The Children's Bureau
An Office of the Administration for Children and Families

Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families Involved in the Child Welfare System

San Francisco Human Services Agency, Families Moving Forward Project

Final Evaluation Report

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CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

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Executive Summary

Homelessness is a national problem, particularly acute in San Francisco. Through the 2000s, the philosophy of "housing first" transformed the supportive housing system, emphasizing permanent housing as a necessary condition to the successful use of services rather than the end-goal of a case plan. Though homeless families were a growing proportion of its caseload, the San Francisco Human Services Agency's (SF-HSA) child welfare program had not integrated the housing-first philosophy into its case planning of child welfare cases involving homeless families. The agency still emphasized services while wishing for housing stability, at best coordinating with the supportive housing system on a case-by-case basis rather than in a structured, systematic way.

San Francisco's Families Moving Forward (FMF) project aimed to reduce the need for foster care among families identified as homeless when they were investigated for maltreatment. While homelessness is not a reason for a child to be removed from his or her parents, it often aggravates other issues such as parental addiction, domestic violence, and trauma. Children in homeless families who come to the attention of child welfare are at increased risk for placement, and children from homeless families who need to be placed are less likely to reunify than maltreated children who are not homeless. SF-HSA believed that a housing-first approach, one that coordinated intensive case management services with permanent housing, was likely to result in better outcomes for these families.

In 2012, the federal Children's Bureau funded five sites nationally to design and test models that provided permanent housing along with supportive services.[1] SF-HSA used this opportunity to develop a more formal collaboration with the San Francisco Housing Authority and a local non-profit agency, the Homeless Prenatal Program, as well as other key partners, to coordinate scattered-site housing with intensive support services. Named Families Moving Forward (FMF), SF-HSA's project featured three main strategies. First, it targeted families early in their child welfare experience so that they could stabilize quickly and address their co-occurring problems, reducing the need for ongoing child welfare involvement. Second, it offered a mix of rapid housing resources, mostly Family Unification Program (FUP) Housing Choice Vouchers. Third, it provided housing search assistance and ongoing, intensive support services. Chapin Hall at the University of Chicago led the evaluation.

Methods

We evaluated the effectiveness of FMF using a randomized controlled trial design. Families with in-home (preservation) cases and families with out-of-home (reunification) cases were separately randomized to a treatment group that was offered FMF or a control group that received usual service. The implementation evaluation assessed the extent to which the program was delivered as intended and used a continuous quality improvement (CQI) approach to promote program design modifications mid-course. The outcome evaluation relied on administrative and survey data. We also examined a subset of the treatment group in order to understand what characterized non-participators and the relationship between outcomes and the timing of housing among those who participated but did not complete the program.

Findings

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[1] *Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families Involved in the Child Welfare System (SHF) grants*

Implementation

Success depended on: 1) efficient targeting to identify and enroll eligible families; and 2) effective partnership among the system partners so that treatment families would receive the full dose of the intervention in the intended sequence along the expected timeframe. Targeting was successful. The cross-system partnerships did not work as expected to house families quickly. Yet the project partners leveraged their resources and relationships to manage the circumstance, preserving the principle of housing first.

Nearly one third of the treatment families were never permanently housed, and it took 10 months, on average, for those who were housed to be settled in their permanent home. This delay was in part due to the difficult local housing market, and in part due to unanticipated challenges in navigating the multiple steps necessary to both procure and use the housing voucher (e.g. porting the voucher to other jurisdictions). A number of strategies were used to stabilize families while they waited for permanent housing, and to accelerate the housing process. Of the 79 treatment families, 48 were eventually successfully housed in permanent homes. Thirty-seven received the full treatment. They "graduated" from the FMF program, having been successfully housed in a permanent home, their child welfare case(s) were closed, and they showed no remaining areas of actionable need on their assessments. Although these families did not necessarily get the intervention in the intended order, they did receive all of the program elements.

Child Welfare Outcomes

Among families who entered the study when their children were in foster care (reunification cases):

- There was modest evidence to suggest that treatment families reunified faster. Nearly all treatment families who reunified did so in the first three months. Treatment families with children in care longer than six months were no more likely to reunify than control families.
- Eighty-five percent of all reunifications preceded housing for treatment families.
- Once reunified, there was no significant difference in the likelihood of later child welfare involvement, including re-investigation, re-substantiation, a new in-home case, or reentering foster care.

Among families with in-home (preservation) child welfare cases when they entered the study, the findings are as equivocal:

- Treatment families were marginally less likely to have removals within the first six months, but the difference diminished by one year.
- There was no significant difference between groups in the likelihood of subsequent child welfare involvement, measured as a re-investigation, re-substantiation, or new case opening.

Housing Outcomes

- Although nearly one-third of the treatment families left the program before being housed, overall treatment families were more likely to secure any form of housing than control families, and preservation families were more likely to secure housing than reunification families.
- Obtaining permanent housing took an average of 10 months, but ultimately treatment families were more likely to become permanently housed than control families.
- Treatment families were more likely to remain stably housed than control families.

Well-Being Outcomes

- Parents who participated in FMF showed meaningful improvements in assessment domains of family strength and family functioning, residential stability, social connectedness, and substance abuse both over time and compared to control group parents.
- Child and Adolescent Needs and Strengths (CANS) screenings trended in the desired direction but showed no significant reductions in need for children in treatment families compared to children in control families.

While we cannot draw causal conclusions from a subgroup analysis of only those who participated in the program, there were a few notable descriptive observations not readily visible in the larger causal analysis:

- Permanent housing did not appear to be essential to prevent placement or to facilitate reunification.
- Reunification families were less likely to engage with FMF. No preservation families failed to engage. Nearly all of the unengaged reunification families had substance-exposed newborns and reunification services were terminated after a period of failure to engage with the child welfare worker.

System Change Outcomes

The project generated a multitude of changes in how housing, support services, and child welfare programs coordinate efforts to serve child welfare involved homeless families. At the outset SF-HSA was not confident that it knew which families in its child welfare program were homeless, the data was so poor. Its early efforts were rudimentary, like settling on a single definition of homelessness, training child welfare workers on it, and monitoring the data to ensure that homeless families were recognized and served appropriately. Today child welfare workers are expected to record the family's housing status and incorporate housing into case plans.

The collaboration between SF-HSA and the San Francisco Housing Authority became more effective and the Homeless Prenatal Program was added as a key player. Administrative processes were changed, making it easier to serve child welfare involved families and accelerating the issuance of vouchers. Strong working partnerships were formed at every level, making it easier to rapidly address and resolve obstacles. Prior to the FMF project, San Francisco was not making full use of FUP Vouchers. Now all of San Francisco's FUP vouchers are being utilized and the San Francisco Housing Authority continues to provide housing support for new families.

Conclusions and Implications

FMF adhered to the principle of housing first, even though it could not be delivered quickly. The promise of housing, which is central to the housing first approach, was a key element of the program even as it became clear that "housing first" did not mean "housing fast."

While case management and the promise of housing may have contributed to fast reunification and helped preservation families stay intact, the housing itself could not have. That said, the absence of immediate housing did not prevent a sizable portion of the treatment group from participating in and benefiting from the intervention. Those that persisted in the program were eventually housed stably and parents experienced improvements in their well-being. We cannot say if families who engaged but did not complete would have had better outcomes had they been more rapidly housed: some families

had less desirable child welfare outcomes that preceded permanent housing; others received housing, but still had further engagement with the child welfare system.

These findings call for an approach that accounts for the variation in needs among homeless child welfare involved families who present to social services systems. Developing that approach will depend on robust, synthesized systems collaboration. This requires detailed attention to collaboration during the earliest stages of program development, long before program launch. Program leadership needs to forge relationships that clearly and early articulate the partner roles and responsibilities to execute the theory of change. Additionally, the specific processes and procedures that govern partnership must be specified, communicated and monitored in order to ensure that they are operating as intended. Equally important, the process for sharing information both related to the case and to support ongoing monitoring and CQI efforts is fundamental and should be arranged early on.

The FMF project was implemented within a larger national and local context of family homelessness awareness. The attention of the Children's Bureau, articulated locally through San Francisco's FMF project, heightened awareness about the unique issues facing homeless families in the child welfare system. Two years ago, the California Department of Social Services launched the Bringing Families Home initiative. Its funding has helped sustain FMF's services, but also allowed surrounding counties to launch similar programs. Today there is a statewide conversation about the role of homelessness in child welfare, and the FMF project has informed that conversation.

Acronym Glossary

ANSA	Adult Needs and Strengths Assessment
BFH	Bringing Families Home
CalWORKs	California Work Opportunity and Responsibility to Kids
CANS	Child and Adolescent Needs and Strengths
CDU	Court Dependency Unit
CQI	Continuous Quality Improvement
CSH	Corporation for Supportive Housing
ER	Emergency Response
FMF	Families Moving Forward
FRC	Family Resource Center
FTM	Family Team Meeting
FUP	Family Unification Plan
HPP	Homeless Prenatal Program
HSH	San Francisco Department of Homelessness and Supportive Housing
HUD	U.S. Department of Housing and Urban Development
ITT	Intent-to-Treat
IPP	University of California San Francisco Infant-Parent Program
MOHCD	Mayor's Office of Housing and Community Development
MOU	Memoranda of Understanding
PCG	Public Consulting Group
SDM®	Structured Decision Making®
SF-DPH	San Francisco Department of Public Health
SF-HSA	San Francisco Human Services Agency
SFHA	San Francisco Housing Authority
SFUSD	San Francisco Unified School District
SNAP	Supplemental Nutrition Assistance Program
SRO	Single Room Occupancy
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TOT	Treatment-on-Treated
UI	Urban Institute

Section I. Overview of the Community and Problem Addressed

Overview of the Community

The Families Moving Forward (FMF) project served San Francisco families, but in helping families search for housing, the project's geography extended to the entire San Francisco Bay Area, a metropolitan region surrounding the San Francisco Bay and San Pablo Bay estuaries in Northern California. According to the 2010 United States Census, the region has over 7.1 million inhabitants and approximately 6,900 square miles of land.[2] The Bay Area consists of nine counties – Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma – and three major cities – San Jose, San Francisco, and Oakland. San Francisco is the only consolidated city-county.

San Francisco has been changed by the advent of the knowledge economy and its concomitant gentrification. It has seen dizzying increases in housing costs, driven by an influx of college-educated workers with healthy incomes who are chasing the city's finite housing stock. San Francisco has never had many families, but it has seen a dramatic out-migration of families to the surrounding exurbs, and today the percentage of the city's population who are children is just 13 percent. In New York, it is 21 percent; in Chicago, 23 percent. Today the median rent for an available two-bedroom apartment is $4,600. A single parent with two children trying to live on TANF in San Francisco receives approximately $1,166 per month, including the value of her SNAP benefits.

Despite its gentrification, San Francisco has seen its poverty rate increase, but who is low-income has changed. The low-income families that remain in San Francisco tend to be immigrant families living in doubled-up situations (45% of the city's Latino families are doubled-up), and the largest group of low-income families in San Francisco today are Asian American (33% of total children and 34% of children in poverty). Latinos are 23 percent of the city's children, and 29 percent of its children in poverty. While African Americans comprised just 7 percent of the city's total children, they were 25 percent of its total children living in poverty.

If not doubled-up, families living in poverty in San Francisco tend to be in public housing, blessed by a rent-controlled apartment, or staying in shelter. In its 2017 homeless count, San Francisco had 190 homeless families, comprising 601 total people. Using the Department of Education definition of homelessness, San Francisco's school district counted 1,844 homeless students in the last year.

Today San Francisco's child welfare system is attempting to serve families who are much more isolated, their relatives often having moved out of the city, and whose hold on housing is much more tenuous.

Primary Issues the Project Addresses

Families who come into the child welfare system in San Francisco, and who are homeless, have historically experienced challenges related both to long-term vulnerabilities and short-term disasters. Most have multiple, intensive needs that contribute to their becoming homeless. In a 2013 San Francisco Human Services Agency (SF-HSA) review of child welfare case files of homeless child welfare involved families, 70 percent of the parents had documented mental health issues; 55 percent were struggling with substance abuse; and 49 percent were victims of domestic violence. Forty percent of the

[2] Data USA. (n.d.). *San Francisco, CA.* Retrieved from https://datausa.io/profile/geo/san-francisco-ca/

parents suffered both addiction and mental health issues; 42 percent suffered with mental health issues in addition to being victims of domestic violence; and 25 percent suffered with all three. The review also found that the children had multiple needs, with 40 percent exhibiting behavioral problems, 30 percent explicitly needing mental health services, 35 percent having physical medical needs, and 20 percent having been born with positive toxicology screens. In these families one often finds that the parents with the fewest resources are raising the children with the most needs, placing the parent-child bond at extreme risk.

Twenty two percent of homeless families who have had child welfare cases opened in San Francisco have only one additional risk factor: domestic violence. The probability that they will have their children removed is still high: 76 percent. For the last thirteen years, SF-HSA has deployed two domestic violence specialists to assess families affected by violence and make case recommendations. The specialists report that a common scenario is for the abusing partner to keep the housing, forcing the mother to leave. Sometimes child welfare workers will also require the mother to go to a shelter in order to keep her children. Coping with her own trauma, the mother sacrifices not only housing, but often her job, dislocating herself and her children from the entirety of their known lives. Often vulnerable to begin with, the mother may find the new demands for parenting - confused children, the necessity of a housing search, and paying rent - to be extremely stressful. Many stay with the batterer rather than risk the perceived instability that would occur if they left. While domestic violence shelters help women find safety, they have few resources for helping them start new lives. With timely, short-term help, some homeless families in the child welfare system have the resilience to be restored to independence.

A key challenge is identifying whether families are homeless. In San Francisco and other urban areas, the experience of homelessness is fluid. Families do not go straight from secure housing to shelter, particularly when shelters have waiting lists. Parents stitch together night-by-night arrangements, spending a few nights in a shelter, a few nights with a relative who may also be in a tenuous situation, a night in a car, and when a check arrives, a week in a Single Room Occupancy (SRO) hotel in the city's Tenderloin, with their children sharing a bathroom down the hall with men suffering with drug addiction. The break from normalcy, the fear, and the exposure to new risks damages families. But parents are also afraid of losing their children, so they withdraw from potential sources of support to avoid scrutiny. As public as their plight may seem, homeless families are often invisible because of their transience, the shifting nature of their circumstances, and the parents' wariness.

Homelessness magnifies the family's underlying vulnerabilities. The adults' ability to parent regresses; the parent/child relationship, often conflicted prior to homelessness, is further disrupted; and the homeless episode can have a lasting detrimental effect on family functioning and stability, even after housing is found.[3,4,5] Park et al. (2004) found that longer stays in a shelter were associated with a higher likelihood of child welfare involvement.[6] The longer the homeless episode is, the more drawn out the trauma, the more it debilitates parents, and the more it damages families. In a review of risk assessment

[3] Boxhill, N.A., & Beaty, A.L. (1990). Mother/child interaction among homeless women and their children in a public night shelter in Atlanta, Georgia. *Child and Youth Services*, 14(1), 49-64.

[4] Lindsey, E.W. (1998). The impact of homelessness and shelter life on family relationships. *Family Relations*, 47(3), 243-252.

[5] Cowal, K., Shinn, M., Weitzman, B.C., Stojanovic, D., & Labay, L. (2002). Mother-Child Separations among homeless and housed families receiving public assistance in New York City. *American Journal of Community Psychology*, 30(5), 711-730.

[6] Park, J.M., Metraux, S., Broadbar, G., and Culhane, D.P. (2004). Child welfare involvement among children in homeless families. *Child Welfare*, 83(5), 423-436.

data of homeless families with an open child welfare case, SF-HSA found that 63 percent had no prior contact with the child welfare system prior to becoming homeless. The sooner a family can be housed and engaged in supportive services, the better the chances of mitigating damage and keeping the family together.

