Cuyahoga Partnering for Family Success

Process Evaluation 2017

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Executive Summary

The Cuyahoga Partnering for Family Success project included funding for a five-year outcome study and two-year process study with the hope that additional funds could be raised outside the PFS deal to support more process evaluation. This report summarizes what we learned in the two-year process study. We also used resources from the outcome study to assess how the project is working thus far in terms of eventually reaching the goal of reducing out of home placement (OHP) days for the treatment group by 25%. These initial outcome results provide some context for interpreting the process evaluation findings and recommendations. As of March 2017, the mean days in OHP difference for treatment and control is less than the 25% target. This suggests that there is a need to better understand what is driving the difference in mean days so the team can work toward increasing the difference between the two groups.

The PFS project hypothesized that providing housing and case management services would help reduce OHP days by reducing time to reunification or speeding up the decision that reunification is unlikely and other permanency exits should be implemented. So far, we see that the treatment group is reunifying more and more quickly than the control group, but fewer treatment than control group children are exiting through legal custody with another relative. For those children in the treatment group who do not reunify quickly, the ongoing emphasis on reunification may be partially responsible for the additional OHP days in the treatment group. These findings suggest a need to understand if exits from the treatment group can be safely increased and/or whether the PFS partners support a greater emphasis on reunification rather than OHP day reduction.

As identified in operating committee meetings and detailed in the process findings reported here, some of the observed delays and potentially, recidivism, might be related to high rates of domestic violence in the treatment group, suggesting a need for more discussion about how to address this risk factor. There are also differences in the service delivery philosophies of DCFS and Frontline Services, suggesting some need to educate DCFS staff about the rationale for housing first and the fact that Frontline services are delivered over time, less intensively, in order to encourage client self-sufficiency over the long term. There may also be a need to have Frontline and DCFS workers meet to discuss cases that have been open for an extensive time to be sure reunification remains a viable and optimal permanency goal for the children.

This report details process findings from the first stages of the Cuyahoga Partnering for Family Success (PFS) program, presenting data from the Homeless Management Information System (HMIS), Cuyahoga County Children and Family Services (DCFS), Cuyahoga County Jobs and Family Services (JFS), progress note information from PFS client files, and from qualitative interviews with staff from DCFS, Frontline Service, and the Cuyahoga Metropolitan Housing Authority (CMHA). The demographic, housing, and DCFS findings reported here cover the program period between January 1, 2015 and mid-December of 2016. Detailed information from client progress notes follow cases for clients who entered the program between January 1, 2015 and December 31, 2015.

Key Findings
Data from HMIS indicate that more clients in the treatment group than the control group report being a domestic violence survivor. In most other ways, the treatment and control groups are similar to one another. The most commonly cited topics covered in progress notes included child-related issues, independent living skills, system-related issues, housing issues, and support. As would be expected, an analysis of FrontLine worker/client contacts indicated that there was a statistically significant decline in the number of worker/client contacts during the second six months in which clients were in the program as compared with the first six months. Interviews with staff revealed that the rapidity with which PFS clients are housed is one of the most successful and important aspects of PFS. Obtaining housing so quickly was seen as a major accomplishment in terms of providing families with necessary stability, meeting basic needs, and providing a foundation to work on other issues such as mental health, substance abuse, and parenting. The collaboration with the Cuyahoga Metropolitan Housing Authority (CMHA) is seen as key to this program element. Having DCFS, JFS, CMHA and FrontLine Service together on the operating committee has facilitated collaboration across systems at the higher organizational levels. Challenges appear to remain, however, such as DCFS/FrontLine worker collaboration, and communication, which appear to vary across staff at both FrontLine and DCFS. The collaborative relationship between FrontLine and CMHA appears to be strong and was reported to be a major factor facilitating clients’ being housed quickly. Improved collaborations were anticipated to be helpful factors in reducing OHP days.

**Recommendations**
Implementing and enforcing consistent practices between FrontLine and DCFS could smooth and/or improve collaborative relationships. Specifically, having the workers meet with one another prior to beginning work on cases, having consistent practices around visitation (who attends and how often), and overall clarifying FrontLine workers’ roles for DCFS workers. Some of these practices are already being implemented, but they appear to vary by worker. Education about the housing first philosophy might benefit some of the PFS partners as would learning about the early successes of the program. Improving responses to domestic violence cases also appears to be a useful area of exploration, particularly in potentially reducing recidivism.
Background & Literature Review

Background
With the rapid expansion and success of Housing First services for homeless single adults with severe mental illness, there is considerable interest in learning how similar service models can be adapted and applied to other homeless subpopulations (Henwood, Wenzel, Mangano, Hombs, Padgett, Byrne, & Uretsky, 2015). However, any attempt to apply Housing First to other populations faces the challenge of adopting the Housing First service delivery philosophy. Social Workers join other providers and advocates in lamenting the lack of service integration and the scarcity of resources available to meet the needs of adults who are homeless with mental illness who also abuse substances. However, the literature of social work and other professions is generally silent on a policy-relevant and practice-relevant debate surrounding service delivery for this population. The point of contention stems from fundamental differences in how people with mental illness who are homeless are viewed and how consumer choice is defined and incorporated into a program’s service delivery philosophy. Put another way, there are two contrasting paradigms in services for persons who are homeless with serious mental illness, one is the traditional continuum of care approach favoring treatment first and the other a consumer-driven movement (housing first). Among a number of differences between them, “a contrast of interest lies in how they deal with substance abuse and whether abstinence is a precondition to independent housing and other services” (Padgett, Gulcur & Tsemberis, 2006 p. 74).

Therefore, any attempt to apply Housing First to niche homeless populations must confront how they will help all the different service providers embrace this housing first service delivery philosophy. One high priority subpopulation for expansion of Housing First services is homeless families who are involved in the child welfare system. In May 2012, the Administration for Children and Families, Children’s Bureau in collaboration with four private foundations launched a pilot program to demonstrate how to provide supportive housing to homeless families involved in the child welfare system (Cunningham, Gearing, Pergamit, Zhang, McDaniel & Howell, 2014). Cuyahoga County applied to be one of these pilot sites, but was not selected. However, knowing that housing first services can be cost-effective (Parsell, Petersen & Culhane, 2016), the County looked for other ways to fund their pilot project using a cost-benefit appeal and eventually using Social Impact Financing to launch the program.

Literature Review

Homeless families involved with the child welfare system face multiple challenges to successful reunification. Not meeting a basic need such as housing means that homelessness or housing insecurity can hinder a caregiver’s ability to complete case plan goals in a timely manner which can interfere with family reunification (Curtis & Alexander, 2012). Children in homeless families spend considerably more time in out-of-home placement as compared with children in families that have stable housing, but the traditional foster care system, like many systems,
suffers from a lack of service and agency collaboration for accessing housing services homeless families need (Courtney, McMurtry & Zinn, 2004).

When a child is placed in out-of-home placement, caseworkers develop a permanency plan which may involve reunification with the child’s family. The caregiver must complete specific tasks and the family’s home conditions must be approved to meet the reunification requirements. One important issue is whether the family has stable housing. However, due to homeless status as well as other factors, housing stability can be difficult for some families to achieve and/or maintain. When caregiver(s) have co-occurring mental health issues, domestic violence, drug and/or alcohol abuse, inadequate income, trauma, and/or unemployment, these issues can interfere with working their case plans as well as securing and maintaining stable housing (Curtis & Alexander, 2012). Families whose needs are so extensive can be difficult for child welfare agencies, which tend to have high caseloads to serve, and can contribute to making these families especially vulnerable (Courtney, McMurtry & Zinn, 2004).

The cost of foster care for families with multiple challenges is substantial and the reunification process can be lengthy. In 2014, more than 400,000 children were in the foster care system in the United States (Child Welfare Information Gateway, 2016). About 55 percent of these cases had a case plan goal of reunification with their families, and the median length of stay in foster care was approximately 13 months. Locally, where our work is being conducted, by the end of 2015, there were 4,574 open cases and 1,744 children in out-of-home placement (Cuyahoga County Division of Children and Family Services, 2016).

To reduce OHP costs, new and innovative approaches are needed to reduce the time children spend in out-of-home placement and identify barriers to reunification and other permanent custody solutions. Studies have been conducted to explore what risk factors influence the speed of reunification and what works in reunifying families. The risk factors that influence family reunification include poverty, substance abuse, domestic violence, mental illness, housing problems and others (Curtis & Alexander, 2012). Among these factors, housing been identified as an important basic need for families that could facilitate family reunification (Curtis & Alexander, 2012). In one study focusing on the connection between the foster care system and homeless families, homeless caregivers were more likely to have their children in the foster care system than housed caregivers (Roman & Wolfe, 1995). Another study found that inadequate housing prevented families with children in foster care from successfully reunifying (Jones, 1998). In a five-year study that explored the prevalence of child welfare services involvement among homeless mothers, Culhane, Webb, Grim, Metraux & Culhane (2003) found that providing housing assistance to families involved with child welfare services helped reduce homelessness.

One study focusing on homeless women with mental illness suggested that programs that increase housed days could facilitate family reunification (Hoffman & Rosenheck, 2001). Another study focusing on the relationship between supportive housing services and child well-being found that supportive housing services had positive impacts on educational outcomes of children,
and argued that policymakers should increase the funding for supportive housing services (Hong & Piescher, 2012). Some researchers have found that service coordination is necessary because of the connection and overlap between homelessness and child welfare involvement (Park, Metraux, Brodbar & Culhane, 2004). One study found out that child welfare services alone are not enough for families in need to get a quick and sustainable reunification, and that additional services that target specific needs of each family with multiple problems are necessary (Marsh, Ryan, Choi & Testa, 2006). Another study suggested that child welfare agencies should provide housing assistance to people in need by developing partnerships with other housing institutions (Courtney, McMurtry & Zinn, 2004).

