane, 2003); further, once involved in the system, the rate of placement in foster care was highest for families with a history of homelessness. Housing difficulties can precipitate admission to the child welfare system (Cohen-Schlanger, Fitzparick, Hulchanski, & Raphael, 1995; Shdaimah, 2009). In these cases, concerns about housing adequacy or housing availability are the reason child welfare services become involved with a family.

Alternatively, once a family is involved with child protective services for other reasons, housing difficulties be discovered and come under scrutiny (Courtney, McMurtry, & Zinn, 2004; Reich, 2005). In a sample of families volunteering to participate in a comprehensive health program, the presence of dangerous housing conditions (e.g., pests, holes in wall) was significantly related to workers' lowered assessments of whether primary caregivers met children's physical care needs (Ernst, Meyer, & DePanfilies, 2004). Most families (86%) involved in the child welfare system do not own their own housing, so their ability to control such problems may be limited (Ernst et al.). Further, once a child is placed out of the home, housing subsidies can be lost (Cohen-Schlanger et al., 1995). In scenarios such as these, housing problems are complicating factors, as they may make family preservation efforts more difficult. Regardless of whether housing difficulties served as a precipitating or complicating factor, they are a hurdle to reunification once a child has been removed from the home (Courtney et al., 2004; Jones, 1998; Shdaimah, 2009). This fact is particularly distressing because preservation and reunification are the desired outcomes in most situations.

Family preservation is held up as a goal by the Adoption and Safe Families Act of 1997 (ASFA). However, approximately 254,000 children enter foster care each year (U.S. Department of Health & Human Services, 2011). Dorre and Mihaly (1996) estimate that 30% of children in foster care could be reunified with parents if only safe and adequate housing was secured to which they could return. Providing housing assistance is often seen as one of the most important service components in treatment. Providing families with housing assistance can reduce the risk of maltreatment (Ryan & Schuerman, 2004) and increase the likelihood of reunification (Hoffman & Rosencheck, 2001).

Supportive Housing as an Integrated Solution

For a sizeable subset of families, housing and child welfare are intertwined, which suggests coordination of services might be beneficial. One program model that might be beneficial for families with dual vulnerabilities is supportive housing. The U.S. Department of Housing and Urban Development (2009) defines supportive housing as programs aimed at achieving stability, increasing skills and income, and obtaining greater self-determination. Most of the literature in supportive housing is focused on homeless individuals, not families, but the outcomes are promising. In one of the first major studies of this program model, Culhane, Metraux, and Hadley (2002) found that for formerly homeless individuals, supportive housing produced stable, positive outcomes and was cost effective compared to alternatives. Supportive housing has supported improved outcomes for homeless individuals even when they present with multiple risks such as mental illness, criminality, and substance abuse (Hickert & Taylor, 2011). These findings

suggest that supportive housing is a promising model for serving the needs of families facing multiple risks related to hosing and child welfare.

Harburger and White (2004) advocate for a supportive housing model for this population. They propose that greater collaboration and cooperation between child welfare and housing systems could prevent out-of-home placements and improve child well being. They also suggest partnerships between these agencies can make economic sense. A supportive hosing program costs an estimated 70% less than foster care. When these savings are applied to the 30% of children in foster care for whom housing is the major barrier to reunification, they project states could save up to $36 million per year.

Despite the promises of supportive housing programs for families in the child welfare system, little is known about how they operate. In an exception to this, Farrell et al. (2010) presented a supportive housing for families model, along with client characteristics and outcome at discharge. Clients with successful program completion had longer lengths of stay in the program, were more likely to have a history of employment and permanent housing, and had higher initial and exit scores on a measure of environment of care. Additionally, greater service utilization and client-staff involvement was associated with positive discharge. One recommendation of the study was for better assessment of client risk at intake so that services could be better matched to client needs. In response to this finding, the current study reports the results of administering risk-screening methods to clients upon referral to the program. Presented below is the rationale for the types of risks screened for in this sample of families with housing and child welfare needs.

Co-occuring risks with family homelessness

Homeless mothers have high lifetime and current rates of substance abuse and major depression (Bassuk, Buckner, Perloff, & Bassuk, 1998). McQuistion, Finerty, Hirschowitz, and Susser (2003), noting the known psychiatric needs among the homeless population of individuals and the increase in family homelessness, suggest more needs to be known about this population if their mental health needs are to be met. Metraux and Culhane (1999) studied repeated homelessness among women and children and found that the risk of repeat shelter stays was significantly associated with the presence of domestic violence in the family, having children in formal or informal foster care, and new motherhood. Comparing homeless mothers recruited from family shelters with low-income housed mothers, Bassuk et al. (1997) found frequent alcohol or heroin use and recent hospitalizations for mental illness to be risk factors for homelessness. Receiving cash assistance or housing subsidies was identified as a protective factor, as were graduating from high school and having a larger social network.