When a child is removed, even if necessary for immediate safety, the odds for a homeless family of ever becoming reunified again are reduced. In a 2012 survey of SF-HSA child welfare workers, several commented that while homelessness itself may not be a reason for removing a child, it is a significant barrier to reunification. In its analysis of historical data, SF-HSA found that homeless families who have their children removed either experience longer separations or are less likely to reunify at all. They may lose their cash and housing benefits, adding to the hurdles they must overcome. SF-HSA's professionals report that many homeless parents are motivated by a desire to be better parents than they had. For some, once a child is removed, the loss is highly traumatic in a way that can be difficult to recover from. Many adults in non-family shelters have already been separated from their children and are now beyond the point of reunification, and this missed opportunity affects both the individual and the family in a profound way.[7,8]

[7] New York (N.Y.). (1992). *The way home: A new direction in social policy*. New York, N.Y.: Commission on the Homeless.

[8] Cowal, K., Shinn, M., Weitzman, B.C., Stojanovic, D., & Labay, L. (2002). Mother-Child Separations among homeless and housed families receiving public assistance in New York City. *American Journal of Community Psychology*, 30(5), 711-730.

Section II. Overview of the Lead Agency and Collaborative Partnerships

Lead Agency

The San Francisco Human Services Agency (SF-HSA) led the Families Moving Forward (FMF) project. It screened families for FMF eligibility and referred them to the Homeless Prenatal Program (HPP), a local non-profit agency, for housing search and family support services. The agency administered the families' child welfare cases. It held the contracts for the remaining partner agencies and administered the project's governance committees. In addition to managing the city's child welfare system, SF-HSA also oversees self-sufficiency programs, including Medicaid, Temporary Assistance to Needy Families (TANF), the employment services for TANF and General Assistance recipients, and Supplemental Nutrition Assistance Program (SNAP). It also coordinates a network of non-profit senior centers, meal programs, and in-home care services for seniors and adults with disabilities. In 2014 all of the city's child care subsidies were consolidated in a new department, the Office of Early Care and Education. This new SF-HSA department provides policy leadership for the city's entire childcare and preschool network. Until August 2016 it also managed the city's homeless service system. A new homeless department was created to implement the U.S. Department of Housing and Urban Development's (HUD's) Coordinated Entry requirements and to consolidate public health, housing, and shelter services for homeless persons. SF-HSA continues to share administrative resources with the new departments and works closely with it on policy development, and SF-HSA continues to manage several specific housing programs, including the Family Unification Program (FUP) Housing Choice Voucher program, operated in partnership with the San Francisco Housing Authority, and a state-funded program that provides housing subsidies to homeless families receiving TANF. In a city of 840,000, SF-HSA has over 225,000 clients. SF-HSA's annual budget is over $980 million; its staff, over 2,200.

SF-HSA is the city's child welfare agency. In California, state-funded social services are administered by county agencies. The child welfare program has an annual budget of $160 million, including $67 million for operations. It has 194 caseworkers and 31 supervisors, plus case aides and other support staff, and a caseload of approximately 1,000 children on any given day, including about 750 children in foster care and another 250 children in open cases, but living at home. Each year the program responds to about 4,500 reports of child maltreatment. In the last decade SF-HSA has made significant strides in engaging families, including them in decision making, incorporating evidence-based and trauma-informed practices, and removing the barriers inherent in traditional child welfare structures so as to improve family outcomes. The number of children coming into care has dropped dramatically and the adoption rate has increased. When removal is necessary for child safety, SF-HSA places the majority of children with relatives. Permanently reunifying children with their birth parents and doing so in a timely manner is a focus for the agency, albeit a continuing challenge.

Committed to evidence-based and promising practices, SF-HSA invests $2.1 million per year in training. Much of this training happens through a contract with a Bay Area Academy, a program of the California State University system. All protective social workers hired since 2016 have been trained on trauma-informed practice and they have access to bimonthly forums with a clinical specialist to discuss the impact of trauma.

SF-HSA's ongoing partnership with HPP occurs within the context of a broader network of family support services. SF-HSA's child welfare program invests over $33 million a year on contracts with community-based organizations. It collaborates with two other city departments (Department of Children, Youth,

and Families; First Five) to fund a network of 22 family resource centers in the community that provide both primary prevention to families and services like visitation, therapy, and parent education specifically for families in the child welfare system. The collaboration across departments has allowed the city to standardized evidence-based practices in the centers and track outcome measures of mutual interest.

SF-HSA's child welfare program has worked closely with the agency's planning unit to become more data-informed and outcomes-focused. A robust group of analysts and researchers, the planning unit works with all of the agency's administrative data and has data use agreements in place to join SF-HSA data with client-level information from other agencies, including the San Francisco Housing Authority and the new homeless department. It also funds an analyst in the San Francisco Unified School District, and it manages a database that joins information from the Juvenile Probation Department, the school district, the Department of Public Health, and child welfare to alert case workers across systems when a child or youth involved in one system subsequently has contact with another system.

SF-HSA has an unusually strong organizational capacity to support program evaluation. Since San Francisco is both a city and county, SF-HSA's planning unit has unique advantages in data matching across public departments, and has opportunities to link its own administrative data with data from the school district, public housing, public health, and economic development departments. This allows a holistic look at how San Francisco as a whole is serving its most vulnerable residents: revealing portraits of Housing Choice Voucher holders and residents in Single Room Occupancy hotels and public housing developments, detailing their utilization of public sector services and identifying unmet needs.

SF-HSA's planning unit utilizes both the UC Berkeley's California Performance Indicators Project and the Center for State Child Welfare Data at Chapin Hall at the University of Chicago, two primary sources of longitudinal child welfare data in the United States. The unit regularly uses these resources to conduct needs assessments, program evaluations, other research, and to teach incoming student interns, staff, and state and national audiences about the effective use of evidence for decision making.

Partner Agencies

The FMF collaboration had a number of partners. Some proved willing and active partners throughout the life of the grant, although the services they provided might have changed over time. Some were added mid-grant to address pressing concerns. Others fell away over time, either through lack of involvement or because they were not effective. The following table classifies project partners. More detail is provided in the narrative that follows.

Table II.1 Partner Agency Classifications

Area of Responsibility	Agency Name	Nature of Partnership
Housing / Support Services	Homeless Prenatal Program	Core Partner
Housing	San Francisco Housing Authority	Core Partner
Housing	San Francisco Department of Homelessness & Supportive Housing	Partner Added
Housing	Hamilton Families	Partner Added
Support Services	Infant-Parent Program	Core Partner
Support Services	Public Consulting Group	Partner Dropped
Support Services	San Francisco Department of Public Health	Partner Dropped
Support Services	Domestic violence specialists	Partner Dropped

Core Partners and Added Partners

The following partners started and ended as strong collaborative partners. Almost all had some level of personnel change and some details of the work changed over the life of the project. However, the nature of the partnership and the general role each partner played remained a constant.

Homeless Prenatal Program

Homeless Prenatal Program is one of San Francisco's most highly regarded non-profit organizations, and its mission is to break the cycle of childhood poverty in partnership with the families they serve. HPP provides prenatal care and broad-based support to families who are homeless or in poverty. They collaborate with SF-HSA on a number of child welfare initiatives including Bringing Families Home (BFH), the state-funded successor to FMF, and three programs to help families retain or regain custody of their children in the face of homelessness.

As initially conceived, HPP's role was to provide intensive service outreach, case management, and housing services for FMF families through a combination of peer mentors and clinical social workers. Almost from the beginning, this role evolved.

The family team meeting - a meeting between the family, their support system, and other members of their inter-disciplinary service management team – was an important element of the FMF theory of change. It was an emerging practice at SF-HSA at the outset of FMF and the FMF Steering Committee rapidly realized that support was needed to ensure these meetings happened as planned. While protective service workers at SF-HSA retained responsibility for developing and monitoring an over-arching safety and permanency plan, HPP assumed responsibility convening, facilitating, and documenting these meetings.

Very early the roles of peer mentor and clinical case manager – initially conceived as separate - blended into one. The peer mentors on the FMF team were very strong and more than able to serve the role of case manager. In addition, the effort required to engage and house some of San Francisco's hardest to serve families proved greater than anticipated. FMF made a concerted effort to serve all eligible families, not just those advocated for by an engaged protective social worker who selected them as the families most deserving or likely to succeed. Understanding that FMF was a demonstration project, SF-

HSA took it as an opportunity to serve all homeless families, even the most challenging. As a result, families came to FMF who were struggling with a range of issues, including substance use and incarceration. Many hours went into engaging families and building sustained relationships. The team did not have the luxury of both a peer mentor and a case manager. Mid-way through the project, an intern was added to the HPP team, with the sole task of reaching out to families who were not consistently engaged in an effort to get them back to the table.

Housing families also proved more intensive than initially anticipated. The tasks involved in assembling paperwork, preparing families to compete in the highly competitive San Francisco Bay Area housing market, navigating both family and landlord through multiple jurisdictions of housing authority bureaucracy and helping families stabilize throughout the journey, took sustained attention and effort. Over time the HPP team evolved to include first one housing specialist (dedicated to finding and cultivating relationships with landlords) and then two. Non-housing related case management was transitioned back to the protective social worker, while the HPP case managers focused on helping families find and maintain homes and providing after-care once the child welfare case was closed.

HPP provided a licensed clinician to provide case consultation and clinical guidance to the FMF team. This clinician facilitated weekly case conferences with the case management team and provided individual clinical supervision to support with case planning and staff development. The larger HPP mental health team has also provided as-needed emergency client intervention and consultation for families where behavioral health crises surfaced and linkage into treatment required collaborative effort. This model continues in the BFH program.

The San Francisco Housing Authority

The San Francisco Housing Authority (SFHA) was FMF's main source of housing resources. Founded in 1938, the San Francisco Housing Authority is the oldest housing authority in California and the 17th largest in the country. At FMF's inception, SFHA managed a portfolio of over 40 housing developments and provided tenant-based rental assistance to thousands of families through its housing voucher program. The Agency has since become part of the U.S. Department of Housing and Urban Development (HUD) Rental Assistance Demonstration project, converting the majority of its housing developments into voucher-funded units administered by property management companies. Across its portfolio, SFHA serves over 20,000 San Francisco residents each year. At most recent count, there were 21,858 SFHA clients: 2,744 clients in public housing and 19,114 using housing choice vouchers. SFHA has undergone leadership changes since the original grant proposal; its current leaders have been champions for FMF and excellent partners in implementing the program as effectively as possible.

Together, SF-HSA and SFHA held 100 housing choice vouchers through the Family Unification Plan (FUP) program. Some were in use as the program began; the rest were available for FMF families. Due to high rents in San Francisco, the majority of FMF voucher holders were ultimately forced to secure housing outside of the city, transferring or "porting" their housing choice vouchers to other jurisdictions. In most cases, SFHA was given a new FUP voucher to replace each ported voucher. In practice this meant that FMF had a large supply of housing vouchers for the duration of the project. In 2016 SFHA successfully lobbied HUD to increase the value of their housing choice vouchers, making FUP vouchers competitive in the city. Since then most FMF families are once again leasing up in San Francisco.

For the first years of FMF, SFHA used grant funds to deploy a manager to expedite voucher applications and resolve interagency challenges. This position was designed to phase out over the life of the grant, as indeed it did. SFHA assigned an exceptional intake specialist to the FUP program. This individual reduced

the need for a separate liaison to track status. Due in large part to the annual grantee meetings, SFHA and FMF leadership formed a strong working relationship and a shared dedication to FMF's success. As one SFHA leader put it, "if we don't have to say 'no', we'll find a way to say 'yes.'" SF-HSA is indebted to SFHA for their excellent and ongoing partnership in this and other matters.

San Francisco Department of Homelessness and Supportive Housing

Upon its creation in 2016, the San Francisco Department of Homelessness and Supportive Housing (HSH) became an instant partner. Prior to its creation, HSH was a part of SF-HSA, and as a new department, it honored the commitments it made in its former capacity. For FMF, HSH provided ten units in the City's permanent supportive housing portfolio (and allowed them to be recycled to new FMF clients when early FMF families stabilized and opted to transition to FUP vouchers). HSH also offered two-year subsidies (under $2000) designed to provide temporary housing support for families who just needed some time to stabilize and who ultimately funded their own housing. In practice, these latter were lightly used: only two families availed themselves of the shallow subsidies: one family using it for one year and one for two years.

Today HSH manages $168 million in homeless and housing resources, primarily through contracts with community-based organizations. At any given time, HSH is funding and overseeing nearly 10,000 housing units and shelter beds. This includes ten year-round adult shelters, four Navigation Centers for adults, seven year-round family shelters, one youth shelter, and additional winter shelters and resource centers. HSH provides homeless prevention services and one-time grants, including eviction prevention and rental assistance, to over 3,000 households per year. It manages $40 million in HUD Continuum of Care grants.

A 2012 data match revealed that 11 percent of families in San Francisco shelters had an open child welfare case, although that number likely understated the need. In urban communities, as in San Francisco, more homeless families are found in makeshift arrangements than in shelter. At FMF's inception, San Francisco's shelter system had capacity for 142 families and a waiting list of 159. This number is harder to come by now - family shelter capacity in San Francisco has increased and coordinated entry has eliminated the waiting list – but anecdotally, the need is still great. Families report staying in emergency shelters; temporary programs such as transitional housing or domestic violence programs; rental settings from which they face imminent risk of eviction; and single room occupancy hotels. They also report staying on the streets or in vehicles and on the couches of friends, family, and acquaintances.

The FMF team initially envisioned a robust collaboration with the city's family homeless shelters. At project launch, San Francisco had three family homeless shelters: Hamilton Family Center, Catholic Charities, and Compass. Each of these organizations signed a Memoranda of Understanding (MOU) describing mutual responsibilities. SF-HSA and the shelters agreed to provide training to each other's staff, and the shelter staff agreed to send representatives to family team meetings convened by child welfare staff. SF-HSA also agreed to send a representative to the quarterly meeting of shelter directors to discuss barriers and opportunities for further collaboration on shared families.

In summer of 2013, "Child Welfare 101" training was held for family shelter providers. The training was fully subscribed and providers asked that it be offered every six month so that new staff could attend. Stimulated by the FMF project, SF-HSA's new deputy director of child welfare attended two meetings of family shelter providers to answer questions and exchange ideas. Additional trainings

were planned to educate child welfare workers on San Francisco's family homeless shelter system and on SFHA procedures.

After this strong start, the integration fizzled and ongoing collaboration never materialized in the way the team hoped. This might be due – at least in part – to the creation of Holloway House which provided shelter for FMF families outside of the HSH shelter system. Holloway was launched to address the lack of short-term shelter options available to FMF families. (Please see section below on Hamilton Families for more information).

In the past few years, HSH has focused on implementing coordinated entry for San Francisco's adult, family, and youth homeless populations. This has reduced the number of set-aside units for FMF and its successor, BFH. HSH and SF-HSA remained committed partners in addressing the needs of homeless child welfare families. Leadership from the two programs meets quarterly on a range of issues and is currently exploring how to ensure that child welfare involvement is adequately weighted as part of the city's coordinated entry assessment.

Hamilton Families

In November 2015 FMF opened Holloway House, a response to the extended timeline for housing families in San Francisco's super-heated housing market. Holloway House provided dedicated bridge housing for homeless families who had no other place to go while they waited for the opportunity to use their housing choice voucher. Prior to this, case managers were maintaining families in hotels, siphoning time and energy from the goal of permanent housing. Located in a large house in a middle-class San Francisco neighborhood, Holloway can serve up to ten unrelated adults and up to seventeen individuals at any one time. FMF uses it to house approximately three to five families at a time.

SF-HSA refurbished the building, posted a request for applications, and selected Hamilton Families to operate Holloway House. Hamilton is San Francisco's largest provider of family shelter. Adding a new partner to the project team in the third year of implementation was not without challenges. Hamilton is primarily a shelter provider and comes from the background of maintaining a harmonious environment among large groups of people. They had less experience with harm reduction and a tendency to want to expel who did not follow the rules. FMF uses strength-based engagement and a variety of family support strategies that are flexible and individualized to support families who are experiencing trauma and are involved in child welfare. To ensure a cooperative atmosphere in the facility, the project had Kadija Johnson from the Infant-Parent Program lead a discussion between the providers to develop a common vision for going forward. Dr. Johnson has expertise in integrating trauma-informed practice and has conducted trainings with project staff. To promote communication and the day-to-day coordination of operations at Holloway, HPP assigned a case manager to be on site three days a week, helping residents with housing readiness and search activities. To improve harmony between residents, the project also added more family-focused, child-centered activities. HPP continues to lean into their partnership in Holloway, recognizing that it is one of the pillars of FMF success. HPP is exploring other ways to expand its work in residential services.