Based on the research findings above, some efforts have already been made to support the child welfare involved homeless families as well as improve agency collaboration. One pilot initiative, Keeping Families Together (KFT) of the Corporation for Supportive Housing (CSH), tested the impact of permanent supportive housing for families that had been homeless for at least one year and were involved with child welfare system. The KFT program worked closely with housing providers, city agencies, and other organizations. Among the families who participated, most had a history of substance abuse, mental illness, domestic violence, or a lack of social support. Of the about half of the eligible families who had been provided with permanent supportive housing, 90% of those remained housed at the end of the pilot period. These findings indicate promising results with regard to agency collaboration and capacity building, and it suggests that supportive housing can lead to increased school attendance and decreased use of foster care among children (Swann-Jackson, Tapper & Fields, 2010).

A recent study presents an evaluation of a supportive housing project in child welfare, Partners United for Supportive Housing – Cedar Rapids (PUSH-CR). The project provides supportive housing for homeless families involved with child welfare as well as service coordination and community collaboration. It is a cross-system approach through collaboration between housing, child welfare and other community partners. The evaluation shows that out of 66 families housed, 91% remained so, and the program has shown promising progress in family retention and housing stability (Landsman, 2016).

**Cuyahoga Partnering for Family Success**

Findings from previous research and program evaluations suggest that an efficient, cross-system collaborative approach is needed to best serve families who are homeless and have children in out of home placement. Such an approach has the potential to bridge the gap between families’ needs and available resources. To fill this gap and better serve this population, the Cuyahoga Partnering for Family Success (PFS) program was launched by Cuyahoga County in 2015. The primary goal of PFS is to house homeless caregivers as quickly as possible, and work to safely reunite families whose children are in out of home placement (OHP), ultimately reducing system costs. Supportive services are provided by a local service provider, FrontLine Service, that specializes in crisis intervention and trauma-focused care, and
is dedicated to ending homelessness through providing case management and therapy services. FrontLine Service is a contract agency of the Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County and a partner agency of United Way Services of Greater Cleveland.

The program is unique in part because it provides resources to build a relationship between the child welfare system, housing providers and other government and local service providers. By partnering with government, housing providers, and other partners, the program is able to provide housing stability for a randomly selected group of homeless families who have children in out-of-home placement. Caregivers are eligible for the program if they are homeless or are deemed to have unstable housing and have a child in temporary custody of DCFS.

In partnership with a variety of service sectors, the mental health service provider (FrontLine staff) connects families to housing services and provides support and advocacy in order to facilitate reunification or another permanent custody arrangement for the child. The FrontLine staff provides intensive case management known as Critical Time Intervention (CTI) (Herman, Conover, Felix, Nakagawa, & Mills, 2007), to help vulnerable families experiencing homelessness to connect to community support networks and settle successfully in newly attained housing. CTI has been found to be promising in addressing housing and mental health issues (Kaspro w & Rosenheck, 2007; Herman, Conover, Gorroochurn, Hinterland, Hoepner & Susser, 2011). CTI is also paired with age-appropriate, evidence-based trauma services intended to strengthen caregiver-child relationships.

PFS also incorporates Trauma Adapted-Family Connections (TA-FC) treatment after families are reunified. TA-FC is a six-month manualized trauma-focused therapy to help address the gap in services for underserved populations (Collins et al., 2011). It aims to reduce risk factors for child maltreatment and improve child safety by delivering family assessment, emergency assistance, service plans, advocacy, and coordinated referrals. One study found that TA-FC showed great promise in filling service gaps and helping families who are chronically traumatized and struggling to meet their children’s basic needs, and was found to be related to a significant reduction in trauma symptoms and parenting stress (Collins, Freeman, Strieder, Reinicker & Baldwin, 2015).

**Process Evaluation Questions**

The process evaluation seeks to answer four key questions.

1. What are the characteristics of PFS clients?
2. What does PFS do/how are services carried out? What is the content of service contacts/what activities are covered and what is the dosage of those services?
3. How does PFS have an impact on clients?
   - a. What is their housing/homeless service history prior to and after PFS?
   - b. What is their JFS service history prior to and after PFS?
   - c. What is their DCFS service history prior to and after PFS?
(d) How do staff feel the program is affecting clients?
(4) How has PFS had an impact on service delivery and how and to what extent has it changed the service model?
(a) How does FrontLine deliver services, from the perspective of FrontLine staff?
(b) How does DCFS deliver services, from the staff perspective?
(c) To what extent do the FrontLine and DCFS staff feel that the model is collaborative, allowing the integration and coordination of services?

**Evaluation Methods**

The overall evaluation has developed a methodology to measure the flow of referrals into the program and relationship between client characteristics, services and out-of-home placement (OHP) outcomes. The process evaluation is focused on understanding the characteristics of the sample, important issues related to service delivery and to share program learning to date, as well as identify any issues related to service delivery that could potentially affect OHP outcomes. By drawing on key data sources and methods, Table 1 provides a view of the approach we used. Each evaluation method is described in further detail below.

**Table 1. Evaluation Methods and Focus**

<table>
<thead>
<tr>
<th>Method</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) <strong>HMIS data</strong>- CoC data on contacts with homeless service providers</td>
<td>Demographic data, “pre” and “post” program, shelter entry/exit stays</td>
</tr>
<tr>
<td>2) <strong>Review of FrontLine Service client progress notes</strong>- case management notes on individual clients contacts</td>
<td>Data on type, frequency, length of service contacts, common service themes</td>
</tr>
<tr>
<td>3) <strong>Interviews with Staff: FrontLine, DCFS and CMHA staff</strong>- in-depth, semi-structured interviews on experiences with PFS</td>
<td>Perspectives on the PFS experience from staff perspective, and the impacts of the program on clients</td>
</tr>
<tr>
<td>4) <strong>Benefit and Child Welfare Analysis</strong> – JFS public assistance data and DCFS child maltreatment and OHP data</td>
<td>Explore changes in TANF and SNAP benefits, child welfare involvement since entry into program</td>
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</table>
Key Data Sources

The key data sources used for the evaluation are described below. Access to client information at FrontLine was provided by Data Use Agreements (DUAs) between Case Western Reserve University (CWRU) and: (1) FrontLine Service (for Homeless Management Information System (HMIS) data and Progress Note data); (2) Cuyahoga County Jobs and Family Services (for public assistance data) and, (3) Cuyahoga County Children and Family Services (for child maltreatment and OHP data). All evaluation activities were approved by the Case Western Reserve University’s Institutional Review Board (consent documents are included in the Appendix). All client data with personally identifiable information were stored on the Center on Urban Poverty and Community Development’s highly secure server and accessed for analysis purposes only.

HMIS Data

HMIS data were used to gather descriptive data on clients, including demographic characteristics, homelessness history, chronic homelessness, being a victim of domestic violence, and disability status. These data elements are self-reported by program participants. Client shelter history before and after entry into PFS was also gathered from HMIS.

Reviews of Client Progress Notes (Treatment Group only)

Client progress notes were examined in-depth to gather information on case management, therapeutic engagement, themes, and service dosage. Progress notes for the 48 treatment group clients who entered PFS in 2015 (January 1, 2015 and December 31, 2015), obtained from the FrontLine electronic medical records (EMR) system (Evolv) were coded over the course of the first year of their involvement in PFS (January 2015 to February 2017). For each client, dosage information was recorded that included the following basic information about each contact: date, duration of the contact, and type of contact (phone/in person). A “deep dive” included these details plus a brief summary of the content of the contact and an associated code was applied. Client information was entered such that one row represented one contact.

Analyses summarized data within and across clients.

Thematic Analysis (“Deep Dives”). A “deep dive” was conducted on FrontLine workers’ PFS progress notes. The goal was to follow PFS clients through their progress notes over the course of a year of involvement in PFS to identify the major categories and topics covered during case management contacts. Using a modified rubric developed for a previous evaluation with homeless families at FrontLine, research assistants coded the content of each case management contact and themes that appeared throughout the progress notes. Two research assistants (authors two and four, with consultation with author one) regularly met, discussed and agreed on the usefulness and appropriateness of the coding schemes. Coding proceeded and recoding occurred when needed, after reviewing codes for best fit for the evaluation’s aims. The frequencies of codes were then analyzed and collapsed to identify the most common types of contacts and topics discussed during client and FrontLine worker interactions.
Dosage. To better understand the extent, timing, and intensity of PFS services, research staff analyzed client “dosage” information. Researchers examined all treatment group case files and documented the date, time spent, and type of contact (phone/in person) in each progress note documented by FrontLine staff on clients entering PFS in 2015. Progress notes entered between January 1, 2015 and December 31, 2016 were coded and analyzed. Each progress note entry was considered a “contact” and contacts were entered individually, line-by-line, for each client. Analyses examined the total number of contacts, the average number of contacts per client, the total number of minutes spent across all clients, the average and median number of minutes per contact, and the type of contact. These data were further broken down by time in the program to explore the ways in which time in the program is related to contact dosage, and to test the hypothesis that, over time, the number of contacts and/or time spent in contacts decrease.

Benefit and Child Welfare Analysis

Data from Cuyahoga County Children and Family Services (DCFS) and Cuyahoga County Job and Family Services (JFS) provided information on reunification, treatment and control group foster care system involvement, child welfare involvement, as well as receipt of public benefits. To explore use of and contact with public assistance and child welfare systems, data for clients who were randomized into PFS in 2015 were examined. Public assistance data from the JFS were used to identify client benefits before and after PFS entry. Data were provided on Temporary Assistance for Needy Families (TANF) benefits and Supplemental Nutrition Assistance Program (SNAP). To examine change over time, the data were examined before and after PFS entry (with “after” defined as after one month in the program). Child maltreatment and foster care data were available for clients entering in 2015 and tracked clients during the five years prior to PFS entry up until June of 2016 (the most recent date available). Other data from DCFS were used to identify if any of the clients’ children had been the alleged victim of maltreatment (substantiated, indicated, or unsubstantiated) in the last two years. The data also allowed us to identify how many caregivers had been in OHP at any point in their lives.

