Partnering for Family Success

Final Evaluation Report

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Executive Summary

When announced in December 2014, the Partnering for Family Success (PFS) program was among the first Pay for Success projects in the United States and was the first sponsored by a U.S. county (Cuyahoga County, Ohio). With funding from Reinvestment Fund, The George Gund Foundation, the Cleveland Foundation, the Sisters of Charity Foundation of Cleveland, and Nonprofit Finance Fund, the project was conceived as an innovative intervention to address the particular needs of housing unstable families who had a child in the custody of the county child welfare agency. As part of the five-year Pay for Success project, a third-party evaluation was commissioned to be conducted by the Center on Urban Poverty and Community Development at Case Western Reserve University.

Study Design. Over the course of the project, the study enrolled 273 housing unstable caregivers who had a total of 540 children in out-of-home placement (OHP). Using a sequential random assignment procedure, the caregivers were assigned to either receive conventional services from DCFS (Control: 138 caregivers, 261 children) or DCFS services coupled with the PFS intervention (Treatment: 135 caregivers, 279 children). The original study included a five-year impact analysis and a two-year process evaluation examining the delivery of the program. A supplemental evaluation was added in 2019 to collect data from caregivers, DCFS caseworkers, and PFS program staff, and to explore additional aspects of program delivery and effectiveness.

Payable Metric. As a Pay for Success project, the design required identification of a key metric that was monetized as a basis for calculating how much the government sponsor would pay for the desired outcomes. For the PFS intervention, the agreed-upon payable metric was total days a child spent in temporary out-of-home placement (OHP), to be judged based on the average difference between the treatment and control groups. The results of the impact analysis reveal a nonsignificant difference between the two groups based on average days in OHP, with a pattern suggesting slightly shorter average stays in the control group (802 versus 871 days). However, when the exit destination is considered, the results also suggest that African-American caregivers in the PFS treatment were more likely to reunify with their child, as compared to African-American caregivers receiving conventional services alone. This greater likelihood to reunify for African-Americans is an important finding in child welfare contexts where this population is disproportionately represented.

TABLE OF CONTENTS

1. Introduction

In response to concern about children remaining in foster care too long, the Adoption Assistance and Child Welfare Act of 1980 was passed. Among other provisions, this law requires states to make "reasonable efforts" to prevent the removal of a child from his or her home and to make it possible for a child to return home from foster care quickly. For over 30 years, in response to this directive, the Child Welfare field has tried to determine how to reasonably and safely prevent foster care placement and reduce length of time in foster care. Cuyahoga County Division of Children and Family Services have been nationally recognized leaders in developing family and community engagement strategies which likely contributed to a 68 percent decrease in the number of children in foster care between 2002 and 2012, from over 6,000 to under 2,000 in county-funded foster care.

Nevertheless, in 2012, when Cuyahoga County was considering the use of social impact financing, they were spending over $50 million annually on foster care, so it made sense to consider targeting foster care with this financing method for cost savings. At this time nationally and in Cuyahoga County, there was the development of new and effective homeless services as described later in this report. Cuyahoga partners considered targeting these homeless services on homeless families who had children in foster care to decrease days in foster care. As detailed in this report, the services they developed did increase reunification of children with their parents, especially for African American children. Therefore, the results of this experiment may have critical implications for the over 400,000 children in foster care in the United States.

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 service providers and other advocates lament the lack of service integration and the scarcity of resources available to meet the needs of adults who are homeless, struggle with mental illness, and/or also abuse substances. The literature of social work and other professions has contributed little to policy and practice-relevant debates surrounding service delivery for this population. The point of contention stems from fundamental differences in how people with

mental illness or substance abuse issues who are also homeless are viewed and how consumer choice is defined and incorporated into programs' service delivery philosophies. 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).

Any attempt to apply Housing First to niche homeless populations therefore must confront how different service providers will be encouraged to embrace the 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 who are 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 used Social Impact Financing to launch the program.

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 to aid families in 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, depending on the case circumstances, might involve a reunification plan for 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 family reunification, and the median length of stay in foster care was approximately 13 months. Locally, where our work has been 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 foster care 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. 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 that child welfare services alone are not sufficient to ensure quick and sustainable family reunification, and that additional services that target the 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. The evaluation found that of the about half of the eligible families who had been provided with permanent supportive housing, 90% remained housed at the end of the pilot period. The findings indicate promising results with regard to agency collaboration and capacity building, and it suggest 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).

2. Discussion of PFS Intervention

Focusing on families who had a homeless history or were housing unstable and a child in temporary custody of DCFS, the Partnering for Family Success (PFS)[1] program was launched by Cuyahoga County in 2015. The primary goal of PFS was to house and stabilize housing unstable caregivers as quickly as possible and then work to safely reunite them with children in out-of-home placement as quickly as possible, thus reducing time in out-of-home placement and reducing foster care costs.

Findings from previous research and program evaluations suggest that an efficient, cross-system collaborative approach is needed to best serve homeless families who have multiple needs, including children in out-of-home placement (Fowler et al., 2018; Fowler & Chavira, 2014). Thus, PFS created a partnership between the primary mental health service provider, child welfare, housing, and other government and local service providers to connect families to local resources and services. FrontLine worked intensively with families to support families, advocate for them, and facilitate reunification or other permanent custody arrangement for the child. The specific partnership with the Cuyahoga Metropolitan Housing Authority (CMHA) enabled program participants to be prioritized on their waiting lists and receive faster housing placement than they would have otherwise. The program employed Critical Time Intervention (CTI) case management, a family trauma assessment, and created a service plan tailored to each family's needs. Post-reunification, Trauma-Adapted Family Connections therapeutic services were offered and/or traditional family reunification services.

FrontLine Services, Inc. (FL), the primary service provider, implemented the PFS program. To meet program goals, the program's staff employed evidence-based and trauma-informed services. Intensive case management using Critical Time Intervention (CTI) (Herman, Conover, Felix, Nakagawa, & Mills, 2007) was employed to help housing unstable families find, settle into and successfully maintain newly attained housing and connect with community support networks. CTI has been found to be promising in addressing housing and mental health issues (Kasprow & Rosenheck, 2007; Herman, Conover, Gorroochurn, Hinterland, Hoepner & Susser, 2011). Using CTI, FrontLine staff first built a strong rapport with clients, identified their

[1] In this report PFS is used to refer to the Partnering for Family Success project in Cuyahoga County, Ohio. When referring to the concept of Pay for Success more generally, no acronym is used.

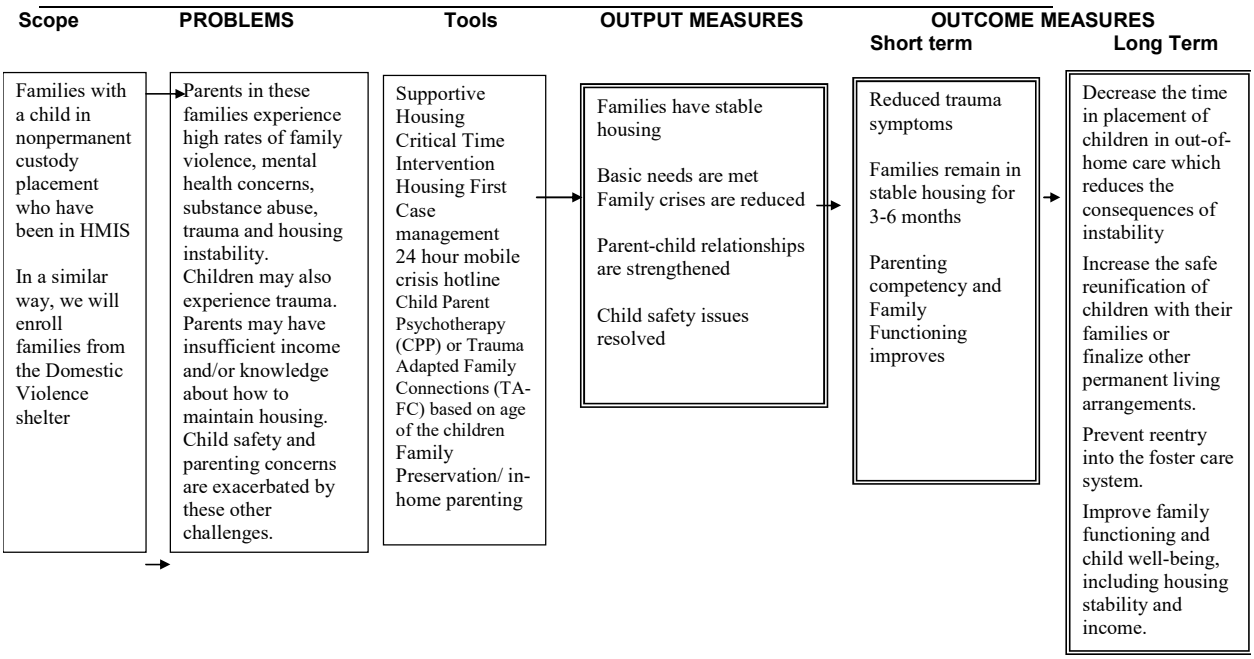
strengths and challenges, worked toward obtaining stable housing situations as needed, and strategized with the families around successfully completing their DCFS case plans.

Throughout the program, the FrontLine staff worked to closely tailor all services to the caregiver and family's specific needs (e.g., mental health issues, substance abuse, etc.), pairing CTI with age-appropriate, evidence-based trauma services to strengthen caregiver-child relationships. These services were aimed toward helping families increase self-sufficiency through coaching, modeling, providing social and emotional support, and identifying appropriate community resources to eventually and ideally transition families into reunification. Based on past research indicating the importance of caregiver engagement with visitation (Landsverk, Davis, Ganger and Newton, 1996), case plan conferences, and family meetings for reducing children's time in out-of-home care (Crampton, Usher, Wildfire, Webster and Cuddaro-Alamin, 2011), the PFS intervention included efforts to increase visitation and target relationship-building between caregivers and their children during visits.

Post-reunification, PFS offered Trauma Adapted-Family Connections (TA-FC), a six-month manualized trauma-focused therapy (Collins et al., 2011) to families after they were reunified. TA-FC focuses on reducing risk factors for child maltreatment and improving child safety through family assessment, emergency assistance, service plans, advocacy, and coordinated referrals. Research has found that TA-FC showed great promise by filling service gaps and helping chronically traumatized families who are struggling to meet their family's basic needs, and has been associated with significant reductions in trauma symptoms and parenting stress (Collins, Freeman, Strieder, Reinicker & Baldwin, 2015).

A simplified logic model for the PFS project is provided.

PAY FOR SUCCESS LOGIC MODEL



3. Study Methods

The Cuyahoga County Partnering for Family Success (PFS) project included funding for a five-year outcome study and two-year process study. Additional funding was later secured to conduct a supplemental evaluation during the final year of the program. The process evaluation focused on the period 2015-2017 of the project and a report and a published article on the work are available for full details (Collins, Bai, Crampton, Liu, & Fischer, 2017; Collins, Bai, Fischer, Crampton, Lalich, Liu, & Chan, 2020).

Described here are (1) the impact analysis which focused on the results of the randomized design and the assessment of the identified outcomes, and (2) the supplemental evaluation which collected data in the final year of the project from programmatic staff and importantly, from caregivers themselves.

3.1 Impact Evaluation

Randomized Design

The PFS intervention targeted families with children in foster care whose primary caregiver had recently experienced homelessness. It sought to reduce the time children spent in foster care or temporary out-of-home placement (OHP) relative to the standard approach followed by the Division of Children and Family Services (DCFS). The time window under which OHP days would be counted was set to start at the time of DCFS custody and end at the conclusion of a five-year observation period.

To assess whether OHP time was shorter under the intervention, we would ideally need to observe each child under two counterfactual scenarios:

1. family receives standard DCFS services
2. family receives the PFS intervention

While this ideal is not possible, randomizing families into treatment and control groups allowed us to estimate an average treatment effect of the intervention for families willing to sign up for the program. In other words, we could estimate the average difference in outcome under the hypothetical scenario that all participating families receive the PFS intervention versus the status quo.

Randomization guarantees there is no selection into treatment, which is desirable for causal estimation. However, randomization does not necessarily produce precise estimates and does not imply balance of all variables across treatment and control groups. Balance over some

covariates thought to influence outcome may be desirable, particularly in small samples, in order to increase precision of estimates (Deaton & Cartwright, 2018). In agreement with the plan, the randomization process was designed to maintain balance across two relevant case and family characteristics. The characteristics considered were (1) number of siblings in the family and (2) time spent in custody by the children during the current spell, but before intake into the study. If a family had two children with different amounts of time in foster care at intake, we balanced on the longest foster care time.

Randomization took place between January 2015 and September 2017, and OHP days were observed until December 31st, 2019. Starting in January 2015, CWRU received periodic data on families (cohorts) that met the selection criteria and had were enrolled in the study. We used Covariate Adaptive Randomization (Frane, 1998; Rosenberger & Sverdlov, 2008) to sequentially randomize monthly cohorts of families into the program. Simply stated, this procedure consisted of allocating new families into treatment or control using a biased-coin design, where the bias is adjusted with each new assignment in order to produce treatment and control groups that are "balanced" in sibling group size and custody time prior to intake. Imbalance or difference in the empirical distribution of these covariates across treatment and control groups was measured using the p-values of the Kolmogorov-Smirnov test for distribution equality.

For the last three cohorts of 2017, we modified the randomization procedure to account for decreased capacity of PFS staff, so as not to exceed this capacity. As an illustration, if the cohort consisted of six families and we could only assign two families to treatment, we randomly selected one assignment among all 15 possible combinations of two-in-six[2].

By September 2017, there were 135 families and 279 children in the treatment group, and 138 families with 261 children in the control group (see Table 3.1). The average number of months since study intake until the end of the observation period was about 40 for children in control and 43 for children in treatment. On average, the families in the control group had 1.9 children, compared to 2.1 children per family in the treatment group. The children in control had spent an average of 119 days in foster care prior to intake into the program, while children in treatment had somewhat fewer days in care (115 days) prior to intake.

[2] This is calculated by the combinatorial $C_2^6 = 6!/(4!2!) = 15$

Table 3.1: Sequential randomization of families into PFS study groups

		Randomized into			
Monthly cohort	Months observed since intake	Control		Treatment	
		families	children	families	children
Jan-15	60	7	11	10	19
Feb-15	59	3	7	4	11
Mar-15	58	1	4	4	7
Apr-15	57	2	4	5	6
May-15	56	4	8	2	2
Jun-15	55	5	8	2	3
Jul-15	54	4	11	2	4
Aug-15	53	1	1	5	13
Sep-15	52	1	1	5	8
Oct-15	51	3	4	7	13
Nov-15	50	4	6	2	9
Jan-16	48	1	1	7	11
Feb-16	47	1	1	7	10
Apr-16	45	5	12	5	12
Jun-16	43	5	11	5	11
Aug-16	41	7	10	6	10
Sep-16	40	10	22	8	14
Nov-16	38	9	17	4	9
Dec-16	37	4	4	3	7
Feb-17	35	3	5	5	12
Mar-17	34	3	10	4	6
Apr-17	33	4	5	6	14
May-17	32	8	12	8	15
Jun-17	31	9	16	10	17
Jul-17	30	15	29	3	7
Aug-17	29	6	15	4	20
Sep-17	28	13	26	2	9
Total		138	261	135	279
Average months observed			39.9		42.9

Note: Cohorts are denoted by the month and year in which the families were enrolled for intake.

3.2 Supplemental Evaluation - 2019

The overall aim of the PFS supplemental evaluation was be to expand on the work of the 2015-2017 PFS Process Evaluation in examining factors that facilitate client success and explore client recidivism. The supplemental study was to inform a better understanding of the PFS experience and communicate the learning from the project to various stakeholders. Thus, the supplemental evaluation was focused on the following questions -

1. What factors facilitated treatment clients' "success" in reunifying?
2. What factors serve as barriers or lead to client recidivism/return to foster care?

The explanatory qualitative research reported here details the qualitative phase of a larger mixed methods study. In-depth interviews were employed to help explain the quantitative outcome findings from the PFS randomized controlled trial. Qualitative interviews were conducted with informants highly knowledgeable about the PFS project who could provide rich information about specific experiences within the project: reunification and recidivism (children who returned to OHP). Clients with these specific characteristics were selected, along with the FrontLine worker who had worked with them, and either their DCFS case worker or a supervisor who had sufficient knowledge of the case. Reunification was defined by a child who had been in out-of-home placement returning home to live with the caregiver from whom they were previously removed. Recidivated cases were defined by reunification occurring and the child or children subsequently returning to OHP. A social constructionist framework informed our approach, as we were interested in exploring shared and unshared perceptions of reality among clients, their FrontLine workers and their DCFS workers (Patton, 2015).

Purposeful stratified random sampling (Patton, 2015) was employed to select the sample. Because we were interested in speaking with individuals highly knowledgeable about PFS, and in particular, individuals who had experiences with recidivism and reunification, we selected cases that would provide us with rich information on such experiences. A list of treatment group clients was generated by CWRU programming staff stratifying clients by their status of having recidivated or reunified. We forwarded the list of potential client interviewees to FrontLine, and FrontLine staff contacted the clients to ask if they would be willing to participate in interviews and how they preferred the researchers contact them (by phone or email) to schedule interview times. FrontLine then forwarded the list of clients and their contact information to the research

team along with the name of the FrontLine worker who had worked with the client and the name of the client's DCFS worker. The researchers then contacted clients to schedule interviews.