Parenting stress & mental health. Most studies looking at parenting measures (whether it be stress, competence, or other dimensions) also include a measure of mental health. In a sample of formerly homeless families currently living in supportive housing (but not necessarily with child welfare involvement), one study found mothers reported significantly higher levels of psychological distress and less than optimal parenting practices compared to low-income housed mothers (Lee, August, Gewirtz, Kilmes-Dougan, Bloomquist, & Realmuto, 2010). The authors reported that many of these needs were unmet and called for greater prevention and intervention efforts. A related study, also taking place in the context of a supportive hosing for families program, matched parenting and mental health concerns to child outcomes. Gewirtz, DeGarmo, Plowman,

August & Realmuto (2009) measured mental health symptoms (with the Brief Symptom Inventory; BSI), observed parenting practices, and parenting self-efficacy among a group of formerly homeless mothers and looked at how they were associated with children's adjustment outcomes. Maternal mental health and parenting practices had a direct impact on child adjustment; the impact of parenting self-efficacy on children's adjustment, however, was mediated through parenting practices.

Co-occuring risks for child welfare involved families

Reviewed below are risk factors that have been shown to influence treatment and impact outcomes in child welfare involved families. There are many studies that explore the relationship of one or two risk factor (e.g., only domestic violence or mental health and substance abuse), but fewer that look at the constellation of risks. For this reason, we review what is known about individual risk factors first and then, when available, follow with the studies that have attempted to get a deeper picture of co-occurring risks in child welfare populations.

Domestic violence. It has been estimated that 30 to 60% of families involved in child welfare also experience domestic violence (Edleson & Erikovits, 1996; Findlater & Kelly, 1999); it could be reasoned that domestic violence, similar to housing, can be a precipitating factor for child welfare involvement. Similarly, domestic violence can be a complicating factor for a family with child welfare needs, even if it is not the reason for involvement with the child welfare system. Once involved in the child welfare system, when there is domestic violence reunification rates are lower (Hess, Folaron, & Jefferson, 1992). One reason pointed to for this negative relationship between presence of domestic violence and reunification rates is that it is often not identified (Aron & Olson, 1997), and

therefore is not addressed in service plans. Also, as mentioned above in the Metraux and Culhane study (1999), domestic violence is associated with a history of shelter stays, so presence of domestic violence may make up one subgroup of families with dual housing and child welfare vulnerabilities.

Mental health. Few studies have looked at mental health risks alone and linked them to outcomes. Many studies look at the co-occurrence of mental health and substance abuse or mental health as one of multiple risk factors; these studies are reviewed below. However, researchers estimate that up to 70% of parents involved in child welfare services have at least one mental health problem (Faller & Bellamy, 2000). Further, because child protective service workers are not trained to identify mental health issues and usually do not conduct in-depth mental health assessments, mental health problems are likely under-identified in many instances (Faller & Bellamy). Such problems are relevant however as they may interfere with parenting and can complicate whatever circumstances brought the family to the attention of the child welfare system. One study of an intensive family preservation services program found parental mental health was one of only two family-level factors associated with placement outcomes, the other being annual income (Bath, Richey, & Haapala, 1992). Given the prevalence of mental health issues and their potential effect on child placement outcomes, an early assessment of symptoms coupled with needed services would be beneficial for families.

Substance abuse. Many cases investigated by the child welfare system involve maternal drug or alcohol abuse (Ondersma, Simpson, Brestan, & Ward, 2000). Children of parents with substance abuse problems are less likely to be reunited with their parents (Lewis, Giovannoni, & Leake, 1997; U.S. DHHS, 2010). When reunions do occur,

reentry rates are higher compared to non substance-abusing populations (Brook & McDonald, 2009). However, the findings that do exist suggest that although substance abuse may be a significant barrier for families, it is one that can be surmounted with proper services.

Green, Rockhill, and Furrer (2007) found that when substance-abusing mothers entered treatment quickly, spent more time in treatment, and completed at least one treatment episode, they were more likely to re reunified with their child(ren). This relationship held after controlling for other known risk factors such as child welfare history, the frequency and chronicity of the substance abuse, and other demographic risk factors. This study was based on examining child welfare system records, and was not evaluating a treatment program that integrated child welfare and substance abuse services.

Ryan, Marsh, Testa, and Louderman (2006) examined the effectiveness of an intensive case management program for families that had a child placed in foster care and where the parent had a substance abuse problem. Clients who participated in the program received a "recovery coach" who coordinated substance abuse services along with helping the client reunify with their child. The authors found that reunification rates were higher for program participants than for those who received the traditional services from the child welfare agency. However, reunification rates were low, with participating families still only being reunited 12% of time.

Co-occuring risks & importance of matching services. Parental mental health issues and substance abuse are both associated with substantiated cases of physical neglect (Carter & Myers, 2007). When these problems are identified in families, services

are not always provided. Staudt and Cherry (2009) found that when child welfare-involved parents had mental health problems, they were offered relevant services only 77.9% of the time, and those services were only utilized by 84% of parents to whom they were offered. Substance abuse treatment needs were even less likely to be met, with 65.7% of parents with substance abuse problems being offered services and only 67.5% of those utilizing services. When substance abuse problems were present, they were more likely to be offered treatment when they co-occurred with mental health problems.