Staff Interviews

Interview data collected in December of 2016 from PFS (n=6) and DCFS (n=10) staff, and in late February of 2017 with Cuyahoga Metropolitan Housing Authority (CMHA) (n=1) staff provided a detailed, on-the-ground account of PFS program elements in practice from the perspectives of practitioners.

Interview Questions. Participants were asked about program goals, protocols, the challenges and strengths of their clients, common community-based resources utilized by clients, their perceived outcomes of the program, recommendations for the program, and their experience working with the program. The Interview Guide is included in the Appendix.

Procedure. Interviews were conducted with DCFS and FrontLine workers in conference rooms at their respective organizations. Supervisors were interviewed separately from case workers. Staff at DCFS and FrontLine Service were interviewed by three evaluation team members and two
researchers conducted the CMHA interview. The interview times ranged from 45 minutes to one and a half hours. At FrontLine Service, the first author came to a staff meeting to introduce herself to the staff and explain the purposes of the evaluation and what questions would be asked. Staff were offered an opportunity to participate in a group or individual interview. All opted to participate in a group interview. Time was set aside at the time a normal staff meeting occurred, and the evaluation interview was conducted during that time. At DCFS, two times were set aside for the interview and the PFS coordinator at DCFS asked DCFS workers who had PFS cases to attend. At each interview, research staff explained the purpose of the evaluation in general and the interview in particular, assured participants that their responses were confidential and that they were free not to participate or to skip questions.

All interviews were recorded using a digital recording device and transcribed by a professional transcriptionist. Analysis proceeded by members of the research team (authors one through three) reading through the interview transcripts individually and reviewing the transcripts as a team to identify and discuss common and important themes within and across interviews and summarizing the results.

Findings

Demographic Analysis/Client Demographics: HMIS Data

In 2015 and up to mid-December, 2016, 163 participants were randomized into PFS, with 90 in the treatment group, and 73 in the control group. Table 2 displays the demographic characteristics of the sample. More than two-thirds of the total sample identified as non-Hispanic black and more than 90% were women. There was a statistically significant difference ($\chi^2(1) = 7.78, p<.01$) between the treatment and control groups with regard to gender; the control group included a greater proportion of men than women. The average age of participants was almost 32 years old, and the average number of children per participant in the treatment group and the control group is just over one. The average household size is just over two people. The proportion of clients reporting as chronically homeless is roughly equal overall, however there is a larger proportion in the PFS treatment group in 2016. Being a domestic violence survivor was reported by most participants in PFS in both the treatment and control groups, with more than two-thirds reporting it. However, the treatment group had higher rates than the control group in both 2015 and 2016 and overall, with more than three-quarters of PFS treatment group clients reporting it, and less than two-thirds of control group in both years.
Table 2. PFS Demographics: Treatment and Control 2015-2016*

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<th>2015</th>
<th>2016</th>
<th>2015 and 2016</th>
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<tr>
<td></td>
<td>Tx (n=48)</td>
<td>Control (n=35)</td>
<td>Total (n=83)</td>
</tr>
<tr>
<td>Race/Ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hisp. Black</td>
<td>77.1</td>
<td>71.4</td>
<td>74.7</td>
</tr>
<tr>
<td>Non-Hisp. White</td>
<td>12.5</td>
<td>22.9</td>
<td>16.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10.4</td>
<td>5.7</td>
<td>8.4</td>
</tr>
<tr>
<td>Gender (% female)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>97.9</td>
<td>97.1</td>
<td>97.6</td>
<td>97.6</td>
</tr>
<tr>
<td>Age: Mean (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(32.8)</td>
<td>(30.8)</td>
<td>(32.0)</td>
<td>(30.0)</td>
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<tr>
<td>(9.2)</td>
<td>(8.3)</td>
<td>(8.9)</td>
<td>(7.1)</td>
</tr>
<tr>
<td>#Kids: Mean (SD)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(1.3)</td>
<td>(1.0)</td>
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<td>(1.5)</td>
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<td>Household size (SD)</td>
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<td>(2.2)</td>
<td>(2.1)</td>
<td>(2.2)</td>
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<tr>
<td>(1.4)</td>
<td>(1.4)</td>
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<tr>
<td>Chronically Homeless (%)</td>
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<tr>
<td>12.5</td>
<td>14.3</td>
<td>13.3</td>
<td>11.9</td>
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<tr>
<td>DV survivor (%)</td>
<td>75.0</td>
<td>65.7</td>
<td>71.1</td>
</tr>
</tbody>
</table>

Data source: HMIS. Number of children and household size differ from other program reports based on DCFS data; HMIS undercounts number of children because parents often do not enter shelter with their children.

Disability Status

With regard to disability status (See Table 3), a mental health diagnosis was the most common disabling condition for both groups. More than 57% of the PFS participants reported having mental health issues (see Table 3). Drug abuse and chronic health condition were the next most common reported disability (17.8%), followed by alcohol abuse (11.7%). Participants in the control group were more likely to report alcohol/ drug abuse than the treatment group. With regard to physical health condition and developmental disability, a greater proportion in the control group had physical health problems, but the two groups had approximately a similar rate of developmental disability. A small percentage of participants reported having HIV/AIDS (treatment 3.3% vs. control 1.4%).
Table 3. Disability status among PFS participants, 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2015 and 2016</th>
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<tbody>
<tr>
<td></td>
<td>Tx (n=48)</td>
<td>Control (n=35)</td>
<td>Total (N=83)</td>
</tr>
<tr>
<td>Disabilities (% yes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>52.1</td>
<td>62.9</td>
<td>56.6</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>12.5</td>
<td>22.9</td>
<td>16.9</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>18.8</td>
<td>31.4</td>
<td>24.1</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>8.3</td>
<td>8.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Chronic health</td>
<td>18.8</td>
<td>14.3</td>
<td>16.9</td>
</tr>
<tr>
<td>Physical health condition</td>
<td>14.6</td>
<td>22.9</td>
<td>18.1</td>
</tr>
<tr>
<td>Developmental</td>
<td>14.6</td>
<td>11.4</td>
<td>13.3</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>6.3</td>
<td>2.9</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Data source: HMIS

Public Benefits

An analysis of PFS participants’ monthly income and non-cash benefits at the time of intake indicated (see Table 4) that about one-third of clients had income sources including TANF, earned income, SSI, SSDI, child support or other income. About half of the participants received non-cash benefits such as SNAP, WIC, TANF transportation, TANF child care or other sources (e.g. section 8). In general, more participants in the treatment group received monthly income benefits than the control group, but both groups had similar rates of receiving non-cash benefits.

Table 4. Public benefits among PFS 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2015 and 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tx (n=48)</td>
<td>Control (n=35)</td>
<td>Total (N=83)</td>
</tr>
<tr>
<td>Monthly income (% yes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANF</td>
<td>27.1</td>
<td>34.3</td>
<td>30.1</td>
</tr>
<tr>
<td>Earned income</td>
<td>25.0</td>
<td>31.4</td>
<td>27.7</td>
</tr>
<tr>
<td>SSI</td>
<td>31.3</td>
<td>37.1</td>
<td>33.7</td>
</tr>
<tr>
<td>SSDI</td>
<td>25.0</td>
<td>34.3</td>
<td>28.9</td>
</tr>
<tr>
<td>Child support</td>
<td>25.0</td>
<td>34.3</td>
<td>28.9</td>
</tr>
<tr>
<td>Other income</td>
<td>29.2</td>
<td>37.1</td>
<td>32.5</td>
</tr>
<tr>
<td>Non-cash benefits (% yes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNAP</td>
<td>52.1</td>
<td>37.1</td>
<td>45.8</td>
</tr>
<tr>
<td>WIC</td>
<td>50.0</td>
<td>45.7</td>
<td>48.2</td>
</tr>
<tr>
<td>TANF</td>
<td>52.1</td>
<td>45.7</td>
<td>49.4</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANF Child care</td>
<td>52.1</td>
<td>45.7</td>
<td>49.4</td>
</tr>
<tr>
<td>Other (e.g., sect. 8)</td>
<td>54.2</td>
<td>48.6</td>
<td>51.8</td>
</tr>
</tbody>
</table>

Data source: HMIS
Housing Stability

As one measure of housing stability, the evaluation team examined the PFS participants’ involvement with HMIS services prior to their entry into PFS and since 2009 (see Table 5). Those data indicate that the treatment and control groups were involved in the various homeless service programs at approximately equal rates, with treatment clients utilizing emergency shelter somewhat more than the control group. Nearly 90% of clients in both groups received emergency shelter services prior to beginning PFS. After the PFS intake date, control clients were more likely than treatment clients to receive rapid re-housing, to enter emergency shelter, and to receive other types of homeless services as compared to treatment group clients.

Table 5. HMIS Before/After Homeless Service Involvement 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2015 and 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tx</td>
<td>Control</td>
<td>Total (n=83)</td>
</tr>
<tr>
<td>Before PFS intake (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Re-Housing</td>
<td>35.4</td>
<td>20.0</td>
<td>28.9</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>81.3</td>
<td>74.3</td>
<td>78.3</td>
</tr>
<tr>
<td>Coordinated Assessment</td>
<td>91.7</td>
<td>85.7</td>
<td>89.2</td>
</tr>
<tr>
<td>Other Services</td>
<td>83.3</td>
<td>85.7</td>
<td>84.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After PFS intake (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Re-Housing</td>
<td>4.2</td>
<td>17.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>16.7</td>
<td>22.9</td>
<td>19.3</td>
</tr>
<tr>
<td>Coordinated Assessment</td>
<td>22.9</td>
<td>22.9</td>
<td>22.9</td>
</tr>
<tr>
<td>Other services</td>
<td>12.5</td>
<td>31.4</td>
<td>20.5</td>
</tr>
</tbody>
</table>

Notes: *Data Source: HMIS from Jan 1, 2009 to Dec 31, 2016. **Other services include: homelessness prevention, service only and street outreach. ***For more detailed information, please refer to the appendix.