Once client interviews had been scheduled and most client interviews had been conducted, FrontLine workers were contacted and their interviews were scheduled. We were interested in speaking with FrontLine and DCFS workers most knowledgeable about the clients' cases, however, many FrontLine and DCFS staff had left the agencies. Although we attempted to recruit former FrontLine staff to interview, only one former staff member agreed to be interviewed. We did not attempt to contact DCFS staff who had left their positions. Fortunately, supervisors of workers at both agencies remained or other workers had taken over clients' cases, so we were able to locate at least one knowledgeable FrontLine worker for all client cases, and in some cases, two workers–a caseworker and a therapist. In only one case were we unable to locate a DCFS worker knowledgeable of the client's case. Both DCFS and FrontLine worker interviews were scheduled with the help of agency supervisors who set aside a several-hour block of time for the interviews and schedule workers who were currently employed by the agency to be interviewed on that day. Although the block of time was set aside and workers were encouraged to attend, no coercion was involved; as part of the informed consent process, workers were informed that there would be no consequences if they did not participate, and their supervisors would neither be informed of their non-participation nor informed of their answers. No participants refused to participate.

A total of 36 individuals were interviewed between July and September of 2019. Sixteen interviewees were clients, five were FrontLine workers, and 15 were DCFS workers. All FrontLine workers and primary client interviewees were women, but one client's husband also participated. All but two DCFS workers were also women. Eight of the 16 clients were African American, 6 were white, and 2 were Hispanic.

Examining the data by reunification status (see Table 3.2), we see the clients were about 32 years old, with reunified clients being very slightly younger. Recidivated clients had more children than reunified clients. Among recidivated clients, more than two-thirds were African American, and one-third of reunified clients were African American. See Table 3.3 for the workers' demographic information. Seven of the clients interviewed had children who returned to out-of-home placement (i.e., recidivated), and nine had reunified.

Table 3.2 Interviewed Client Characteristics by Reunification Status (N=16)

	Recidivated (n=7)	Reunified (n=9)	Total (N=16)
Age (M(SD)), Median	32.0 (6.1), 31	31.4 (9.7), 28	31.7 (8.1), 30
Gender (% women)	100%	100%	100%
# kids (M(SD)), Median	5.3 (1.4), 6	3.1 (1.7), 2	4.1 (1.9)
Race			
African-American/Black	71.0%	33.0%	50%
White	14.2%	44.4%	31.25%
Hispanic	14.2%	22.2%	18.75%

Table 3.3 Interviewed Worker Demographic Characteristics (n=20)

	FL Workers (n=5)	DCFS Workers (n=15)	Total (N=20)
Age (M (SD))	34.0 (4.8)	40.3 (10.0)	38.8 (9.3)
Median	33	41	37.5
Gender (% women)	100%	93.3%	100%
Mean Time in Field (SD)	9.2 (6.6)	12.4 (9.0)	11.6 (8.5)
Median	8	11.5	11.6
Race (self-identified)			
African-American/Black	20.0%	60.0%	50.0%
White	80.0%	26.7%	40.0%
Hispanic	--	6.7%	5.0%
Multiracial	--	6.7%	5.0%

The client interviews focused on the clients' experiences, asking them to reflect on their experiences with PFS in general, and FrontLine and DCFS in particular. We asked that they walk us through the timeline of their experiences, describing their perceptions of the reasons for their child's/children's initial removal into OHP, how their cases progressed, and especially factors that they believed were responsible for their child's initial reunification and later return to OHP, if that was applicable to the case. Client interview questions included, "We understand that at one point while you were in the program, your child/children who were in foster care came back to live with you. In your opinion, what happened to make that possible?" In cases in which

children returned to OHP, we asked, “We also understand that one or more of your children ended up going back into foster care. How would you describe what happened? How do you think that could have been prevented or avoided?” Probe were added to this question as needed, for example, “Could your FrontLine worker have done anything? Could your DCFS worker have done anything? In your opinion, could anyone else have done anything to help prevent it?” Clients were also asked “How much would you say the program has helped you? How and how not?” Probes included, “What kinds of things has it helped you with?” and “Would you say you have any new skills because of the program? If so, what skills?”

FrontLine and DCFS staff interview guides focused on particular clients with whom they had worked (the clients we had interviewed), but we also asked them to share their experiences working with the program in general and their experiences working with staff from the other partnering agencies. Questions included, “We would like to start by asking you about your general reactions to and feelings about the program. First, what do you think the program did well, overall?” “In general, what have been some characteristics of cases that have had successful reunifications that have “stuck” or were ‘successful’?” “What are some characteristics of cases that have reunified but then the child returned to custody?” Questions that referred to specific aspects of the selected case included, “Now we would like to ask you about the specific experiences of a particular client, <name>, who reunified. Tell us a little bit about the basic characteristics of this client’s case. Based on your experience with this client, what factors do you think led to the client being able to reunify with his/her child/children? What factors served as major challenges and how were these resolved? In your opinion, what services best supported the client toward reunification? To what extent do you think the PFS program played a role in the reunification?” Similar questions were posed about cases for whom reunification was not maintained, asking for reasons it was not maintained. Finally, we asked staff to comment on the race findings that indicate higher rates of reunification for African American clients. We asked, “From this program, we have learned that African American families are more likely to reunify. Why do you think this might be? What factors, in your opinion, would particularly support African Americans to reunify?” The complete client and staff interview guides are available upon request.

Most client interviews (n=11, 69%) were conducted in clients’ homes. In four cases, we met in public libraries, and for one we met at FrontLine in an interview room. All but one of the

FrontLine worker interviews took place in a single office at FrontLine. The other FrontLine interview (with a former employee) took place in a private office at that worker's new place of work. DCFS interviews were conducted at two different DCFS offices, one on the east side and one on the west side of Cleveland. Interviews at both locations were conducted in a conference room at the offices. All but two DCFS interviews were conducted at the east side office. The study was approved by a university-based institutional review board, and all interviewees read and signed informed consent documents prior to beginning the interview (see Appendix for copies of these documents). Client and DCFS staff interviews lasted between 30 minutes and one hour, and FrontLine worker interviews lasted between 30 minutes and two hours. Clients received a $50 Target gift card as a token of appreciation for their time. No interview incentives were provided for workers. All interviews were recorded using a digital recording device and transferred to a professional transcriptionist for transcribing. Recorded interviews and transcripts were stored on a secure server.

The researchers worked collaboratively to interview each participant. One author was present at all interviews, and two authors conducted all client and FrontLine interviews. Interview analysis proceeded by members of the research team meeting on a weekly basis to read through each interview transcript individually, discussing what quotes significantly addressed the project's aims and provided rich details, and what themes we believed were being communicated within and across interviews. Because we had previously completed two other studies on this and similar populations, and we had specific questions to answer, we created a codebook using codes created in previous studies. We also employed inductive, open coding of specific, grounded quotes using participants' own words and perspectives (Patton, 1990).

Our codes related to key concepts related to the study, including current housing situations and feelings about housing, experiences with child welfare and FrontLine, and specific information on how FrontLine assisted them, with social supports broken down by support type (e.g., instrumental, material, social and emotional). The Appendix contains our complete list of codes and their definitions.

Qualitative data trustworthiness included techniques for establishing confirmability, including using investigator and data triangulation; multiple investigators were involved with the data collection and interpretation, and multiple (up to three) data sources (client, FrontLine worker, and DCFS worker) were consulted in gathering data. Confirmability was also established using an

audit trail, the maintenance of detailed and careful notes about our process. To enhance credibility, the findings from the preliminary analyses of the data were shared with the full research team to ensure perspectives and experiences of the partner organizations were represented with fidelity. Prolonged engagement was also established by the authors' long-term experience with the topic of study and P.I. Crampton's long history of research on and engagement with the child welfare agency. Credibility was also established by random sampling of the participants, examination of prior research related to the topic, an interview approach that put interviewees at ease and encouraged their open and honest sharing of their perspectives, and negative case analysis.

Human Research Subjects Protections and Data Security

The multiple research studies related to the PFS project were all reviewed and approved by the CWRU Institutional Review Board (IRB). The IRB approved all consent forms, data collection procedures and data storage protocols. All of the data files associated with the study were treated in a highly confidential manner. Data were individually identifiable to permit linkage across data systems. Electronic files were stored on a secure research server. Data management and analysis personnel were trained in procedures for handling confidential data and only authorized researchers had access to the study's files. Research reports and publications regarding the study's data contain aggregate statistics and no identifiable information appears in published reports.

4. Findings

4.1.Impact evaluation

4.1.1. Baseline Comparison of Study Groups

To ensure that randomization was successful, the two study groups were compared at study baseline based on available characteristics. As illustrated previously in the methods section, the sequential nature of family qualification and entry into the program makes the data right censored, meaning with some children still in OHP, the full length of their OHP stay is not observed. The window of observation of children's OHP days varied considerably. Children entering at the beginning of 2015 could be observed for almost five years or 60 months, while those entering at the end of 2017 were observed for a little over two years (28 months).

Furthermore, the level of censoring varied across treatment and control groups since it was not possible to allocate the same number of children across treatment and control groups within each cohort. On average, children in the control group were observed for 40 months, while those in treatment were observed for 43 months. Thus, any comparisons between treatment and control outcomes influenced by time of observation should be interpreted with caution when not explicitly accounting for censoring.

Table 4.1a shows that children of families assigned to the treatment and control arms of the program were well balanced on main demographic characteristics. About half of the children were male within each group. In the treatment (control) group 76% (69%) of children were African-American. The treatment group had somewhat older children (6 years old mean) at entry into custody compared to the control group (5.3 years old mean).

Table 4.1b shows that families and primary caregivers enrolled in the study. The primary caregiver is the individual who had custody of the child(ren) prior to the removal by DCFS. Families had about two children on average in each group, and a little under a quarter of primary caregivers had a record of DCFS contact as a child. The rate of primary caregivers with homelessness records (i.e., appear in HMIS) in Cuyahoga County prior to PFS intake was 67% in treatment and 64% in control.

Table 4.1a. Summary statistics of children by study group

	Control	**Treatment**	**T-test Diff**
CHILD	Mean (std dev)	Mean (std dev)	p-value
Female	0.48	0.51	0.52
	(0.5)	(0.5)	
African-American/Black	0.69	0.76	0.1
	(0.46)	(0.43)	
White	0.28	0.23	0.18
	(0.45)	(0.42)	
Race other/unknown	0.03	0.01	0.31
	(0.16)	(0.12)	
Age at intake (years)	5.59	6.33	0.08
	(4.94)	(4.92)	
Age at custody (years)	**5.26**	**6.02**	**0.07**
	(4.93)	(4.89)	
Age at custody (<5 years old)	**0.58**	**0.49**	**0.03**
	(0.49)	(0.5)	
Age at custody (5 -16 years old)	**0.39**	**0.48**	**0.05**
	(0.49)	(0.5)	
Age at custody (>16 years old)	0.03	0.04	0.55
	(0.16)	(0.19)	
Number of children	261	279	540

Table 4.1b. Summary statistics of families by study group

FAMILIES	**Control**	**Treatment**	**T-test Diff**
	Mean (std dev)	Mean (std dev)	p-value
Mean number of children	1.89	2.07	
	(1.16)	(1.48)	0.26
Caregiver's race is African-American/Black (%)	0.67	0.71	
	(0.47)	(0.45)	0.43
Caregiver's race is white	0.33	0.28	
	(0.47)	(0.45)	0.36
Caregiver's race unknown	0	0.01	
	0	(0.09)	0.31
Caregiver in custody as child (2 missing in C)	0.24	0.23	
	(0.43)	(0.42)	0.8
Caregiver used homeless services pre-intake	0.64	0.67	
	(0.48)	(0.47)	0.53
Caregiver is biological mother	0.88	0.95	
	(0.32)	(0.22)	0.06
Number of families	138	135	273

Noting that randomization was performed at the family level, we further check for balance across treatment groups in the child sample by estimating a linear probability model of treatment assignment at the child level. See Table 4.2.

Table 4.2 Regression Models for treatment assignment at the child level with standard errors clustered by family

Dependent variable: child assigned to treatment		
Covariates	Mod1: All covariates	Mod2: All observations
	coefficient/sd error	coefficient/sd error
Number children	0.0495**	0.0478*
	0.0249	0.0243
OHP days custody to intake	-0.0348	-0.0167
	0.107	0.106
Primary caregiver - used homeless services	-0.0115	-0.0175
	0.0754	0.0751
Primary caregiver - in custody as child	-0.0311	.
	0.0878	.
Male	-0.0326	-0.0288
	0.0416	0.0421
African-American/Black	0.0240	0.0102
	0.0730	0.0722
Race other/unknown	-0.136	-0.140
	0.205	0.207
Age at custody (5 -16 years old)	0.0640	0.0516
	0.0558	0.0560
Age at custody (>16 years old)	0.138	0.138
	0.125	0.125
Intake year = 2016	-0.0514	-0.0504
	0.0939	0.0939
Intake year = 2017	-0.120	-0.140
	0.0864	0.0860
Constant	0.442***	0.451***
	0.116	0.115
Observations	533	540
R-squared	0.051	0.047

Note: Since custody as a child cannot be determined for two caregivers, 7 children are excluded from Mod1. Sd error clustered by Case_ID; *p<.05; **p<.01; ***p<.001

We consider the following covariates: gender, race, age at entry to OHP, sibling size, flags for caregiver's contact with HMIS, and PFS intake year. In Mod1 we include a flag for caregiver being in custody as a child. Since this information is missing for two caregivers in the control group, who are jointly associated with seven children, we lose seven observations. So Mod2 omits this variable in order to include all observations. We also cluster standard errors by case number to account for children in the same family. Estimates confirm that our child-level samples are well balanced over most covariates, although having more children in the family is positively correlated with belonging to the treatment group.

4.1.2. Monitoring Metrics

Though the overall evaluation was designed to be based on a model conducted at the conclusion of the five years, several monitoring metrics were used for the purpose of routine reporting. Initially the monitoring focused on the difference in average mean OHP days between the two study groups. This calculation compared the unadjusted days between groups based on the onset of each child's OHP experience prior to study entry up to the date of exit (if applicable). If a child recidivated into care, these days were also added to the calculation. This measure - difference in total days between treatment and control groups divided by control group days - was labeled M1. As time passed, two additional monitoring metrics were added to better represent the varying lengths of time that had elapsed since cases had entered the study. M2 was calculated as the average percentage difference in OHP days between treatment and control groups across referral cohorts. Similarly, M3 was calculated as the difference in mean OHP days between treatment and control groups, across referral cohorts, divided by control group days.

Figure 4.1 depicts the calculation of the three monitoring metrics over the twenty quarters of the study period. Bars below the intercept convey that the treatment group showed shorter OHP days than the control group, whereas bars above the line convey shorter OHP days in the control group. The pattern shows that based on M1 the treatment group initially had fewer average days in care up until quarter 8, after which the control group had shorter average lengths. The M2 and M3 metrics, which better accounted for the varying lengths of time in the study, continued to favor the treatment group until quarter 11 (M2) and quarter 16 (M3), after which all measures suggested shorter OHP lengths in the control group.

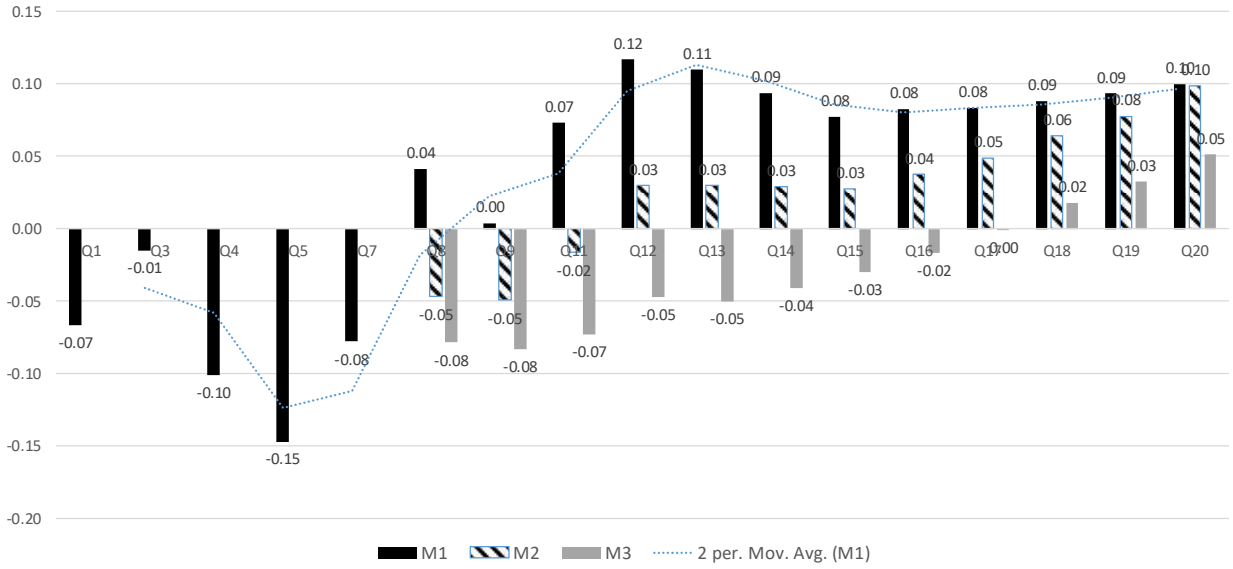


Figure 4.1: PFS Monitoring Metrics by Quarter

Additional monitoring metrics were employed over the course of the project. These included a detailed set of programmatic reporting counts and throughputs, as well as OHP exit types and reentry into care.

4.1.3. Patterns of Out-of-Home Placement and Recidivism

Table 4.3 displays tabulations for end of custody (exit from OHP) and recidivism for each treatment cohort. The tabulations are presented by year of intake into the program (2015-2017) and for the entire sample (Total). Overall, we see that 86% of children were observed to ever exit OHP and these rates were equal for the treatment and control groups. We also find that 22% of children in control are currently in custody (current exit rate is 78%), and 28% of children in treatment are still in custody (current exit rate is 72%). However, since children in treatment are observed on average for three more months than those in the control, these rates are not readily comparable.

However, we can compare statistics based on criteria that all children meet, regardless of their intake month. For instance, since we observe all children for at least 28 months, we compare the rate of exit by two years since intake, or "two-year exit." Children in the treatment group have a two-year exit rate of 78%, compared to 75% for children in control.