Recognizing the association between substance abuse, other psychosocial characteristics, and the risk of disrupted parenting, the Washington State Parent-Child Assistance Program (PCAP) aims to provide matched services to mothers with substance abuse problems (Grant et al., 2011). The program is targeted to mothers who self-report substance use and are either pregnant or six months post-partum. A study of the program found that mothers were more likely to have their child in care when they had more substance abuse and mental health needs met. Secure housing was also a major factor associated with mother's having custody of their child at program exit. Mothers who had multiple psychiatric diagnoses were at the greatest risk of not having custody, but outcomes were improved for this group when they completed substance abuse treatment.

One program, which was the result of a collaboration between substance abuse and child welfare agency (discussed above; Ryan et al., 2006), found that overall reunification rates, although higher for program families compared to traditional child welfare families, were still very low. This was hypothesized to be because of other problems faced by the families in addition to child welfare involvement and known substance abuse. To obtain a better understanding of the multitude of possible problems

facing these families, Marsh, Ryan, Choi, and Testa (2006) collected data on program clients in three additional risk areas: domestic violence, housing, and mental health. They found that very few families (8%) were dealing only with substance abuse; the majority (53%) was dealing with at least three problems simultaneously (in addition to their involvement with child protective services). Further, when families only had substance abuse problems, reunification raters were 21%; having even one problem in addition to substance use nearly halved the likelihood of reunification, with rates ranging from 11-12% for those with one, two, or three additional problems. In a program with similar characteristics to a supportive housing program (intensive case management for child welfare involved families) clients were shown to come in with varying levels of risk and these levels of risk were associated with reunification rates.

The value in programs knowing the client characteristics is that they can tailor services to meet clients' needs. After all, knowing some clients face greater barriers than others and that these differences predict outcomes is not helpful if there is not the potential for these risk profiles to be used in case planning. Using a sample of families from the same program discussed above, Choi and Ryan (2007) found that when services were matched to client needs (in mental health, housing, and family counseling and substance abuse treatment), likelihood of family reunification was increased.

Study Goals

While a great deal is known about risk factors in homeless families and in child welfare involved families, little is known about the risk characteristics of clients with these dual vulnerabilities. The overall goal of this project was to get a better picture of the characteristics, risks, and needs of clients referred to a supportive housing program. Specifically, the goals were:

- Present self-report data on the prevalence presence of mental health symptoms, levels of parenting stress, and risk of substance abuse for a sample of families referred to a supportive housing program
- Present data on family strengths and barriers from the perspective of assessment staff in the program
- Examine how these factors interrelate and to what degree clients are experiencing co-occurring problems

Method

Sample

The sample consisted of 80 clients referred to the Supportive Housing for Families (SHF) program during the period from the 6-month period of May to October 2011. The Supportive Housing for Families (SHF) program operates under a partnership between The Connection, Inc. (a private agency) and the Department of Children and Families (DCF, the state of Connecticut's child welfare agency), with support from the Department of Mental Health and Addiction Services (DHMAS) and the Department of Social Services (DSS). DCF caseworkers refer clients for whom housing status is a

compromising factor in their child welfare status. Cases can be focused on family preservation or reunification.

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

The clients in this sample were mostly female (87.5%) and currently not married (93.8%). Most clients were White. Client ethnicity was 50.0% White, 26.4% African America, 20.8% Latino, 1.4% American Indian, and 1.4% undisclosed. Client age ranged from 18 to 53 years old (M = 31). Nearly half (45.7%) did not complete high school; 44.3% had a diploma/GED and 10% had education beyond high school. A majority of clients reported being currently unemployed (61%), though a sizeable number reported being employed full-time (25%). The remaining clients were either disabled (8%), not working pending disability (3%), or employed part-time (3%).

Clients are referred to the program based on child welfare system involvement and housing needs, though the nature of these needs can vary. The most common type of DCF involvement was receiving child protective services in-home (66%) followed by child protective services out-of-home (24%); other clients were either receiving voluntary services from DCF (10%) or were involved through a Families with Service Needs (FWSN) order (5%) (A FWSN petition is filed when a child commits a status offense).

As for housing needs, most clients reporting being in transitional housing (72.5%). Ten percent were currently in a shelter, 6.3% were living in a substance abuse treatment program; the remaining clients were either in residential care (n=3), temporary housing (n=1), homeless (n=1), or had missing information (n=4).

Procedure

The study took place as SHF was changing its intake and assessment process. These changes involved creating an Assessment Unit (assessment was previously one of the responsibilities of the Case Managers) and implementing new screening tools. When a client gets referred from DCF to the program, an Assessment Specialist goes out and conducts an in-home assessment of the client. The assessment consists of biological-psychological-social interview, completing an agency form that includes basic demographic information (as well as other factors relevant to service planning), and administering the self-report screening measures to the client. Following the assessment interview, Assessment Specialists complete the North Carolina Family Assessment Scale based on their overall experience with and impressions of the client. Clients are then accepted into the program and assigned to a Case Manager.