Progress Notes: Themes and Dosage

Progress Notes. Critical Time Intervention (CTI), provided by FrontLine workers for each client, is a crucial feature of PFS. Progress note data were analyzed to better understand the content and frequency of these CTI case management services. In interpreting the dosage data that follow, the reader should keep in mind that a total of 48 clients’ data were examined (all clients who entered PFS in 2015). Of those clients, 12 ended custody in the first 6 months. One client reunified with her children in the first 6 months, and 10 clients exited the program in the second 6 months.

Thematic Analysis. The major codes the team developed are displayed in Table 6 and the frequency and ranking for each topic are displayed in Table 7. Fifteen higher order codes
(including items such as Housing and Child-Related codes, see Table 6) were developed that represent groupings of a total of 61 lower order codes. For example, the higher order domestic violence code included lower order codes that included clients talking about their domestic violence history with their FrontLine worker, the FrontLine worker addressing current concerns about domestic violence or shared domestic violence information with clients, and FrontLine workers discussing or processing a domestic violence-related class (e.g. anger management class) with the client.

The frequency of codes was analyzed according to time in the program, that is, being in the first six months and second six months in PFS. The most commonly cited topics in the progress notes included Child (16.3%), Independent Living Skills (15.4%), System (15.2%), Housing (12.9%), and PFS Support (7.9%). Codes of domestic violence were the least frequently mentioned topic (1%).

Table 6. Progress Note Thematic Analysis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>• General housing (housing situation, housing application, assisting clients)</td>
</tr>
<tr>
<td></td>
<td>• Rent</td>
</tr>
<tr>
<td></td>
<td>• Utility issues</td>
</tr>
<tr>
<td></td>
<td>• Housing maintenance</td>
</tr>
<tr>
<td></td>
<td>• Housing crisis</td>
</tr>
<tr>
<td></td>
<td>• Issues with landlords</td>
</tr>
<tr>
<td></td>
<td>• Evictions, moves, or failed housing inspections</td>
</tr>
<tr>
<td></td>
<td>• Infestation</td>
</tr>
<tr>
<td></td>
<td>• Discussion of material needs for housing (furniture, cleaning supplies, etc.)</td>
</tr>
<tr>
<td>Independent</td>
<td>• Educating client on skills: cleaning, communication, budgeting, maintaining the home, making and keeping appointments, client behaviors and parenting</td>
</tr>
<tr>
<td>Living Skills</td>
<td>• Demonstrating positive or negative independent living skills</td>
</tr>
<tr>
<td></td>
<td>• Coaching clients (DCFS, housing, other)</td>
</tr>
<tr>
<td></td>
<td>• Empowering clients (DCFS, housing, other)</td>
</tr>
<tr>
<td></td>
<td>• Discussion of parenting skills, mentioning parenting class</td>
</tr>
<tr>
<td></td>
<td>• Education of clients</td>
</tr>
<tr>
<td></td>
<td>• Discussion of job</td>
</tr>
<tr>
<td>Alcohol and</td>
<td>• Alcohol and drug abuse history</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>• Current concern of alcohol or drug abuse</td>
</tr>
<tr>
<td></td>
<td>• Went to assessment and treatment like AA meeting</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>• Domestic violence history</td>
</tr>
<tr>
<td></td>
<td>• Current concern of domestic violence</td>
</tr>
<tr>
<td></td>
<td>• Coaching clients with domestic violence knowledge</td>
</tr>
<tr>
<td></td>
<td>• Domestic violence classes</td>
</tr>
</tbody>
</table>
| Mental Health              | • Mental health symptoms  
|                          | • Assessment of a client’s mental state  
|                          | • Psychological assessment and development  
|                          | • Trauma experience  
|                          | • Attending mental health appointment and medication adherence  
|                          | • General feelings (e.g., being overwhelmed, feeling depressed or having anxiety)  
| Child                     | • Material needs of children (food, clothing, diapers etc.)  
|                          | • Any health, mental health or behavioral concerns  
|                          | • Traumatic experiences  
|                          | • Need for daycare or help enrolling children in school  
|                          | • Child education  
|                          | • Client had positive or negative child visit  
|                          | • DCFS involvement  
| Financial                 | • General finances  
|                          | • Budgeting or obtaining government benefits such as PRC funds, SSI, TANF, etc.  
|                          | • Any discussion of employment or education for the client  
| Social Environment        | • Interactions (+/-) with family, friends, neighbors, relationships with sig. others  
|                          | • Any social event that the client may have attended  
| System                    | • Attempted collaboration between FrontLine, DCFS, and other  
|                          | • System barrier  
|                          | • DCFS system  
|                          | • Collaboration of agencies  
|                          | • Involvement with the legal system, including going to jail  
| Health                    | • Discussion of client or family member health  
|                          | • Pregnancy or any health crisis  
| Food                      | • Food shortages  
|                          | • CM takes client to food pantry or grocery store  
|                          | • Supplemental Nutrition Assistance Program (SNAP) benefits  
| Transportation            | • CM transported client  
|                          | • Client receives bus ticket or disability bus pass  
|                          | • Transportation issues  
| Resources                 | • Use of discretionary funds  
|                          | • FrontLine workers provide referrals  
| FrontLine Support         | • Help clients process feelings  
|                          | • Advocate for clients (DCFS, housing, other)  
|                          | • Outreach for clients  
|                          | • FrontLine workers attended Family Team Decision Making  
| Other                     | • Client missed DCFS, FrontLine, and other appointments  

**Table 7. Frequency of Progress Note Codes**
## One Year (n=9,437) | First 6 months (n=5,663) | Second 6 months (n=3,774)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Topic</th>
<th>%</th>
<th>Rank</th>
<th>Topic</th>
<th>%</th>
<th>Rank</th>
<th>Topic</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Child</td>
<td>16.4</td>
<td>1</td>
<td>Child</td>
<td>17.0</td>
<td>1</td>
<td>System</td>
<td>15.7</td>
</tr>
<tr>
<td>2</td>
<td>Independent Living Skills</td>
<td>15.4</td>
<td>2</td>
<td>Independent Living Skills</td>
<td>15.6</td>
<td>2</td>
<td>Child</td>
<td>15.5</td>
</tr>
<tr>
<td>3</td>
<td>System</td>
<td>15.2</td>
<td>3</td>
<td>System</td>
<td>14.8</td>
<td>3</td>
<td>Independent Living Skills</td>
<td>15.0</td>
</tr>
<tr>
<td>4</td>
<td>Housing</td>
<td>12.9</td>
<td>4</td>
<td>Housing</td>
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<td>4</td>
<td>Housing</td>
<td>11.4</td>
</tr>
<tr>
<td>5</td>
<td>FrontLine Support</td>
<td>7.9</td>
<td>5</td>
<td>FrontLine Support</td>
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<td>5</td>
<td>FrontLine Support</td>
<td>7.4</td>
</tr>
<tr>
<td>6</td>
<td>Transportation</td>
<td>6.3</td>
<td>6</td>
<td>Transportation</td>
<td>5.7</td>
<td>6</td>
<td>Resources</td>
<td>7.3</td>
</tr>
<tr>
<td>7</td>
<td>Resources</td>
<td>5.5</td>
<td>7</td>
<td>Mental Health</td>
<td>5.5</td>
<td>7</td>
<td>Transportation</td>
<td>7.1</td>
</tr>
<tr>
<td>8</td>
<td>Mental Health</td>
<td>5.2</td>
<td>8</td>
<td>Social Environment</td>
<td>4.7</td>
<td>8</td>
<td>Mental Health</td>
<td>4.8</td>
</tr>
<tr>
<td>9</td>
<td>Social Environment</td>
<td>4.1</td>
<td>9</td>
<td>Resources</td>
<td>4.4</td>
<td>9</td>
<td>Alcohol and Drug Abuse</td>
<td>3.7</td>
</tr>
<tr>
<td>10</td>
<td>Alcohol and Drug Abuse</td>
<td>3.0</td>
<td>10</td>
<td>Financial</td>
<td>2.8</td>
<td>10</td>
<td>Social Environment</td>
<td>3.2</td>
</tr>
<tr>
<td>11</td>
<td>Financial</td>
<td>2.9</td>
<td>11</td>
<td>Alcohol and Drug Abuse</td>
<td>2.6</td>
<td>11</td>
<td>Financial</td>
<td>3.2</td>
</tr>
<tr>
<td>12</td>
<td>Health</td>
<td>1.6</td>
<td>12</td>
<td>Health</td>
<td>1.4</td>
<td>12</td>
<td>Health</td>
<td>1.9</td>
</tr>
<tr>
<td>13</td>
<td>Food</td>
<td>1.4</td>
<td>13</td>
<td>Other</td>
<td>1.3</td>
<td>13</td>
<td>Food</td>
<td>1.7</td>
</tr>
<tr>
<td>14</td>
<td>Other</td>
<td>1.2</td>
<td>14</td>
<td>Food</td>
<td>1.1</td>
<td>14</td>
<td>Other</td>
<td>1.2</td>
</tr>
<tr>
<td>15</td>
<td>Domestic Violence</td>
<td>1.0</td>
<td>15</td>
<td>Domestic Violence</td>
<td>1.1</td>
<td>15</td>
<td>Domestic Violence</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Note.** Percentage is calculated by taking the frequency of the code and dividing by the total number of codes.
**Dosage Data.** The dosage data were examined by six-month intervals (see Figures 1-4). A total of 2,963 contacts were recorded for 48 treatment group clients, accounting for 86,488 (53,229 in 2015 and 33,259 in 2016) minutes, or 1,441 hours of service time. A paired samples t-test revealed that the mean number of contacts FrontLine workers had with clients was statistically significantly lower during the second six months in the program compared with the first six months \( t(47), 2.28, (p<.05) \). During the first 6 months after a client entered PFS, more than half of FrontLine worker/client contacts were in person (53%), and each contact occurred on average, every 5 days for an hour. As would be expected given the service model, during the second 6 months, FrontLine workers had fewer in-person contacts (43%) and each contact lasted less time (30 minutes), but the contacts still occurred on average, every 5 days.