While children in treatment had a higher rate of ever exiting care than those in control, they also exhibited a higher rate of recidivism, leading ultimately to a higher rate of children in treatment

currently in care (current exit rate lower in treatment). When ignoring censoring, we see that recidivism for children in the treatment group is about twice the rate in the control group. That is, 27% of children that ever exited OHP in the treatment group returned to custody, versus 14% for the control group.

Focusing on early recidivisms - those that occurred within a year of exit - allows us to remove censoring issues and compare outcomes on equal grounds. Thus, we restricted our sample to children who exited at least a year before the end of the observation period and counted how many children returned to care within a year from exit. That left us with a restricted sample consisting of 197 children in control and 214 children in treatment. Here, we see that early recidivism was five times more likely in the treatment than in the control group (4% in control versus 20% in treatment). Recidivism was consistently much higher in treatment as compared with control, across all year cohorts and whether we use the censored measure or the early, uncensored measure of recidivism.

Table 4.3. Censored (marked by *) and censored-adjusted measures for the rates of exit from OHP, recidivism and OHP days by study group and year of intake

	Full Sample		2015 intake		2016 intake		2017 intake	
	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment
Ever exit rate*	86%	86%	98%	87%	95%	88%	74%	84%
Ever exit count*	225	241	64	83	74	74	87	84
Current exit rate*	78%	72%	88%	68%	87%	79%	67%	71%
Current exit count*	204	202	57	65	68	66	79	71
Recidivism rate among exits*	14%	27%	16%	33%	15%	24%	11%	25%
Recidivism count*	31	66	10	27	11	18	10	21
Ever exit by 2 years since intake	75%	78%	71%	76%	81%	79%	73%	79%
Ever exit by 2 years - count	195	217	46	72	63	67	86	79
Recidivism in 1 year since exit	4%	20%	0%	15%	4%	20%	5%	26%
Recidivism in 1 year -count	7	42	0	12	3	14	4	16
OHP days from intake to current - mean	547.92	628.48	665.86	768.56	518.14	565.74	502.64	548.11
OHP days from intake to current - total	143,008	175,346	43,281	73,013	40,415	47,522	59,312	54,811
OHP days from custody to current- mean	666.48	743.86	816.03	912.75	609.88	635.75	621.5	674.24
OHP days from custody to current- total	173,950	207,538	53,042	86,711	47,571	53,403	73,337	67,424

A more formal approach to comparing recidivism rates across treatment and control is to model a process for all children that ever exited care, where the event of interest is their first recidivism. This is also a censored process where children exit care at different times in the period of study and they were only observed to the end of 2019. We used a Cox Regression model to account for censoring. See Table 4.4.

Table 4.4. Cox regression models for recidivism among all children who exited care

Cox Regression Model for Recidivism among Exits		
	Basic specification	With interaction
VARIABLES	Hazard ratio/ (std error)	Hazard ratio/ (std error)
Treatment	2.034**	
	(0.658)	
Treatment - children of AA/black caregivers		1.971*
		(0.767)
Treatment - children of white caregivers		2.197
		(1.294)
Number of children	1.184*	1.185*
	(0.104)	(0.105)
OHP days custody to intake	0.999	0.999
	(0.00154)	(0.00156)
Primary caregiver - used homeless services	1.252	1.257
	(0.435)	(0.435)
Gender of child is male	1.040	1.044
	(0.241)	(0.241)
Race of primary caregiver is African-American/Black	0.841	0.896
	(0.327)	(0.465)
Age at custody	0.952	0.952*
	(0.0284)	(0.0281)
Intake year = 2016	0.879	0.873
	(0.340)	(0.344)
Intake year = 2017	1.248	1.239
	(0.494)	(0.500)
Observations	462	462

Note: Standard error clustered by Case_ID; *p<.05; **p<.01; ***p<.001

In column 1 of Table 4.4, we display the estimated hazard rates for recidivism among 463 children of African-American/Black and white primary caregivers that ever experienced an exit out of custody.

We found that children in the treatment group had double the risk of experiencing recidivism than children in the control group. We also found that children of a larger sibling group were at higher risk of experiencing recidivism and older children were somewhat less likely to recidivate.

In column 2, we performed a similar analysis, but this time, we allowed treatment to affect recidivism differently for children of African-American/black versus white caregivers. Here again, children in treatment had about double the risk of experiencing recidivism upon exit, but this effect was only significant for children of African-American/black caregivers.

4.1.4. Time in OHP and Probability of Exiting OHP

As specified by the PFS contract, the main estimates of average treatment effects are based on the time in custody spent by children of families that entered the study. Even when the intervention had no influence on OHP time prior to intake, the contract specified that outcomes would be compared across treatment groups including days in OHP that the child had accrued during the spell in which the family signed up for participation. However, all subsequent analyses were also performed considering time in custody since intake only, resulting in no substantially different findings.

Figure 4.2 shows the empirical survival curves for treatment and control groups and Table 4.5 provides select data points of this curve for reference. In the context of the study, for any value in the x-axis, this curve plots in the y-axis the probability of remaining in custody for at least x days. If children exited care and were observed to reenter custody during the study, we added the OHP time across multiple spells. If the child continued to be under care at the end of the study, we counted their time as censored, regardless of the number of spells the child had experienced.

At the start of custody – day 0 - all 100% children were in custody. We see that 79% of children in control and 80% of children in treatment were in custody for at least 365 days or one year. Over time, the probability of remaining in custody was somewhat larger for children in treatment, however differences are not statistically significant at the 10% level.

Table 4.5. Estimated probability of remaining in custody by study group

Days after custody entry (x)	Control	Treatment
0	100%	100%
365	79%	81%
730	39%	43%
1095	26%	28%
1460	13%	25%

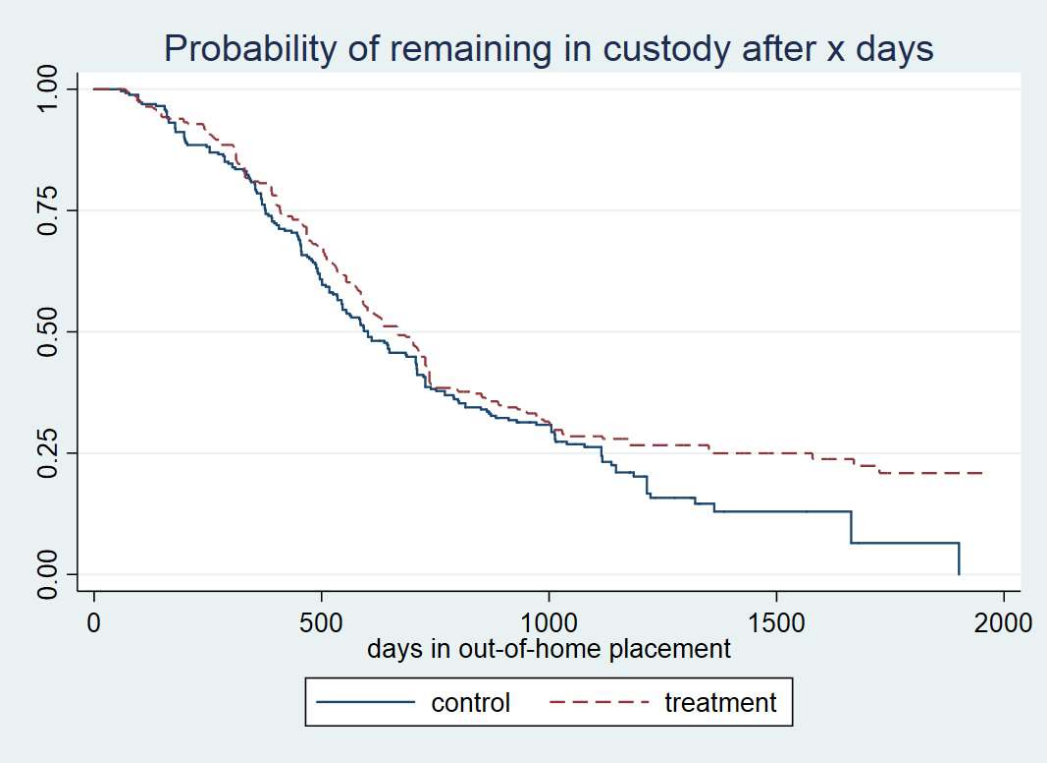


Figure 4.2. Kaplan-Meier empirical curve for the probability of remaining in out-of-home placement for at least x days

We complemented this empirical analysis by estimating a Cox proportional hazards model for the probability of exiting custody, controlling for our selected covariates. See Table 4.6. Here, we use the race of the child as covariate rather than the race of the caregiver, but results were virtually unchanged with either specification. The high level of collinearity between these covariates prevented us from including both.

We found that children in treatment had a lower rate of exiting custody relative to children in the control group, although this difference was statistically indistinguishable from zero. Having more children and having had a longer spell in OHP before intake into the program decreased the chance of exiting custody, and these effects were statistically significant. No other covariates appeared to influence the risk of exiting custody, but current exits seemed to be higher among children that entered the program in 2016 relative to those in 2015.

In a model not shown here, we allowed for potential differing effects by caregiver's race as with the recidivism model and found no significant effect of treatment on exit from custody for either group.

Table 4.6. Cox proportional hazards regression model for probability of ending custody

Cox Survival Regression model	Hazard ratio/ (std error)
Treatment	0.858
	(0.127)
Number children	0.873***
	(0.0388)
OHP days custody to intake	0.999**
	(0.000578)
Primary caregiver - used homeless services	0.955
	(0.156)
Male	1.003
	(0.104)
African-American/Black	0.928
	(0.160)
Race other/unknown	1.101
	(0.758)
Age entering custody	1.013
	(0.0133)
Intake year = 2016	1.498**
	(0.274)
Intake year = 2017	1.237
	(0.231)
Observations	540

Note: Standard error clustered by Case_ID; *p<.05; **p<.01; ***p<.001

4.1.5. Estimation of Treatment Effect

Our estimates of average treatment effects account for the censored nature of the data and controlled for the aforementioned covariates. The model specifies a treatment selection equation and an outcome equation to produce inverse-probability-weighted regression adjustment estimators of treatment effects on OHP-time using STATA's stteffects ipwra module. As before, standard errors were clustered by family. See Table 4.7.

Censoring was handled through the log-likelihood function for outcome. Intuitively, this means that we seek parameter estimates that maximize the likelihood of obtaining such level of censoring in the data along with the non-censored data points observed. In that sense, this method is more formal than imputation, which uses non-experimental data to assign ad-hoc

values to data points that are missing due to censoring. Using imputed values would prevent us from calculating meaningful standard errors around the average treatment effect estimates.

Table 4.7. Average treatment effect estimates for days in OHP

Survival treatment-effects estimation Number of obs = 540
Estimator : IPW regression adjustment
Outcome model : Weibull
Treatment model: logit
Censoring model: none
(Std. Err. adjusted for 272 clusters in Case_ID)

_t	Coef.	Robust Std. Err.	z	P>|z|	[95% Conf.	Interval]
ATE						
treatment (1 vs 0)	103.4716	98.84823	1.05	0.295	-90.26736	297.2106
POmean						
treatment 0	791.416	60.78886	13.02	0.000	672.272	910.56

Survival treatment-effects estimation Number of obs = 540
Estimator : IPW regression adjustment
Outcome model : Weibull
Treatment model: logit
Censoring model: none
(Std. Err. adjusted for 272 clusters in Case_ID)

_t	Coef.	Robust Std. Err.	z	P>|z|	[95% Conf.	Interval]
ATE						
treatment (1 vs 0)	69.10924	96.99197	0.71	0.476	-120.9915	259.21
POmean						
treatment 0	801.5941	65.16351	12.30	0.000	673.8759	929.3122

Consistent with our Cox regression results, we found no evidence of treatment effects. The average number of days in custody for children in the control group was estimated to be 791 days in a model that only accounts for number of siblings and custody days prior to intake (ATEE1). In a model that accounts for all our selected covariates, estimated time for control is 801 days (ATEE2). While children in the treatment group would seem to accumulate on average

more days than control in both models, these estimates are not statistically significant, so that the average treatment effect is indistinguishable from null.

It is worth noting that the raw descriptive statistics of time in custody for children in control who entered the program was 667 days (Table 4.3). This calculation ignores censoring and was much lower than our estimates of 801 days (Table 4.7). However, if we calculate a raw average across all children in control who entered the program in 2015, we reduce censoring and obtain a value of 816 days, much more in line with our model estimates.

4.1.6. Statement on Success Payment Calculation

Relying on our modeling of the length of OHP days, we conclude that based on point estimates children in the PFS treatment group will spend 69 more days in care as compared to the children in the PFS control group (8.6% longer stays in OHP). When statistical testing was applied, however, the result was not statistically significant. This leads us to conclude that the average OHP stays in the two groups are not different from each other in a statistical sense.

	Control	Treatment	% Difference
Total Days in OHP	802	871	+8.6%

Total Out-of- Home Placement Days Avoided per Child Served = 0

As described in the PFS contract and in the program's evaluation plan (Appendix A of the contract), the Success Payment shall be equal to the greater of (a) $0 and (b) "Total Out-of-Home" Placement Days Avoided" multiplied by $75.00. Given this, the Success Payment due is $0.

4.1.7. Likelihood to Exit to Reunification

Though the main outcome of interest for potential contract payments was OHP time, we explored other outcomes that may influence child and family well-being in the long term. We explored differences in treatment and control outcomes by type of exit. In particular, we were interested in the rate of reunification with the primary caregiver.

Table 4.8 compares exit types for children that were currently not in custody across control and treatment groups. As derived from Table 3, 28% of children in treatment (n=77) and 22% of children in control (n=57) were still in custody at the end of the observation period. Among those that were exited from custody on December 31, 2019, 59% of children had reunified in the treatment group, while 47% had reunified in the control group.

Table 4.8. Exit types by treatment and control groups among children that were not in custody at the end of the observation period

	Control		Treatment	
	Freq.	**Percent**	**Freq.**	**Percent**
Adoption	22	10.78	9	4.43
Non Removal Parent	13	6.37	15	7.39
Non Relative – legal custody	5	2.45	9	4.43
Other	7	3.43	11	5.42
Relative – legal custody	61	29.9	40	19.7
Reunification	96	47.06	119	58.62
Total	204	100	203	100

This gap in reunification between children in treatment and control widens when focusing only on children of African-American caregivers. In that case, as we see in Table 4.9, 62% of exits in treatment were reunifications, versus 44% in the control group. For children of white caregivers, the trend reverses as 46% of exits are reunifications in treatment versus 55% in the control group.

Table 4.9. Exit types by caregiver's race for treatment and control groups; African-American and white only - Exits among children that were not in custody at the end of the observation period

	Control		Treatment	
	African-American caregiver	White caregiver	African-American caregiver	White caregiver
Last exit (N/col %)				
Adoption	15	7	2	7
	10.27	12.07	1.33	14.58
Non Removal Parent	9	4	13	1
	6.16	6.9	8.67	2.08
Non Relative – legal custody	5	0	4	4
	3.42	0	2.67	8.33
Other	7	0	9	2
	4.79	0	6	4.17
Relative – legal custody	46	15	28	12
	31.51	25.86	18.67	25
Reunification	64	32	94	22
	43.84	55.17	62.67	45.83
Total	146	58	150	48
	100	100	100	100

In order to control for our standard covariates, we present a regression model for reunifications among all exits of children of African-American and white caregivers. We specify the model with an interaction term in order to estimate possible differences in treatment effect by race. Table 4.10 presents the model estimation, confirming that children of African-American caregivers in treatment who exited care were more likely to be reunified than their counterparts in control.

Table 4.10. Standard regression model for reunification among all current exits - Children of African-American and white caregivers only

Dep variable: exit to reunification	
VARIABLES	Coefficient/ (std error)
Treatment - children of African-American/Black caregivers	0.177**
	(0.0850)
Treatment - children of white caregivers	-0.0727
	(0.138)
Number children	0.0293
	(0.0243)
OHP days custody to intake	-0.000173
	(0.000274)
Primary caregiver - used homeless services	-0.0834
	(0.0793)
Male	0.0406
	(0.0488)
Caregiver's race is African-American/Black	-0.0941
	(0.111)
Age at custody	-0.00532
	(0.00591)
Intake year = 2016	0.0260
	(0.0926)
Intake year = 2017	0.134
	(0.0865)
Constant	0.489***
	0.132
Observations	402
R-squared	0.066

Note: SE clustered by Case_ID; *p<.05; **p<.01; ***p<.001

It is important to note that this analysis conditions on a censored variable: exit from custody, without adjusting for censoring. An alternative approach is to model reunifications as a desired exit type, "competing" with other types of exit, and including children still in care. This is done using what is called a competing risks model (Fine and Gray, 1999). The estimated model suggests that children of African-American caregivers in treatment have a 30% higher chance of reunification, relative to their counterparts in control. However, this estimate is noisy and not

statistically significant. Here again, we see a clear difference by race of caregiver. Children of white caregivers clearly do not have higher chances of reunification under treatment.

Table 4.11. Model for the probability of exiting custody to reunify versus other possible exits - Children of African-American and white caregivers only

Competing Risks Model for Reunification	
	Hazard ratio/ (std error)
Treatment - children of African-American/Black caregivers	1.328
	(0.326)
Treatment - children of white caregivers	0.879
	(0.368)
Number children	0.979
	(0.0588)
OHP days custody to intake	0.999
	(0.000841)
Primary caregiver - used homeless services	0.762
	(0.174)
Male	1.158
	(0.165)
Caregiver's race is African-American/Black	0.859
	(0.289)
Age at custody	0.999
	(0.0179)
Intake year = 2016	1.240
	(0.367)
Intake year = 2017	1.274
	(0.326)
Observations	536

Note: Standard Error clustered by Case_ID; *p<.05; **p<.01; ***p<.001

So focusing on children of African-American caregivers, we provide a visual representation of reunification probabilities that account for censoring (Figure 4.3). Using the estimated competing risks model, we set race of caregiver to African-American/black and set all other covariates at their mean. The derived curves compare estimated incidence of reunification under treatment and control (Coviello and Boggess, 2004).