University of California San Francisco, Infant-Parent Program

SF-HSA's analysis of data from the child welfare risk assessment tool revealed that not only did homeless families have higher rates of mental health issues that might disrupt the parent-child relationship, but also that 35 percent of families in the profile had children under one year; 63 percent, a child under five. To address this issue, FMF enlisted the Infant-Parent Program (IPP) at University of California San Francisco to provide home-based mental health services to families with children birth to five years of

age through child-parent psychotherapy. Offering this specialized treatment modality in the home, even if that home is temporarily a shelter, ensures that disenfranchised dyads will receive needed mental health services. The Infant-Parent Program has longstanding working relationships SF-HSA and HPP, and provides ongoing mental health consultation to various family support programs regarding support of the parent-child relationship during times of trauma and transition.

IPP proved an excellent partner for the entirety of FMF. The program initially encountered some obstacles in the referral mechanism: case workers initially had to "opt-in" qualifying families which led to inconsistencies in how the intervention was delivered. This improved when the project shifted to an "opt-out" model, automatically referring every family with children 0-5. In total IPP served 12 treatment families and three pilot families. Throughout most of the project, they also provided monthly case consultation to HPP case managers.

Partners with Less Successful Collaboration

Public Consulting Group

The FMF Steering Committee believed that to remain housed in San Francisco's feverish rental market, families needed steady income. According to a case file review done during the readiness assessment, 70 percent of parents had mental health issues and 21 percent physical health needs, and many of the children had serious mental health and physical challenges, too. Yet a data match against the list of families in family homeless shelters or on the waiting list found that only two persons were receiving Supplemental Security Income (SSI). To explore this apparent inconsistency, the team hired the Public Consulting Group (PCG) to provide SSI advocacy services to families. The assumption was that the very nature of the individual's disability could prevent him or her from sequencing the steps necessary to applying for SSI.

The hoped-for benefit of this partnership never fully materialized. Shortly before FMF was launched, PCG lost their (much larger) contract to screen adolescents in foster care for SSI eligibility. For FMF, logistical obstacles initially prevented PCG from getting the data it needed to screen families for eligibility. Once these concerns were addressed, the majority of individuals failed the eligibility screening or had their SSI applications rejected. In addition, it was felt that this service duplicated an already-existing contract provide a similar service across FMF. Several years into FMF, this program component was eliminated and the money re-directed towards housing support.

San Francisco Department of Public Health

The San Francisco Department of Public Health (SF-DPH) manages the city's public behavioral health services for adults, families, and children. As San Francisco's main provider of behavioral health services to homeless and high-risk families, they were a valuable prospective partner to FMF. Despite repeated efforts, however, the FMF team was unable to bring them to the table as a partner.

In the child welfare population, rates of repeated trauma exposure, Post-Traumatic Stress Disorder, and other co-occurring conditions are exceedingly high. In 1996 SF-DPH created the Foster Care Mental Health Program specifically to improve the coordination of mental health services for the children and youth, from birth to age 18, in San Francisco's child welfare system. The program is comprised of a multidisciplinary staff that has expertise in working with abused and neglected children, including child psychiatrists, psychologists, social workers, marriage/family therapists, case managers, and psychology and social work interns. The program has four teams that work collaboratively to offer services: The

Clinical Team, the Medical Team, the Child and Adolescent Needs and Strengths (CANS) Assessment Team, and the Authorization Team.

In 2012, as a result of a statewide legal settlement known as "Katie A," SF-DPH expanded mental health services to children with in-home child welfare cases. Part of the implementation was to ensure that every child under the supervision of the child welfare system received a CANS screening, which would trigger full assessment and needed services for the child and family. The FMF project hoped to be a pilot for this broader system change, ensuring that all FMF-involved children were screened early in their cases and rapidly received the support that they needed.

The reality, however, fell short of expectations. SF-DPH was sporadically able to dedicate attention to FMF experiences and DPH partners occasionally attended steering committee and continuous quality improvement (CQI) committee meetings early in the project. But organizational challenges at SF-DPH prevented the team from tracking the extent to which the intended rapid referral, evaluation, and service delivery occurred. It also prevented them from diagnosing or addressing challenges with the implementation of universal CANS screening. This process eventually improved as SF-DPH was able to staff up clinicians to meet the goal of quickly screening all children in in-home and out-of-home cases, but there is still some way to go. Midway through the project, 26 percent of FMF children had a CANS screening within the target window of 2 months of case opening, and 26 percent of cases closed without ever being screened. By the end of the project, those figures had improved to 48 percent and 19 percent, respectively. This improvement was tangential to FMF and not directly related to the work of the project.

SF-DPH also provides behavioral health support for adults, including funding for many of the city's drug treatment programs, and the FMF team initially hoped to collaborate with them to provide priority treatment for FMF families. Initially promising attempts to secure an MOU and to present the FMF model to adult behavioral health providers fizzled, however, and the anticipated collaboration never materialized.

San Francisco Domestic Violence Partners

The FMF team anticipated that domestic violence would be a factor for some project families. A preparatory data review in 2012 indicated that 22 percent of homeless families who had child welfare cases opened in San Francisco had only one additional risk factor: domestic violence. These families still had a 76 percent probability of having their children removed. Since 2007, SF-HSA has contracted domestic violence specialists to provide crisis intervention and consultation services such as risk assessment, safety planning and information referrals for families with an open CPS case. Currently two domestic violence specialists are co-located with child welfare hotline and emergency response staff to provide domestic violence services onsite; however, these specialists were never integrated into the FMF project.

Although not currently in this role, HPP has prior experience as a city-contracted provider of domestic-violence related services. They had the experience to help families navigate housing complexity related to domestic violence. And they had the understanding and connections to ensure that families received the support that they needed.

Overview of System-Level Goals and Approach

Prior to FMF the systems serving child-welfare involved homeless families were disconnected. Child welfare case plans seldom had any formal element that addressed housing, and child welfare workers had only glancing contact with the public housing system. Child welfare plans directed families to address the underlying issues that led to homeless, such as substance use and behavioral health, but without housing, families lacked the stability to use those services effectively. With their situations in chaos, families struggled to find their way to services, much less to housing.

The FMF project aimed to integrate resources from the Housing Authority, and from SF-HSA's own housing and homeless services system (now the Department of Homelessness and Supportive Housing), with the child welfare sphere of family support services, coordinating them to come together quickly, to make housing the first priority, and to calibrate interventions according to family needs that have been carefully assessed.

FMF's goals for systems-level change were directed at stabilizing and housing the child welfare involved homeless families quickly and wrapping them with supportive services aimed at their underlying vulnerabilities.

Goals included:

- Accelerating the identification and engagement of homeless families coming into the child welfare system;
- Providing a consistent definition of homelessness that can be used across the child welfare and housing systems;
- Establishing a housing first approach to serving families, improving coordination between the city's child welfare and housing systems;
- Addressing the families' long term needs so that they reduce subsequent contact with the homeless and child welfare systems;
- Providing evidence-based, trauma-informed services that wrap the family with support and are sequenced according to the families' most salient needs.

Systems Integration and Operations

FMF was designed as an integration of services, achieved through changes in child welfare's internal processes and its external relationships with other agencies. FMF's main goals did not change over the life of the project, but many of the implementation details did, shifted by changes elsewhere in the system or by the impracticality of the original goals. System change goals included the following.

Identification of Homeless Families

The project successfully encouraged child welfare investigators to use a standard and generous definition of homelessness, ensuring that homelessness is quickly identified and that protective services workers and housing service providers have the same understanding of what it means to be homeless. Child welfare investigators identify a homeless family by a checking a box – homeless or not homeless – on the Structured Decision Making® (SDM®) tool. This actuarial tool is used by the worker to decide if a case should be opened, based on level of risk and safety issues for the child/children. Prior to FMF, the challenge with a single, binary question on homelessness was that child welfare workers used idiosyncratic judgments about the housing status of families. Homeless families in an urban setting have

shifting circumstances, moving from one untenable situation to another every few days, and if the worker was not fully informed of their circumstances, or holds a mental image of homelessness as only meaning that the family is on the streets or in a shelter, homelessness is not flagged at the outset of a case. Since the SDM® tool itself is proprietary and cannot be altered, all emergency response (ER) and ongoing child welfare workers now have a laminated, 8 ½" x11" printout of the San Francisco definition of homelessness to keep on hand. Homelessness definition criteria are also summarized on the investigation narrative form.[9]

FMF successfully changed the way that the child welfare system relates to homeless families. Child welfare workers see housing for homeless families as an important element in the child welfare case plan: not as something a family must "fix" but as an underlying element of case plan success. Equally importantly, they see homelessness as something they can help change.

The implementation of this goal has changed slightly over time. For example, BFH recognizes that homelessness may be detected at the outset of a case, but may also occur after case opening, and it accommodates this fluidity. In addition, changes related to coordinated entry have changed the way HSH emphasizes the San Francisco definition of homelessness. The child welfare definition now joins the San Francisco Unified School District definition as being more liberal than that of HSH. HSH and SF-HSA remain committed partners in addressing the needs of homeless child welfare families. They are currently working through the ramifications of these disparate definitions and are exploring how to ensure that child welfare involvement is adequately weighted as part of the city's coordinated entry assessment.

Housing First for Families

The FMF team understood how difficult it can be for families to comply with child welfare mandates before they have the security of permanent housing. They understood that the experience of homelessness is traumatizing and damaging to a family's functioning. FMF used a blend of resources – targeted housing search support, bridge housing, housing choice vouchers, supportive housing units, rental subsidies and discretionary dollars from child welfare, to place families in stable housing that was not time-limited as quickly as possible following referral. The hope was that this would enable families to concentrate on the next steps in their case plans.

In reality, it is still very difficult to house families quickly in San Francisco. The team has done a lot to make it quicker (families are housed nearly twice as fast under BFH as they were under FMF) and Holloway House has done much to give families a stable platform sooner, but executing Housing First so that the housing is actually first, remains an ideal that the team is shooting towards, rather than a certainty.

Accelerated Engagement and Mobilization of Service Team

At the outset of FMF, emerging practice required that a family team meeting be held in the first 30-60 days after a case was opened. The family team meeting - a meeting involving family members, extended support systems, and other members of the family's inter-disciplinary service management team – is primarily utilized for decisions about child removal and agreements for ongoing case requirements

[9] The City and County of San Francisco defines homelessness as including individuals or families who lack a fixed, regular, and adequate nighttime residence and who have a primary nighttime residence in one or more of the following categories: shelter, street, vehicle, make-shirt, doubled-up, or transitional housing. See Appendix A for the complete definition.

and child safety plans. Initially, FMF's goal was for the investigations worker to set up a Family Team Meeting (FTM) within one week of a family being screened into the project, with newly required partners, including members of the HPP outreach team, the SF-DPH assessor and a housing specialist, either from the Housing Authority or HSH, as a core partner, ensuring that the case plan is cognizant of housing and be used to integrate efforts of the community.

In reality, the FMF team found that this approach was too much, too fast. The rapid intervention approach overwhelmed families with information and outsiders while the fact of their child welfare involvement was still raw. Early in FMF implementation, most of the new partners were dropped from the initial Family Team Meeting (convened by HPP, as detailed above) and were included in subsequent meetings as relevant and appropriate.

The FMF team also found that rapid intervention prior to the development of a family's case plan caused a great deal of confusion and inefficiency. Families rapidly transfer social workers in the initial stages of their child welfare cases: moving from an emergency response (ER) worker to a court-dependency unit (CDU) worker to a worker in the family stabilization unit. It is this last worker who holds the family's story and guides their case plan. Protective services workers in the ER and CDU often lacked the full measure of the family's story and could not adequately participate in planning meetings. Further, trying to assess housing for the children before it was understood which parent was getting custody proved problematic. Involvement in the BFH program pushes the critical, housing-focused FTM back until the family is working with the family stabilization unit. When the CDU process works as it should, this means that families are beginning to engage in housing case management services 2 to 3 weeks later than they would have under FMF. For complicated custody cases, dispositions are sometimes delayed and the CDU process takes longer. This adjustment notwithstanding, the overarching goal of rapid and coordinated intervention remains the same.

Peer Outreach Integrated into Case Work

Homeless families involved in the child welfare system may have been uprooted from geographic attachments, isolated from natural supports, and suspicious of the new agents in their lives. FMF deploys peer outreach specialists to engage families quickly and build trust so that they their needs can be properly assessed and so that they have a reliable advocate who can help them accomplish their case goals.

Note that this important aspect of FMF will continue even as the intervention shifts slightly later in a family's child welfare case. Being free of the child welfare system and often having similar backgrounds to those they service, HPP's peer advocates and case managers form a bond with their clients that child welfare workers cannot.

Improved Coordination with the Housing Authority and the Housing Continuum of Care

As noted above, safe and stable housing can have a huge impact on parenting: both the ability to parent well and on the ability to regain custody of any children removed from the home. The child welfare system serves many families who struggle for lack of housing support. It also serves many families who are in public or subsidized housing. Yet prior to FMF these systems were in different orbits, with different timelines and considerations, and families stuck in the middle. To many housing providers, child welfare remains a mysterious force, making unpredictable decisions and withholding information about families. A major FMF goal was to better integrate these systems. Although work remains, FMF has been the catalyst for substantial gains in this area, as described above.

Assessment

An FMF goal was for every child and every adult to receive an evidence-based assessment, which would inform their service plan.

As described above, SF-DPH expanded mental health services in 2012 to ensure that every child under the supervision of the child welfare system received a Child and Adolescent Needs and Strengths (CANS) screening, which would trigger full assessment and needed services for the child and family. Although SF-DPH was not able to scale up this process as quickly as the FMF team had hoped they would, the process improved over time as DPH was able to add clinicians to meet the goal of quickly screening all children upon case opening.

The Adult Needs and Strengths Assessment (ANSA) was used to both establish the baseline constellation of caregiver needs and strengths as well as to measure progress over time. Early in the project, full HPP caseloads and housing delays led the CQI team to examine the relationship between ANSA scores, time to housing, and case manager time use. The purpose was to understand how case managers spent their time in relation to caregivers' changing needs, particularly in relation to when housing occurred. Generally, caregivers required somewhat less case management time once they secured housing, and declining needs on some ANSA items corroborated that finding. The team also used the ANSA to set objective criteria for program graduation. Caregivers were advanced from check-in status to graduation if, among other criteria, they showed no acute need on the ANSA. The ANSA is limited in its ability to identify levels of services that would correlate to level of need. It is also limited because it is adult-focused and assesses very little from the family perspective. The team continues to use the ANSA in BFH, but will look to a more family-centered assessment tool for future programs.

Trauma-Informed, Evidence-Informed Interventions

Having IPP and HPP as FMF partners dovetailed with SF-HSA's existing work to incorporate trauma-informed interventions early in the case planning process and to include these interventions as part of a plan to support housing stability. In particular, having IPP integrated into the case management model for FMF families was beneficial and gave IPP some flexibility in their service delivery model. IPP serves non-FMF child welfare families through other contracts with the city, including home visits within San Francisco, and under FMF extended that service to families that moved outside of the county.

Self Sufficiency Support

SF-HSA operates both the child welfare program and the self-sufficiency programs for the county, yet does little to coordinate these services for child-welfare involved families. A program to coordinate TANF and child welfare case plans exists, but has never been as robust as planned. Often the underlying issues that cause homelessness are so salient that the long-term financial stability of the family is not considered in the case plan. FMF included wage subsidies for all families: to help these parents regain or advance their position in the labor market. The project ran into sequencing issues, however. Case managers felt that introducing wage subsidies at the same time as all of the other elements of parents' case plans could overwhelm the family and detract from the important work of finding housing and keeping or regaining custody of their children. Many FMF families were forced to move out of San Francisco to find housing, further complicating the picture. For these reasons, case managers rarely presented wage subsidy opportunities to parents, even when those parents were actively seeking to participate in the labor market. FMF tracked the rate of benefits enrollment among project participants. About half the participants had benefits prior to FMF referral and there was no indication

that project participation increased the likelihood of enrollment. Twenty FMF families were hired with SF-HSA funded wage subsidies after referral to the project, but that did not differ significantly from the number of families who were hired with the subsidies prior to referral. Nor did it differ significantly from the number of control group families hired before or after randomization.