**Figure 1. Number of contacts between FrontLine workers and clients, over one year**

![Graph showing dosage data](image)

*Note: Data represent one year of data for clients who entered PFS in 2015 \( n=48 \)*
Figure 2. Number of minutes spent in contacts between FrontLine workers and clients over one year

Note: Data represent one year of data for clients who entered PFS in 2015 (n=48)

Figure 3. Average number of contacts between FrontLine worker and client, per client

Note: Data represent one year of data for clients who entered PFS in 2015 (n=48)
Figure 4. Average number of minutes per contact between FrontLine worker and client

![Average Minutes Per Contact](image)

Note: Data represent one year of data for clients who entered PFS in 2015 (n=48)

**Public Assistance and DCFS Data**

**Public Assistance Receipt**

Examining clients’ public benefits prior to and after enrollment into PFS shows that over half of clients in both groups received SNAP assistance prior to PFS, and after entry, nearly all clients in the treatment group (92%) and 80% of clients in the control group received SNAP assistance. However, few clients in both groups received TANF assistance before the PFS program. After involvement with PFS, the proportion of clients in the treatment group receiving TANF increased slightly, while the control group remained about the same.

**Child Maltreatment and DCFS Involvement**

Data on the number of substantiated and alleged maltreatment cases were analyzed for five years prior PFS entry, up to 18 months after entry (for clients entering in January 2015), and as little as six months after entry (for those entering in December 2015) (see Table 8). More than three-quarters of clients in both the treatment and control groups had substantiated/indicated child maltreatment incidents in the five years before PFS. After entry, no clients in the treatment group had substantiated maltreatment cases with DCFS compared to 6% in the control group. Both groups had similar rates (over 90%) of a child being a potential victim of any maltreatment (substantiated or unsubstantiated), prior to PFS and after enrollment into PFS. After entering PFS, the treatment group had less maltreatment reported (19%) compared to the control group (23%). Both groups had open DCFS cases prior to PFS, but after PFS entry, more cases closed in the control group (14%) compared to the treatment group (8%). A higher proportion of children exited OHP within nine months after entering the PFS program in the
treatment group (35%) compared to the control group (26%). These data point toward positive changes and could indicate increased family stability in the treatment group.

Table 8. Public Assistance and DCFS Involvement (2015 PFS entries)

<table>
<thead>
<tr>
<th></th>
<th>Treatment (n =48)</th>
<th>Control (n=35)</th>
<th>Total (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Received SNAP assistance (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month before entry</td>
<td>75.0</td>
<td>60.0</td>
<td>68.7</td>
</tr>
<tr>
<td>Month of entry up to 9 months after</td>
<td>91.7</td>
<td>80.0</td>
<td>86.8</td>
</tr>
<tr>
<td><strong>Received TANF assistance (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month before entry</td>
<td>4.2</td>
<td>2.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Month of entry up to 9 months after</td>
<td>6.3</td>
<td>2.9</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Client’s child was victim of Substantiated/Indicated Maltreatment (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 5 years before entry date</td>
<td>83.3</td>
<td>68.6</td>
<td>77.1</td>
</tr>
<tr>
<td>Up to 6 months after entry date</td>
<td>0.0</td>
<td>5.7</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Client’s child was alleged victim of any maltreatment report (including unsubstantiated) (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 5 years before entry date</td>
<td>95.8</td>
<td>94.3</td>
<td>95.2</td>
</tr>
<tr>
<td>Up to 6 months after entry date</td>
<td>18.8</td>
<td>22.9</td>
<td>20.5</td>
</tr>
<tr>
<td>Client had open DCFS case (as a parent) at entry date (%)</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Case closed by 6 months after entry date</td>
<td>8.3</td>
<td>14.3</td>
<td>10.8</td>
</tr>
<tr>
<td><strong>Client’s child was in OHP at entry date (and not in permanent custody) (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child exited OHP within 9 months after entry date</td>
<td>35.4</td>
<td>25.7</td>
<td>31.3</td>
</tr>
<tr>
<td><strong>Client was in OHP as a child (%)</strong></td>
<td>27.1</td>
<td>25.7</td>
<td>26.5</td>
</tr>
<tr>
<td><strong>Client aged out of OHP</strong></td>
<td>10.4</td>
<td>17.1</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Notes: *Child maltreatment and out of home placement data, 2010 through June 2016, provided by Cuyahoga County Children and Family Services. **Prepared by: Center on Urban Poverty and Community Development, Jack, Joseph and Morton Mandel School of Applied Social Sciences, Case Western Reserve University

Staff Interviews

Client Challenges
FrontLine workers tended to mention transportation, self-sufficiency, chronic trauma, and lack of social support as important client challenges that affect both time in OHP and recidivism. They mentioned that they have concerns that service providers hold assumptions about and prejudices against the PFS population. DCFS workers saw lack of income, self-sufficiency, mental health, drug abuse, and domestic violence cases as important challenges to case progress and recidivism. One DCFS worker said: “The domestic violence, the mental health, and substance abuse is a big key…” FrontLine workers talked about lack of employment as an important barrier to self-sufficiency. One FrontLine worker pointed out that lack of income represents a critical barrier: “Well even according to DCFS, they want them to be self-sufficient
before they reunite ... they have no cash. A lot of them don’t have jobs, so they aren’t self-sufficient.”

**Social Support.** FrontLine workers stressed the challenges of their clients’ having limited social support systems that could have helped them become more self-sufficient. Said one worker:

I would say close to 100% of my people have been in foster care, and it’s such a cycle of the family at large not being able to provide supports, and it’s something that we see with homeless families all the time, that it’s not just ‘I don’t have a job.’ It’s ‘I don’t have a job and I’ve lived with several family members who also did not have a job,’ or ‘My parent is living in a senior care center and so I can’t stay with them with my children.’ Family members are going through their own life cycle transitions and are sometimes really combative with our parents, and so the whole system is unable to support the family.

Workers added to the idea that clients are often not only unable to count on their support systems, but also sometimes are negatively influenced by them.

So you’re dealing with the father of your kids... Like she said her own words, ‘He’s not really providing. He’s not really that great of a support.’ So you decide for you and your family that you no longer want him involved, and you tell him he can no longer come over. So now she has two new Hotline calls, because he’s pissed, and she’s trying to reunify with some of her kids. So this just delays the process.

**Domestic Violence Cases.** The FrontLine and DCFS interviewees agreed that domestic violence issues provided stumbling blocks in PFS, both with regard to days in OHP and recidivism. Said one FrontLine worker:

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

DCFS workers also talked about the challenges presented by domestic violence cases, especially when the client was not ready to share that the relationship was violent with her worker(s),
and/or recognize the relationship as violent. One worker said, “Mom engaged in a volatile relationship, which has always been Mom’s downfall, and she kind of kept the relationship a secret, so that Frontline Worker couldn’t even begin to address it, ‘cause no one even knew...”

**FrontLine/DCFS Workers as Collaborators**

Some staff talked about the FrontLine and DCFS collaboration in very positive terms. DCFS workers, in both the previous (2016) and current interviews, felt that FrontLine workers served as important linkages between clients and DCFS. FrontLine workers were sometimes seen as “translators” who could serve as a bridge between the clients and their DCFS workers, whom the clients sometimes view antagonistically. One DCFS worker said she saw the FrontLine worker this way: “Someone else to kind of back me up, too, at meetings,” to provide support and more information about the client’s progress. Another DCFS worker talked about the FrontLine worker “translating” due to the client’s mental health issues: “[the] case manager with this service has been awesome. Like she helps me a lot because my client has mental health [issues], so sometimes it can be difficult with explaining things.” Another DCFS worker expressed similar sentiments: “Some of these parents, they can’t communicate. They don’t know how to communicate, and maybe the Frontline Worker can kind of help them with that.”

One FrontLine worker spoke explicitly about the way FrontLine workers are sometimes perceived by DCFS, but also the ways in which they can serve roles as bridges and translators.

> It’s been learning how to speak the client’s language and speak the worker’s language has been really helpful, and I’ve had workers where they feel like we’re very contentious. You know like Pay for Success, we’re in there to spy on them, or we’re for the client and against them or whatever, and I’m sitting in a staffing and there’s looks of shock on their face ‘cause I’m saying nice things about the worker, or the client’s saying ‘You know I really want to work on this, but my worker, this person, doesn’t do this,’ and I’ll say ‘You know how as a mother, it’s very hard for you? Sometimes you have to hold your children to that discipline we talked about, ‘This is what we do next (x2)?’ This is the same way your worker is with you, very gently trying to hold you to the discipline of the plan that you guys have set up together,’ and the workers or the supervisors are nearly in tears because people don’t have their backs, you know, and people don’t step in and help them participate with the client when neither party’s feeling heard.

A DCFS worker confirmed the idea that the FrontLine worker could be a “safe” person to vent to: “So she had that person that ‘If I’m frustrated and I’m overwhelmed, then I can call this Frontline Worker and get everything out how I’m feeling and still go back to what I need to do.’ So I think that was very positive.” Another DCFS worker talked about how helpful the FrontLine workers were to her:

> I mean it does help a lot to have somebody that is you know working with the family kind
of like more hands on and to kind of get them maybe also to see from a different perspective, ‘cause they look at us as ‘You have to do this, and you’re the bad person,’ or whatever. So it kind of, you know, like a mediator, to some level, whatever, and maybe if they don’t understand the urgentness of doing things (and our job is to protect children, but also making sure that we work with the family together, that this mom or this dad is stable enough to return this child to home.