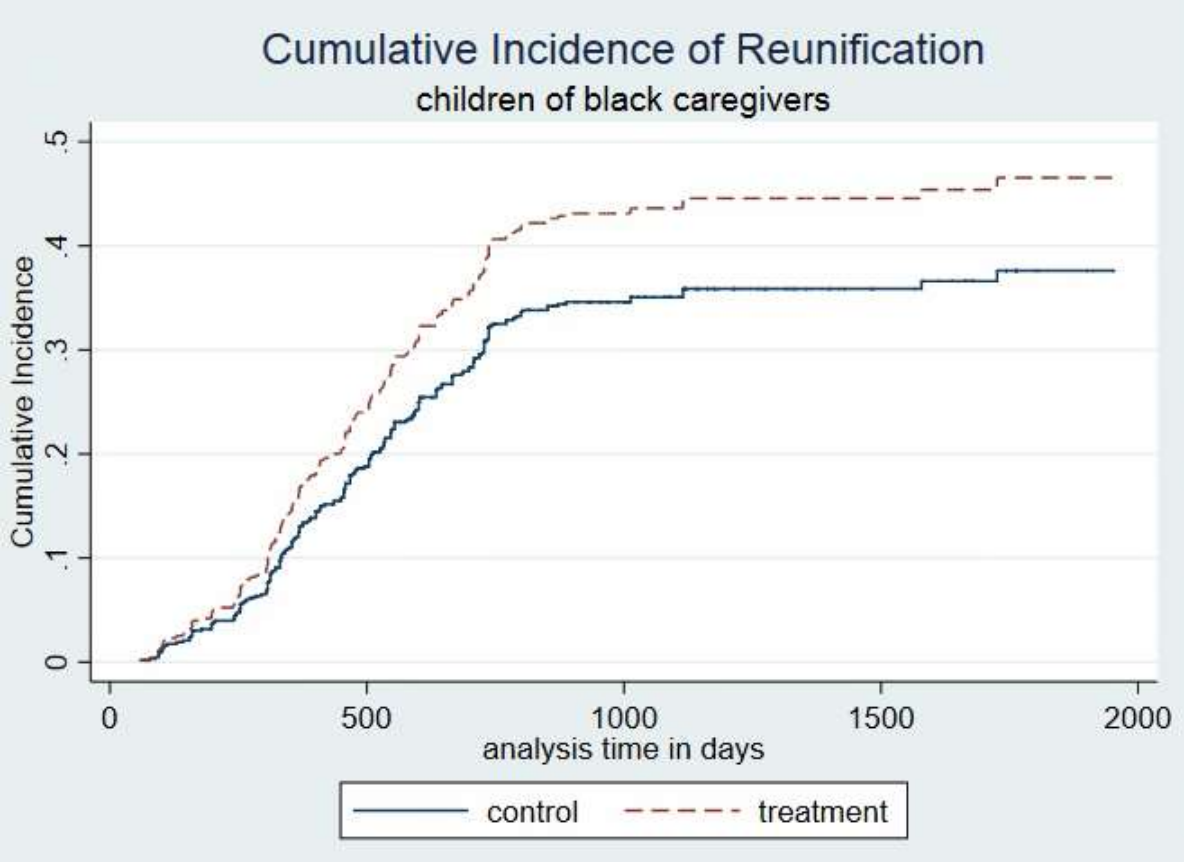


Figure 4.3. Cumulative Incidence of Reunification by treatment group – Children of African-American/Black caregivers.

Based on the results from these multiple approaches, we think the data strongly suggest that children of African-American caregivers are more likely to reunify if receiving treatment services rather than the standard services (control).

4.18. Discussion

Based on the core findings of the impact analysis, we offer the following discussion of two key issues.

Why no reduction in length of stay?

Given the focus of the project on reducing days in care as the sole payable metric, the ultimate no reduction finding between groups should be discussed. With this metric the sole focus was on children exiting care quickly, with no explicit focus on how they exited. That is, whether a child exited to reunification, adoption, or legal custody was not a primary consideration under the payable metric. However, in practice and by policy, all cases begin with

consideration of reunification as the most preferred outcome if this can provide a safe and permanent option for the child. Throughout the process, DCFS staff engage in concurrent planning, meaning they are examining and pursuing all possible alternative solutions for the child's exit from care. The DCFS caseworker is in communication with other relevant parties in this process, such as a Guardian Ad Litem (GAL) and Court Appointed Special Advocate (CASA) when these are assigned by the court. If reunification becomes a nonviable option, DCFS then changes the case plan to an alternative exit option.

With the PFS project, an additional staff person was now involved in the case process. This individual was assigned to work with the caregiver on resolving their housing instability and providing a variety of other supports. As an advocate for the caregiver, this individual supported them in making progress on their DCFS case plan and responding to other court-specified objectives. As such, the evidence suggests that on the margin the intervention allowed some caregivers to make sufficient progress on their case plans, such that a goal of reunification could be maintained. In fact, 59% of children in treatment were initially reunified with their caregivers compared to 45% in the control group. This served, in fact, to lengthen some children's stays in care as reunification was pursued. Had reunification not remained a viable option, some cases would have proceeded to an alternative exit outcome, such as legal custody or adoption.

An additional factor in the calculation of days in care is the extent to which children re-entered care after an exit. When a child returned to care after an exit, these additional days were counted in the total length of stay. Over the course of the study, children in the PFS treatment group experienced a recidivism rate approximately twice as high as children in the control group (27% versus 14%). Recidivism is a serious concern as it suggests that the circumstances of the case changed sufficiently that DCFS had to re-take custody of a child due to concerns about the child's well-being.

There are at least two aspects to explaining the higher recidivism rate among children in the PFS treatment group. First, as a rule most child recidivisms within DCFS occur from an exit to reunification. These are cases where prior circumstances led to the initial removal of the child, so the families are known to have ongoing challenges they are addressing and these could re-emerge as issues. By contrast, exits to legal custody and adoption are less likely to recidivate.

Given that the PFS treatment led to more child reunifications than resulted from usual services, a somewhat higher recidivism would be expected among the treatment group. However, this cannot fully explain the patterns we see, as the rate of recidivism from reunifications alone is also higher for families in treatment relative to control. Furthermore, about half of current exits after a return from reunification in the treatment group are to caregivers other than the removal parent, while this only occurs in 11% of cases in control. This raises the question of whether reunification in the PFS treatment occurred too broadly initially (primarily in the first year of the program), leading to a recidivism event. This is not measured in the present study. What is known is that in every case that reunified there was a determination by DCFS and agreement by the court that the child could be safely reunified with the caregiver. It is clear that the active involvement of the caregiver with the PFS treatment would both assist in achieving the necessary case goals and provide an additional valuable perspective on the caregiver's situation. However, when caregivers experienced a reemergence of concerns such as mental health, substance use, or domestic violence, circumstances had to be re-assessed.

Why is reunification increased for African-American families?

The important finding related to race and reunification is salient, especially given that the PFS intervention was not particularly designed to be culturally tailored. Yet, African-American caregivers receiving the PFS treatment were 30% more likely to have their children exit to reunification as compared to African-Americans receiving usual services.

In considering this finding the context is important. In the general DCFS population, African-American families are more likely to reunify than whites (58% vs 46% among exiters). However, this reflects the experience of all families regardless of their housing instability. Among housing unstable African-American families (that is, the PFS control group), the reunification rate is lower. In the PFS treatment group, among African-American families whose child had exited care reunification rates were markedly higher than for African-Americans in the control group (69% vs 55%), suggesting that PFS services are particularly well-targeted to address the needs of these families.

Though there is no definitive way of knowing why African-American families experienced reunification at a greater rate due to the PFS treatment, there are likely several pathways to this outcome. First, the involvement of FrontLine Srevices staff is seen to result in

more effective advocacy for African-American families in maintaining a DCFS case plan of reunification. Through this advocacy and support, caregivers were able to make better progress on their DCFS case plans and stay on track to reunification. Second, it is likely that African-American caregivers were more responsive to the treatment due to being served within a context wherein they felt that the odds of getting their children back were low. This sense of hopefulness for caregivers is a powerful asset to maintaining progress on a case plan and stabilizing their home and personal situations. Finally, we must consider that the treatment, through its emphasis on advocacy and client empowerment, was also more successful in helping these caregivers overcome the effects of racial discrimination in the housing market, which could have further aided them in maintaining stability.

Did the context in which PFS operated change over time?

As a five-year project, PFS was designed based on information about the child welfare context available during the design phase. A primary data source involved information on a 2010 cohort of DCFS-involved families with past housing instability. This provided estimates of the number of days children from these families spent in OHP. With the project launch in 2015, a reasonable question is whether the outcomes for similar families served by DCFS changed over the course of the study.

To examine this, we compared exit rates in PFS with those for a cohort of children who entered DCFS in 2010 and whose data served to design the program. The cohort was divided by whether the caregiver had or did not have contact with homeless services in a six-month window prior to the child entering DCFS custody. The 2010 data showed that children of families with homeless services that entered care exited at a lower rate than those without signs of homelessness in the data. By two years, 33% of children in the housing unstable group remained in custody compared to 53% in the non-housing unstable group. See Table 4.12.

Table 4.12. In-custody rates comparison w 2010 DCFS cohort -observed for 5 years

	2010 DCFS Cohort		PFS Study	
Years in custody	Not homeless	Homeless	Control	Treatment
0	100%	100%	100%	100%
1	65%	70%	79%	81%
2	33%	53%	39%	43%
3	22%	34%	26%	28%
4	13%	23%	13%	25%
5	7%	13%	6%	20%

Assuming similar patterns of services, clients, and contexts in 2015, we would expect children in the PFS control group to have exit rates similar to the 2010 cohort with homeless services. However, we see that our PFS control group exited at a faster rate, more closely resembling the exit patterns of the 2010 cohort without homeless services. See Figure 4.4. For example, at the three-year point 34% of the 2010 homeless group remained in custody, whereas only 26% of the PFS control group did so. This suggests that the rate of children exiting care generally improved during the time-frame of the study.

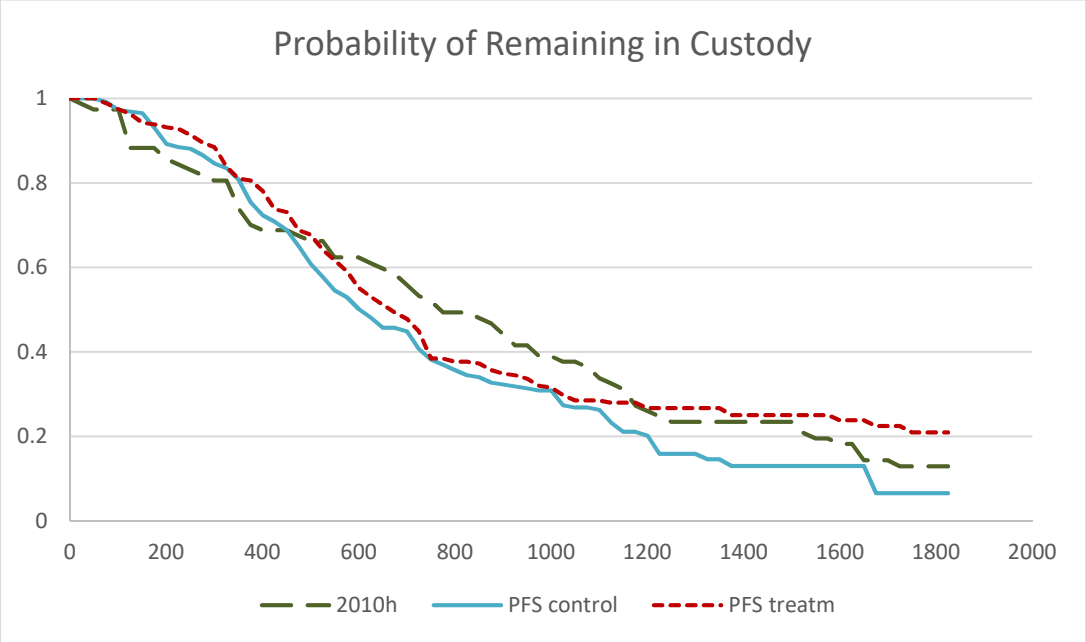


Figure 4.4. Probability of Remaining in Custody – 2010 DCFS homeless sample vs. PFS Study Groups

4.2. Supplemental Evaluation - 2019

The supplemental evaluation drew on rich interview data from caregivers (clients), Division of Children and Family Services (DCFS) staff, and Frontline Service (Frontline) staff. This section presents the response themes identified though these structured interviews.

Program Purpose & Referral Sources

Asked what they though the purpose of the program was, clients gave a number of answers, but they included having someone to show you how to do things, advocacy, having a counselor or friend, help with court, that the program was intended to help people get stability, keep family together, guide people through difficult times, someone to talk to, and someone to connect you with the community. Five clients reported being referred through emergency shelter staff, five through DCFS, and five through an unspecified "caseworker." Although the clients were asked to expand on who the "caseworker" was, the clients were not clear on who the caseworker represented, which was common among these clients who were served by multiple agencies; they did not always distinguish between them. That said, they were clear on who FrontLine and DCFS were and what roles they played.

Reasons for Child's Initial Removal

Asked about reasons for the child's initial removal, some clients acknowledged their individual challenges, such as domestic violence, unstable housing, substance abuse, child abuse and neglect, and mental health issues. Other clients claimed that they were not sure why DCFS removed their children, and they blamed the DCFS or family members/friends who called DCFS for losing the custody of their children. One client said, "they were taken from the hospital. They didn't even have to do that because there wasn't nothing wrong with my kids, or anything like that. They did that because of a prior case that I had." (CL12) Several clients said their children were taken because of past history with DCFS, "hearsay," or the accusations of vindictive family members. Some clients did not admit to substance abuse or domestic violence issues in the interview as a reason for initial removal, but such reasons were stated in interviews with FrontLine and DCFS workers. In three cases the parent explicitly said housing instability was the primary reason the children had been removed.

Factors Identified as Supporting Reunification (9 Clients)

Overwhelmingly, clients and DCFS workers credited FrontLine for providing extensive social support and advocacy for clients in navigating the welfare system and the courts, and accessing community resources in support of their stability. For some clients, additional familial and community social support was identified as critical to their maintained reunification, but FrontLine's involvement was seen as critical for achieving reunification. Client readiness for change was also identified as important, but FrontLine's assistance was seen as a factor that gave clients hope that their lives could be different and that reunifying with their children was a real possibility. FrontLine's advocacy, support (social support, including emotional, instrumental, and informational support), gave them the tools and resources to move forward.

System Actors. DCFS and public defenders were identified by FrontLine workers as important system actors in supporting reunification. One FrontLine worker said she felt that the DCFS worker is the most important factor.

> I think the [DCFS] worker is probably the number one characteristic of cases that have been successful, a worker who is willing to work with the head of household, recognizing that keeping the humanity in the work and realizing that they're humans too and they're trying to do a really hard job of raising a little person, or little people in this world, and they maybe didn't have that example.…Being willing to do that piece really shows the family that "Your worker is invested in you," and there are a lot of really good workers who I have come across. (FL2)

Another FrontLine worker emphasized the positive experiences she had with public defenders. "Some of them are really, really great and really passionate and really skilled, and that's where I find the people who are just as fierce advocates for my clients as I am." (FL2)

External Supports. Clients described having support outside of FrontLine that had been important to their reunification. These included having a supportive spouse, neighbors or neighborhood, parents, siblings, grandparents, and having a sponsor and being part of a 12-step program. Other external resources clients mentioned using included job programs, food banks and food pantries, Beech Brook for counseling, parenting program, DCFS' Neighborhood Collaboratives (Lakewood mentioned specifically), Defending Childhood, Recovery Resources, EDEN, furniture banks, Percentage of Income Payment Plan (PIPP), Ohio Guidestone, transportation to interviews, Cuyahoga Metropolitan Housing Authority (CMHA), United Way

211, Toys for Tots, the Home Energy Assistance Program (HEAP), Westside Catholic Center, and the Friendly Inn (which helped one family avoid near-eviction from CMHA by providing temporary rental assistance of $200).

How FrontLine Helped Clients/Factors Supporting Reunification

Nearly all interviewed clients described being pleased with PFS and expressed their gratitude for their FrontLine workers. DCFS workers and clients both spoke in strongly positive terms about FrontLine workers in describing how they had helped clients. One DCFS worker said FrontLine workers go "above and beyond" (DCFS11) the call of duty to serve their clients. One client described the PFS program as a "blessing," and she said that without her FrontLine workers, her life would be very different. This sentiment was widely shared among clients and workers alike, and FrontLine was noted as having helped clients in numerous ways. Three key themes were developed related to how FrontLine helped clients in supporting reunification. These included: (1) providing instrumental and material support; (2) helping clients develop life skills; and (3) providing social and emotional support, which included sub-themes of increasing client hope and motivation and being advocates and promoting empowerment.

FrontLine provided instrumental and material support. FrontLine workers provided extensive instrumental support for clients. Instrumental support was defined by FrontLine workers' providing clients with concrete items, services, and resources. Clients mentioned a range of resources and services FrontLine provided; these included attending staffings, visitations, providing counseling services, helping with children, paperwork, housing, EDEN, CMHA, court support, Pampers and wipes, food, advocacy (with courts, G.A.L.s, landlords, and DCFS), Christmas party, supplies, gift cards, and getting identification cards. All interviewed clients said that FrontLine helped them prepare for and attend DCFS visits, staffings, and court hearings. These data support FrontLine's data indicating that FrontLine workers attended 1,107 visits for 84 clients, 695 staffings for 133 clients, and 839 custody hearing for 138 clients. These data suggest the intensive involvement FrontLine workers had in working with clients, DCFS, and working toward successful completion of client case plans. One client said of FrontLine: "Everybody was so nice and sweet and considerate and helpful. They tell me about everything I need to know to get the things that I need, if I needed it, at a certain point in time where I didn't

have maybe the money or something like that." (CL12, recidivated) Another client discussed the variety of resources with which FrontLine helped her.