Prior to spending more time focusing on improving this integration for the BFH initiative, the project team will study whether this additional effort makes sense. It is possible that benefits and wage subsidies are already functioning efficiently for families and that energy should focus on streamlining the experience for families or on something else entirely.

FMF initially planned to screen all families for SSI eligibility, to identify parents who had disabilities and could not work, or who had children whose disabilities demanded so much of them that they could not work. This was deemed ineffective and redundant and was discontinued. Child welfare conducts SSI screening for all of its families as part of a separate, agency-wide initiative.

Aftercare

The FMF team planned for HPP case managers to remain engaged with families for a period of at least six months after the families had found housing, had their child welfare cases closed, and improved family functioning as measured by the ANSA. The team understood that homeless families often have their child welfare cases closed after completing service requirements, but continue to have lingering conflicts that make them vulnerable to child welfare involvement. Case managers would provide continued support, crisis intervention, and problem-solving assistance until it no longer felt required. Over time the intensity of the case services could be calibrated according to the families' needs.

Aftercare proved to be a vital part of the FMF initiative. Less well understood, but equally important, was FMF's role in providing housing stabilization services for at least a year post-housing. Both tenants and landlords looked to HPP to resolve conflicts and help navigate the uncertainty of housing authority bureaucracy (especially the one-year re-certification process). FMF participants also looked to HPP housing specialists to help re-house them when necessary. These were important elements of housing case management that often resurfaced. This was a factor in the very high rate of housing retention among those FMF participants who were successfully housed.

In addition to the above, FMF participants have ongoing access to the wide range of services that HPP provides as a Family Resource Center (e.g. peer support; diapers; drop-in services).

Integrated Service Delivery

A model for structuring and continuously improving integrated services among multiple agencies was an unanticipated benefit of the FMF project, as detailed in the sustainability section below.

System-Level Logic Model

Please see Appendix B for the System-Level Logic Model.

Section III. Description of Demonstration Project and Implementation

Service Model and Goals

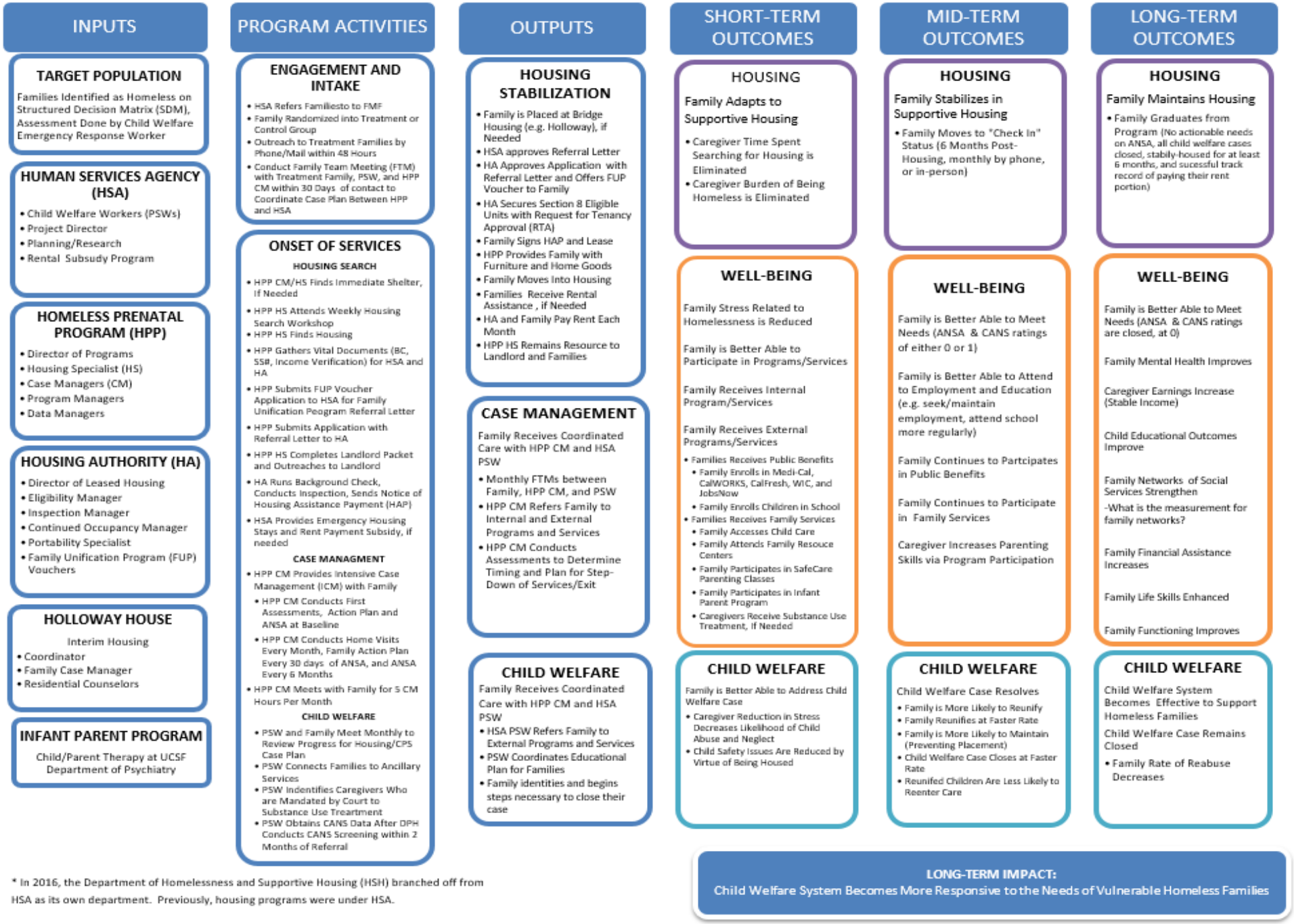
Families Moving Forward (FMF) was a collaborative initiative designed to reduce the probability of placement and increase the probability of reunification to the families referred to the child welfare agency who are also homeless. The FMF program was intended quickly stabilize and house families, while provide case management and support services to family members as they sought secure housing, close their child welfare cases, and improve full family functioning and well-being.

Service-Level Logic Model

The service-level logic model (below) outlines the process by which FMF planned to lead to improved housing, child welfare and well-being outcomes for participating families. San Francisco Human Services Agency (SF-HSA) theorized that by providing families involved in the child welfare system housing and enhanced case management, family stress related to homelessness would be reduced and therefore families would be better able to address their child welfare cases and participate in supportive programs and services. In the long-term, families who maintained stable housing would be more likely to exit the child welfare system, less likely to reenter the child welfare system, and more likely to have improved well-being outcomes.

Subsequent subsections outline the major program activities that comprise the FMF model.

Service-Level Logic Model



* In 2016, the Department of Homelessness and Supportive Housing (HSH) branched off from HSA as its own department. Previously, housing programs were under HSA.

Provision of Housing

FMF had the initial goal of serving 160 families over five years - enrolling 32 families a year into the FMF treatment group.[10] Subsequently, the Children's Bureau requested that the first year be reserved for planning activities, although FMF did implement a pilot with 20 families during the planning phase and used the lessons learned to refine the project model.[11] The goal of 160 families eroded in the face of unforeseen complexities: some inherent to program design, others due to external forces, all described below. Ultimately only 59 families were permanently housed.[12] Please see Appendix C for more detail related to housing and engagement challenges and resulting program impacts.

Housing for the project came from three main sources:

- Up to 100 Family Unification Program (FUP) Housing Choice Vouchers from the San Francisco Housing Authority (SFHA);
- 10 units of permanent supportive housing through San Francisco's local operating housing subsidy; and
- Up to 50 "shallow" rental subsidies of up to $800 per month that could last from 12 – 24 months, drawn from San Francisco Human Service Agency's (later the Department of Homelessness and Supportive Housing (HSH)) existing portfolio of housing assistance.

From the start the plan was for existing FUP Vouchers to turn over during the life of the project, so that new FUP vouchers would continue to be available as additional families joined the treatment group. U.S. Department of Housing and Urban Development (HUD) confirmed that families who have used FUP vouchers to stabilize their living situations can be transferred to regular Section 8 Housing Choice Vouchers without having to be on the waiting list for the regular vouchers. This can be done by documenting the local preference in the Housing Authority's Administrative Plan. SF-HSA worked with SFHA to change their Plan accordingly. SFHA committed to turn over 20 vouchers per year. The FMF team never needed this mechanism. Long-standing challenges using FUP vouchers in San Francisco led to an over-supply of FUP vouchers. New FUP voucher recipients moved to other housing authorities in the Bay Area and those housing authorities "absorbed" the vouchers, choosing to use their own voucher supply to house these families rather than billing the cost to SFHA. SFHA kept the original FUP voucher. This meant that FMF had a seemingly endless supply of FUP vouchers at its disposal. Not until the end of 2018 would demand finally outpace supply.

The permanent supportive housing vouchers also proved to be a renewable resource. Several families moved in, stabilized for a year or two, and then opted for the increased independence of a FUP voucher. HSH allowed FMF to keep the supportive housing slots for program use: a new FMF family could move in to the vacated unit.

The shallow rental subsidy slots were barely used. Given market conditions, the subsidy value increased to $2000 during the project. Still, only two FMF families were able to use them: one for 12 months and one for 24.

[10] This number was derived from the estimated need: roughly 64 families met the program selection criteria each year and roughly half of these would be randomized to the treatment group.
[11] As part of the planning process, FMF piloted the initiative with 20 families, 12 of whom maintained a strong involvement with HPP and 11 of whom were housed with SF-HSA's FUP vouchers.
[12] 48 treatment families were housed, along with 11 families who were part of planning-year pilot.

The base housing funding was augmented in several ways over the course of the project:

1. During the planning phase, the FMF team identified a problem with timing. FMF hoped to catch homeless families soon after their cases were open; expected outcomes relied on timely housing. However, neither permanent supportive housing units nor housing choice vouchers could be relied upon to be available on demand. Aligning case opening and housing availability seemed impossible. In response, SF-HSA committed over $500,000 per year of child welfare funds (available through the Title IVE Waiver) to create deep bridge subsidies. Homeless families coming into the FMF project would have immediate access to a deep rent subsidy, getting them off the street or out of shelter or away from untenable situations.
2. The team realized that move-in costs could be prohibitive, with a rent deposit in excess of $2000 preventing a low-income family from taking advantage of a housing voucher. Funds were allocated to create flexible accounts for each family. With Homeless Prenatal Program's (HPP) supervision, families could use these funds to pay rent deposits, repair credit, or otherwise remove barriers to permanent housing.
3. Using local funds, FMF opened Holloway House in November 2015, a response to the extended timeline for housing families in San Francisco's super-heated housing market. Holloway House provided dedicated bridge housing for homeless families who had no other place to go while they waited for the opportunity to use their housing choice voucher. Prior to this, case managers were maintaining families in hotels, siphoning time and energy from the goal of permanent housing. Located in a large house in a middle-class San Francisco neighborhood, Holloway can serve up to ten unrelated adults and up to seventeen individuals at any one time. FMF uses it to house approximately 3 to 5 families at a time. HPP provides onsite case management and other programing to help families prepare for and find permanent housing.
4. The project also benefited from the use of the SHARE Housing Subsidy: a local rental subsidy with a maximum value of $2,800-3,200 a month, depending on bedroom size. The program started in January 2016 with the intent to identify families with a documented need to stay in San Francisco and house them within county limits.

San Francisco's very high housing costs caused two additional noteworthy program changes. Together these changes also impacted the number of people that FMF could serve.

1. The SFHA's payment standard proved an inadequate match for market-rate rents.[13] Against the team's strongest wishes, FMF families were mostly housed outside of San Francisco, in the wider Bay Area. This affected time-to-housing: it took longer and required more energy to navigate the bureaucracy required to transfer a voucher from one authority for use in another. It also affected the program model: travel took up more of case managers' time, home visits were less frequent, workers spent more time helping families navigate other bureaucracies to get benefits and other vital supports transferred.
2. As indicated in the 'Partner Agencies' section above, the program structure also changed to include first one housing specialist (dedicated to finding and cultivating relationships with landlords) and then two. These vital resources worked with HPP's case managers to assemble paperwork, prepare families to compete in the highly competitive San Francisco Bay Area

[13] The mismatch between market rent in San Francisco and SFHA's payment standard persisted until a 2016 rent reasonableness study by the San Mateo, San Francisco and Marin housing authorities led HUD to substantially increase fair market rent for those three counties. It is now once again possible to house families in San Francisco using housing choice vouchers. Most FMF families stay in the city; those that do not generally have a good reason for not doing so.

housing market, and navigate both family and landlord through multiple jurisdictions of housing authority bureaucracy.

With SFHA's guidance, SF-HSA suggested a change to the SFHA's Administration Plan that was approved in January 2015. In San Francisco, FUP voucher applicants would now only be denied a voucher based on HUD's two mandatory rejection criteria, registered sex offender status or a conviction for producing methamphetamine on Housing Authority property. Prior to this change, applicants were rejected for criminal history or other offenses and were then subject to a complicated appeal process before being granted a voucher. The change to the Administration Plan significantly reduced the time it takes for new families to receive a FUP voucher once their applications have been submitted. SFHA also agreed to allow automatic extensions of up to one year on FUP vouchers and has agreed to allow HPP to renew FUP vouchers on behalf of families (with the standard release of information form).

Target Population

Homelessness and Other Risk Factors

FMF's eligibility criteria followed from the rationale that shaped the project design: that child maltreatment deriving from a family's homelessness and other undesirable circumstances and behaviors could be ameliorated with a combination of housing and focused, intensive social services for the family unit. The program was designed to treat families at highest risk for placement and serve them early in their child welfare service trajectory. This was to give the family the benefit of intervention in order to prevent deeper child welfare involvement.

The question of who to serve was separate from the question of when to serve them. The evidence below explores both. It demonstrates that FMF criteria delineate a high-need population that is at extraordinarily high risk for placement into foster care, even when compared to the general population of children reported for maltreatment. It also shows that identifying them early improves the possibility of having a desirable impact.

The project team conceptualized high need as the set of identifiable risk factors for some outcome, most notably, those less disruptive child welfare trajectories that lead to placement in out-of-home care, when a more effective treatment may be an alternative to foster care. We identified those risk factors by examining a past group of children and parents who came to the attention of the child welfare system and looked to see which characteristics and circumstances tended to lead to deeper child welfare involvement and which did not.

The team then targeted the intervention to those families at the earliest available opportunity in order to maximize the ability to observe statistical impact in a small sample. For the child welfare agency, this translated to targeting high-risk families at child welfare case opening. Limiting eligibility to families with *no* prior child welfare cases would have drastically reduced the sample. A compromise was to require that at least one child in the family did not have prior cases.

The project used historic data to estimate the size, characteristics, and outcomes for the target population. We analyzed administrative child welfare data and Structured Decision Making® (SDM®) risk assessment data for all children investigated for maltreatment in San Francisco between February 1, 2008 and December 31, 2012, and administrative child welfare data *statewide* for all children ever

reported for maltreatment in San Francisco between 2008 and December 31, 2012. We used SDM to determine homelessness and to determine other risks that would affect the outcomes of interest. The data presented in this section are at the child level, although the FMF program selected families as defined by the children and caregivers in the household.

1. *Homeless at the time of investigation:* FMF restricted selection to those who were homeless at the time that they were investigated for maltreatment. We did not include families who are at risk of homelessness, nor did we further narrow the criterion based on prior homelessness spells.