Measures

Simple Screening Instrument for Alcohol and Other Drugs. The SSI-AOD is a 16-item screen for identifying respondents who might be at risk for alcohol and other drug abuse. The SSI-AOD was developed by a panel for the Substance Abuse and Mental Health Services Administration (CAST, n.d.). Scores are calculated by counting the number of question to which the client responded “yes”; these scores are then used to place clients in one of three levels of risk for substance abuse: “none to low”, “minimal”,

or “moderate to high”. In this study the SSI-AOD had a 0.95 alpha level, indicating excellent internal consistency. The SSI-AOD was developed to be extremely sensitive to possible substance abuse and therefore the SSI-AOD has been found to produce more false positives (Small, 2007). While this can hurt the instrument’s ability to accurately categorize clients, the SSI-AOD is only meant to be an initial screening; a “positive” result is meant simple to reflect an individual should undergo additional screening.

Parenting Stress Index-Short Form. The PSI-SF (Abidin, 1995) is a 36-item measure of stress in the parent-child relationship. The PSI-SF measures the amount of stress a parent is experiencing across three domains which reflect potential sources of stress in the parenting role: Parental Distress, Difficult Child, and Parent-Child Dysfunctional Interactions. The PSI-SF also has a Defensive Responding (DR) scale, which assess the extent to which respondents approach questions with a strong bias toward presenting a favorable impression, thereby minimizing indication of problems or stress. In this sample, P-CDI, DC, and Total Stress all had alphas above 0.90 indicating excellent internal consistency. The PD subscale had acceptable internal consistency (α=0.76).

The PSI-SF is a widely used and validated instrument. Based on a normative sample of 800 mothers, each of subscales and the total stress subscale showed moderate to high internal consistency: Total stress (α= .91); PD (α=.87); P-CDI (α=.80), and DC (α=.85). Test-retest reliability was determined on a normative sample of 530 mothers who brought their children for a 1-year check-up visit to a group pediatric practice. Over a 6-month interval, the PSI showed adequate test-retest reliability on each of the subscales (PD= .85, P-CDI= .68, DC= .78) and on the Total Stress measure (.84).

Correlations between the PSI-SF and the full-length PSI have shown there is a high degree of correlation (0.94) (Abidin).

Parents completed the PSI-SF with one child in mind. If the parent has more than one child, he or she should choose the one about whom they are most worried. The PSI-SF is intended for use with mothers who have children 0-12 years of age. In this sample, clients only completed the PSI-SF if they had a child in the home or the Assessment Specialist judged they had sufficient enough contact with the child to make it meaningful to complete.

Brief Symptom Inventory. The BSI (Derogatis & Spencer, 1982) is a 53-item self-report inventory that provides information on psychological symptom status; it is an overall picture of a person's mental health. Items are problems people might experience (e.g., "Trouble sleeping") and respondents answer on a 0 to 4 Likert-type scale (where 0= "not at all" distressed by and 4="extremely" distressed) based on their experience of the problem in the past 7 days. The BSI produces three summary scores. The Global Severity Index (GSI) gives an overall picture of a client's psychological distress level. The Positive Symptom Total (PST) is simply the number of non-zero responses (e.g. symptoms a client reports as at least a "little bit" distressing). The Positive Symptom Distress Index indicates the average level of distress among items that were endorsed. In this sample the BSI had a Cronbach's alpha of 0.97, indicating excellent internal consistency.

Internal consistency coefficients for the BSI have been reported by multiple studies and across varied samples. In one example from a nonclinical population, Croog et al. (1986) observed coefficients ranging from .78 to .83 based on a sample of 626

males with mild to moderate hypertension. Test-retest coefficients were derived from a sample of 60 nonpatient individuals who were tested across a two-week interval. The GSI showed excellent test-retest reliability with a coefficient of .90. The PST and PSDI showed good test-retest reliability with coefficients of .80 and .87, respectively. In a cohort of patients receiving psychiatric services, 87% of patients found by the BSI to have positive symptoms were later found to have a diagnosis (Kuhn, Bell, Seligson, Laufer, & Lindner, 1988), suggesting the BSI has predictive validity for some populations.

North Carolina Family Assessment Scale. The NCFAS is a comprehensive family functioning and outcome instrument specifically designed for programs providing intensive family preservation services (Reed-Ashcraft, Kirk, & Fraser, 2001). The NCFAS consists of five scales that are used with all families and two additional scales used only with families where a child or children have been placed outside of the home. The scales cannot be combined together to produce an overall score. Items are rated on a scale from +2 (clear strength) to -3 (serious problem), with 0 being the baseline. These scores can be re-coded to be put on a 1 to 6 scale, where higher score reflect more sever barriers. In this study, the NCFAS-R was completed by Assessment Specialists after their meeting with clients.