> When I didn't have money to get Pampers, they'll bring me Pampers and wipes, and I needed clothes a little bit, then I'm a get that. Just about everything I needed, food, when we was down, everything. They changed my life. Cause I was in a downward spiral at that time. I was upset about my son and it was just me and my kids' father wasn't getting along. Everything was terrible, and then they gave us a referral for counseling, and me and my kids' father did that and it actually helped. (CL8)

Another client spoke to how her life would be different without PFS and FrontLine.

> The program was a blessing to me. I never even knew they had programs out here like that. Yeah, it really, really helped me, because if I didn't get the help from them,…I'd probably still be doing the same thing. I mean I'd probably still be homeless, probably still been an alcoholic.…I wouldn't have got no help that I needed, and I wouldn't have had FrontLine help me fight to get custody of my kids and things like that. (CL4, recidivated)

DCFS workers agreed that FrontLine workers were able to serve clients in ways that DCFS workers said they often were unable to, due to their time constraints and high caseloads. The instrumental supports FrontLine workers were able to assist clients with, such as helping clients become housed using the CMHA housing partnership, and other service referrals (e.g., mental health, substance abuse treatment). FrontLine workers were described as playing a critical role in clients' reunifying with their children. This included helping clients to access to transportation, whether through bus tickets, driving clients themselves, or otherwise helping clients attend scheduled child visitations. Visitations were described as playing a particularly strong role in increasing the likelihood of reunification, both by allowing clients time to bond with their children, but also demonstrating to DCFS workers clients' interest in and motivation to reunify. Another client said, "If she <FrontLine worker> couldn't take me to my appointments, she would drop me off a bus ticket." (CL6, recidivated) One DCFS worker emphasized how essential transportation access is to parents' completing their case plans, and demonstrating and maintaining engagement.

> It's a lot, but I think [transportation] helps out the family a lot, because when you have parents that are overwhelmed, I think they get frustrated. They stop doing services, and I've seen that with a couple of my families. So and especially when the agency has a time period, they only have one or two years.…and they're like "Well (I have to do) Parenting, Substance Abuse, Mental Health, this, this and that," and they can only get services from here, here, here because they live in one area and they don't have transportation. So they

> have to go this place and this place, and they have to get it all done in one time period. So I mean that's a barrier as well. **(**DCFS9)

FrontLine helped clients stabilize through housing. A key instrumental support was the housing partnership offered by PFS. A little under two-thirds (62.5%) of clients described having been homeless at some point before becoming involved with FrontLine. About half of clients who recidivated and 25% of the clients who had reunified reported that FrontLine helped them with housing. Only one client who recidivated was housed by CMHA; four who reunified were. One client was currently living in a homeless shelter at the time of the interview; all others were housed with EDEN (25% of the sample), a Housing First facility, through HUD, with family (stable), or self-pay.

While not all clients were unstably housed either at the time of their program enrollment or at the time of the interview, they had been at some point, and FrontLine workers aided them in completing housing paperwork, dealing with inspections, and locating new housing when necessary. Workers (both FrontLine and DCFS) were very enthusiastic about the CMHA partnership, and DCFS and FrontLine workers alike emphasized how important it was. One FrontLine worker said:

> That [CMHA] partnership, I wish we had it right now!…please give it back to us. The housing, you just make sure they had their documents and we could go three months, you're in the door. (FL3)

This quick housing was considered unheard of, and a huge benefit for clients. A DCFS worker, similarly, attributed the PFS housing partnership, in part, to their client's reunification. "They did very quickly find housing for this client and it was the quickest I ever seen anyone do housing before, and we were able to get the kid back home with the parent." (DCFS10) One client described how FrontLine's help with housing helped her leave her domestic violence relationship.

> The housing was a big one, because I know like me and my kids' father, we didn't get along, so it helped me out a lot to have that, because he still stayed in the house and I eventually moved out. I was like "I can't do this no more." That right there alone was just great.…So I don't pay rent, and I get a utility check to help my gas bill, 'cause that's all I get, and I don't know. They helped me. They paid the deposit when they got me the apartment, 'cause I didn't have it. The housing was a big, big thing for me, 'cause I felt like I was kind of trapped with my kids father with nowhere to go. (CL8, reunified)

Clients who reported that they had not been housing unstable at the time of their child's removal or beginning of their involvement with FrontLine and had EDEN reported feeling their housing was generally stable. Non-CMHA clients, however, had to deal with landlords, who were sometimes unscrupulous. One FrontLine worker described such a situation and how she helped her client work through it.

> There was a lot of assistance as far as with the housing piece, 'cause she had relocated several times while she was in the program, due to various reasons. I know the last reason was just issues with the utilities and landlords and it wasn't on her end, but even us just trying to work through those things, working with landlords, if needed, and again bringing the budgeting piece into play and making sure things are in order and you are keeping track of the lease and being able, like again, advocating for yourself, 'cause a lot of times these families are working with some not so good landlords that are trying to get money out of them or something. (FL1)

Although clients with EDEN generally seemed happy with their units/neighborhoods, they would say they were happy but then mention safety concerns, concerns about neighbors or landlords, or mention housing quality issues. One client who was a substance abuser lived in an area with a lot of drug dealers and described that a major challenge.

> I am in the process of trying to move, because this area, I wasn't fully aware of how bad it is right here.… I already put in paperwork for a new house.… The drugs. I can't walk to the gas station without getting stopped and propositioned.…A lot goes on on this corner, and me being a recovering addict, that is not a good thing. (CL11, recidivated)

Nine of the 16 clients (56.3%) reported safety issues with their housing, describing shootings and/or drug activity in their areas. One client said, "where I was staying, there was violence and I would hear gunshots at night and stuff like that. I was scared for my kids." (CL12, recidivated) Another said "Out there it's kind of like at night it gets kind of dangerous: gunshots, fighting, loud. It get kind of hectic." (CL14, reunified) Others complained about their neighbors, the quality of their housing and local schools, the convenience of the location (to their children's school, groceries, and transportation). Clients with CMHA in particular, said they were happy to <u>have</u> housing but were not happy with their housing overall. All clients in CMHA viewed their housing as temporary, and said they did not want to raise their kids there. Only one client reported feeling satisfied with her CMHA housing, describing her neighbors and community as good support systems for her. However, she too planned to move. One client reported that she lived with her husband (a partner with whom she previously had an interpersonal violence relationship) most of the time because of the issues in her CMHA unit (safety, rats, etc.). Another

client in CMHA and her husband have their children live with family members because of concerns with their CMHA complex's safety and poor schools nearby. They said they see their children only on weekends. Another client reported declining CMHA because she could not get housing on the West side (near family, friends, and her job), and instead lives with her parents, which appears to be a stable situation for now.

FrontLine helped clients develop skills. FrontLine workers were also described as helping clients progress toward reunification by providing clients with intensive support through teaching them new skills. These skills were intended to help clients work toward self-sufficiency. Skills clients mentioned learning include self-reliance, how to get things done, how to deal with documents and paperwork, independence, self-advocacy/how to have a voice, patience, resources for dealing with domestic violence, coping skills/ways to deal with stress, how to express oneself, how to communicate with DCFS and landlords in an assertive way, how to manage budgets and bills, parenting skills, how to navigate public transportation, and how to change their attitudes. One client said, "she helped me with a lot, like confidence, patience, managing money. I got a lot of skills from her." (CL14, reunified) Some clients gained seemingly small but critically important skills. One client described learning how to take the bus. "I didn't know how to take the bus, and they helped me take the bus. She got on the bus with me and showed me where a certain place was at. I didn't know how to take the bus when I first got involved with them. I was scared. Didn't want to get lost. So they helped me get myself transportation by myself." (CL6, recidivated) Teaching these skills were not a small part of FrontLine's work, rather they were important skills that could enhance client self-sufficiency and were intentionally taught. One FrontLine worker explained how she worked with clients in building skills with regard to working with DCFS.

> There had been a lot of guidance around just how to go about working with DCFS, how to handle that kind of relationship, how to present at court, that sort of thing, how to just advocate for yourself. I think there's a lot of modeling that happens on our ends where just showing that appropriate and that professional way of presenting yourself, especially when you're involved with Juvenile Court and Children and Family Services. (FL1)

FrontLine provided clients with social and emotional support. A key theme in clients' discussions of how FrontLine helped them was social and emotional support. Clients said that FrontLine's social and emotional support helped them: become motivated to get things done; feel

encouraged; keep their spirits up by advocating for them around visits with their children, at staffings, and court dates; feel empowered; feel less alone; by listening to them; through demonstrating that they really cared; by trying to help; feel at home/not out of place' by giving off "no negative vibes"; by being easy to talk to and nonjudgmental; by being a source to talk to about mental health issues; by helping with coping skills, and teaching clients how to talk to people; by teaching them strategies for interacting with their children; by increasing their sense of hope, by being someone to check in and check up on them; by being a support system; and being "like family." Only three clients (one recidivated and two reunified) spoke negatively about FrontLine. Two clients had a positive relationship with one FrontLine worker but a negative relationship with another one. Another client mentioned not feeling supported/having a negative experience. Two clients had DV situations that the FrontLine worker was having challenges around and felt was not being resolved. In one of the cases, the client experienced her FrontLine worker as intrusive, and when the worker's concerns about the client's mental health issues were shared with DCFS, the client became angry and felt her children's reunification chances would be threatened.

Clients talked about how their FrontLine workers encouraged them to move forward at a time in their lives in which they felt most hopeless. One client talked about the verbal encouragement and emotional support her FrontLine worker gave her. "She always told me, 'You're not a bad mother. You're a great mom.'" (CL1, recidivated) Another client talked about the qualities that most helped her related to emotional support.

> They understanding. They really sit and listen. They don't rush you and be like "Oh, it's over with. Hurry up and go home." The services they was offering. The facility, when I went down there for my appointments was always clean, you know, and just a good staff, 'cause you got some staff that won't sit and listen to you. They ready to go move on to the next person, and you got some that really care and really try to help you and guide you in different programs. So everybody is just different, but I didn't get no staff that did me like that. I was nice. The supervisor...she used to always talk to me and help me out, and so it wasn't never like no negative vibe from them. The security guard that work there, he's always nice. (CL4, recidivated)

Another client explained how her FrontLine worker helped her manage her emotions and feelings of powerlessness. "So I was just like ready to punch the walls and everything. She was just, 'Calm down. You're gonna get your son back.'" (CL10, reunified)

FrontLine were advocates for clients and empowered them. FrontLine workers' efforts were extensive in the areas of client advocacy and empowerment. Clients said the advocacy of FrontLine workers on their behalf helped them feel protected and shielded, and that FrontLine workers highlighted their strengths. FrontLine workers and clients described situations in which clients were not treated fairly or respectfully by system actors (e.g., DCFS worker, G.A.L.s), but clients reported that they felt they had to do whatever their DCFS worker said or that they would not get their child back, that they were under the worker's thumb and that DCFS had great power over them. FrontLine workers, however, were described as standing right by the client and providing advocacy and coaching. One client said, "They would back me up and speak on my behalf, and they were always there." (CL12, recidivated) Another client said the following, regarding how her FrontLine worker had advocated for her:

> She let me know "You have rights, and it doesn't matter what got you here.…That's your child, and that things will work out if you take the proper steps," because sometimes with [DCFS], you kind of feel stuck, like what they tell you is the way it is, and you just really don't have anywhere to turn, and she let me know it wasn't like that. Like DCFS has to follow certain guidelines, and she was gonna make sure that they did. (CL3, reunified)

Another client described the multiple roles her FrontLine worker filled for her, closely tailored to her needs.

> I think it's mostly, it's just good to have that advocate for you. It's someone to talk to, for one. Somebody to kind of overlook everything and make sure that things are going the way they're supposed to.…I don't know how to explain it. It's almost like having a counselor, but also just having a friend that you can ask questions that they might know a little more than you, or somebody that's more informed on how everything's gonna work in court, and 'cause it could be confusing. (CL2, reunified)

Another client spoke to these ideas as well.

> When FrontLine came in and I started to have a little bit of a support team, I feel like the judge wasn't really grilling me because my FrontLine worker, she was letting them know, "Well this is what's going on. <Client> did this and this,…and she's accomplished this and this."…The judge really didn't have too much to say, and I'm like 'Yeah, shove that! Eat that! You don't got that mouth no more. (CL14, reunified)

One FrontLine worker credited the program's flexibility in allowing time for the workers to do what was needed for the clients.

> Just going every step of the way and even just sitting at the courtroom for three hours, just being there, like just the presence. So I think the huge piece of it was the advocacy and

> just being there, and I think that played a big role, because a lot times, these families, I mean these moms don't have anyone to speak for them, anyone on their side. (FL1)

Eight clients described the work toward getting their children back and advocacy with FrontLine in terms using the word "fighting." One example was:

> They believed in me and the fact that I should have my kids back, and that's what <FrontLine worker> expressed at staffings and everything.…<FrontLine worker> fought for me, too, 'cause <FrontLine worker> would tell them in staffings like you know "Mom's doing such a great job. Why doesn't she have these kids back?" and they looked back and they said "Hey. She's got a point. Why does she not have her kids back yet?" (CL16, reunified)

Another client said, "I wasn't alone. I had somebody fighting for me and what was best for my family. Instead of feeling like I was always up against somebody, I had somebody behind me, for once." (CL3, reunified)

Clients also talked about how their FrontLine workers helped them navigate the various systems with which they came into contact. Many clients described not having the resources or strategies for how to work on their case plans. One client said that working with DCFS was "almost like the big, bad wolf is coming, that type of feeling, like 'Oh god.'" (CL3, reunified) This client said that her work with FrontLine felt more collaborative and used a more helpful approach:

> "Let's mend what's happening," and not just kind of like, "Okay, well this is happening, and you need to fix it," and you're kind of left to your own devices, and if you don't know what to do, where do you start? Like "Here's your case plan. Do this." Like "Holy shit. How do I start this? I need to stop using drugs before I can even think about doing anything that's on this case plan, and if you don't help me try to navigate that, then I'm just stuck." (CL3, reunified)

While FrontLine provided strong advocacy and empowerment, two FrontLine workers described struggling with balancing their clinical judgment with program expectations. One worker said:

> I know there were some cases where when we looked back, we were able to say "we shouldn't have pushed this hard with reunification as what we did."... It's so hard to tease out making sure we're making the best clinical decision while completely keeping out the fact of what're trying to accomplish with the program…. I think maybe early on, it was a bigger struggle for me until I really [was] like "we have to be doing what's clinically appropriate, no matter what that means for the project." You know I think that like <client>, she was open for a long time. It took a long time for her to reunify, and she recidivated like a week later….So in kind of looking back at that, I mean there continued to be concerns around her, substance abuse, DV, and what we were seeing is that because

> of family, or because of a mom had completed all of her case plan services, that does not always mean that it is time to reunify. (FL 4)

This quote reflected some of the pressures workers felt to show the program was "working" while trying to do the right thing as practitioners, a theme we heard in the prior process evaluation study as well. DCFS workers respected this approach and emphasized the balance FrontLine intentionally built to be advocates for clients while also practicing ethically. One worker said:

> I had a great experience.…I know I had a great worker. She fought hard for the family, but she was very open about what needed to be done. She was very forthcoming with information as she seen that she knew that was harmful, so as she was talking to the family, she explained to them that "I'm here to help you, but also if I see anything that's alarming, I'm gonna report it," and that was her a line I think of ethics, that "As much as I want to help you, I still have to be honest and I have to do what's right." So I mean again, like I said, I had a great experience.… I think that if she would have the kids now, if they would've allowed the services to continue, I think some of the issues that they're experiencing right now with the two children in legal custody, they wouldn't be having them, because that continuity of care. (DCFS6)

FrontLine provided clients with hope and motivation. Clients described "motivation" as an outcome of FrontLine workers' empowerment and advocacy efforts. Motivation, as clients described it was a combination of hope and a call to action based on that hope. Clients said that FrontLine workers provided them with unconditional support and helped them feel motivated, hopeful, and supported. As one client said, "they showed me motivation by helping me with things that I couldn't do for myself at the time when I was homeless" (CL5, recidivated). "They was my stone, my work and my backbone, even though I did as successful, I still miss my stone and my rock." (CL15, reunified) One client explained that FrontLine's emotional support helped keep them moving forward. "She always stayed in my butt, too: 'You gotta get up.' She was giving me motivation: '(You gotta get up) and come to court.'" (CL1, recidivated) Another client spoke to how her FrontLine worker motivated her through demonstrating that she had the client's best interests at heart and would advocate for her.

> Well she gave me a lot of motivation. [FrontLine worker] definitely gave me a lot of motivation, because she pushed me and she stopped everybody from trying to do harm to me. She kind of shielded me. She definitely did.…She gave me a lot of advice and she kind of strained me out some. Just her advice in general. She was kind of like talking to me like my mother, you know, and she made sure I made it to every court date, and she was just always there. (CL10, reunified)

Another client described how her FrontLine worker worked with her like a family member.

> She came off like a mother figure to me, like "You gotta get it together. You're not a baby, and you've got children," and she kind of opened my eyes, because you know before, I was on a one-track mind thing like if it's not my way, it's the highway, and that's not how life go, and she taught me that and that's why I will never fumble, because she went over it and over it. (CL14, reunified)

Several DCFS workers commented on FrontLine workers' characteristics that made them particularly effective in their work with empowering program clients and motivating them to believe in themselves. One worker said, "FrontLine seems to have very engaging people working for them, so I think that empowers the parents, and you know kick starts them, so to speak into believing in themselves, and if tied with the right workers, you know 'cause there are so many different personalities and workers in our agency, you know that can affect a lot and, unfortunately, sometimes that's the way it goes." (DCFS1)

> Another DCFS worker commented on the program as a whole and what it did for clients. I think (that we gave parents) hope, a shot, sometimes more than once, that we had somebody who believed in the parent. We weren't just punishing them because they abused or neglected their child or, God forbid, had a mental health crisis and had to be hospitalized and the kid was dependent and then it took us two years to get the kid back. (DCFS15)

FrontLine workers also noted that they enjoyed being an advocate for their clients who face so many obstacles in their lives. One worker said, "I love having the ability to facilitate change worker-to-worker, and to empower my client in that space when no one else is." (FL2)

One FrontLine worker talked about the approach FrontLine takes to motivate clients.