Table III.1 shows the basic characteristics of 557 children who were investigated for maltreatment and were deemed homeless during the investigation, and between February 1, 2008 and December 31, 2012 in San Francisco. It also shows how they compare to 8,746 children investigated during the same period who were not homeless. It should be noted that children in either group could have had homelessness spells prior to implementing the SDM® tool in 2008.

The primary differences between the two groups are that African American children and babies made up a greater share of the homeless group. An additional point of information not shown in the table is that the median age of mothers of the homeless children was 32 years.

Table III.1 Characteristics of Children Investigated for Maltreatment by Homelessness Status, 2008-2012

	Number		Percent	
	Homeless	Not Homeless	Homeless	Not Homeless
Total (9,303)	557	8,746	6%	94%
Race/Ethnicity				
Asian/Pacific Islander	41	1,487	7%	17%
African American	250	2,727	45%	31%
Hispanic	159	3,001	29%	34%
Native American	0	34	0%	0%
White	102	1,091	18%	12%
Unknown/Missing	5	406	1%	5%
Gender				
Female	275	4,332	49%	50%
Male	281	4,383	50%	50%
Unknown/Missing	1	31	0%	0%
Age				
0	196	798	35%	9%
1-5	157	2,382	28%	27%
6-12	120	3,435	22%	39%
13-17	83	2,127	15%	24%
Missing	1	4	0%	0%
Year of Risk Assessment				
2008	134	2,580	24%	29%
2009	147	2,843	26%	33%
2010	85	1,419	15%	16%
2011	97	1,189	17%	14%
2012	94	715	17%	8%

Table III.2 shows the frequency of child welfare cases prior to and following the child's first SDM® risk assessment. Homeless children identified at investigation were unlikely to have had a prior case and were less likely compared to non-homeless children. On the other hand, homeless children identified at investigation were more likely to have an in-home case opened and were more likely to be placed than non-homeless children.

Table III.2 Child Welfare Events Prior and Subsequent to First SDM® Risk Assessment, 2008-2012

	Number		Percent	
	Homeless	Not Homeless	Homeless	Not Homeless
Prior In-Home Case	23	139	4%	2%
Prior Placement	49	687	9%	8%
Subsequent In-Home Case	357	2,390	64%	27%
Subsequent Placement	282	1,156	51%	13%

2. *Beginning a first child welfare case:* There were a number of reasons to select on the basis of first case opening. From a clinical perspective, the increment of change we expected the intervention to exert on families needed not be large if targeted early, because a small change in the probability of recurrence could accumulate over time and make a big impact on the overall trajectory. This had a double meaning for FMF's target families. First, young children were likely to be overrepresented in the client population: Table III.2 shows that 63 percent of homeless children investigated for maltreatment were age five or under. Second, for families with children at any age, early intervention interrupts downward trajectories quickly, when as little damage as possible has been done and as much time as possible remains for recovery.

If the project were to delay the intervention until families are well into their child welfare (and perhaps other public system) trajectories, child risk levels may be heightened as caregiver co-occurring risks worsen if untreated. Under these protracted, exacerbated circumstances, the intervention would have to exert a particularly powerful effect on families and in a short amount of time in order to generate significant and lasting positive outcomes.

Since FMF was a child welfare intervention, it did not have the capacity to target families before they came into contact with the child welfare system, even though the risky behavior and/or unfortunate circumstances may have started well before the first case opening. Identifying families at the earliest opportunity within the child welfare system allowed the project to maximize the potency and impact of the intervention, while also targeting those at highest risk for placement. In the absence of any intervention, recall that over half of homeless children go on the foster care placement, compared to 13 percent of non-homeless children. This is a broad rate, not accounting for the additional risk factors identified by the project, which are analyzed in Table III.5.

The analysis that follows explicitly considers where children were in their child welfare trajectories when their homelessness was identified. Consider a trajectory to consist of a series of events in chronological order. For our purposes, the events of interest are a maltreatment referral, a case opening, a placement into out-of-home care, or homelessness. Table III.3 shows when homelessness typically occurred among these possible events. Nearly two-thirds (63%) of children identified as homeless on the SDM® risk assessment had *no* child welfare contact prior to the current investigation, either in San Francisco or statewide. Among those who did, the vast majority of those children (90%) who had that activity were

limited to maltreatment reports and not deeper involvement in the form of cases or placements. Recall that babies made up about one-third of the homeless group (see Table III.1). The next most common trajectory was homelessness preceded by one event – almost always a maltreatment report. This pattern occurred for 12 percent of homeless children.

Table III.3 Timing of Homelessness in Child Welfare Event Sequence, 2008-2012

Timing of Homelessness	Number	Percent
Total children	557	100%
1st Event	353	63%
2nd Event	67	12%
3rd Event	48	9%
4th Event	12	2%
5th Event	16	3%
>5th Event	61	11%

3. *Children were not yet in out-of-home care:* The rationale for this was that, as explained above, the project sought to intervene at the start of a child's exposure to child welfare system involvement because it is at this point that they stood the best chance of preventing deeper involvement. Table III.4 shows that homeless children who were placed into foster care had different exit patterns than their non-homeless counterparts. Once placed, homeless children were more likely to be adopted and less likely to reunify with their families, although this is likely due to the fact that babies were overrepresented in the homeless group, and babies tend to exit to adoption more than older children. Once placed, homeless children were also more likely to remain in care for longer periods. The FMF program intended to halt the accumulation of negative sequelae that necessitate foster care.

Table III.4 Exit Destination for Placed Homeless and Non-Homeless Children, 2008-2012

	Number		Percent	
Exit Destination	Homeless	Not Homeless	Homeless	Not Homeless
Total Placed	331	1,843	100%	100%
Adoption	47	98	14%	5%
Guardianship	20	82	6%	4%
Kin Gap	5	72	2%	4%
Reunification	134	1,100	40%	60%
Non-Permanent Exit	14	81	4%	4%
Still in Care	111	410	34%	22%

4. *One or more of the following risk factors were present in the family: caregiver domestic violence, mental illness, substance abuse, criminal history, child mental illness, developmental disability, physical disability, medical fragility:* These risk factors placed children at elevated risk for placement into out-of-home care and as such, are primary items included on the SDM® risk assessment tool. Loman (2006) found that families deemed high-risk by virtue of high scores on risk-assessment scales and by having multiple problems and minimal protective factors are the

families most likely to have frequent later encounters with the child welfare system.[14] In cases where acute poverty and lack of social support, especially in families with young parents and children, combine with reports of child abuse or neglect, he urges preventive efforts. Furthermore, these and other forms of "childhood adversity" are linked to generally poor long-term outcomes for children such as future homelessness.[15]

Table III.5 focuses on the subset of homeless children who met the FMF eligibility criteria in that they had a newly opened case but no prior child welfare involvement, and had one or more of the eight targeted risk factors. The event pattern for these children at the time of eligibility determination was a Homelessness/Referral/Case Opening event sequence, although they may have had any number of maltreatment referrals prior to the identification of homelessness on the SDM® that did not lead to a case or a placement. The purpose of the table is to examine how each risk factor related to the probability of placement. In every case, the risk of placement was very high – between 61 and 89 percent. Recall that these children were observed through 2012; some may have gone on to foster care placement since then, making the true placement risk even higher.

Table III.5 Probability of Placement for FMF-Eligible Children by Risk, 2008-2012

Risk Factor	Number			Percent		
Total Eligible (n=303)	Total*	Placed	Not Placed	Total	Placed	Not Placed
Caregiver						
Domestic Violence	79	57	22	100%	72%	28%
Mental Health	157	128	29	100%	82%	18%
Substance Abuse	187	160	27	100%	86%	14%
Criminal History	145	129	16	100%	89%	11%
Child						
Physical Disability	8	6	2	100%	75%	25%
Developmental Disability	23	14	9	100%	61%	39%
Medically Fragile	45	39	6	100%	87%	13%
Mental Health	25	21	4	100%	84%	16%

*Total adds to more than the total eligible because risk factors can co-occur.

Finally, Table III.6 presents logistic regression models that estimated how well the chosen criteria predicted the likelihood of placement following the SDM® risk assessment. Children who were assessed in 2012 were excluded in order to allow at least one year to observe placement for all children. Model 1 shows that children who met all of the eligibility criteria were over 18 times more likely to be placed than children who did not. This effect was greatly attenuated in model 2 after adjusting for other observable factors including child age, race, gender, and for caregiver and child risk factors. However, eligible children remained 6.5 times more likely to be placed than other children.

[14] Loman, L.A. (2006). Families frequently encountered by child protective services: A report on chronic child abuse and neglect. Institute of Applied Research. St. Louis. Retrieved from http://www.centerforchildwelfare.org/kb/ChronicNeglect/FamiliesFrequentlyEncountered.pdf

[15] Cutuli, J.J., Montgomery, A.E., Evans_Chase, M., & Culhane, D. (2013). Factors associated with adult homelessness in Washington state: A secondary analysis of behavioral risk factor surveillance system data. Final report June 1. University of Pennsylvania.

There are a few other notable effects. African Americans and babies remained at higher risk even after controlling for caregiver and child SDM® risk factors. Homelessness on its own did not predict placement, which supports SF-HSA's practice model. All of the caregiver risk factors and child medical fragility significantly increased the likelihood of placement. While children possessing the other child risk factors – mental health, developmental disability and physical disability – were at elevated risk for placement as shown in Table 5, their significance diminished once other characteristics were accounted for.

Table III.6 Logistic Regression Models of FMF Eligibility on the Likelihood of Placement, 2008-2012

	Model 1. Eligibility Only (n=8,068)		Model 2. Full Model (n=8,068)	
Variable	Odds Ratio	p	Odds Ratio	p
Eligible (not eligible as ref.)	18.06	<.0001	6.50	<.0001
Race/Ethnicity (White as ref.)				
Asian			1.02	0.156
African American			1.36	0.001
Hispanic			1.19	0.398
Female (Male as ref.)			1.19	0.013
Age (13-17 as ref.)				
Age 0			2.65	<.0001
Age 1 to 5			0.75	<.0001
Age 6 to 12			0.55	<.0001
Year of SDM® (2011 as ref.)				
2008			1.39	0.002
2009			1.10	0.268
2010			1.22	0.511
Prior Referral			1.52	<.0001
Caregiver Risk Factor				
Homeless			1.16	0.426
Domestic Violence			1.34	0.002
Mental Illness			1.77	<.0001
Substance Abuse			2.39	<.0001
Criminal History			1.52	<.0001
Child Risk Factor			1.99	0.002
Medically Fragile			1.48	<.0001
Mental Illness			1.18	0.352
Developmental Disability			1.05	0.882
Physical Disability[a]			N/A	N/A

[a] Sample size is too small to estimate an effect.

The criteria for the project were consistent with the recommendations in a memo from the Corporation for Supportive Housing (CSH) and Urban Institute, *Guidance on Targeting Supportive Housing*. We did not make a distinction about the quantity of presenting risk factors for two reasons. First, not all factors exert the same level of risk of harm to children. As shown in Tables 5 and 6, the effects of the risk factors vary. Second, we were unable to measure the acuity of the factors with the tools available at case

opening. One risk factor in one family could be as severe and debilitating as another family's three risk factors that are all at a mild severity level.

An examination of the number of risk factors present on the 304 eligible cases provides some support. Table III.7 shows that while 70 percent of eligible children presented multiple risk factors at the time of the SDM® risk assessment, the remaining 30 percent presented with only one risk factor. We hypothesized that the three most commonly incapacitating factors would make up the bulk of this 30 percent: caregiver substance abuse, mental illness, and domestic violence.

Table III.7 Number of Risk Factors among FMF-Eligible Children, 2008-2012

	Number	Percent
Total	304	100%
1	92	30%
2	96	32%
3	87	29%
4	23	8%
5	5	2%
7	1	0%

Table III.8 shows that this is the case. Among the 92 children with one risk factor, for 70 percent that risk factor was domestic violence, mental health concerns or substance abuse among caregivers.

Table III.8 FMF-Eligible Children with One Risk Factor, 2008-2012

Total (n=92)	Number	Percent
Caregiver		
Domestic Violence	20	22%
Mental Health	23	25%
Substance Abuse	21	23%
Criminal History	13	14%
Child		
Physical Disability	0	0%
Developmental Disability	8	9%
Medically Fragile	6	7%
Mental Health	1	1%

In summary, Tables III.2 through III.8 above demonstrate that targeting homeless children whose families had one or more co-occurring risks did, in fact, identify those who were very likely to be placed into foster care. Doing so early in their child welfare trajectories maximized SF-HSA's ability to prevent this likely outcome, even though as Table III.2 shows, few homeless children had prior case activity.

Final Criteria for Program Eligibility

At project inception, FMF had the following eligibility criteria:

1. Family is currently homeless
2. A case has been opened

3. This is a new case (typically defined as opened within the last 30 days)
4. At least one child on the case has no previous child welfare cases[16]
5. One or more of the following co-occurring risks are present:
    a. Caregiver:
        i. Domestic violence
        ii. Mental illness
        iii. Substance abuse
        iv. Criminal history
    b. Child:
        i. Medically fragile
        ii. Mental illness
        iii. Developmental disability
        iv. Physical disability
6. Children are not yet in out-of-home care

In December 2013, in order to increase the number of families served by the project, the FMF team, in consultation with the executive leadership of the partner agencies, made the decision to expand enrollment criteria to include child welfare cases in which children had been removed from the family. This decision took effect in January and worked as intended.

In the months that followed, the project further clarified its targeting criteria. The team wanted to be sure to only target families for whom the intervention was intended, i.e., prevention and reunification families. The logic of the change was as follows. A family maintenance case (hereafter preservation) signifies that a family is eligible for prevention because the children have not yet been placed into foster care. Similarly, a Family Reunification case (hereafter reunification) signifies that a family is eligible for reunification. However, during regular continuous quality improvement (CQI) reviews of homeless referrals to child welfare, the team discovered that a small number of families are effectively unqualified for reunification but have not yet terminated reunification services. Under Welfare and Institutions code 361.5, these cases, known as Permanent Placement in California, are typically tracked to adoption, and reunification services are bypassed. The team conducted a case review of 31 infants removed from home and randomly sampled from a five-year cohort of children who would have met FMF targeting criteria between 2008 and 2012. The cases reviewed revealed that these unqualified reunification cases are nearly always newborns removed soon after birth for whom all prior maternal siblings were permanently removed. These cases are initially designated as reunification and changed to Permanent Placement further down the case process, once the court approves the plan. For more information see Appendix D: Newborn Exclusion Rationale and Criteria.

The FMF program sought to target families rapidly, within 30 days of the maltreatment investigation, so it was not possible to wait until the case was formally transitioned to Permanent Placement status. Instead, the program tried to identify and screen these cases out during the FMF screening phase. To do this, they excluded families meeting the following criteria, both specified under the Welfare and Institutions Code 361.5:

1. Newborn removed within the first 30 days of life AND
2. All prior maternal siblings have been permanently removed.

[16] The initial desire was that this be the first child welfare case for all children on the case, however a review of the data showed that this would exclude too many families. The criteria were modified in order to have enough families for the study.

Note that this did not exclude first newborns, nor newborns for whom siblings are in foster care in reunification status.

Adult family members were further screened for lifetime sex offender status, one of the two factors that renders individuals ineligible for HUD-funded housing choice vouchers.

The screening process is also noteworthy for what it does not include. In the interests of equity, caseworkers were unable to advocate for specific families. They were similarly unable to deny the resource to any family because they felt that the family would fail. All had an equal opportunity.

FMF strove to provide the connective tissue that formed around existing social service supports, making them easier to navigate for families coping with complex challenges and, often, a high degree of trauma. Included in this approach are social systems that, while sometimes necessary, can have a profoundly disruptive influence on family life. This includes inpatient treatment and short-term incarceration. For young mothers who are themselves wards of the foster care system, it can also include transitional housing. FMF resolved not to deny a family enrollment because that family's need for housing was pending completion of a residential stay. Nor would the program shorten the course of a residential program in order to hasten permanent supportive housing. Whenever possible, HPP case managers had access to families in these transitional settings and worked to build relationships with families prior to program completion. In coordination with housing specialists, they planned for the time when families were ready to move to the permanent housing options available through FMF and worked with parents to obtain stable housing prior to release. This was an important system change, as these families would otherwise be graduating from treatment with no continuing support and no permanent housing, heightening the risk that they would either relapse or return to destructive environments.