FrontLine workers, for some DCFS workers, were also seen as helping to decrease the DCFS workers’ workloads: “…it’s been very helpful like kind of helping them. Takes some of the burden off of us…” One DCFS worker even talked about her FrontLine worker as “like an assistant. I could use that more.” One FrontLine worker talked about how her presence at staffings helps clients and how she prepares clients when things haven’t been going well. I don’t think that the clients would be supported, and sometimes they can’t even express themselves. I have a client who rarely even advocates for herself. Just recently she began talking, but she felt attacked. That’s why she lashed out. I think they would have no other way of getting across what they’ve been doing, and I think there’s so many other people, specifically DCFS, who they are so afraid of that that support and then we’re able to say like what they’ve been doing and what their progress has been, either lack thereof or whatever... I usually share that with my clients, if I’m not gonna say something favorable, or things have not been going well. I always say, ‘Well what do you think it’s gonna look like?’ and preparing them for anything like that.

A FrontLine worker talked about the importance of building strong relationships with DCFS supervisors to facilitate communication and deal with any issues early on:

I think that I’ve definitely been able to make good relationships with several of the Supervisors, at least to the point of being able to help, you know have back and forth communication. So really that’s all that I want. I just want to make sure like ‘Can we communicate about this case to make sure we’re on the same page, to make sure that we’re not stalling for whatever reason?’

Barriers to FrontLine/DCFS Worker Collaboration

While we heard that the FrontLine and DCFS workers worked well together in some cases, and that FrontLine often helped to facilitate the relationship between the client and the DCFS worker, FrontLine and DCFS workers at times felt that the communication lines were not open. Workers from each organization talked about workers not returning their calls and/or being difficult to reach. FrontLine workers felt that DCFS workers were not sharing enough information, and DCFS workers complained that the FrontLine workers were inappropriately pushing cases forward when the DCFS worker thought it was inappropriate. In all, there were times they did not feel they were on the same page. One FrontLine worker shared a specific example:
{Mom] completed parenting classes successfully, and the worker felt like she didn’t benefit. So she completed parenting classes again successfully and the worker felt, in her opinion, she didn’t benefit. So she went through parenting coaching successfully and the worker felt like she didn’t benefit. This is one we took to the chief, because it was just outrageous...and this is children... in custody for 18 months because the worker’s just making Mom redo things on the case plan.

In contrast to the quote above expressing concern that DCFS workers were not moving cases forward, a DCFS worker gave an example of what they saw as inappropriate advocacy on the part of FrontLine workers:

Part of that advocacy is great, but they are prone to be very pushing at a point to where we’re not ready to move forward with certain places, and the case with that client. And regardless to reunification, they’ll push to say ‘Hey, they got the housing. Well at least they’re trying, so go ahead.’ A try is not always good enough.

Another DCFS worker recounted a time when she felt unsupported by the FrontLine worker. “I know this mom. Her case has been opened on and off for about six years. Mom is completely high. So back me up. I shouldn’t have to defend myself in front of my client to you.” This quote highlighted a common sentiment from DCFS workers in which they saw PFS as a useful and helpful program, but also a temporary one. They felt that when PFS was over and had stepped out of clients’ lives, DCFS would still be involved and would be called back in if and/or when the client’s situation worsened. Another worker expressed a common feeling that the role of the DCFS worker was advocacy for the child and not the parent, and FrontLine workers were more there for the parent.

There’s no friendship. ’I’m here for the kids and not for the parent, but I felt like when the [FrontLine] worker came on, I felt like it was myself against the worker and the mother, when the worker is supposed to stand with me. ‘It’s a reason that I have the stance that I have, and you have to learn the case before you can take any sides. You’re here for resources, and you’re here to motivate, but you’re not necessarily here to turn anybody against anybody...

**PFS as Supportive and/or Enabling**

One DCFS worker talked about how the program helped with self-sufficiency: “...the worker really keeps giving her resources to try to get her to be more self-sufficient.” One FrontLine worker talked about how she felt the program was seen by some:

‘You take this person everywhere. You do everything for them. (You’ve got them) a house, furniture. What would they do without?’ Well that’s true. This is a service that’s beyond any other, and it really is there to help individuals get on their feet, and even though we explain that like our services wean off and the Therapist comes in and we do
work on self-sufficiency and all those other things to help them stand on their own two feet, that always comes up, we’re enabling. How are we enabling, if we’re supportive? We’re supportive, not enabling, and maybe sometimes it may look that way, but this is a program that’s supposed to help this individual. How is that enabling? And I get that sometimes.

DCFS workers had contrasting ideas about the extent to which PFS enabled clients rather than guiding them toward self-sufficiency. Some DCFS workers felt strongly that the FrontLine workers did too much for their clients, while others disagreed. To some extent, the differing opinions varied based on which FrontLine worker was working with the client, as well as clients and their specific characteristics. One DCFS worker said “...it’s like I find that sometimes it’s always them doing the work, versus the parent working with them...” Other quotes, reflecting concerns about enabling behavior included:

...this is like ‘Oh I’ll carry you here,’ and I’m more so like ‘...I have to see that Mom is able, Mom or Dad... that can step up and say ‘Okay, this is my child. This is my family. I can do these things,’ versus... just ‘Oh well <worker> is gonna do this for me,’ and this is like they don’t take that initiative because ‘My worker’s gonna do that.’

...but it’s just that you’re doing everything for them, when they’re not taking the initiative to say ‘Well this is my child. I need to be at this visit to see my child. I need to be at this visit to bring food for my child,’ or they get housing, it’s just like ‘Everything’s okay.’

One DCFS worker talked about what she saw as the process of FrontLine workers’ learning how to best work with clients on self-sufficiency.

...the worker ends up finding out that she/he has to allow them to become independent, allow them to struggle a little bit, to understand truly what they need to do in order to maintain their progress that they made. If they continue to allow them to manipulate the situations (by always) taking them bus tickets, taking them somewhere, they’re not helping them to continue to progress. They’re only hindering them.

Another DCFS worker talked about how she felt that too much had been done for one of her clients, so much so that the client would not be successful over the long term:

We held her hand for so long, I really don’t think we benefited her the way we could have. We got her housing. I mean her housing is impeccable. Washer/dryer, furniture, that part we did, but the self-sufficiency, we did it too much for her where she does not know how to stand tall on her own, and it’s to the point where her case may open up again, and that’s a big issue that I have.

On the other hand, another DCFS worker discussed the PFS/client relationship differently, actively saying that “enabling” was not what was going on.

She [FrontLine worker] was really hands-on with that client. If that client needed assistance, she would help her, but again, she didn’t enable her. So like if the client
called for the same thing over and over, she would say ‘Okay, so remember the resources I connected you with? Have you contacted them?’ you know, so kind of putting the ball back in Mom’s court, is ‘Well I have equipped you with the knowledge, so what are you doing with it?’

**Benefits of Housing**

The PFS program was widely praised in all interviews for the quickness with which clients are able to secure housing. The quick housing and stability it provides to help clients build a solid foundation was the first thing workers mentioned about the program and the most positive and least controversial aspect of the program. One FrontLine worker said:

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

A DCFS Worker agreed with this assessment:

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

Another DCFS worker however, felt that housing was not enough, and that underlying client issues such as mental health, substance abuse, and the client’s own trauma will ultimately keep the client from being able to move forward. The quote below suggests that the DCFS worker does not feel the FrontLine workers understand the full “picture” of the client system:

> Finding housing for them is not the issue, because if you do not address your mental health, your substance abuse, then trying to be a good parent... I lay it on the table ‘...because at the end of the day, if you don’t want to change, don’t have kids, because you put these kids in bad situations,’ and we see it every day. We appreciate Frontline, but Frontline really needs to understand and see what is really going on with the clients that we have and what’s going on in the lives of these children. The children suffer because... I mean parents have suffered and basically they just grow up and they’re still age 3 or 6 or 10 and they’ve had kids. So finding housing and getting them not to be homeless again, housing cannot be the top priority, because they have not addressed the main issues. It cannot be.

Although housing outcomes were praised overall (nearly all workers were amazed at how quickly families could be housed), some workers expressed concern that public housing was a short-term remedy because parents did not want to raise their children, particularly young boys, in public housing in the long term, primarily because of safety concerns.

**Communication Issues**

DCFS and FrontLine workers alike talked about some difficulties they have had communicating
with each other. One FrontLine worker said she hadn’t been given appropriate information on her case:

I have the worker who didn’t even tell me they had court or SAR [semi-annual review], which that’s where you hear all your information. Regardless of what the client may be saying, you hear all the information. Now you know who’s involved and what’s going on. So they refuse to even say anything to me about court or about the staffing.

One DCFS worker talked about the need for FrontLine workers to communicate more closely with them:

Frontline are more hands-on with our clients. They spend a lot more time with them one-on-one and they see a lot more, but they’re not reporting that to us, as things that they observe, and it doesn’t help the client. It really doesn’t.

One DCFS worker suggested that the FrontLine and DCFS worker need to connect prior to the beginning of the case:

We give you any type of history on the family, but before the Worker actually meets the family, we need to have a meeting outside of that before we add the family into that, because you have a lot of people that are on drugs. They’re manipulators. They know what/how to say. I have a worker. I call her. She doesn’t return my phone call. It’s just a lot of things that go into place, and it’s really hard to support somebody that you really don’t know.

One DCFS worker talked about how useful it would be for FrontLine to attend family visits “...it would be nice if the worker would come to some of the family visitations. They could kind of see the parent interacting with the kids.” Other workers, however said that their FrontLine workers do attend family visits, suggesting a lack of consistency across workers.