The Environment subscale looks at housing stability, income and employment, adequacy of food and nutrition, and availability of transportation. The Parental Capabilities scale looks at parenting skills as well as mental and physical health of parents. The Family interactions scale looks at the relationships in the family, levels of mutual support, and expectations of children. The Family Safety scale includes items

asking about child abuse (physical, emotional, and sexual), child neglect, and domestic violence. The Child Well-Being subscale looks at the relationships the child(ren) has, behaviors, and school performance.

Reed-Ashcraft, Kirk, and Fraser (2001) studied the reliability and validity of the NCFAS with a sample of 228 cases. The cases were drawn from families being served by intensive family preservation service programs in North Carolina in the 10-month period between September 1996 and June 1997. In this sample, Cronbach's alphas ranged from .71 to .94 for the various NCFAS domains. They also compared NCFAS domain scores to other relevant measures such as the Child Well-Being Scale, the Family Inventory of Resources for Management, and the Index of Family Relations. They found 5 of the 6 hypothesized relationships were statistically supported, with concurrent validity correlations ranging from .26 to .71.

Another study (Kirk, Kim, & Griffith, 2005) used data 1,279 families receiving Intensive Family Preservation Services. The authors found that closure ratings and change-scores (from intake to closure) were related to later placements in foster care Kirk et al. (2005) found the NCFAS closure scores predicted future placements of children. Clients who had lower NCFAS scores (indicating greater problems) at case closure were more likely to experience foster care placement in the future than clients with higher scores.

Results

Client risk characteristics

Two specific risk characteristics were collected from the Assessment Specialists after meeting with the client. A history of domestic violence was reported for 15 (18.8%)

clients (data on this question was available for all 80 clients). This was simple a yes/no answer to a question worded: "Check here if domestic violence exists." There was no indication as to the extent and severity of the domestic violence or if it was recent. All analyses reported below were run separately for this subgroup to see if presence of domestic violence was associated with being high or low on any of the other measures. No differences were observed for this group on scores of any of the other measures or on any of the demographic factors.

Assessment Specialists also answered a "yes/no" question about the history of substance abuse problems. Of the 75 clients for whom this data was available for, 49 (65.3%) were reported to have had prior substance abuse problems. This was a measure of known past substance abuse as opposed to the SSI-AOD, which measures current or potential substance abuse problems.

SSI-AOD Descriptives

All clients (n=80) completed the SSI-AOD form and results are presented in Table 1. The mean SSI-AOD score is 2.98, corresponds to a minimal degree of risk; the median score, 2.00, also corresponds to a minimal degree of risk. The SSI-AOD places clients in risk levels based on their scores; these risk levels are perhaps more meaningful than the simple numeric score. In this sample, over a quarter (26.3%) were predicted to have a minimal risk of substance abuse and just below a third (31.3%) were predicted to have a moderate to high risk of substance abuse. It should be noted, however, that the distribution of SSI-AOD scores was significantly skewed, with many clients (42.5%) scoring in the lowest risk category. Using a very low threshold, 57.5% of clients had at least a minimal risk of predicted substance abuse.

Comparing the SSI-AOD categories with the question about past substance abuse problems largely reveals similar, though not identical results. The categorical breakdown is presented in Table 1 below. Of clients who had a reported history with substance abuse, 39 (79.6%) were in the "minimal" or "moderate to high" categories; this means about 20% of clients with known substance abuse histories were in the little to no risk category of the SSI-AOD. When clients did not have a reported past substance abuse problem, 85.2 percent were predicted to have little to no risk of current or future substance abuse.

Table 1

SSI-AOD Risk Scores and Categories

Mean	Median	Minimum	Maximum	Alpha
2.98 (3.25)	2.00	0	13	0.95
Score	Degree of Risk	# of clients (n= 80)	No sub abuse history (n=27)	Sub abuse history (n=49)
0-1	None to low	34 (42.5%)	23 (85.2%)	10 (20.4%)
2-3	Minimal	21 (26.3%)	3 (11.1%)	17 (34.7%)
4 or more	Moderate to high	25 (31.3%)	1 (3.70%)	22 (44.9%)

PSI-SF Descriptives

The Parenting Stress Index-Short Form was only administered when the client was actively parenting. Because a subset of clients may not have their child(ren) in the home, only 67 clients were administered the PSI-SF. As discussed above, the PSI-SF has a Defensive Responding scale, the purpose of which is to determine if clients might be minimizing difficulties in order to present themselves in a more positive light. In this sample, 6 clients (9.0%) had Defensive Responding scores suggesting the PSI-SF was not a valid measure for them. These 6 clients are removed in the presentation of descriptives below, resulting in 61 clients for whom valid measures of parenting stress were available.

Overall, the mean subscale scores are in the normal range. The normal range for the PSI is between the 15th and 80th percentiles. Scores at or above the 85th percentile are considered to be high. Table 2 below presents the number and percentage of clients who had elevated PSI scores. The percentages are calculated based only on clients with valid PSI scores (N= 61). Overall, 28 clients (46.0%) had at least one subscale or the total stress score elevated.