Ensuring that Eligible Families were Referred

Described above is the approach SF-HSA took to identify potentially eligible families, using the SDM® assessment tool and the modified Investigative Narrative which now includes a checklist of FMF eligibility criteria to assist workers and their supervisors in identifying and referring eligible families.

FMF's goal was for social work supervisors to proactively refer all eligible families to the FMF lottery, via email to a shared inbox. For all submissions, one of a small number of analysts reviewed the data sources to verify that the referred cases were eligible. See Appendix E for the referral process diagram and Appendix F Lottery Protocol for a full list of criteria and data sources.

The CQI team foresaw a challenge in getting workers to consistently refer all eligible families. They formed a group to monitor, measure, and facilitate the client screening process. On a monthly basis, analysts reviewed the data from the SDM® risk assessment tool for all child welfare cases. They identified any families that met the eligibility criteria, but were not referred to the FMF lottery. They also worked with the National Council on Crime and Delinquency to create an automated alert from California's SafeMeasures database that informed the team of any new, potentially eligible cases. Combined, these two sources identified families that were potentially missed by the referral process. The team screened the family; if the family qualified, they reached out to assigned supervisor to start a conversation about why the family was not referred. This approach ensured that families were submitted promptly. The rapid feedback loop encouraged behavior change among child welfare supervisors. Supervisors began referring families to the lottery with increased consistency. After a while, very few eligible cases were missed. In addition, supervisors began detecting and referring families

whose homelessness was not noted during the initial child welfare investigation, but who were eligible for FMF.

Integrated Housing Case Management and Service Structure

FMF's service structure consisted of housing support (typically provided through housing choice vouchers) coupled with housing search, intensive case management, and a customized selection of programs and services. The hub was an HPP team who conducted outreach, facilitated monthly Family Team Meetings (FTMs), and oversaw the creation and execution of the family's coordinated case plan, complementary to, but separate from, the child welfare case plan.

Family Team Meetings (FTMs)

When a family was referred to HPP, an HPP outreach case specialist brought the families to HPP's family resource center, conducted appropriate assessments, including the Adult Needs and Strengths Assessment (ANSA), and introduced them to an FMF case manager. Within a month of FMF referral, HPP convened an initial FTM with the family and its supports, child welfare workers, and an HPP team including a housing specialist and case manager. FTMs were facilitated by a designated HPP staff, trained and coached in Safety Organized Practice. Consistency was guided by the Family Action Plan: a standard template documenting the family's housing status, strengths, needs and worries; the concerns of the Human Services Agency; and clear action items. Action items included a range of services available to FMF families, expounded in more detail below. The ANSA helps case managers identify which life domains are most impacted so that they may be addressed in an action plan. Family Team Meetings included the family and engaged them in the development and completion of a jointly-agreed upon case plan. Subsequent FTMs were held monthly until the family met the program's exit criteria.[17] Additional partners would attend when their work was relevant to the content of the meeting. Family Action Plans developed as the family situation changed and their needs evolved.

Case Management

HPP's FMF case management model was strengths-based and client-centered, integrating three main evidence-based practices: Motivational Interviewing, Solution-Based Casework, and Safety Organized Practice. Housing was core to the model and – as explained above – HPP's role shifted over time to become increasingly focused on helping families find and keep housing. FMF embraced an approach to housing families that eliminated barriers typically facing high-need families in the housing process. In some instances, families had immediate goals that did not include becoming housed. In those cases, as neutral advocates for the families, FMF case managers supported families in meeting those goals while maintaining a Housing First focus through coordination with Housing Specialists.

Over the course of the intervention's implementation, HPP came to understand that the families who need supportive housing are those who by design, cannot obtain or sustain housing on their own without services. They understood that obtaining housing consists of multiple smaller objectives, and that clients will most likely not demonstrate the ability to effectively carry out the steps needed to meet those objectives. This more nuanced understanding of how to most effectively support FMF clients in

[17] A family would exit for positive reasons when their child welfare case was closed, they were stably housed, they had completed a six month "check-in" period of relative stability, and they have no scores on the Adult Needs and Strengths Assessment (ANSA) that indicate severe, unmet need. A family might disengage, but the only negative reason for mandatory exit was the termination of a family's reunification services.

their quest to secure permanent housing was codified in the revised practice model; the core practice components of the FMF case manager and a summary of tasks associated with each are outlined below.

HPP's case management complemented that of SF-HSA's child welfare workers. SF-HSA's casework approach incorporates Safety Organized Practice (Signs of Safety), a strengths-based approach that allows parents to demonstrate their capacity as protectors over time. Combined with the Strengthening Families Protective Factors Framework, Safety Organized Practice also informs the home visiting model used by the Homeless Prenatal Program (HPP), For families with children aged 0-5, SF-HSA's home visitation services utilize the Project SafeCare model, an evidence-based home visitation program that is effective in improving parent/child interactions, home safety, and the family's health. FMF families with children 0-5 who were participating in family treatment court were able to receive a targeted referral to the program. All other FMF families were eligible for referral by their protective services worker.

Table III.9 Core Practice Components of the FMF Case Manager and Associated Tasks

Engagement, Team Collaboration & Assessment	**Service Partnership Engagement & Advocacy**	**Housing Search, Advocacy & Placement**	**On-going Housing Stabilization & Maintenance Services**
1. Develop initial "plan of care" 2. During 30-day assessment period, CM meets with family at least once weekly 3. Arrange Rapid Team Meeting; secure informed consent from family 4. Identify family strengths 5. Prioritize needs and goals of family and assign action steps to team members 6. Determine outcomes and indicators for each goal 7. Determine potential serious risks; develop safety plans 8. Finalize plan 9. Complete documentation and logistics	1. Connect family with initial services, provide treatment recommendations, advocacy 2. Orient family to supportive housing program and case management services 3. Identify any immediate concerns and stabilize crises 4. Engage other team members 5. Elicit information from child welfare about concerns and potential crises 6. Explore family strengths, needs, culture 7. Discuss the family's previous experiences with and current view of seeking help	1. Work with head of household to gather all documents needed for housing applications 2. Once applications have been submitted, follow-up with each housing option with periodic phone calls 3. Provide contact information for appointed case manager on all housing applications so PHA/other housing entity have someone to contact 4. Refer family to FMF Housing Clinic or provide 1-on-1 Housing Search appointment for families unable to participate in Housing Clinic	1. Conduct regularly scheduled home visits, matched with level of need 2. Carry out action steps, track progress, evaluate success 3. Celebrate family successes 4. Revisit and update the plan: consider new strategies 5. Maintain and build team cohesiveness, trust, "buy-in" 6. Complete necessary documentation and logistics 7. Create a transition plan for reducing intensity of case management, including post-transition crisis management 8. Document the team's work 9. Celebrate success 10. Conduct regular check-ins

Housing

In addition to their work with HPP's case manager, families worked with one of two housing specialists at HPP to access available housing funding sources and navigate the housing search process. Support included but was not limited to support in:

- Searching listings and identifying possible housing opportunities, including city-subsidized below market rate units
- Communicating with landlords
- Clearing barriers to housing, such as unpaid rent or utility bills
- Compiling important documents for an individualized folder to be shared with prospective landlords to facilitate communication and improve landlord confidence
- Completing the application for a housing choice voucher through SFHA's FUP program
- Navigating the complexities of leasing a property using an SFHA housing choice voucher
- Paying move-in costs

Families in the FMF project had many challenges and were suffering from complex trauma. All staff working with the family understood that the issues that brought the family to FMF were also the ones that made it difficult for them to assemble a housing authority application packet and continue through the complicated process of becoming housed with a public subsidy. In order to house families quickly, child welfare workers and the housing specialist worked hand-in-hand to assist their clients with applications and obtaining documents.

In order to advocate for the family as a potential tenant, the FMF Case Manager and/or the Housing Specialist often spoke with landlords in general about the FMF program, focusing on the benefits of case management, without disclosing confidential client information.

Services offered by housing specialists continued after the family was housed, including:

- Resolving landlord-tenant issues related to maintenance, repairs, or lease compliance;
- Satisfying unpaid rent through arrangement of payment plans with tenant and/or one-time financial assistance through the program; and
- Navigating administrative issues that may arise periodically between landlord, family, and the PHA.

Services

Wherever possible, FMF program components adapted existing SF-HSA and HPP programs. This approach preserved existing evidence-based efforts such as Safety Organized Practice (Signs of Safety) and Motivational Interviewing. It also minimized training and coaching requirements and ensured that the project was aligned with existing organizational goals. Please see Appendix G for a description of the selection and fit of the evidence-based practices used as part of FMF.

In order to address specific needs identified in the Family Action Plan, FMF case managers and SF-HSA child welfare workers[18] used targeted referrals through "warm hand-offs" to a network of community partners. In addition, certain service providers were core project partners, most notably the University of California San Francisco Infant-Parent Program (IPP), which provided Parent-Child Dyadic Therapy. Please see the above section on project partners for more information on services delivered by project partners and how they evolved over time.

[18] SF-HSA child welfare workers were involved up until the child welfare case is closed.

SF-HSA manages workforce development activities for Temporary Aid to Needy Families (TANF) and General Assistance recipients, and has been a national leader in using wage subsidies. The program gives clients vouchers for up to $5,000 over six months and connects them with employers, who use the voucher to pay the client's wages during this period, with a reasonable commitment to sustain the client if they perform their duties satisfactorily. SF-HSA committed wage subsidy slots to all FMF families as part of this project. The timing of the family's case, combined with the family's capacity to address multiple domains identified in case plans made it challenging to participate in the California Work Opportunity and Responsibility to Kids (CalWORKs) job search requirements. Currently, 60 percent of FMF families also have an open aid case with TANF/CalWORKs. These families receive coordinated services in order to maximize resources and reduce duplication of efforts. As their circumstances settled and their child welfare obligations were underway, parents had continuing access to wage subsidies as a part of their CalWORKs case plans.

Services followed the family to their permanent housing location. See Appendix H for the FMF Intake Flowchart which details tasks by organization from time of initial screening of families to time of case closure.

Context for Changes in Service Model

The FMF model – fleshed out conceptually at the end of the planning process – continued to evolve over the life of the project. It evolved further as FMF transitioned into Bringing Families Home (BFH). Some project partners were added and others were dropped, as detailed above. HPP codified and standardized their logic model and case management model. In early 2016, the FMF team shifted some case management efforts to the child welfare worker, freeing room for the HPP case managers to double down on housing search, preparation, and acquisition immediately upon enrollment. The shift was made possible by shifting roles within SF-HSA. Almost all project partners experienced significant turnover.

FTMs evolved as the model was implemented. The goal was originally to convene a meeting within one week of case opening. This proved infeasible as during FMF implementation the child welfare the timeframes for case transfer from Emergency Response (ER) to Court Dependency (CDU) were shortened. Thus, the expectation that child welfare workers would be able to schedule and convene an FTM within one week of case transfer to CDU was too ambitious. In the first two to three weeks of receiving the case, the CDU child welfare worker is familiarizing themselves with the family and case information as well as completing the SDM® assessment and preparing the court report for the disposition hearing. As a result, the initial FTM completion due date was revised to within one month after case transfer to CDU. This alignment with the new SF-HSA timeframes allowed for convening of the initial FTM as prescribed. The goal was to integrate the FTMs into the teaming structure that SF-HSA was then implementing throughout the child welfare system. As with all change in child welfare practice expectations, the integration occurred subsequently with the advent of the BFH grant.

It proved overwhelming to have too many service providers at the initial FTM, when the focus was on explaining the program and developing an initial case plan. Housing providers, representatives from the IPP, behavioral health specialists and others were best deferred until later meetings, when their work was relevant. To protect confidentiality and to promote ongoing communication and coordination of case plan identified goals, HPP case managers and SF-HSA child welfare workers were responsible for engaging collateral providers as appropriate or needed outside of the FTMs to support the family.

Section IV. Evaluation

Overview of Local Evaluation Design and Implementation

Purpose and Design Rationale

The theory of change underlying Families Moving Forward (FMF) was that child welfare involved homeless families, with acute co-occurring risks would achieve substantial benefits, including progress toward functional self-sufficiency, if they were housed stably and were provided case management support early in their interactions with public systems. The early provision of housing and support services would stabilize families and would support their efforts to keep their families intact and improve family members' well-being. Sustained support would offer long-term stability and a more promising future.

The evaluation was designed with two goals. The first goal was to assess the extent to which the process, quality and capacity investments necessary to launch and sustain this intervention were implemented and adapted, if necessary. The evaluation was designed to answer a set of questions to establish whether the intervention successfully recruited and enrolled treatment families and provided them necessary services (including housing). The second goal was to understand the extent to which the intervention led families to experience better housing, child welfare, and well-being outcomes than they otherwise would have had.

The primary implementation and outcome questions are listed in Table IV.1.

Table IV.1 Research Questions, Method, and Data Sources

Research Question	Statistical Method	Data Sources
PROCESS/IMPLEMENTATION		
Housing		
1. Were treatment families permanently housed?	Descriptive	HENRI
2. How long did it take?	Survival Analysis	
3. Did they remain stably housed?	Descriptive	
Case Management/Services		
1. Did project partners adhere to the planned process of care?	Rapid cycle tests	HENRI/Staff interviews
2. Did the treatment families experience the intended process of care?		HENRI/Family interviews
3. Were project partners prepared and able to make the process and quality changes associated with project implementation?		Core Database, sub-studies, case review
4. Did treatment children receive faster CANS screens?	Cox regression	CWS/CMS and DPH-Avatar
OUTCOMES		
Housing		
1. Were treatment families less likely to enter shelters or use other homeless services?	Chi-square	HMIS, Shelter wait list, permanent supportive housing, rapid re-housing, SFHA, short-term rental assistance, below market rate housing, other shelters
2. Were treatment families more likely to obtain stable housing?	Chi-square	
3. Was their housing more stable, of higher quality, more affordable, and safer?	Chi-square	UI Survey
Child Welfare		
1. Were treatment children less likely to be placed into foster care?	Logistic regression	CWS/CMS
2. Did they avoid foster care placement longer?	Survival analysis	
3. Did they spend less time in foster care?	Survival analysis	
4. Were they more likely to reunify?	Logistic regression	
5. Did they reunify more quickly?	Survival analysis	
6. Did their cases close faster?	Survival analysis	
7. Were they less likely to be re-abused?	Logistic regression	
8. When they reunified, were they less likely to reenter care?	Chi-square	

Research Question	Statistical Method	Data Sources
Well-Being		
1. Were treatment families more likely to use public benefits?	Logistic regression	CalWIN
2. Did treatment families increase their earnings more than control families?	Descriptive	CA EDD
3. Were treatment families more likely to obtain subsidized employment?	Chi-square, logistic regression	JobsNOW! administrative data
4. Did treatment parents have greater improvements in well-being?	T-tests, Chi-square	ANSA, UI Survey
5. Did treatment children show greater improvements on the CANS?	Factor analysis, multilevel growth	DPH-Avatar database
6. Did treatment children have better educational outcomes?	T-tests, Chi-square, multilevel growth	SFUSD database
7. Were treatment families more likely to use subsidized childcare?	Chi-square	OECE database

Notes: HENRI is HPP's case management database; CWS/CMS is California's child welfare administrative database; CalWIN is an eligibility and benefits payment database; EDD is the Employment Development Department; Avatar is the DPH case management database; OECE is the SF Office of Early Care and Education.

Primary Features of Design

A causal question is best answered using a randomized controlled trial (RCT) design, and the desired improvements are most likely to be observed if families are targeted to the intervention as soon as possible. That is, child maltreatment deriving from a family's undesirable behaviors and circumstances (including homelessness) can be ameliorated with a combination of housing and focused, intensive social services for the family unit, delivered before the family is further impaired by deeper child welfare involvement. The program was designed to treat families who were at highest risk for placement or for failing to reunify and served them early in their child welfare service trajectory. For a discussion of this rationale for early intervention and how risk was determined, see Section III.