> A lot of times, they feel like, you know, they automatically feel like their parenting is being criticized. I mean "It's not saying that you're a bad parent. You just go down wrong paths and makes some mistakes and you just have to go through it," and a lot of times they don't know how to get through it, or feel not confident or even motivated because they are constantly being criticized and feel like they can't. So the clinicians in this program really play a role in just kind of helping them to build that confidence and that motivation to even believe that they can do it, and they can be a better parent, and then helping them go through the steps to get to that place, just the basic needs and you know attending classes, figuring out what it is that they even need to do in order to get to that place of reunification, and just being there to help out through the ongoing life stressors. I mean they're still humans. They deal with stuff that us all humans deal with, and then they have all this to deal with. So it's I mean they're faced with a lot, and a lot of times it's just a matter of having someone work with you alongside and just normalize that and making them feel like this is, "This stuff is hard." (FL1)

How PFS Helped Clients DCFS Workers: FrontLine Helped us do our Work

A major theme that we developed from the DCFS interview data was that of FrontLine workers being helpful to DCFS. Whether FrontLine workers were serving as a communication bridge between DCFS workers and their clients (who, DCFS workers noted, did not tend to trust them), ensuring clients had transportation to meet their case plan commitments and visitations, or securing resources for clients, DCFS saw FrontLine as helpful and made their jobs easier.

FrontLine helped DCFS as an "extra set of eyes". DCFS workers agreed that FrontLine was an advocate for families, but many of them felt FrontLine was helpful for them as well. In particular, DCFS workers, who often felt overwhelmed in their work, felt they could not be everywhere at once, said FrontLine helped because they were another set of professionals that had "eyes on" the family, and could not only serve as a second opinion, offer alternative interpretation of the client's situation and help the DCFS workers process what they were observing.

> For me, it was an extra set of eyes. Sometimes, you know we're human, we don't see everything. I wear glasses. Sometimes I forget my glasses. I may forget something. I may be moving too fast, I don't see something. So our families that have FrontLine in the home, that's an extra set of eyes. If I go out and I'm questioning something, I have called Ms. <FrontLine worker> like, "I need you to go check and let me see if I'm overreacting," and we normally compare and like "No. We're seeing the same thing." So it is an extra set of eyes, extra covering, and I think that's probably why most of the families have gone through reunification. (DCFS6)

DCFS workers also talked about how helpful it was to have another professional at visits to observe parent-child interactions, and for DCFS and FrontLine to compare notes on how things were going for the family overall.

> It's just like a set of eyes, too…on the visits. We all supervised the visits, but just to see like <FrontLine worker> would pop in days when I wasn't there. So it was just different times to see how the kids were adjusting during their visits, and what she observed as opposed to what I observed. (DCFS3)

FrontLine as Communication Bridge: Helped DCFS by Helping Change the Conversation

In addition to being another set of eyes, one key way DCFS saw FrontLine as helpful was that the FrontLine workers served as communication bridges between DCFS and the clients. Several DCFS workers talked about the adversarial relationships they tend to have with clients

and how clients become afraid, confrontational, and powerless when dealing with DCFS. One DCFS worker said FrontLine was a bridge to one mom she was working with and allowed the DCFS worker to have "a way to keep in contact with Mom, because Mom wouldn't contact." (DCFS2) Another DCFS worker said FrontLine could help translate information from DCFS to parents in a non-threatening way.

> My experience was great. I mean they were willing to work with us, which was great. They were willing to fill in the gaps, especially in my case, when I had a mom who didn't want to hear certain recommendations from me. They had a great way of presenting that information, and I think in the parents' eyes in a more nonthreatening way. Like "The agency's not gonna make me do this, but it's coming from a place of I see you as somebody who's helping me." So that was really helpful, I think. (DCFS12)

Taking an approach from a place of trust in clients' eyes, FrontLine was often able to serve as an intermediary, someone who could see the perspectives of both DCFS and the client and could communicate effectively with both. One worker expressed this this way:

> FrontLine is an advocate for our families. That's that middle piece for them, and they're at the table. When you come to a table and have an SAR, a case review, it could be intimidating. You're walking in a room with social workers, supervisors that you just don't like. Your preconceived notion when you walk into that is that we want your kids for life. Having FrontLine and meetings I've had, the families I have them linked with, they're a voice of reason: "No, we're not here because of the social worker. We're here because there's a concern. There's an issue that we're trying to help you rectify," and that changes the conversation. So it helps remove the hostility. It helps keep the healthy balance and an open flow of communication. (DCFS6)

Another DCFS worker described a case he/she was working on and said that FrontLine helped after reunification, during "the transition so that there was always someone there, if Mom needed it, if she had concerns." The worker went on to explain that when the mom was experiencing behavior problems with the children, the FrontLine worker was able to intervene and help the mom develop skills in dealing with her child. The worker explained that the FrontLine worker's presence, and both the parent's and the DCFS worker's trust made the experience smoother.

> And she would come and just assess and make sure that everything was on track.…I think that she was like a, I don't know, safety net for both Mom and the oldest child. So Mom felt like she had support, and the child also felt like he had someone he could turn to, other than Mom, if needed.…So I was able to get a lot of information, based on her, because she's observing the kid....she's able to observe Mom and see if there were any strange behaviors that may indicate substance use or something like that. So because the FrontLine worker didn't have any concerns, I was able to just go along with her provider drug screens and didn't ask her to drop for me. (DCFS13)

Another DCFS worker talked about how high caseloads keep DCFS workers from being able to fully serve clients, and how FrontLine helped pick up the slack, like the two were fellow team members.

> I think especially the way turnover has been in this agency, Lord knows we can't keep anybody, so there's times where I have every intention on doing something and I'm like "This trumps you today, sorry. This has to wait," and I think that it's really helpful when we had the people like I could call <FrontLine worker> and be like "Listen. I know I told her I was gonna do this today. I can't do it. Can you do this?" and she's like "Oh yeah. Got you," and it was awesome support.… I just feel like <FrontLine worker> was very much so on the front line with me. (DCFS7)

Another DCFS worker spoke to the essential support FrontLine provided.

> Whatever I needed.…She would also help with resources and things like that, just help with everything.…she was really supportive of <client> as well. She was at every court hearing, as long as she was free. She was at every staffing, everywhere. Literally, she was right there with <client> through most of everything, so it was great.…I think it was just awesome to have extra support. (DCFS7)

Although overwhelmingly, DCFS workers commented on FrontLine positively, one worker shared a less positive experience and his/her feeling that the case was inappropriately helped and there was direct conflict between the two agencies. The worker objected to FrontLine's presence at visits and providing transportation, saying that DCFS needed evidence from mother that she would be able to function without FrontLine's assistance.

> She sits through every visitation because Mom wants her there, but I need Mom to be able to parent without you there.…"You're not gonna be there to take her to every appointment, like you've been doing. How is she gonna function without you?" So Mom is leaning on her harder than she should.…Unfortunately, the kids came back into custody, and it's for the same reasons that they came into custody [initially]. So the parents did make that change, like we had thought and, unfortunately, it continues to happen.…We've had multiple cases of DV, and FrontLine and the agency see differently, despite the fact that we've outlined what's going on, what our concerns are and where everything is, and so their idea is different, and I think that at some point, the FrontLine worker is just very much advocating for the mom and losing sight of the fact that there's a safety issue that we have going on here that we cannot change. (DCFS8)

Despite these experiences with this particular case, this DCFS worker added, "I just really do hope that you guys continue it. There are some families that would really benefit from it." (DCFS8)

Another DCFS worker commented on how cases progress without FrontLine intervention.

> I think it helped because with other families, if I don't have FrontLine, then that all falls on me. So that helped a lot that <FrontLine worker> was able to really help navigate with these DD services, whereas I have another client where I don't have a FrontLine Worker, so navigating is all on me. So that helped take off some of that, and they have more time to spend with Mom and to take her for services and things like that, where I don't. She did take her for appointments to [client's Medicaid provider] and things, where I might not have that time to do that. (DCFS3)

Another worker, asked specifically about the extent to which FrontLine "enabled" clients (a topic that was brought up in the prior process evaluation), responded:

> It was really rough, and I think <FrontLine worker> really helped <client> be accountable, actually. I was like "Get your client." You know it would be like, you know how like when parents, you call a parent and you're like "Oh that's your kid today." We definitely have had moments like that where I'm like "I can't deal with her today. She's mad. You talk to her," and so we were really able to balance that, but I don't think she enabled her at all. (DCFS7)

Factors Identified as Responsible for Recidivism (7 clients)

Clients and workers identified factors that were reasons children re-entered OHP, and several factors were explicitly identified as reasons for recidivism. DV was identified as the primary factor responsible for recidivism in four of the seven cases (57%), and FrontLine workers tended to emphasize that DV issues were some of the most challenging and difficult to deal with. Drug abuse/relapse was identified as a recidivating factor in six of the seven cases (86%), and cognitive issues or mental health issues were identified in five of the seven cases (71%). Among clients identified as struggling with cognitive issues (n=3), all clients recidivated. As mentioned earlier, PFS clients face a variety of challenges in their life. Recidivism is inevitable in some cases. One FrontLine worker commented, " I think there is always gonna be a high risk of recidivism when you have that many things. I do think that domestic violence and chronic developmental trauma are something that's multi-generation process to work on. (FL 5)

In addition to individual client issues, larger structural system issues were also identified as factors that played a role in clients' recidivism. FrontLine workers in particular mentioned that they felt that recidivism was due to larger system issues. DCFS workers' biases, intractability, and unwillingness to recognize client progress was one factor, and a general lack of compassion among system actors, including G.A.L.s, who at least one FrontLine worker felt were prejudiced against clients (this was mentioned in the prior PFS process evaluation as well). Magistrates and judges were also described as making decisions against workers' (both FrontLine and DCFS)

recommendations, seemingly without considering the facts of the cases. As one FrontLine worker described,

> The magistrate knew like active DV. (The client) is still living with (the partner), and they're reunifying, and it's just like DCFS and everybody in the courtroom like "what the hell? This is scary," and then you just do the best you can, even though you're feeling super-uncomfortable with the situation. Like "Hey, nobody recommended this, but the magistrate did." (FL 4)

Both clients and workers talked about system actors' judging clients based on what was on paper about the clients, and not giving clients second chances. At times, FrontLine workers felt powerless to influence the outcomes of their cases, and that time to reunification or recidivism were completely out of their control. One FrontLine worker spoke to this idea:

> The other piece of like the success is who they get assigned to in Juvenile Court.…There is no protocol there. There are ones who are more willing to work with parents than other judges.…Those are the two biggest predictors for success, because I could do amazing work, but if the [DCFS] worker's not well in the work and if she's not, and/or if he's not an advocate for Mom, we get placed in front of a judge who always sides with the agency and has many cases overturned, then it doesn't matter how good my work is. (FL2)

It is worth mentioning that despite all the services FrontLine workers provided, structural level barriers could impede the process of reunification. For instance, judges, magistrate, or G.A.L.s, FrontLine workers said, sometimes seemed to have made up their minds about the client's case before the court hearing. Additionally, not all DCFS workers were forthright about sharing the client's critical information promptly with FrontLine workers which could cause problems. As one FrontLine worker said,

> I think, overall, I was not expecting to feel so powerless in the reunification process. I felt like my opinion and the clients' opinions were really irrelevant when it came to the adjudication of the cases. It seemed like a lot of the script was written before any of us ever stepped on the scene. People's minds were made up, particularly with some of the Guardians ad Litem. They seemed to have very strong reactions, and I had one man tell me straight out. He was like "I have certain cases that if I see something's been done to a child, I'm going to do everything to prevent the family from ever reunifying, regardless of what the parents do, because I think there are some things that disqualify you from ever being a parent again." I think there was no good sharing of information from Children Services, so we would be like in treatment team plannings and talking to the workers, and they'd be very vague and wishy-washy, like "Well it looks like they're doing their plan," and we're like...advocating, advocating, you know providing a lot of positive affirmations to Mom and Dad about what they're doing, and then it's strung along for months and months and months and then we get to a final trial, I'm called in to testify, I don't even know what else has been testified about, and they determine the

> people's rights have been terminated. So a lot of information, if I'm the treating Therapist, I need to know. Like there was one time when I did not know a sexual abuse claim had been substantiated, and to work with someone for 18 months and not know that is pretty egregious, if that's what I'm supposed to be working on with the person. (FL5)

Clients also talked about feeling judged by system actors. One said:

> I got in my head you know 'Maybe the Guardian ad Litem's right. Maybe I'm not good for my kids,' and I relapsed, but it was a short relapse, but it got bad quickly, too, during the short relapse. So yeah, so now I have to work twice as hard to get them back, if they'll even let me get them back. (CL11)

This quote reflects the flip side of hope and motivation; several clients had such fragile self-images that when they felt down-and-out and one more thing happened, it was easy for them to slip into destructive behaviors such as drug use.

Factors Associated with Recidivism/Individual Client Challenges

Clients in PFS faced a wide range of challenges in their lives including poverty, mental health, cognitive delays, substance abuse, domestic violence, few supports or toxic social support systems, aging out of foster care, extensive trauma histories (e.g., sexual abuse, domestic violence human trafficking), experiences with racial profiling, and the inability to meet the most basic needs (e.g., housing, food, transportation etc.). FrontLine and DCFS workers cited these challenges as playing important roles in the child's initial removal, longer time in OHP, and later recidivism. FrontLine workers also talked about the difficulties of working with clients with so many challenges. Unaddressed domestic violence and mental health and/or cognitive issues were mentioned as particularly important issues, and FrontLine workers commented on sometimes burdensome processes involved in getting clients proper screening and assessment so they could receive appropriate services. One FrontLine worker said, "if the DCFS Worker received an Assessment from a third party, they wouldn't necessarily have permission to share the results of that Assessment with me. So I was a third party to their existing Release of Information." (FL5) Another FrontLine worker described the difficulty of working with the client population:

> This has been the hardest [group of] clients I've ever in my life had to work with....You could scratch the surface and…another topic would open up….I didn't realize you could have this many things going on. So when a client did get their kids back, I felt like we had hit the jackpot.…So I just never had so many needs to be met or to address. That was the thing that stood out the most about this program. It was so many different topics,…mental health, lack of support. Just hadn't seen it like that before. (FL3)

Domestic violence. Ten of the 16 (62.5%) clients had experiences with domestic violence (DV). We learned about the DV either directly from the clients as they either listed it as a reason their child/children had been removed, and/or programs with which they had been involved and classes they participated in. In some cases, the client did not share their DV experience in the interview, but the researchers learned about it from their FrontLine or DCFS worker. In two cases, the DV partner was present, and the clients mentioned the DV in matter-of-fact terms (both were reunified). In at least three recidivated cases, DV was not mentioned to us at all, and was discussed by the FrontLine or DCFS workers as generally not acknowledged as a problem by the client.

Some clients, workers said, did not recognize the signs of DV, and their life experiences had led them to see it as normal. One FrontLine worker said:

> Domestic violence is part of life for them.…I think (DV) it is widely accepted. So many of my clients grew up witnessing that.…It is so normal, and when I talk to my clients, like "have you ever been in a relationship with somebody who hasn't put his hands on you?" their answer is "no." (FL2)

One client confirmed this idea and described what she had learned about DV and her difficulties in working through her own DV relationship.

> I'll like want paperwork on bad relationships to learn how to deal with them, or not go back, and you know a pattern of going back into a bad relationship, or seeing my mom, when I was raised up and I learned the domestic violence. When you learn violence in your home, they said it could be a relative's house, grandma's house, anywhere, if you even hear them arguing, that's domestic violence and, see, I never knew that. Like if you hear somebody in the other room just throwing stuff. I just thought domestic violence was fighting, but it still mess a child mind up, so that's probably why I'll linger towards bad relationships. It don't be intentionally that I want to be in a bad relationship, but it's like I'll keep accepting that type of abuse from this person 'cause I think it's okay. (CL4, recidivated)

Workers and clients alike recognized the difficulties clients faced in leaving DV relationships when those relationships fulfill clients' needs. It can be emotionally and logistically difficult for clients to walk away from these relationships, especially for those who are socially isolated, and for whom their partner is a key member of their social support system. As one FrontLine worker said:

> With domestic violence, that love and attachment is so important. <Client> is a really good example,...she wanted to be loved and wants to be loved so much that the

> relationship with <partner> just continued to cycle and cycle….I think sometimes the DV is harder to understand too for clinicians, and if we break this down and understand mom is just seeking this love and attachment, it makes sense. It's going to be hard to ask dad to leave, if there's nothing that replaces the love and attachment in the same way that he does. You know even he brings all this other stuff with him, you still feel a connection, wanted, loved in these little moments, and walking away from that can be really difficult, especially when you're walking away completely alone. Like "oh shit. He helped me pay the rent," or "he was able to watch my kids when I went to work," or "he was able to watch my kids when I went to classes." It is not all violence all the time. There is something about this relationship that makes sense, no matter what it is. (FL4)

Other clients, one FrontLine worker said, grew up without father figures in their lives, and "they so badly want their children to have both parents in their lives, because that's something they never had, and it's a lot of moms raising boys and they're just like 'I want them to have a dad. They need a male role model.'" (FL2)

Unacknowledged DV was a separate, but related issue. One FrontLine worker talked about being so close to families that she could see that the children were in danger due to the DV relationship, even when the DCFS worker and the courts did not see it. This type of situation could lead to delayed reunification, no reunification, and/or recidivism. "I mean we could try to do everything possible, but some of the factors haven't changed. If that [DV] continued and the kids went home, I was like, 'I don't feel like this is good.'…Had a couple of clients, I'm like 'They should not have their kids' [because of their DV]." (FL3) One FrontLine worker talked about how challenging DV cases were, particularly with White workers giving advice to African-American clients. She said, "that's outside of my scope, and it doesn't [work] for a White person to come in and be like 'Don't let somebody hit you.' That's not going to do anything." (FL2)

Substance abuse. Twelve of the 16 (75%) had some kind of substance abuse (SA) issue, and six clients (37.5%) had both DV and SA issues. Although clients tended to be connected with services for substance abuse treatment, they were still struggling to stay sober. Many clients lived in communities in which they experienced violence, and drug/illegal activities, and this toxic environment was described as unhelpful for their recovery. One client in recovery said, about her housing, "I mean I'm not worried about anything like anybody coming here and anything happening to me, but as far as a relapse, stuff like that" (CL11, recidivated) due to drug dealers being nearby.