Table 2

Descriptive Statistics and Elevated Scores on the Parenting Stress Index-Short Form

Scale	Mean (SD)	Percentile	Minimum	Maximum	Alpha
Parental Distress	29.25 (7.23)	75th	19	49	0.76
P-C Interaction	21.23 (9.16)	60th	12	54	0.91
Difficult Child	26.92 (10.32)	60th	12	58	0.92
Total Stress	77.39 (22.23)	72nd	44	155	0.93

Elevated Scores on PSI-SF

Scale	Raw score cut-off	# of clients	% of clients
Parental Distress	33	18	29.5
Parent-Child Interaction	26	16	26.2
Difficult Child	33	14	23.0
Total Stress	86	20	32.8

Brief Symptom Inventory Descriptives

The BSI was completed by 79 of the clients. To interpret the BSI, raw scores can be compared to an appropriate reference population to obtain t-scores. All clients were compared to non-patient norms, as opposed to psychiatric inpatient or outpatient norms. However, there are different reference for males and females. Therefore, raw scores are not presented as the meaning changes based on gender. Instead, the standardized t-scores resulting from the appropriate population comparison are presented below. T-scores of 63

or higher, which place clients at or above the 91st percentile, are considered to be in the clinical range.

Table 3 below reports the number of clients who were in this range for the three summary measures: Global Severity Index, Positive Symptom Total, and Positive Symptom Distress Index. Over one third of clients scored in the clinical range on the GSI, which is the broadest measure of mental health the BSI produces. The PST, which simply looks at the number of symptom endorsed but not the severity, placed a sizeable minority of clients in the clinical range. Finally, the PSDI, which looks at the severity of reported symptoms, placed nearly 30% of clients in the clinical range. Overall, the BSI indicates around one third of clients come in with mental health concerns in the clinical range.

Table 3

Clients with Elevated Scores on the Brief Symptom Inventory

Scale	# of clients (%)
GSI (n= 79)	27 (34.2)
PST (n = 78)	24 (30.8)
PSDI (n= 76)	22 (28.9)

North Carolina Family Assessment Scale

NCFAS scores were available for 75 of the 80 clients. Scores were re-coded and put on a 1 to 6 scale, such that 1 = “clear strength”, 3 = “baseline”, and 6= “sever barrier”. Scores higher than a 3 represent domains on which the client is experiencing some problems, from mild to severe. As can be seen in Table 4 below, a majority of clients were above baseline on the Environment (91%), Parental Capabilities (88%), Family Interactions (55%), and Family Safety (83%) subscales; the only scale for which a

majority of clients were at baseline or better is the Child Wellbeing subscale. Considering the program is designed for families facing housing and child welfare barriers, this picture of a relatively high-risk group is not surprising.

Table 4

Descriptive Statistics for the NCFAS Subscales

Subscale	Mean (S.D.) (n=75)	# of clients above baseline
Environment	3.73 (0.44)	68 (90.7%)
Parental Capabilities	3.47 (0.30)	66 (88.0%)
Family Interactions	3.14 (0.46)	41 (54.7%)
Family Safety	3.36 (0.30)	62 (82.7%)
Child Wellbeing	3.20 (0.39)	34 (45.3%)

Co-occurring Problems

Using the three self-report scale measures, it can be determined how many clients were high across multiple domains. The GSI is the broadest measure of mental health produced by the BSI and the one most often used in previous studies; also, with very few exceptions, a client was rarely high on PST or PSDI without also being high on the GSI. So a clinically significant score on the GSI was used to determining if a client had mental health needs. The PSI-SF taps total stress and three sub-dimensions; elevated sores on any of the subscales or the total score were used to indicate parenting stress. Finally, for the SSI-AOD, scores in the highest category were used to indicate substance abuse needs (given what is known about the insensitivity of the measure, the middle category could still be considered relatively low-risk. Due to the limited nature of the information on the circumstances surrounding the domestic violence, this information was not counted as a risk in the analyses below.

Because a sub-set of clients were not given the PSI-SF or had invalid PSI-SF scores, they could only be high on a maximum of two measures. Because of this, results are presented separately for those who had valid PSI-SF scores and those who did not (either because they didn't take it or invalid results). As can be seen in Table 5 below, of those with valid parenting stress scores, over a quarter (26%) were high on only one problem. It was most common for these clients to have two problems (41%), though a sizeable minority had 2 problems (23%). Six clients, about 10 percent of this subset that could be high on all three, were high on all three. Eighteen clients had scores for all of the measures except parenting stress (one client only had an SSI-AOD score and they were excluded from these analyses). In the group for whom a maximum of two co-occurring problems was possible, half (n= 9) were not high on any measures and the other half (n=9) was high on only a single measure. It should be noted that by nature of being referred to the program, all clients are facing housing problems and are involved in the child welfare system. Therefore, these risks (substance abuse, mental health, and parenting stress) are in addition to the vulnerabilities in housing and child welfare already present.