The RCT design was implemented using an online randomization tool developed and maintained by the Urban Institute. The treatment group was divided into two subgroups according to their target child welfare outcomes – preservation and reunification – and as dictated by their child welfare case types – family maintenance (preservation) or family reunification (reunification). [19] The intervention was applied to families. Families were randomized on a rolling basis as they presented to the system between November 6, 2013 and May 5, 2016.[20] In some cases, children within the family had different case types (some preservation and some reunification); these families were categorized as reunification, according to the more serious case type.

Case type is time-varying, e.g., a child may begin in an in-home case and later be placed into foster care. Results are reported based on the case type at randomization. Housing outcomes were measured at the family level and child welfare outcomes were measured at the child level and adjusted for clustering of children within families. Other outcomes were reported according to the unit of analysis indicated in the research question (See Table IV.1).

As discussed in the narrative on targeting in Section III, we narrowed the eligible population in two respects after implementation began. We initially conceived of the intervention as applying to only preservation families; we soon realized that we needed to include reunification families in order to serve the desired numbers. This led to a second change: newborns removed within the first 30 days of life were excluded if all prior maternal siblings were permanently removed. The purpose was to screen out this very specific and vulnerable group for whom the theory of the intervention's effect would not reasonably occur quickly enough to match federally mandated timelines for permanency. A detailed description of the logic for these exclusion criteria is in Appendix D: Newborn Exclusion Rationale and Criteria.

Methods

The primary method was an Intent-to-Treat (ITT) approach, whereby all families randomized into the experiment were included in the analyses. However, because approximately one-third of treatment group families either never engaged with FMF or left before they were housed, we believe that attrition may have diluted treatment effects. We addressed this by conducting a Treatment-on-Treated (TOT) analysis of key housing and child welfare outcomes that excludes families who never engaged with FMF.

[19] In California, preservation cases are called Family Maintenance and reunification cases are called Family Reunification. A case is unique to the child (not the family). A child can have multiple cases over time although never concurrently.

[20] See Appendix I for a justification to suspend the lottery.

All outcomes were first examined using descriptive statistics and, as appropriate, t-tests, chi-squared tests, and multivariate regressions of different types.

Data Sources

The outcomes evaluation relied upon administrative, survey, and assessment data. Table IV.1 describes for each outcome, the method and data source. Child welfare, some housing, and public benefits data are housed under San Francisco Human Services Agency (SF-HSA). Other administrative data and Child and Adolescent Needs and Strengths (CANS) assessments were obtained from other city agencies. Survey data consists of the Urban Institute family survey. Case management and adult assessment (ANSA) data were obtained from HENRI, Homeless Prenatal Program's (HPP) case management database.

Children randomized to the treatment and control groups were linked to longitudinal files containing statewide child-level maltreatment, in-home case and out-of-home placement information through 6/30/2018. For example, if a child in a reunification case returned home, moved to another county, and was later re-referred for maltreatment in that county, the new referral is included in the file. This casts a broader net than most studies which are typically limited to child welfare activity in the subject jurisdiction.

Staff Training and Continuous Quality Improvement (CQI) to Support the Evaluation

The project's governance structure included a CQI committee that reported up to the steering committee. The group consisted of representatives from all project partner organizations. The purpose was to address ongoing design, implementation, and evaluation issues in real time by producing and using data evidence from the sources above. The group met every single month throughout the project without fail, marking the high level of engagement among partners. Since the evaluation design used a CQI framework, there were numerous efforts to engage staff in the process of improvement in three areas related to the evaluation: targeting, implementation evaluation, and outcomes evaluation.

Targeting

See Section III "Ensuring that Eligible Families Were Referred".

Implementation Evaluation

The team developed and iterated an implementation dashboard that captured program inputs and outputs in order to quickly identify model fidelity problems and successes, such as frequency of family team meetings and regular assessments. Examples of an early and a mature dashboard are in Appendix J: Early and Mature Implementation Dashboards. The use of the dashboard during CQI meetings led to a number of rapid cycle tests during implementation. Two examples are provided below:

- HPP augmented their case management database to longitudinally capture events related to the process of housing. This allowed the CQI team to narrow in on where, exactly, housing delays were occurring.
- The CQI team conducted a time study among HPP program staff. We combined these data with case management time data in HPP's case management database to produce information about the timing and dosage of case management delivery to families. In turn, that provided needed evidence to develop the casework model, caseload planning, and program sustainability planning.

Outcomes Evaluation

The CQI committee structure allowed us to identify and resolve data collection problems early, to demonstrate the importance of high-quality data to staff, and to serve as a place to discuss emerging outcomes findings.

- Few FMF referrals occurred during the first three months of implementation. The planning team analyzed data on program referrals to date along with the prior five years of data on homeless cases in order to understand why. We discovered that eligible children tended to be placed into foster care very quickly upon investigation. This meant that it would be difficult to meet our study enrollment goals if we continued to limit our eligibility to children starting in-home cases, so we expanded eligibility to reunification cases. For a detailed discussion, see Appendix K.
- Midway through the program, we conducted an analysis of referrals to services that HPP staff made for families. During the program planning period, evaluators worked with HPP to enhance their database so that it could record discrete referral and service types. The data were not reliably entered in the early program years, so staff and evaluation partners reviewed cases and back-entered the data using case notes.
- Master of Social Welfare (MSW) and doctoral student interns placed at SF-HSA and HPP participated in various analysis for the outcomes evaluation. They regularly participated in CQI meetings in order to receive feedback about their approach and findings. These projects are listed in the dissemination section (Appendix L).

Implementation/Process Study Methods, Analysis, and Results

FMF was designed to be a collaborative intervention for child welfare involved homeless families struggling with one or more co-occurring risks. The collaboration between a neighborhood-based family resource center (HPP), San Francisco Housing Authority (SFHA), Infant-Parent Program (IPP), SF-HSA, and San Francisco Department of Public Health (SF-DPH) was developed with the intention that families referred to the program would receive coordinated attention to their housing needs, child welfare case plan, as well as early assessment of specific family member strengths and needs.

The evaluation was designed as a developmental evaluation with a specific continuous quality improvement (CQI) focus so that as the project team encountered challenges the intervention could be adapted as necessary in order to reach full implementation. (See Sections I and II for details about the partnership and adaptations to the model.) Early implementation is documented in the first evaluation report.[21] The developmental aspects of the evaluation played out in the monthly CQI meetings (also described earlier) during which project partners regularly reviewed program data to ensure that the process of care was unfolding as planned. Concerns about the process, including quality, were therefore addressed in close to real time.

Following initial implementation, local evaluators drew from the core services database (described in Section IV - Outcomes Method) to populate monthly dashboards that were reviewed during the CQI meetings. These dashboards provided current information about the extent to which treatment families where achieving their housing goals, receiving case management services, getting connected with outside support services when necessary, and progressing towards program graduation. Measures that suggested deviation from the model triggered further investigation. Summary data on the program participants was provided in each semi-annual report.

In addition to data collected in the core services database, evaluators collected qualitative data to supplement the information contained in the project database. Table IV.2 below outlines the interview participants, schedule and general topics. Interviews were taped, transcribed, and uploaded into Atlas.ti for coding and further analysis. Writes-ups of most of the staff and family interviews were appended to the semi-annual reports, and all are attached as appendices to this report (See Appendices M and N). Finally, as families completed the program and graduated, HPP case managers conducted an exit interview with 25 of the 38 families that graduated from the program. Data from those interviews are reported below.

As noted elsewhere, FMF's early development and implementation was reviewed in the July 2014 evaluation report (see Appendix II). For this current report, evaluators focused on full implementation and considered the extent to which treatment families received the key program services described in the updated logic model, which reflected adaptations that occurred subsequent to early implementation. Those key questions, along with the data source, are outlined in Table IV.3 below.

[21] See appendix II for the version of the report included in the October 2015 semi-annual report.

Table IV.2 Interview Schedule

Year	Interviewees	n	Interview Topics
2014/2015	HSA: child welfare workers (Investigation, early adopters, ongoing), leadership	7	Implementation, housing, services, system change
2014/2015	HPP: managers and frontline staff	7	Implementation, housing, services, system change
2015/2016	HSA: leadership	2	Implementation, housing, services, system change
2016/2016	HPP: managers and frontline staff	5	Implementation, housing, services, system change
2017/2017	families (random sample)	9	Experience with program and services
2018/2018	Holloway House families	4	Experience with program and services
2017/2017	SF-HSA: child welfare workers	9	Program implementation and coordination question
2018/2018	graduated families	3	Experience with program and services, focus on check-in phase and moving to graduation

Data from the core services database, the services study, and the interviews are the primary resources for the implementation evaluation. The table below outlines the specific implementation/process study questions that are addressed in this report, along with their data source.

Table IV.3 Implementation/Process Study Questions

Implementation Evaluation Questions	Data Source
Housing	
Were treatment families stabilized as they prepared for the housing search?	Core services database
Were treatment families permanently housed?	Core services database
Did treatment families stay housed?	Core services database
How long did it take for families to be housed?	Core services database
Case Management	
Did families receive initial FTM meeting? What was timing?	Core services database
Did families have ongoing FTMS?	Core services database
Did family members meet regularly with HPP case managers?	Core services database
After moving to check-in, did they have monthly visits?	Core services database
Services/Mental Health	
Were families with children under 6 referred to IPP?	Core services database
Were adults assessed with the ANSA? Were they reassessed?	Core services database
Were children assessed with CANS? Were they reassessed?	CANS study
How many children received services from IPP?	Core services database
To what extent were families referred for additional services?	Core services database/Services Study
How often did they participate in those services?	Services Study
Did HPP make referrals for outside services?	Core services database/Services Study
Did HSA make referrals for outside services?	Services study
Additional Qualitative Questions (see appendices M and N)	
How effective were collaborative efforts in providing appropriate services to treatment families?	Family interviews/staff interviews
How would families characterize the effort to secure housing?	Family interviews
How would families characterize the services they received in the program?	Family interviews
How would families characterize their overall experience in the program?	Exit interviews
How would project partners characterize the FMF program?	Staff interviews

Collaborative Partnerships

Section II (above) describes in detail the evolution of the collaborative partnership between the project partners. This evolution was borne out of necessity, when it became clear that key aspects of the intervention that depended on collaboration with project partners were slow to occur. Securing rapid permanent housing was, of course the most notable of these challenges. Concerted efforts with SFHA, attention to the details associated with porting vouchers, adding a dedicated housing specialist at HPP helped to address this challenge. And in May 2017, the clarified responsibilities of staff at HPP, SF-HSA, and SFHA were documented in a case management practice manual (described above and available in Appendix III). The manual details the revised case management protocols that govern the collaboration

between HPP, SF-HSA, and SFHA during the final years of the project as well as for the BFH sustainability initiative.

Other challenges, like accomplishing timely CANS screening for treatment children, were harder to overcome. Early in the project, the evaluation team realized that despite the MOUs, steering and CQI committee meetings with project partners, scheduling and completing CANS screens for treatment children early in the case was rarely happening. Doggedness on the part of program planners, combined with the impact of a statewide policy to conduct CANS screenings early in child welfare cases helped to address the immediate problem.

At the case level, both treatment families and project staff consistently reported obstacles and challenges associated with having multiple workers responsible for different aspects of their case plan. As one staff person remarked early in the early years of the program: "I think our biggest challenge is this is a model where a lot of component parts work together, and I don't know that we did as much planning as would have been ideal about the very nitty-gritty detail of how that was going to happen."[22] Other families interviewed reported being referred for similar services by different project partners, resulting in complicated schedules and difficulties achieving project goals. Evaluators eventually concluded that the effective, durable collaboration that would result in true systems integration required much more deliberate attention to planning and implementation than was originally expected. This then led to the development of a hypothesis about the necessary ingredients of effective multi-system collaboration, which was informed by two frameworks relevant to both public child welfare and homelessness services systems. That hypothesis, the two frameworks, and the essential components of systems collaboration were the subjects of several presentations (see Appendix L. Dissemination Products) and are the subject of a manuscript in process. And although the elements were not fully institutionalized in the FMF project, the focus on communication and partnership at the leadership level persisted through the end of the project and into the sustainability project.

In addition, the evaluators are working with colleagues at the University of Pittsburgh School of Social Work to operationalize and test the hypothesized collaborative framework within a Title IV-E Waiver evaluation in a different state.

Service Implementation – Key Demographics

Families started getting referred to the FMF experiment in November 2013, when the lottery was turned on (see Section III "How Families Were Identified" for details on the lottery and referral process). Table IV.4 shows an overview of total families referred and their subsequent path through the enrollment process. Of the 256 families referred, sixty percent were eventually randomized into the experiment. Most of the remaining 40 percent were found ineligible, based on the program's targeting criteria, although eight families never progressed to enrollment because they were referred when the lottery was temporarily turned off.

[22] Fall 2014-15 HSA Interview

Table IV.4 Family/Child Enrollment and Participation in Program and Evaluation

Participant Status	Number of Families	Number of Adults	Number of Children
# Referred	256	338	284[a]
# Ineligible	94	99	14[a]
All Children in Referral Had Prior Cases	15		
Family Determined Not to Be Homeless	28		
Newborn Likely Reunification Bypass	34		
Other	16		
Sex Offender	1		
# Eligible	162	239	270
# Not randomized	8	12	9[a]
Lottery Closed	8	12	9[a]
# Randomized	154	227	261
Treatment	79	119	133
Preservation	36	58	70
Reunification	43	61	63
Control	75	108	128
Preservation	33	46	60
Reunification	42	62	68
Local Evaluation Participation	147		
Treatment	72		
Control	75		
Treatment			
Completed baseline	50		
Completed follow up *(timepoint 1)*	39		
Control (if in local evaluation)			
Completed baseline	26		
Completed follow up *(timepoint 1)*	22		

[a] Not always collected at the child level

Note: All treatment and control families were included because consent for analysis involving administrative data was waived.

Characteristics of Families at Baseline

By the time the lottery closed in May 2016, a total of 154 families with 227 adults, and 261 children had been referred to the FMF experiment. Table IV.5 below shows the distribution of families, adults, and children by program type and experimental group.

Table IV.5 Families and Children Randomized into Experiment (2013-2017)

Participants	Total	Treatment	Control	Total	Treatment	Control
Families	154	79	75	100%	51%	49%
Preservation	69	36	33	45%	24%	21%
Reunification	85	43	42	55%	28%	27%
Adults	227	119	108	100%	52%	48%
Preservation	104	58	46	46%	26%	20%
Reunification	123	61	62	54%	27%	27%
Children	261	133	128	100%	51%	49%
Preservation	130	70	60	50%	27%	23%
Reunification	131	63	68	50%	24%	26%

Although cases were randomly assigned, there is no guarantee that it creates equivalent, i.e., comparable groups. The following tables demonstrate the extent to which there was baseline equivalence in the treatment and control group based on attributes of the families that we were able to observe and document at the time of referral.

At the time of enrollment, treatment and control families had similar patterns of housing needs. Between 30 and 40 percent of families were doubled up – this was truer of the control families than treatment families - while between 20 and 25 percent of the families were in shelters. The third largest group was those in transitional housing, which included, “Anyone staying in SRO hotel room without tenancy rights; anyone formerly homeless who is now incarcerated, hospitalized, or living in a treatment program, half-way house, transitional housing, or anyone formerly homeless who has obtained supportive housing or permanent housing for less than 30 days.”