Mental health issues, lack of support/toxic support. Seven clients (43.8%) of clients had mental health or major cognitive issues (n=3). Not having social support systems was mentioned as very common for PFS clients. Workers talked about the necessity of strong social support for helping clients move through their challenges, but many PFS clients were socially isolated, and their relationships with their family members were toxic and/or complicated. As one FrontLine worker said, "the family history was huge. I recognized that a lot of them, they may have family, but it was inappropriate." (FL3) Another FrontLine worker shared similar thoughts. "In so many instances, especially with the families that we have seen, their support system is either not there at all, or not supportive." (FL 4) FrontLine workers were often mentioned as important social supports, but they also talked about the necessity for clients to have their own, natural supports. "Everybody in your life should not be paid…'cause if you got all paid workers and we all get burned out, you always start from scratch." (FL3) However, mental health issues were cited as direct challenges to clients being able to maintain their social supports, as clients tended to either have toxic social supports (e.g., individuals who were part of their current or past trauma histories and/or substance abusers, etc.) or they had destroyed relationships with their family/natural supports due to their mental health issues. "They like burned every bridge, mental health, 'cause people don't understand mental health. They have used every service,…they're cognitively-delayed, so they keep doing the same things over and over and over." (FL3)

In one case, a client had been sexually abused by her mother's ex-boyfriend and was placed into foster care when she was young. A later encounter with the perpetrator at her mother's house when her daughter was present "and it's like <the client> relived it. It was like she was saying it as if he was doing it all over to her again. 'He can't be in the house. He touches,' and she was saying it in a reference of being touched, but O knew she meant 'my child might be getting touched.' It was like watching glass break."

Other individual challenges. In addition to the above mentioned challenges, PFS clients also struggle with mental health, deep poverty, low educational attainment and low self-esteem. These challenges created difficulties for clients in many aspects of their life. In particular, these challenges impede client's progress on their DCFS case plan. For example, some PFS clients did not have adequate transportation access and so may be unable to get to DCFS child visits, court dates, and other appointments, including child medical appointments related to their DCFS case

plan, which can demonstrate lack of engagement with their case plan and even the child/children. Another client mentioned was that some clients are illiterate and they are unable to read paperwork.

> I [have]clients who can't read. I never experienced that, ever. Like she literally cannot read, so she can't fill out an application.…I never realized how the impact of reading is so important, and you'll hear another worker at [JFS] say, "Well I sent a client the paperwork," and I'm thinking,…"I gotta race to the house to read the mail." I'm reading mail. So now I'm working overtime. I'm going to your house three and four times to read mail. (FL3)

Structural Challenges. In addition to individual challenges, clients and FrontLine workers both talked about clients facing racism, prejudice and bias from various service providers. Clients felt they had few or no choices in many situations. Even when they wanted to make positive changes, they talked about getting pushback from the system. For instance, one FrontLine worker explained:

> <The client> has an EDEN voucher and she's very very committed to her family not growing up in the same environment that she did. So with her Eden voucher, she has had three units so far [in different areas]. So in the course of all that, she's gotten a ton of pushback from EDEN around the amount of rent that the unit she's identified.… Like "she's entitled to choose wherever she wants to live in Cuyahoga County, and you don't have any stipulations on this voucher, and she is following the protocol that she needs to follow." So to get pushback, is there this system thinking of "you are only worthy of living here?" (FL 4)

Another FrontLine worker explained that some of the DCFS safety planning guidelines are not tailored in a way to fit the client's actual situation. For instance, one FrontLine worker talked about this problem in a DV context.

> The moms would say to me, "I feel like I'm damned if I do and damned if I don't, because the safety plan is, if he's here and I feel threatened, I call the police. So I either call the police and then they go ahead and reopen my case, or I don't call the police and then my kids are in danger." So it was hard for them to feel like they had a win in either way. (FL5)

Clients' Relationships with DCFS

Clients had mixed relationships with their DCFS workers. While some had positive relationships and felt that they were "cool," others struggled in their relationships and felt

disrespected. One with multiple workers currently had a positive experience but had mixed and negative relationships with other workers. She said:

> When they took my children, she came to my mom's house and I asked her, "Can I please put my kids in the car and say goodbye to them?" "No. Give me your kids." She almost snatched his arm out of the socket. Like she was such a B, laughing in my face while taking my kids.…Yeah. It was bad…. So I literally had to threaten this woman several times to get her off my case, 'cause I told them, "If you don't take this woman off my case, I'm gonna end up fighting her." So they took her off my case and they put <2nd DCFS worker> on my case, which me and her got a good bond. I can call her and tell her anything. She's a good worker.…Supervisor is a B too. I don't like her at all, and I told her "I'll come across this table and smack the shit out you. I don't care." So I know I've gotta control my anger sometimes, because my anger is not gonna help the situation, but I don't like nobody running over me either, or trying to play me like I'm stupid, because I aged out of foster care.…so I know the law. I know my rights. You cannot legally take my child.... Even though you stamp it, you still can't take my child without a court approval. They thought that I was stupid, that I didn't know that. (CL7, reunified)

One DCFS worker talked about her interactions with a particular reunified client, and how he/she felt that their relationship contributed to her reunification. The client's perspective is included below.

> I think a big part of it was probably growth. I mean at some point you have to grow.…I mean <client> had AA meetings. (She had) NA meetings, a sponsor, a minister/pastor that worked with her. She was part of other groups, support groups. So I said "There's no way you could have all of this surrounding you and not grow." So I figured with her growth would come change, and I think that's what happened, and I think, too, by me not backing down. I mean <client> would call me almost daily, whining, screaming, yelling, "Hey, you won't! It's your fault!"…I would just stand my ground like "No. We're gonna do it like this, and you're gonna follow this protocol and we're not moving it faster. We're gonna take our time." And one thing I would always remind her is that "This is the only time in your life as a parent where you're allowed to be selfish. This is the time that we're giving you to focus on nobody on you to get sober, to stay sober. Trust me, when you get them back, it's all about them. Mommy gets pushed to the back. Stop rushing the process, and go through the process, because that's the only way you're gonna learn." So she eventually did it and thanked me in the end for not letting her rush and not giving in to her demands, because she was very demanding. (DCFS14)

The client, from her perspective, described feeling bullied by her DCFS worker (her first one) when she attended an emergency staffing with no support from FrontLine or her family. She said, "I feel like they bullied me, when nobody else was in the room" and went on to explain that her son's foster parents wanted to adopt him. She said,

> I don't think that they knew, or I don't think they really thought that I would get him back, and I wasn't giving up, and so we just kind of butt heads and they just said a lot of

> nasty things about the way he was born.…So I felt like I was bullied and nobody was standing up for me, or saying anything and I wasn't allowed. I couldn't have a reaction, because if I did, then it would be used against me. (CL2, reunified)

In describing her interactions with her first DCFS worker, she said

> She definitely made a lot of mistakes. I think that she cared a lot, but they just have way too many caseloads that they can't handle and it's very clear, 'cause she would mess up visits all the time.…I never even got a letter that said that my case was closed.…Even the Judge in the courtroom was like scolding the caseworker,…'cause she was supposed to do the case plan within 30 days, and it was like three months later, 90 days, and she had just sent it, and they almost had to drop the case over it because they didn't file any kind of a case plan. (CL2, reunified)

The client shared her better relationship with her second DCFS worker.

> I was getting so frustrated and I would be like "This is taking forever. I thought this was gonna only be like six months, and it's turning into a year," and I would be really upset, and whereas <First DCFS Worker> might've just blocked my number and hung up on me or something, she was like actually could calm me down. She was really nice. She's like just encouraging. (CL2, reunified)

While clients' attitudes toward DCFS were often negative, and clients felt their DCFS worker was out to get them, waiting for them to make a mistake, and generally not on their "side," FrontLine workers had a somewhat more balanced perspective, but could see when DCFS workers were not being fair toward clients and advocated for them. One FrontLine worker talked about observing DCFS workers "setting up" clients for failure.

> Sometimes I think [DCFS] workers, when they're filing for permanent custody and they're not really sure of it, they do this thing where they intentionally try to set off a client. So instead of saying, "We're taking PC of your kid because of this, because of this thing that I'm not too sure about, I'm gonna wait for you to fly off the handle and I'm gonna say we're taking PC of your kid because you have anger issues and because you can't engage with me, and you can't do this. So how can we expect you to take your kid to the doctor when you're not able to even do this?" And it's not the same with every case, and not every Worker is like that, but it's just like this strange dynamic thing that goes on, and the more likely a family is to respond like that, the more likely they are to make decisions about Permanent Custody. (FL2)

While all DCFS workers saw themselves as child advocates with children's safety their primary concern, two in particular demonstrated direct hope, compassion, and concern for the parents as well. One said, "I have hopes. I always have hopes for all my families." (DCFS4) Another recognized the need and opportunity for DCFS to serve as an additional emotional support for parents.

> Making them feel like "You are not alone. We're here to assist you, to help you. We're not here to remove your kid." Don't give them the notion like "I'm a police social worker. I'm coming to take your kids away because you did x, y and z. I'm only here to support you and understand life is tough. How can we do to help you make sure you get your children back? You have beautiful children. You want them home."…Right now, [client] said she needs somebody to be talking to her, give her the courage and say "Hey, you can do it." She's hearing like "Oh they're gonna take my kids…" I was like "Stop thinking about they're gonna take your kids." So she needs somebody to talk to her all the time: "You're gonna do it. You've made a mistake. That's not the end of it. We all make mistakes. We can work on this." I always use the word "We" can do it. "We" can work on it. "'We' can get your kids back." It makes her have that trust, 'cause you know a lot of them don't trust social workers. You know when they see us, they're like "Well she's coming to take my kids." That's just it. They're lovely families. I want her to get her kids back. (DCFS5)

At least two clients felt that part of their negative relationships with DCFS stemmed at least in part from racial and ethnic discrimination (one was Hispanic and one was African American).

> It [The relationship with DCFS worker] was never good.…I just feel like she was maliciously moving through her authority, so she abused it a lot.…So she'll take hearsay and run with it, when you could see when you walk in my house, it's home. It's my kids' home. It feels home. I mean what else could you say? And it was always like a manipulation thing. She would try to manipulate me half of the time, put words in my mouth, swear it under oath about a lot of situations. So it was never a good battle, and I think authority played a part. Probably race played a part, and intimidation, 'cause I was a single Black woman, and I was single and my kids still wore a smile on their face and they still was happy, fed and loving kids. (CL9, recidivated)

Another client spoke to these same issues.

> She is like "God's not gonna be able to save you." "What? Girl." I was like ten minutes late to go and visit my son one time because they actually got a hold of taking him from me. So I went to visitation. Traffic was crazy. So she says "Oh, what kind of mother is late to see her son?' and I said 'I am a good mother okay? Everybody makes mistakes." She's like, 'If you're a good mother, he would not be here."…[FrontLine worker] knew that [DCFS worker] had something out for me, and she started to ask for requests too for another social worker, 'cause she saw how she treated me and everything. She's like "social workers are not supposed to do that. They're here to help you, not to belittle you."…[FrontLine worker] spoke up for me, when I couldn't.…I mean she [DCFS worker] was belittling me. It's kind of like bullying, and I couldn't even speak Spanish around her 'cause she would look at me some type of way, or treat me some type of way because of it. (CL10, reunified)

Although most DCFS workers had limited experiences with the program, having only had one family go through it, one worker was able to speak to more than one experience.

> I like the program. I think it's been a benefit to the families that have worked in it, and having three families that have gone through it, reunification may not have been the end result of it, but they did support the families in a really good way and, like I said, I had one mom that that was the most stable that she had been, because she had that support and that she had that someone that could help her find what she needed within the community. So I think it's a good program to continue to have around. (DCFS8)

How PFS Helped Clients: Funding Flexibility Allowed FrontLine to Meet Client Needs

FrontLine workers described the PFS funding flexibility as incredibly helpful, as it allowed workers the time and flexibility they needed to properly meet client needs. In addition to the benefits the housing partnership provided, mentioned earlier in this report, workers talked about the funding flexibility the program provided, and the trauma-informed perspective that helped the cases move forward. One FrontLine worker said: "So I felt like the money, it was like awesome that I could actually buy my client what they actually needed." (FL3) Another major benefit of the program, a FrontLine worker noted, was the ability for FrontLine to continue to be involved with clients post-termination. This approach was seen as so beneficial because it gave the client necessary support at a difficult time after clients' children returned home, and terminate cases at the appropriate time, working with a trauma-informed perspective.

> I love this model, because we can continue working with the families after permanency, and that to me is so trauma-informed. It allows them proper time for termination, instead of being like 'Well you got your kids back. Peace out,' because that's the most vulnerable time for these families is right after reunification, especially when we're looking at families who've reunified with six, seven, eight kids. That is incredibly overwhelming. (FL2)

Race Findings: DCFS & FrontLine Worker Perspectives

Asked why they thought reunification would be more common for African American clients, 35% of FrontLine & DCFS workers said they did not know how to interpret the findings. Workers expressed surprise, particularly workers who were aware of issues of structural racism within the child welfare system and consistent findings of racial inequities in which African Americans are disadvantaged. The findings below reflect the perspectives of workers who offered an explanation for the findings.

Structural Racism. One FrontLine worker (FL2) offered a hypothesis that due to structural racism, less severe cases among white clients get screened out at earlier stages, so white clients whose kids end up in OHP tend to be more severe and have a higher level of risk than African

American families. A DCFS worker suggested a similar idea, that there are simply more African American clients represented at DCFS overall. (DCFS9, Multi-racial)

Reframing Expectations and Cultural Issues. Other DCFS workers discussed the importance of considering worker characteristics, including race and age. One worker noted that race and age matter to clients.

> Oftentimes dealing with minority families, you get an issue as far as, I mean let's be real. Most people that work here are White. A lot of them are younger, or the older ones, they're more so in their ways about how things should be done and they don't relate to their clients, and I feel like oftentimes I run into situations where my clients are thrilled to meet me. They're like 'Oh, you're young.' They don't know what to make of me. I'm Hispanic and White, but they don't know. They're like 'Oh, you look Black,' whatever, and they're thrilled when they see me 'cause they're like 'There's somebody like me.' They're like 'Oh. I thought you were gonna be like some old, crabby White lady… and you're gonna come take my kid,' and I was like 'No. We need some changes to happen, but no.' I think that having that additional support from another professional to me I think will help bridge that kind of gap. (DCFS7, Hispanic)

Another worker talked about how she felt that FrontLine workers were skilled in working with this difficult-to-serve population, and that they tended to be straightforward and honest with African American clients. She said FrontLine workers were able to say, "'Hey. I understand this is how you grew up, or this is how you learned, but you could do something different.'…I just think it's letting them know that it's something different than what they used to, what they mom and dad didn't do.**"** (DCFS4, African American).

Other FrontLine workers had other perspectives on why FrontLine's involvement might influence reunification in particular, by helping DCFS reconsider judgments they make based on families' behaviors, and adjusting their expectations. For example, she said that FrontLine tended to think critically about behaviors of African American kids and families, and not through a deficit/abnormal/ pathological lens. One example given was that given of "other people" being around a child's home as not being normal or acceptable, but rather having extended family and others as a normal part of the cultural milieu. Examples offered included interpreting children's "acting out" behaviors as a normal response to the trauma of removal from their parent's custody rather than as evidence of mistreatment and being exposed to violence. One worker discussed how violence can be interpreted differently based on the perspective taken.

> The whole violence piece itself is very difficult to address, because I am not raising a Black boy in government subsidized housing, and that's a completely different thing I will never understand. So a lot of my clients tell me like the agency will have an issue with their kids fighting and say "Oh that's because they witnessed domestic violence," but I don't know that it is, because when you have a little 5-year-old fighting and Mom's not stopping it, it's not because she believes that's how boys interact (sometimes they do), but it's because she's raising a boy of color who she's gonna put out on the streets to walk to school, to go and do things for his family, and he's gonna get up and have to defend himself, and that's why that's happening. It has very little to do with specific incidents of domestic violence, and it's more just like a cultural thing. Like that's what they have to do to keep themselves alive, and that's how we should see it. (FL2)

"It Takes a Village." Recognizing the Importance of Being Interdependent. DCFS workers frequently answered the question about the race findings by explaining how effective FrontLine was in general for clients, sometimes, but not always, addressing the race piece specifically. One worker, an African American woman whose PFS client was white, said she felt that an important lesson for clients was to learn that their need for help did not mean they were weak.

> I definitely feel [the program] sets them up to not just be able to stand on their own, but it's almost like a situation where <client> had to learn that it's okay to need help. It's okay to not be okay. You have to depend on people. It takes a village… it's definitely important in our culture for women to be strong and independent and not always depend on a man. (DCFS14, African American)

FrontLine workers' approach, described as nonjudgmental, open, and meeting clients where they are, DCFS said, allowed them to develop a strong rapport and become strongly connected with clients. One DCFS worker said FrontLine workers "didn't come in with a whole lot of preconceived notions…appealing to [clients] as human beings: mom to mom, sister to sister. So making that connection." (DCFS6, African American) Another DCFS worker pointed out that FrontLine workers' advocacy for clients played a very important role. Assuming that clients, particularly African American clients, have many negative experiences with the systems with which they come into contact, particularly with institutional discrimination and racism, FrontLine workers serve an important role, and as professionals, call out unfairness when they see it and advocate for their clients when needed. One worker felt that this could have a particularly positive impact on families who have been mistreated over time.