Table 5

Number of Co-occuring Risks

	Clients with PSI-SF score	Clients without PSI-SF score
High on 0 measures	16 (26%)	9 (50%)
High on 1 Measures	25 (41%)	9 (50%)
High on 2 Measures	14 (23%)	0 (0%)
High on 3 Measures	6 (10%)	n/a

Cross-Measure Relationships

SSI-AOD. The SSI-AOD was not correlated with any of the BSI summary scales or parenting stress scales and only one of the NCFAS subscales, Child Wellbeing ($r(75)=-0.273$, $p < .05$). This might be due to the nature of the distribution of scores, with a majority of clients scoring a 0 or 1, and remaining scores spread out over the 2-14 range. This distribution violates one of the assumptions of correlations. To look at these relationships another way, SSI-AOD scores were used to divide clients into two groups: those in the highest risk category (scores of four or more) and those in the low and medium risk categories. Cross-tabulations were then conducted to see if the dichotomous SSI-AOD categories were associated with being high on any of the other measures. There was still no relationship between SSI-AOD category and any of the mental health or parenting measures. However, there was a relationship with the NCFAS Parental Capabilities scale, suggesting parents at a high risk for substance abuse were likely to be assessed as having more severe parenting problems by the Assessment Specialist ($\mathcal{X}^2(1) = 4.245$, $p=0.04$). There was also a relationship between SSI-AOD category and the NCFAS Child Well-Being scale ($\mathcal{X}^2(1)= 9.261$, $p<.01$); surprisingly, this relationship was in the opposite direction with greater risk of substance abuse likely to result in fewer reported risks to child well-being. This relationship was not due to having children placed in out-of-home care. It is unclear based on the available data why this relationship would be in the unexpected direction, but it might partially be due to the SSI-AOD being an overly sensitive indicator of risk.

Brief Symptom Inventory & Parenting Stress Index. The PSI-SF Parental Distress was significantly correlated with all of the BSI summary scores: Global Severity

Index (r (61)=0.568, $p<0.01$), Positive Symptom Total (r (60)=0.527, $p<0.01$), and Positive Symptom Distress Index (r (59)=0.564, $p<0.01$). (Note: all correlations are presented in Table 6) The Parental Distress scale focuses on the stress the parent is experiencing related to personal factors and their adjustment to the parenting role. It is the one most focused on the parent, so it makes intuitive sense that it might also be related to the broader mental health measures of the parent. Conversely, the Difficult Child and Parent-Child Dysfunctional Interactions subscales, those less focused on the parent as an individual, were not correlated with any of the BSI scales; this suggests that parenting distress arising from child characteristics or parent-child dynamics are independent of parents' symptom distress. The Total Stress score was related to the Global Severity Index (r (61)=0.316, $p<0.05$) and the Positive Symptom Total (r (60)=0.345, $p<0.01$). The Total Stress score is partially comprised of the PD scale, so it might make sense that it is also related. However, it should be noted that the correlations of the Total Stress score with the BSI measures are much lower than the same correlations of the PD scale.

NCFAS & Parenting Stress. The NCFAS Child Wellbeing scale was positively correlated with all of the PSI-SF subscales except for Parental Distress: Parent-Child Dysfunctional Interaction (r (59)=0.350, $p<0.01$), Difficult Child (r (59)=0.471, $p<0.01$), and Total Stress (r(59)= 0.419, $p<0.01$). This seems to indicate that the NCFAS Child Wellbeing scale is related to parenting stress factors that involve the child, but it is not as sensitive to parental distress caused by personal factors. This means the PSI-SF subscales are measuring different sources of stress; the PD subscale is tied to parental mental health measure while the rest of the subscales are more related to child-focused measures. Other

than the Child Wellbeing scale relationships, there were only two other significant correlations. Parental Distress scores correlated with the NCFAS Environment scale ($r(59)=0.266$, $p<0.05$) and the NCFAS Family Interactions scale ($r(59)=0.321$, $p<0.01$).

NCFAS & Mental Health. The NCFAS Parental Capabilities subscale was correlated with all three BSI summary score measures: GSI ($r(74)=0.371$, $p<0.05$), PST ($r(73)=0.353$, $p<0.01$) and PSDI ($r(71)=0.240$, $p<0.05$). The only other significant correlation between the NCFAS and the BSI was the correlation between the NCFAS Family Safety subscale and the PSDI ($r(71)=0.281$, $p<0.05$).