**How the Program is Perceived**

Throughout the interviews, both FrontLine workers and DCFS workers had questions about the extent to which selection into the treatment group was truly random, and others wanted more of their clients to qualify, feeling that the program was so valuable, they hated to keep it from their needy clients. Said one FrontLine worker:

So is there a possibility, instead of the families being selected, that it’s like an actual application that we could fill out? Because I have a family like that as well. I think they were selected before, but there wasn’t a contact number for the family. But looking at all the families that I’ve had that you all helped, this is one of those ones that I would advocate over anyone that’s been selected. So instead of you all using what you read on paper to select a family, do you think maybe it’s a way that we could sign an application and say ‘This is a family that I can advocate for, I can support. They’re working their services and they are truly worthy. Housing is the only thing that’s gonna stop this person from being reunified with their child’? So do you think maybe down
the line that that’s something that you all would change, instead of you selecting a
family that you don’t know, as opposed to selecting?
Other workers said that their clients did not believe selection into the program was random,
and that clients have been recommending the program to their friends, and in a few cases,
those friends were selected for the treatment group. These instances did not feel random to
the workers, though the interviewers assured them that it was.
Finally, in the FrontLine worker interviews, it became clear that the staff feel some
pressure on the program to help reduce OHP days, and at times, the known need to reduce
those days and clinical judgment regarding what was best for the client could clash. It was clear
that supervisors were helping staff through such decisions and advocating for making the
clinically correct call, even if it would extend OHP days.

Issues with GALs
In terms of collaboration with Guardian Ad Litem (GALs), some FrontLine workers discussed
issues with some GALs not showing respect to their clients, appeared to be prejudiced against
them, and were unwilling to make home visits promptly, which sometimes led to cases being
delayed.

Collaboration between CMHA and FrontLine workers
The interviewee from CMHA described the experience with PFS as very good, saying, “it’s a very
rewarding piece for us to actually see families get housing, which is typically the final step in
reuniting...” Regarding the quick housing process, the CMHA interviewee felt that PFS clients
are more motivated compared to other CMHA clients. “You know so we did find that typically
the Pay for Success clients will bring all their documentation. A lot of times they’ll bring their
caseworkers with them...and so it seemed like everybody was really involved, and it wasn’t
pulling teeth to get stuff.” Asked how she thought the clients were more motivated than usual,
the interviewee felt that FrontLine workers educate clients to have a better understanding of
the housing application process and help clients to gather all the necessary documents and
have them ready. “So maybe part of it is the motivation with the caseworker kind of helping
them along and understanding.... Maybe that is a driving force.” At the end, the interviewee
from CMHA spoke highly about the collaboration with FrontLine workers: “We’ve had a really
good experience working with Frontline, with the contact at Frontline and the communication
level has been great. Even when there’s been issues, or maybe concerns from when they’re on
the property, that person from Frontline has even gotten in touch with us, and we worked it
out that way and it’s wonderful...”

Collaboration with JFS
With regard to collaboration with JFS, FrontLine workers suggested having a liaison at JFS to
help run through all the problems and make sure clients get benefits promptly. As one
FrontLine worker said, “A contact person at ODJFS [asked] about if a family [is] reunified, why
are we waiting two months for their food stamps to be in place? Like yeah, we covered those
food... The family’s not going without food, but then it’s just this added layer of stress for the family, and ODJFS is probably even harder to reach than DCFS is.”

Possible Explanations for extended OHP days in Treatment Group
FrontLine workers had several explanations for why they felt treatment group children might have more OHP days compared to the control group. First, one worker suggested that some clients in the treatment group might not do anything for their case plan before entering to the PFS program and until the FrontLine worker has stepped in. One FrontLine worker said in the interview: “Mom hasn’t visited in eight months, and she starts visiting, and she starts engaging in services, typically what we’ve seen is that the Magistrate will say, ‘We’re gonna extend custody. Mom is now showing that she’s interested,’ where if maybe if FrontLine had not stepped in, if they had maybe been referred to the control group, this is a clear-cut permanent custody.” This quote suggests the potential value of the FrontLine workers’ involvement in encouraging clients to work through case plans and toward reunification.

Another Frontline worker provided another perspective on FrontLine workers’ involvement with regard to how their involvement can lengthen OHP days. While the workers can be helpful in identifying other possible caregivers if the situation with the primary caregiver doesn’t look promising, changing the identified appropriate caregiver can drag the process on, as the worker said:

Well let’s say Dad looks a touch better than Mom. Okay, so we open Dad with the intention that he, let’s say he just needs housing. This is kind of how we thought about it a year and a half ago. We’ll open Dad, if he just needs housing. Housing’s the only thing that he needs to reunify... Now he is an option for reunification. Mom’s still kind of over here looking okay. So now they clash in court. So now we’re extending custody. I think it’s kind of like a Catch 22. So then do we stop serving Mom? ‘Cause if we keep serving Mom, then we’re gonna advocate for Mom in court, but we’re also gonna advocate for Dad in court, and it’s gonna be this long, drawn-out process.

Lastly, one example was shared in which a client was doing everything she needed to do in order to get her child back, and then relapsed into drug use. The FrontLine worker might advocate for the client based on her clinical judgment for the client to undergo treatment before reunification which could subsequently extend OHP days.

Discussion
Summary of Findings
This report has documented the characteristics of clients participating in PFS in 2015 and through most of 2016, their homeless histories and housing after PFS, the types of and time spent in service contacts, and finally, child welfare involvement and public benefits before and
after entry into the program. Quick housing was identified as a major success for the PFS program and was confirmed through interview and HMIS data with the vast majority of clients becoming housed and staying housed. HMIS data are limited, however, as permanent supportive housing is not technically the correct category for PFS clients’ housing situations, and there is no established routine for entering client housing service data prior to PFS entry. Interview data suggest that the quick housing provides an important foundation for building up clients’ strengths and resilience. Through coaching and guidance (information gleaned from progress notes and staff interviews), FrontLine workers help clients deal more effectively with DCFS workers, assist them in accessing housing, and serve as bridges and guides in navigating the social service system. Data collected on client contacts with FrontLine staff indicate the major categories that service contacts represent and how that changes over a year in the program, and dosage information communicated the amount of time FrontLine workers spend on the cases. The dosage data clearly indicate that over time, FrontLine workers spend less time with clients as their time in the program increases, reflecting the service model. For treatment group clients, child welfare involvement appears to decrease after PFS entry and clients appear to gain access to TANF and SNAP benefits. While PFS treatment group families increase their receipt of SNAP and TANF after being in the program, our data do not allow us to see if they are pursuing work-generated income, thus long-term self-sufficiency remains a potential concern.

**Housing Stability**

As anticipated, housing caregivers who have children in OHP allows the caregiver to address their case plan more effectively, which potentially speeds up reunification. What was not anticipated is that it might be that the FrontLine worker, who assists with housing, becomes heavily invested in reunification, making other types of permanency options less likely and more time consuming. Exacerbating this issue is a service delivery philosophy clash between those in child welfare who are focused on issues like addressing substance abuse first and want to see clients follow established rules, in contrast with housing first, which is more consumer-driven. Although rapid housing was an important strength of the program, and nearly all PFS clients are housed after entry into PFS, the interviewees questioned the extent to which public housing could be a long-term solution. It is possible that clients accepted public housing as a housing option quickly to escape homelessness, but whether public housing was truly “chosen” by the consumer is unclear, and it also unclear the extent to which clients see it as a desirable option over the long-term.

**Domestic Violence**

In the interviews, staff suggested that domestic violence cases are some of the most challenging cases and can lead to longer reunification times or recidivism, particularly when clients hide their domestic violence situation from their workers (FrontLine and DCFS). The HMIS data indicate that more than two-thirds of the total sample in PFS reported being domestic violence survivors. While it appears that more clients in the treatment than control
Group reported being domestic violence survivors, the data captured only a point in time and do not necessarily indicate involvement in a domestic violence relationship at the time of PFS entry. Progress note analysis also suggested that domestic violence was the least frequently discussed topic. The meanings of these data are unclear. Not discussing domestic violence with the client does not necessarily mean the client wasn’t experiencing domestic violence; it might have been that the client did not share her experiences for fear of losing services or delaying reunification. Regardless of our finding that domestic violence was infrequently discussed in FrontLine worker contacts, domestic violence has been raised as an issue in the PFS operating committee as a factor that could potentially delay reunification. Because domestic violence relationships tend to cycle through periods of violence, separation, and then reunification, with a permanent separation occurring only after a number of such cycles (Wuest & Merritt-Gray, 1999), it is possible that domestic violence could delay reunification. The PFS operating committee is aware of the issues are addressing the need for and utility of improved domestic violence related services. While PFS anticipated that domestic violence would be a common risk factor in the target population, it appears to be more common in the target group than in other homeless populations and warrants more attention going forward.

Collaborations

A number of issues were raised around collaboration and system coordination. It appears from our data that when the collaborations work, they are quite effective, but there is a lack of consistency across staff members at DCFS and Frontline with regard to how cases are handled and how the staff communicate with one another. According to our interviews, while the relationship between FrontLine and DCFS is mixed, collaborations between FrontLine and ODJFS, and FrontLine and GALs appear to be weak and those between CMHA and FrontLine are strong. One important point to note is that to the extent a child welfare agency is issue-driven, partnering with them in a housing first approach which is consumer-driven, will be more difficult.

Recommendations/Considerations for PFS

- The process evaluation findings suggest that the outcome evaluation might consider including the following variables in the final analysis as potential contributors to numbers of out-of-home placement days:
  - Client domestic violence involvement
  - Mental health and substance abuse issues
  - Receipt of TA-FC
- In the future, client interviews and/or surveys could provide additional insight into:
  - Reasons for recidivism, from client perspectives
  - Reasons for sustained reunification
Strengths of PFS from the client perspective
- Sustainability of the public housing option, extent to which public housing was their choice
- Long-term goals around housing
- Contributors to long-term self-sufficiency

The data collected here also suggest some potential service changes
- Increased consideration and attention to how domestic violence cases are handled and what could be improved (currently being addressed)
- Initiating a liaison or single point of contact at JFS for FrontLine workers or figuring out how to improve communications
- Increased coordination between DCFS and FrontLine, which might include worker-suggested changes in practice:
  - Case workers (DCFS and FrontLine) meeting prior to case start to share family history
  - Case workers strive to maintain open lines of communication
  - Increased consistency in how workers handle cases (e.g., attendance at family visits, staffings, types of services offered and in what manner)
- Increased education about PFS (and perhaps more general training on vulnerable families and trauma), for GALs, DCFS, magistrates; FrontLine workers raised strong concerns in this area (especially with GALs)
References


Appendices

Appendix 1. Consent Documents

Appendix 2. Interview Guide

Appendix 3. HMIS tables

Appendix 4. Progress Note Dosage tables
Appendix 1. Informed Consent Documents for Interviews

INFORMED CONSENT DOCUMENT: PARTNERING FOR FAMILY SUCCESS (STAFF)

Purpose
The purpose of this research is to better understand people’s experiences with the Cuyahoga County Partnering for Family Success project. Researchers at Case Western Reserve University are conducting this study. You are being asked to participate because you have been involved with Partnering for Family Success. We will be talking to staff that have been part of the program about their experiences. This informed consent document contains important information about the study. Please read it and feel free to ask any questions that you have. We will provide you a copy for your records.