> Families have "an advocate to speak on their behalf.…They now have someone to say the client's not being treated fairly.…I mean they [FrontLine workers] see their primary role

> as speaking for that parent…[without FrontLine]…I think [DCFS workers] just give up and give legal custody." (DCFS15, White)

Recommendations for program improvement

In general, when clients were asked about their recommendations for improving the program, they overwhelmingly said that the program was extremely helpful to them, and they did not have much to say about program improvement.

Longer contact time/post-termination support. Given how much FrontLine had helped them, many clients expressed great sadness and loss regarding losing FrontLine's support when they were terminated from the program, both post-reunification and post-permanency. Several clients smiled sadly and said their only wish or recommendation was that the program could continue forever, while others noted that despite their reunification, they still feel vulnerable and like they could really use the intensive support FrontLine supplied. They wished FrontLine workers could continue to check on them once in a while. One client talked about recently being nearly evicted from the CMHA unit they had been able to get under PFS, but their financial situation remained precarious, even after reunification.

> Having a longer or at least an emergency contact afterwards…I mean we fought so hard to get our children back, but then for their betterment [because of unsafe housing], we had to kind of get them away, in a sense, so we're missing out on a lot. So yes, we are reunited and there's nothing legally stopping us, but I figure like if maybe they would've stayed and helped us get to where we wanted to go, instead of having to stay here [live in housing that was less than ideal], that would've helped a lot.…Just that maybe it ended too soon. I think maybe a visit three months after the initial time, maybe six months out, and then just having somebody there, if you get in a pinch, like "Yes, our case is closed, but something came up. Is there A, B or C you can do for us still?" Bus passes would even help now.… I think it could've been a little bit longer, the help, just for if we needed it. You know like maybe every other month visit, "You can call me if you need something." I think it would've helped. (CL13, reunified)

A DCFS worker discussed a similar idea, noting the need for additional resources for particular types of cases.

> For all kids that we reunify, we put some kind of in-home family preservation, or in-home therapeutic program. The model FrontLine offers is really, really good, and the continuity of sort of the same agency, even if not the same through that whole thing, helps the family engage better.…I would definitely have a backend intervention for the kids who stay in care, and I would have probably a frontend intervention, too, that looked for relatives more quickly. So I would do both. I mean I would place with relatives, in the hope that the kid could go home, but I think if we couldn't send the kid home, it would be faster to exit them, if they had been placed with a relative, 'cause that's just a faster

> process than adoption.…I would have some specialized adoptive home recruitment or family finding or something. I do think some kind of advocate for a parent is really important. (DCFS15)

Worker turnover. The second important theme mentioned around improvement was FrontLine worker turnover. Having a consistent worker to work with was identified as very important both from the perspectives DCFS, FrontLine and clients. Given the clients' often complex trauma history, it can be difficult for clients to build trusting relationships with their workers, "like who wants to tell their story that many times, right?" (DCFS15). Recounting trauma histories and developing rapport with new workers is challenging. As one client said " I feel like a human tape recorder, like I got to keep expressing that to the different workers, keeping opening that." (CL 9, recidivized)

The FrontLine worker shared similar opinions. "If individuals were hired for this position and signed a contract and stayed through the whole scope of the program, I think that would be huge, too. I think (the client) is a really good example of that, cause she had what? Five different workers or something in this project….I think that if our clients had an opportunity to work with their case manager and their therapist through the whole course of their custody case, I think that would make a huge impact, cause we know transitioning workers is not good. (FL 4)

One client suggested the program should help clients work toward addressing higher level goals post-reunification. The client said she wanted to go back to school to continue her education, and had hoped that the FrontLine worker could have provided more support in that area. "I really wish she would help me a little more with that, because we talked about things. It never came to fruition. So I mean that's where she has to take the initiative, or get a kick in the butt from me, taking a ride out to maybe Tri-C and getting to start somewhere." (CL2, reunified)

One DCFS worker said that the design of the study did not seem to be closely informed by DCFS staff, and said one thing he/she would have changed would be to include DCFS in the study design. The worker also felt that having had a DCFS voice could have caught some challenges in the overall design. One worker discussed the possibility of having particular DCFS workers that specialized in cases experiencing housing instability.

> Maybe we should've had one unit dedicated to housing. I think that would've made a huge difference. Maybe we could've had a one-worker model that would've then followed the kid all the way through to adoption. (DCFS15)

Another DCFS suggested more frequent progress reports.

> One of the things that I would like to see more is those Progress Reports coming out to us more than they have been, for me, so that I can track it a little bit better what they're working on with my family, where we're going with it, and what the goals are. That was a struggle for me with my last case was getting those Progress Reports, which I think would've been really good. And I think all of the workers that I've worked with, and the families that they've worked with, they've all supported them in a really good way and it's been positive. I just think definitely knowing what the goals are that they have come up with, so that we can all work together for that would be good. (DCFS8)

FrontLine workers also made several suggestions for program improvements. One FrontLine worker thinks "we could continue to work on building the relationships with the DCFS worker. I think there's many cases where the relationship, when the relationship is really healthy between the client and the DCFS worker, as well as us and the DCFS worker, I feel like the case progressed in a more positive way. When that relationship is really negative, we've seen well like families don't believe they are being believed, or they kind of get to the place where 'I am gonna put my foot down because this worker is so against me.'" (FL 4).

Discussion

Efficient, interagency collaboration approaches are increasingly being suggested as necessary to decrease service silos, reduce service fragmentation, and best serve families who are experiencing both housing instability and child welfare involvement (Bai, Collins, Fischer, & Crampton, 2019). Such collaborative approaches have the potential to bridge gaps between the needs of these families and available resources.

Integrating our findings and current research on other programs, while housing is extremely important for stabilization, it appears to be ultimately insufficient for stimulating reunification (Fowler, 2017). Programs focusing on housing may be unable to detect increases in reunification over relatively short periods of time (i.e., two or three year periods) in part because of the persistent pressures of sustained poverty and lifetime trauma experiences. When poor families are housed in public housing and very low-income areas, they continue to experience a variety of adversities, including but not limited to concentrated disadvantage and community violence (Fowler & Schoeny, 2017), which may be additive to existing mental health, substance abuse, and domestic violence situations. Continued research is much needed on identifying practices that may be most successful in increasing and maintaining reunification among housing-unstable families with varying and multiple needs.

Recommendations from clients brought up clients' feelings about PFS ending, even if it had a been a happy ending for them (i.e., reunification); this was a major loss for them. Some clients jokingly said they wished they could have FrontLine involved "forever" and others said they just wished the program was longer. Indeed, these clients' multiple, intersecting needs and were not always fully resolved within the program's time frame. Most clients still were dealing with their poverty, unsafe or otherwise not fully satisfactory housing conditions, and limited support systems. Several families were in nearly immediate need of services at the interview, but their time with PFS had ended, and reported the agency was unable to help them.

Interestingly, workers' recommendations were similar to the clients'. While several DCFS workers asked that the program be extended to all their families, others said felt the program was unfair in its randomized approach, and they had their own ideas about certain families that would really benefit from the program. FrontLine workers and DCFS workers alike found the CMHA partnership to be incredibly beneficial and it was hoped the partnership could be continued. One FrontLine worker commented that she really had appreciated it and now that the program was ending, she wished it was still there. Quick housing was considered a major boon for focusing intensive case management on clients' basic needs; finding housing for clients was described as incredibly time-consuming, as found in prior research (Collins et al., 2018).

Though PFS was originally envisioned as a mechanism for serving housing unstable clients and then quickly and safely reunifying children with their families, data here indicated not all clients were housing unstable enough to require housing assistance. Instead, some clients had achieved a moderate level of housing stability by their entry to the study, such as having EDEN services before becoming enrolled in PFS. The findings from this study may not necessarily be applicable to recently homeless or housing unstable clients, rather they may instead apply to clients who have had some history of housing instability. Regardless, the housing resources available to FrontLine, particularly the CMHA partnership and prioritization of program clients were cited as incredibly valuable and helpful, and essential to reunification. DCFS and FrontLine workers alike praised the program for having these resources, ones that had been a definite barrier to clients in the past. Although clients were not always pleased to live in CMHA due to issues with safety, neighbors, drugs, and housing quality, and saw the housing as temporary, they were grateful to be housed, and among those who had been in shelter, saw it as preferable to shelter.

Additionally, when we visited clients, fully one-third of the sample had changed classification since the sampling list had been generated, suggesting the dynamic nature of the sample. That is, several clients classified in the child welfare data as "reunified" were either actually recidivated or their children had achieved a permanency option that was not with the removal parent. Similarly, some cases were classified as recidivated but when we visited the client, the children were present and they had reunified, but the data had not been updated. In one case, a recidivated client was reunified with her children two weeks after the interview, and in another, a reunified client had recidivated shortly before the interview. Given the constantly changing nature of PFS families' structures and life situations, it may be useful for the core team to think through timing and whether PFS families who have reunified since the program ended (but were classified as recidivated at the "official" time of their PFS exit) should be considered reunified or recidivated for the purposes of the outcome analyses, and perhaps triangulate the data sources if even recent reunification or recidivism should be taken into account and ensure the data are as up-to-date as possible.

Finally, it would be useful to (re)consider the definition of "success" for PFS families. The interview data presented here suggest that "success" could be defined in a number of ways. Although the project's payable outcome was number of days in OHP, FrontLine staff did not feel this was the best measure. In fact, a speedy return to a troubled home (not only because of housing instability) was sometimes clinically unwarranted, regardless of the removal parents' progress on case plans. FrontLine workers' roles as an "extra set of eyes" meant they were very tuned-in to clients' strengths as well as their challenges, and were aware when challenges had been fully resolved or not. They also felt responsibility to ensure children were not at risk, and their collaboration with child welfare kept them tuned in to the needs of both the families and the systems, helping to bridge communication gaps between clients and system actors. While they struggled with the desire to help the project achieve its objectives, their clinical decision-making ultimately appropriately rested with doing what was right for the client, the child(ren) and the family. This approach enhanced the trust DCFS workers had in FrontLine workers, strengthened their collaboration, and even clients overall praised FrontLine workers for helping them remain accountable, work through their issues, and stand on their own feet. FrontLine workers modeled, coached, taught clients skills and provided clients with both a variety of instrumental and

emotional support resources that are skills clients will take into their future lives, wherever their paths take them.

5. Conclusions

The study of the Partnering for Family Success project has yielded a wide array of knowledge pertaining to both providing effective services to a disadvantaged population and conducting a Pay for Success methodology to undertake a project of significance. We offer observations in these two domains.

1.1.Learnings related to child welfare/housing practice and policy

The study of Partnering for Family Success advances the field's knowledge about methods to work with a highly disadvantaged population that has not been well served by existing systems. A family's experience of either housing instability or child welfare involvement alone are substantial risk factors for the children in those families. If experienced concurrently, these two factors place families at substantially more risk for poor outcomes across a range of domains. The emphasis on stabilizing the housing of these families, coupled with intensive social, therapeutic, and navigational support, offers a path toward better outcomes for these families. Several findings are now highlighted.

Housing as one element of challenge for families

Providing housing is crucial for family reunification, but ultimately insufficient to reduce days in foster care. Our data suggest that the stability housing provides is essential, but it was not a uniform need for all families in the sample, and it was not the primary reason children were removed in any PFS cases. Families were grateful for their housing, but issues of poor housing quality, safety, and convenience hampered their being fully satisfied with the housing, leading them (especially CMHA clients) to see their housing situations as temporary. This suggests that the housing options provided in PFS may be temporary solutions, and it is possible families could experience housing instability again over the long term. A number of other individual and system challenges also were cited as critical in determining reunification. Individual challenges included domestic violence, deep trauma histories, mental health and cognitive issues, substance abuse, lack of social support, and poverty. These individual issues persisted for some clients, despite their work with FrontLine. System challenges included system actors such as DCFS workers, G.A.L.s, magistrates, and judges, who FrontLine workers (and to some extent, DCFS

workers as well) felt had tremendous power over the reunification process, and often disregarded the work FrontLine workers and clients had done toward completing case plan objectives.

Length of Stay in OHP versus other measures of success

Length of stay in OHP, while the primary metric of interest, was not necessarily seen as the primary indicator of "success" for those closest to the project. As mentioned earlier, the work FrontLine Service contributed and the progress clients made were not always recognized or reflected in OHP stay lengths, especially considering the influence of system actors. What did FrontLine Service workers see as success for their clients? Success, for them, was for the child to return home safely, but not necessarily *quickly*. Indeed, FrontLine workers discussed the necessity for their clinical judgments to override the project goals of speedy reunification when that was not clinically warranted and the parent needed more time to stabilize so that reunification could be maintained. Clients' reports that they learned new skills that will help them become more self-sufficient–from relatively "simple" things such as learning to access public transportation, to more complex skills such as stress management and coping with past trauma–are significant measures of "success." While these skills may not result in immediate and easily measured financial cost-savings, they should not be discounted and could result in cost-savings over the long term.

Additionally, though reunification with a parent was not necessarily considered important from the outcome evaluation perspective, it was clear that this was a goal for FrontLine workers. Additional research may be warranted regarding the benefits of reunification with the removal parent/caregiver as compared to other permanency placements.

Collaboration between DCFS, FrontLine, and Housing partners

Efficient, interagency collaboration approaches are increasingly being suggested as necessary to decrease service silos, reduce service fragmentation, and best serve families who are experiencing both housing instability and child welfare involvement (Bai, Collins, Fischer, & Crampton, 2019). Such collaborative approaches have the potential to bridge gaps between the needs of these families and available resources. Though collaboration among service partners is crucial, it is challenging in practice. Ongoing communications among program staff and with the caregiver is necessary for progress to be maintained. For DCFS caseworkers and other partners

which have high caseload volume, the capacity to effectively collaborate is often strained by these overall demands. PFS developed regular meetings between FrontLine Service and DCFS staff to discuss the progress in each PFS case to improve collaboration.

1.2.Learnings related to Pay for Success research

As a tool of social innovation, Pay for Success has been explored and adopted widely in the U.S. Specific Pay for Success projects are accompanied by evaluation and research strategies that seek to determine effectiveness. This research also contributes to the field's knowledge about how to best study Pay for Success projects and how to design projects that best deliver the benefits to the intended population. Based on the research on Partnering for Family Success several findings are offered in this regard.

Importance of integrated data

From prior to its inception to the conclusion of the study, the Partnering for Family Success project has drawn heavily on the value of integrated data. Without the capacity to integrate data between the DCFS, HMIS (Homeless Management Information System) and other systems, it is unlikely that the project could have adequately identified and tracked the selected service population. As a tool for social innovation, Pay for Success projects require a detailed understanding of the underlying conditions of concern, as well as the ability to track cases prospectively (Fischer, Richter, Anthony, Lalich, & Coulton, 2019). In the current project, before an intervention was conceived, it was necessary to characterize those families that had an elevated risk of long stays in OHP. Using integrated data, hazard models were used to identify the risk factors associated with longer times in foster care. This analysis helped determine the target population, which was composed of families with children in OHP and with caregivers who had experienced homelessness or housing instability within 6 months of having a child in OHP. Successful Pay for Success projects need to have established access to integrated data both prior to project formulation and during project execution to meet the data demands of these projects.

Evaluation of impacts versus payable metrics

One of the central features of Pay for Success projects is the identification of payable metrics which are outcomes that are monetized as a basis for calculating how much the government sponsor would pay for the desired outcomes. In the early stages of Pay for Success in the U.S. (2012-2016), most of the ten PFS projects that launched utilized a single payable metric measurable in the short-term, as was the case in the current project. This reflects two challenges somewhat unique to Pay for Success. First, for a project to advance, outcomes must be identified that will accrue sufficient savings to the unit of government sponsoring the project if achieved. A fuller evaluation of a social intervention would consider measurement of a wide range of participant outcomes, regardless of where any system savings might accrue. This is more consistent with a social return on investment (SROI) framework (Fischer & Richter, 2017). Second, Pay for Success projects are inherently time delimited, meaning that any payable metrics must be observable within the window of the project. Again, broader SROI thinking often considers outcomes that may play out well into the future when dealing with participants facing multiple challenges. As the Pay for Success field has advanced, there has been movement to overcome both of these limitations. This includes the identification of multiple payment metrics and the inclusion of outcomes that are not specifically monetized, yet are still highly valued by the project developers. The current project was limited by the knowledge of the Pay for Success field at the time of the launch. As such, while there is report out on the single payable metric (OHP days), there is also attention given to the other areas of benefit observed as part of the project.

Changing context for Pay for Success projects

The nature of Pay for Success projects requires the use of historical data to design and plan intervention, as well as the formulation of success payments. Yet, as projects are carried out there may be shifts in the underlying context that result in departures from historical norm data. In the case of this project, projections regarding the expected exit rate of children from OHP proved to differ from the actual outcomes observed in the control group. The PFS control group outperformed the historical sample in respect to exit rate for those children beyond one year in custody. Though the control group provides the best estimate of outcomes in the absence of the PFS treatment, the historical data were those on which the program and its study were based.

This shifting programmatic landscape suggests that methods to share risk between the funders and the government sponsor may be a path forward for future Pay for Success projects.

Importance of including qualitative data

Approaching the study's qualitative questions with an eye toward "getting an in-depth, individualized, and contextually sensitive understanding" (Patton, 2015, p. 6) of PFS's impact on the local level extends our understanding of the program and allows us to contextualize the outcome metrics findings. Collecting qualitative data allowed us to explore the *meaning* of the program to those closest to it: FrontLine workers, DCFS workers, and clients. Examining the quantitative data alone would leave us with many unanswered questions about why the program did or did not succeed in meeting its stated payable outcome objectives, but collecting qualitative data allowed us to explore the potential reasons behind the outcomes from those most knowledgeable about the program. In collecting these data as a complement to the quantitative data, we have been able to elucidate contextual factors at play both within individual clients' lives and at the system levels–agencies, courts, etc.–that have important influences on reunification rates and the number of days that children stay in out-of-home placement.

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