Table 6

Correlations among Measures

	NCFAS					PSI-SF				BSI	
Enviro	Par.Cap.	Fam Int	Fam Safety	Child WB	Parental Distress	P-CDI	Diff. Child	Total Stress	GSI	PST	PSDI
Enviro	.216	.098	.111	-.062	.266**	-.086	-.091	.008	.009	.075	-.001
Par.Cap.		.059	.103	.026	.254	.047	-.099	.056	.371**	.353**	.240*
Fam Int			.400**	.083	.287*	.053	.158	.189	.224	.206	.223
Fam Safety				.105	.321*	-.008	.042	.121	.222	.158	.281*
Child WB				1.00	.164	.350**	.471**	.419**	.192	.224	.142
Parental Distress					1.00	.353**	.338**	.627**	.568**	.527**	.564**
P-C Dysf Int						1.00	.816**	.906**	.148	.202	.033
Diff. Child							1.00	.910**	.151	.192	.124
Total Stress								1.00	.316*	.345**	.255
GSI									1.00	.948**	.789**
PST										1.00	.628**
PSDI											1.00

Note: * indicates $p < .05$ and ** indicates $p < .01$

Discussion

Overall, the SHF program is serving clients with relatively high needs. Mental health concerns were present for 34.2% of incoming clients. Although this comprises over a third of the sample, this rate is much lower than some estimates for child welfare involved families. However, DCF refers clients to SHF when housing is seen as one of the most important barriers for a client, so this lowered rate of mental health issues may be due to DCF referring cases that are of lower risk in some respects.

Forty-six percent of clients, of those for whom valid measures were obtained, showed high levels of parenting stress. Sources of stress could be due to parental factors, child factors, parent-child interactions, or overall total stress related to parenting. This suggests that parenting supports might be needed for a sizeable portion of SHF clients. Substance abuse rates were rather high with 65% of clients having a history of substance abuse problems and 31.3% placed in the highest risk category of the SSI-AOD. These results show that clients are often facing barriers beyond housing and child welfare; only 25 clients, based on self-report, were not experiencing any mental health issues, parenting stress, or at risk for substance abuse.

The self-report screenings were just one part of the overall assessment process. Much of the information assessment specialists collected through interviewing clients is also likely to inform case management and reveal treatment needs. Whereas not all of the information from those interviews can be quantified, the NCFAS scores provide us with a way of quantifying overall impressions of family functioning and environment. One benefit of using the NCFAS is it allows for strengths, not just barriers, to be identified. Perhaps unsurprisingly, a very high number of clients showed barriers in the areas of

home environment, parental capabilities, and family safety. However, on each of these scales a small number of clients, 10-18% depending on scale, actually were at “baseline” or “better than baseline” levels. Just over half of clients face barriers relating to family interactions, but this still leaves just under half that did not. Further, on measure of child wellbeing, clients were actually more likely to be at “baseline” or “better than baseline” levels. Focusing on these family strengths is important to balance out the focus on risk that comprises much of the screening and assessment process. Focusing on the strengths in these subgroups is one way to help deliver services.

One important risk factor in the literature that was available only in a limited way in this study was domestic violence. It was a simple yes/no factor and it was unclear the severity, chronicity, or even if it was historical or current, the potential to analyze this was limited. Still, 18.8% of clients had some experience with domestic violence, which might be a potential risk factor depending on the situation. In the future, perhaps better screening of domestic violence could be fruitful.

One shortcoming of this study was the limited amount of historical data available for clients. The BSI only measures mental health symptomology within the past 7 days. There is likely variability in the severity and chronicity of mental health issues that is not fully captures in the BSI. The information on substance abuse is similarly limited. The SSI-AOD measures potential for substance abuse; the only measure of a client’s history was a yes/no item. Similar to mental health, there is much more information about the exact history and severity of past substance use that would be helpful to know about clients.

This study had a relatively small sample size. However, these data were drawn from a pilot period of a new assessment system. As these screening and assessment process continue, data will be available on a greater number of incoming clients so that an even more accurate view typical risks can be obtained. The most serious limitation of this study, however, is its cross-sectional nature. Data on these measures for clients are currently available only at one point in time, at intake. It is unclear how these risk factors will impact service utilization, program length of stay, procurement of stable housing, or child welfare outcomes. However, these clients can be followed through the program. Once these data are available, we will be able to look back and see to what degree these risk factors impacted clients' program experiences and outcomes. Knowledge of these potential links might make it possible to develop client profiles, which at intake can help determine levels of care. Accurately assessing risk and being able to match services to clients' needs can help both improve clients' experiences and assure limited programmatic resources are used efficiently.

Conclusion

The findings of this paper demonstrate that many families faced with housing and child welfare barriers also face risks in other areas. This paper contributes to the broader literature on families with housing and child welfare needs and helps to document how risk factors are likely to co-occur. Recognizing that these families face barriers in multiple domains is important for policymakers making decisions regarding these families and for program that serve these families. These results suggest that integrated programs that offer multiple services are more appropriate than involving families with multiple programs, each serving different needs.

While this paper has established what families look like at intake, it still remains to be seen how these families look over time. The current findings, coupled with longitudinal data that follow clients from intake to exit, will be instrumental in understanding where clients enter these systems, what services they need, and how successful outcomes can be attained. The ability of a program to deliver cost-effective services should be of great value for programs, which are so often in environments fraught with threats of budget cuts. Thus, it is important for future research, in SHF and similar programs, to continue identifying risks and finding ways to match services accordingly.

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