Procedures
If you agree to be part of this research, we ask that you read and sign this consent form. If you give consent, it will allow us to interview you for approximately 60 minutes when we will ask you questions about your experiences with Partnering for Family Success. We will be asking you about your impressions of your clients’ experiences as well as about your own experiences to better understand how the program functions. We will audio record the interview.

Voluntary Nature of the Study
Your participation is totally voluntary. If you choose not to participate, your current or future relationship with any entity will not be affected— including but not limited to FrontLine Service, DCFS, any government or housing organization, service providers, or Case Western Reserve University. There is no penalty or loss of benefits for not participating or for withdrawing.

Risks and Benefits to Being in the Study
There are no foreseeable risks to your participating in this research; we will be asking you about your day-to-day work with clients and other program staff. However, you may skip any question that you would prefer not to answer or end the interview at any time without penalty. While there are no known benefits to you from being in this study, we expect your responses will help improve programs and services for current and future Partnering for Family Success clients.

Confidentiality
What you tell us will be kept private, and your interview will be stored on a highly secure server at Case Western Reserve University. In any report we might release, no information that makes it possible to identify you individually will be included. If it is necessary to have paper copies of the interview, they will be kept in a locked filing cabinet, and access will be limited to the researchers, the University Review Board responsible for protecting human participants, and sponsors and funding agencies. If you participate in the interview, we will use the recording to create a written summary of your comments, which will include neither your name nor names of persons mentioned in the interview. Audio files will be stored on password protected computers and destroyed within four months of the interview.

Contacts and Questions
The researchers conducting this study are David Crampton, Ph.D. and Cyleste Collins, Ph.D. You may ask any questions you have at any time. If you have any questions, concerns or complaints about the study, you may contact Dr. Collins by email: c.c.collins44@csuohio.edu or by phone at: 216-

IRB NUMBER: IRB-2014-910
IRB APPROVAL DATE: 10/10/2016
IRB EXPIRATION DATE: 09/29/2017
687-4571. If you cannot reach the researcher, and/or if you would like to talk to someone else about: (1) questions, concerns or complaints regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects issues, please contact Case Western Reserve University’s Institutional Review Board at (216) 368-6925 or write: Case Western Reserve University; Institutional Review Board; 10900 Euclid Ave.; Cleveland, OH 44106-7230.

Statement of Consent
I have read the above information, and I have received answers to my questions. I consent to participate in this research. I am at least 18 years of age.

Print Name of Participant: ________________________________
Signature of Participant: ________________________________ Date: ______
Signature of Person Obtaining Consent: ______________________ Date: ______

IRB NUMBER: IRB-2014-910
IRB APPROVAL DATE: 10/10/2016
IRB EXPIRATION DATE: 09/29/2017
Appendix 2. Interview Guide

Cuyahoga County Partnering for Family Success

Interview Guide

*Pass out informed consent documents, get signed, give participants a blank copy

*Introduction: Thank you for agreeing to participate in this research. We are here to talk to you about your experiences with the Partnering for Family Success program. We will be preparing a report based on this interview to share with the program partners to help everyone better understand the program, what's working well and less well, and its impact. What you say is completely confidential. Although we are recording the interview, we will write our report based on the transcript, and any names that are mentioned will be redacted. Please know that if you decide to leave in the middle of the interview or would prefer not to answer our questions, this will not be reported to your supervisor or anyone else and will not have an impact on your job or relationship with any entity.

1) We’d like to start by just getting your general reactions of the program. What is the program doing well?
   a. Probe: From your experiences, how good a job do you think the PFS model does to improve parent functioning, family stability and child well being? How is it good and how not so good?

2) Given that one of the hopes for Partnering for Family Success is that the program will help to safely reunify children with their families or finalize other permanency plans, what does this mean to you, and to what extent do you think that is happening and/or possible for your clients?
   a. What are some characteristics of cases that have had successful reunifications that have "stuck"?
   b. What are some characteristics of cases that have reunified but then the child returned to custody?
      i. In your view, how could this have been prevented?

3) From your experience, to what extent has Partnering for Family Success had an impact on your clients—positive and/or negative? How so?

4) How do you define “success” for Partnering for Family Success client?

5) What recommendations would you make about how to improve Partnering for Family Success going forward? How would you change it to make it better?

6) If appropriate for provider: Please talk a bit about how your PFS cases are different or similar to the cases that did not end up in PFS. In what ways are the clients different? In what ways are the services they receive the same or similar or different? Do you have a sense for how they each are doing in comparison to one another?

7) What kinds of things could help you in your work with Partnering for Family Success clients?

8) Is there anything else you would like to share about your experience with Partnering for Family Success?

Case Managers/Case Workers: Interview Questions

General

1. Brief introductions – interviewers, case managers (names, positions, how long have worked in field, at organization)

2. We’d like to start by talking about the basics. Based on what you know and your experience, what is the purpose of the Partnering for Family Success program?

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IRB APPROVAL DATE: 09/09/2015
Cuyahoga County Partnering for Family Success

Interview Guide

Program Protocol and Description

3. Next we'd like you to tell us a little about your PFS clients. Who are they? What are their major challenges? What are their strengths?

4. Please walk us through your “typical” protocol when dealing with Partnering for Family Success clients for the first time. (These will be ongoing cases with DCFS so this question might not be relevant for DCFS staff.)

5. What do you anticipate your interaction with your clients will look like at the conclusion of the “official” service period for clients in Partnering for Family Success (12-15 months)?

6. How does what you do with Pay for Success clients differ from what you would “normally” do with a similar client, or what you would have done before PFS started (if applicable)?

Follow-up/further probe-DCFS staff only: Please talk a bit about how your PFS cases are different or similar to the cases that did not end up in PFS. In what ways are the clients different? In what ways are the services they receive the same or similar or different? Do you have a sense for how they each are doing in comparison to one another?

Supportive Services, Referrals and Resources

7. How are clients referred to other community-based services?

8. What community-based services are referred most frequently for the Partnering for Family Success population?

9. From your perspective, to what extent do your PFS clients’ needs for and involvement with supportive services change over time (DCFS: especially as compared to similar cases not in PFS)?

10. From your experience, what services best support your PFS clients toward maintain family reunification or stability after reunification?
Cuyahoga County Partnering for Family Success

Interview Guide

11. From your experience, how good a job do you think the PFS model does to improve parent functioning, family stability and child well being? How is it good or not so good?
12. Given that one of the hopes for Partnering for Family Success is that the program will increase the safe reunification of children with their families or finalize other permanency plans, what does this mean to you, and to what extent do you think that is something that is happening and/or possible for your clients?

Overall Reflections/Suggestions

13. From your experience, to what extent has Partnering for Family Success had an impact on your clients—positive and/or negative? How so?
14. How do you define “success” for Partnering for Family Success client?
15. What recommendations would you make about how to improve Partnering for Family Success going forward? How would you change it to make it better?
16. What factors help you to do your job most effectively?
17. How do you feel about the collection of data in the program and the use of technology?
18. Understanding that the work you do can be stressful, to what extent would you say that your organization supports your own resilience? How do they currently help with burnout and/or compassion fatigue? What could they do to better help you?
19. What kinds of supports could help you in your work with Partnering for Family Success clients?
20. Is there anything else you would like to share about your experience with Partnering for Family Success?

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IRB APPROVAL DATE: 09/09/2015
### Appendix 3. HMIS tables

#### Table 3a. HMIS Before/After Homeless Service Involvement 2015-2016

<table>
<thead>
<tr>
<th>Services</th>
<th>2015 Treatment (n=48)</th>
<th>2015 Control (n=35)</th>
<th>2015 Total (n=83)</th>
<th>2016 Treatment (n=42)</th>
<th>2016 Control (n=38)</th>
<th>2016 Total (n=80)</th>
<th>2015 and 2016 Treatment (n=90)</th>
<th>2015 and 2016 Control (n=73)</th>
<th>2015 and 2016 Total (n=163)</th>
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<td></td>
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<td></td>
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<td>6.8</td>
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### Appendix 4. Progress Note Dosage Tables

Table 4a. Dosage summaries, one year of client contacts (treatment group only, N=48)

<table>
<thead>
<tr>
<th>Client Contacts with Case Manager</th>
<th>Total/Year (N=48)</th>
<th>First 6 months</th>
<th>Second 6 months</th>
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<td>N</td>
<td>%</td>
<td>N</td>
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<tr>
<td>Total number of contacts</td>
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<tr>
<td>Phone</td>
<td>1513</td>
<td>51.1</td>
<td>767</td>
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<tr>
<td>Other</td>
<td>7</td>
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<tr>
<td>Average contact per client</td>
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<td>19.73</td>
<td>15.96</td>
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<tr>
<td>Person</td>
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<td>10.48</td>
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<tr>
<td>Total number of minutes</td>
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<td>53229</td>
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<td>9.4</td>
<td>4246</td>
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<tr>
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<tr>
<td>Average number of minutes per contact (SD)</td>
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<td>32.5 (41.5)</td>
<td>25.1 (36.7)</td>
</tr>
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<td>54.28 (44.7)</td>
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<td>4.00 (SD=3.5)</td>
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</table>

*Note: Data represent one year of data for clients who entered PFS in 2015 (n=48)*