Table IV.6 Family Characteristics at Baseline

Possible variables	Treatment N	Control N	Treatment %	Control %	p-value of difference
Housing status at referral	79	75	100%	100%	0.45
Doubled Up	27	29	34%	39%	
Shelter	18	16	23%	21%	
Transitional	16	16	20%	21%	
Street	12	13	15%	17%	
Vehicle	6	1	8%	1%	
Child welfare status	79	75	100%	100%	0.85
Preservation	36	33	46%	44%	
Reunification	43	42	54%	56%	
Mean Family Income Year Before Randomization	3,731	2,994			0.61
(Standard Deviation)	(9,808)	(6,861)			
Number of children	1.68 (1.41)	1.71 (1.12)			0.91
Household size	3.19 (1.51)	3.15 (1.37)			0.85
Race (Primary Parent)					0.99
Black	22	23	28%	31%	
White	21	22	27%	29%	
Latino	22	17	28%	23%	
Asian	12	11	15%	15%	
Native American	1	1	1%	1%	
Missing	1	1	1%	1%	
Parent age (primary parent)					0.15
Under 30	46	35	58%	47%	
30 and older	33	40	42%	53%	
Previous Investigation or Case	52	48	66%	64%	
At least one family member entered shelter before randomization	33	30	42%	40%	0.82

Significance: *p≤.05; **p≤.01; +p≤.1

Assessment of family needs at the time of referral for both treatment and control families is available from the SDM® safety and risk assessments that each family received in association with the investigation leading to the referral. Table IV.7 below depicts those needs. Additionally – treatment families, upon enrollment in the program, were referred to HPP for intake and were administrated the ANSA assessment. Results from the 65 treatment families who were administered an initial ANSA are provided in Table IV.17.

Table IV.7 Adult and Child Need Characteristics at Baseline

SDM® Risk/Safety Assessment Results		Treatment n	Control n	Treatment %	Control %	Chi Square	p-value
Total Families		79	75	100%	100%		
Adult Needs							
	Substance Abuse	59	55	75%	73%	0.04	0.85
	Mental Health[a]	50	45	65%	63%	0.1	0.76
	Domestic Violence	33	28	42%	37%	0.32	0.57
	Criminal Arrest History[b]	50	43	66%	61%	0.43	0.51
	History of Abuse as Child[b]	53	45	70%	63%	0.67	0.41
	Dev Disability/Cog Impairment			0%	0%		
Identified Child Needs							
	Mental Health[b]	21	18	28%	25%	0.1	0.75
	Diminished physical capacity[c]	10	4	13%	5%	2.5	0.11
	Diminished mental capacity[d]	8	6	10%	8%	0.21	0.64

Significance: *p≤.05; **p≤.01; +p≤.1

[a] 2 children from Treatment Group and 3 children from control group dropped because missing risk assessment and did not receive SDM® Safety Assessment Version 3

[b] 3 children from Treatment Group and 4 children from control group dropped because missing risk assessment data

[c] Diminished physical capacity considered present if any child on referral is identified as having a 'physical disability' or being 'medically fragile or failure to thrive' on risk assessment, or having 'diminished physical capacity (e.g. non-ambulatory, limited use of limbs)' on safety assessment

[d] Diminished mental capacity considered present if any child on referral is identified as having a 'developmental disability' or 'learning disability' on risk assessment, or having 'diminished mental capacity (e.g. developmental delay, non-verbal)' on the safety assessment

Engagement – Enrollment and Housing

Were treatment families stabilized as they prepared for the housing search? Were they permanently housed?

Figures IV.1 and IV.2 below provide visual representation of the sequence and timing of events that treatment families experienced immediately after referral. We provide separate figures for preservation and reunification families, which allows for consideration of the distinct experiences corresponding to case type. For each group, families are listed in chronological order of referral, so that the viewer can understand the extent to which patterns shifted or were stable over the course of the intervention.

The main purpose of these figures it to provide a more tactile method for understanding the order of key events referred families experienced. For example, in both figures, the families with grey boxes following referral were families who were temporarily housed in hotels. That became less common over time. Similarly, families with a red box had a stay in Holloway House.

These figures are especially useful in understanding the timing of housing relative to child welfare outcomes. In Figure IV.1 depicting preservation families, the extent to which a yellow box precedes a green box indicates when a removal preceded permanent housing. Placement was relatively rare, placement prior to housing was especially rare. In Figure IV.2, depicting reunification families, the extent

to which the pink box precedes the green box alerts the reader to the pattern of reunification before lease that many reunification families experienced. Reunification, as the figure shows, tended to occur early in the FMF intervention, and generally it preceded housing.

Figure IV.1 Sequence and Timing of FMF Events Following Randomization - Preservation Families

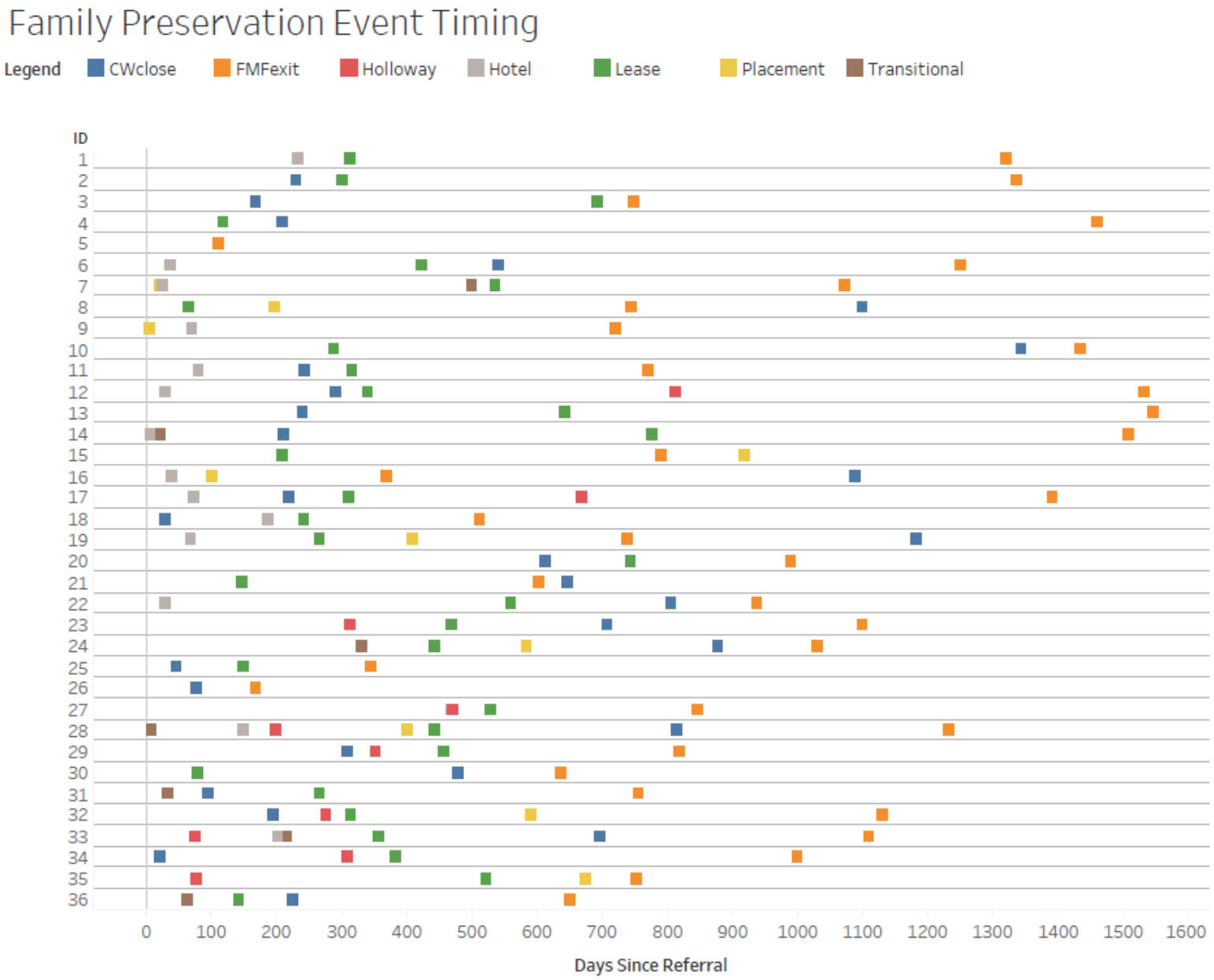
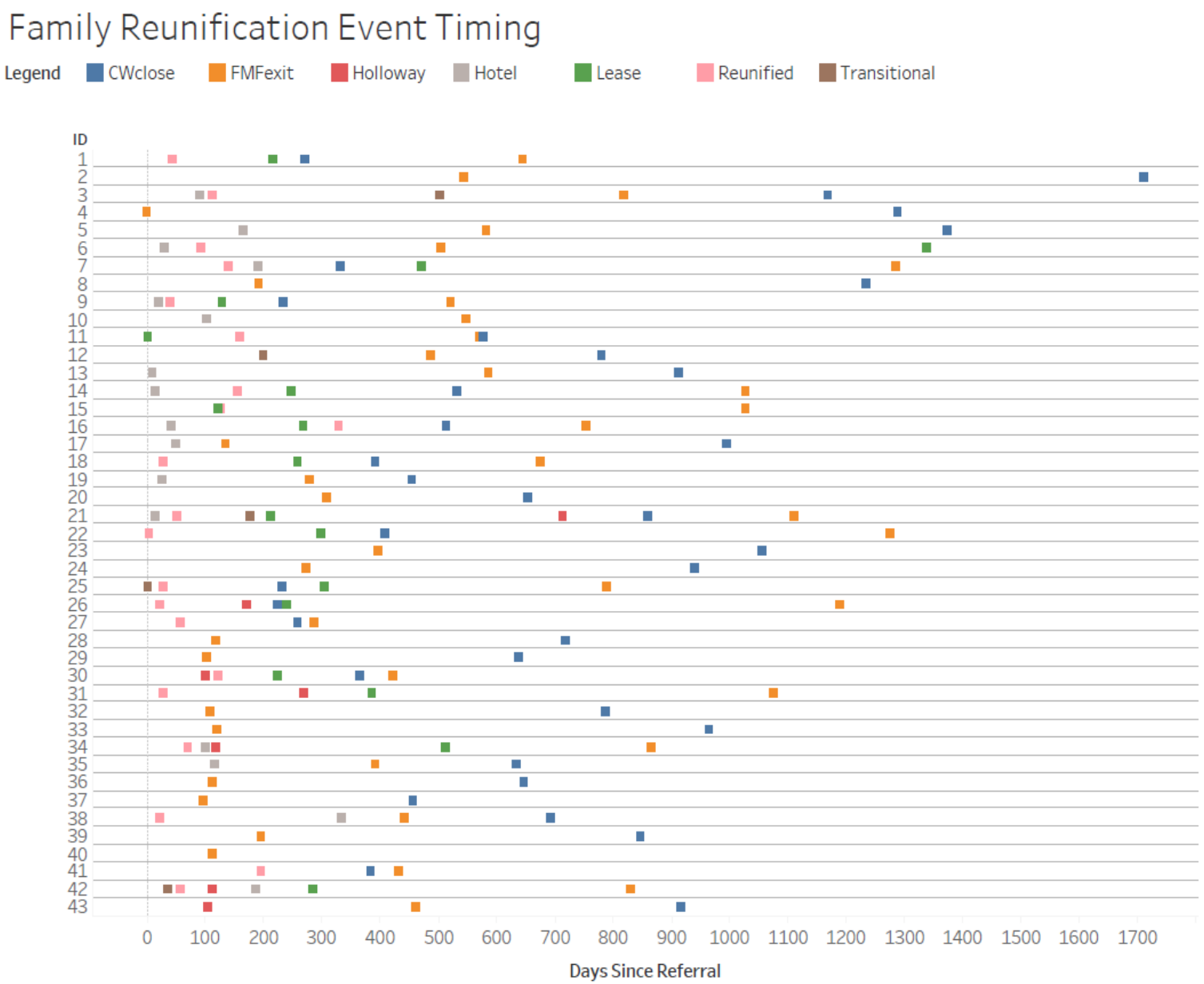


Figure IV.2 Sequence and Timing of FMF Events Following Randomization - Reunification Families



The original FMF program theory emphasized *rapid* re-housing, arresting the trauma and deterioration of fragile families by providing them with permanent housing quickly to serve as platform on which other services could be layered. Between the time that SF-HSA submitted its grant proposal to the Children's Bureau and the actual launch of the program, rents in San Francisco rose at a breathtaking rate. While San Francisco was the economic engine of the Bay Area as it emerged from the Great Recession, the city could not create housing fast enough to keep pace with its job creation. Since the end of the Great Recession, the median rent for a two-bedroom apartment in San Francisco has risen by 60 percent, and the impact of the city's gentrification has rippled outward to surrounding counties, increasing their rents, too. The inflation of the rental market prevented FMF from ever fully testing its premise about *rapid* permanent housing. FMF made valiant adaptations to the situation, however, and did provide housing, although at a slower pace than was originally conceived.

Following referral to HPP for the FMF intervention, treatment families began the intake process which triggered the housing stabilization and acquisition efforts. The FMF program relied primarily on scattered site housing, secured following a housing search and funded with Section 8 housing vouchers. (There were a small number of site-based supportive housing slots set aside for qualifying treatment families). As described earlier, the effort associated with securing housing vouchers, locating appropriate housing, and final lease-up was more protracted than originally anticipated. In the first two years of the project, one-third (26 of the families who were referred and who required immediate stabilization) were temporarily housed in hotels (see Figures IV.1 and IV.2).

Staff and families alike quickly realized that the hotel solution was imperfect. Families were exhausted and demoralized by the effort required to manage the hotel stay, which made it difficult (if not impossible) to focus on both their child welfare case requirements and the search for permanent housing. As one HPP case manager noted: "We are moving families into hotels and they can still be in crisis mode even though they're more stable than they were. And we can surround them with a lot of different supportive services but it's still hard for them…."[23] That perspective was affirmed by an HSA child welfare who worker who said in same round of interviews: "So we're definitely not housing rapidly, and I think it's causing all sorts of problems, obviously, because people are spending a lot of time just managing the situation by staying in hotels and not being able to work as much on stabilization, and so I think it is problematic…."[24] The families themselves recounted challenges with the hotels. One early program participant, responding to a question about how long s/he had been in a hotel offered:

> "Al*most four months, four and a half months. That sucked because they always moved me. They didn't schedule it…. If they are going to have families in motels, they have to be mindful and have it not be all the second thought. Okay, this family might have a big meeting today. This family might have a school first day or something, and keep that in mind with their moves. As it was, they didn't care. I would have to move with multiple pieces of luggage on the bus and make a meeting or a class. Subsequently, I missed a lot of them…. They would push it [hotel stays] out as far as they could and then if they couldn't extend it, oh well, we've got to move you over here. Sorry, you've got an hour to move. That is really nerve-wracking to live that way. Even though they tell you, "It's better than being in a shelter." Okay, but it's still really nerve-racking because you let*

[23] 2014-2015 Interviews, HPP-1.
[24] 2014-2015 Interviews, HSA-6.

your guard down a little bit more and feel a little bit more comfortable, and then when it's snatched out from under you, it's upsetting."[25]

The CQI team and the steering committee closely monitored both the delays in securing permanent housing and the distractions inherent in managing treatment families in hotels, and the impact both the delay and the distraction had on meeting program goals. A key remedy was acquisition and operation of Holloway House as a temporary residence for treatment families, which provided a much more stable setting from which families could pursue both program and housing goals. One Holloway resident (who had previously been sheltered in a hotel) noted: "It was – well, you have to comply with rules, which I understand that. At a certain time, you had to go to sleep. It wasn't – I don't know what to say of it – a normal place, like home, like a regular home. It did its job. It helped us move forward as far as waiting for that opportunity to come up for the apartment. So it was a godsend basically."[26] In short, Holloway was clearly not the permanent housing solution, but for 15 treatment families, it was an important way on the path to securing a permanent home. (The acquisition of Holloway house, as well as other barriers and their remedies are described in more detail in Section II under "Core Partners and Added Partners).

Were treatment families permanently housed? And how long did it take?

Even with Holloway House providing important stability to treatment families, time to housing was still protracted. And the delay in housing may have impacted the project's ability to deliver the full set of services to all referred families. Table IV.8 below provides an overview of the housing outcomes for families referred to the treatment group. Among the 79 families referred, just under half were successfully housed and graduated from the program. A further 11 were housed, but did not successfully complete the program, due to child welfare case re-openings, program disengagement, and / or loss of eligibility. Among the remaining 31 families who were not housed, 15 exited the program because reunification services were terminated. Another 13 either never engaged or disengaged for an extended period of time, and were then exited. Of the final three families, two lost eligibility, and one was incarcerated making program completion impossible.

An analysis of the time to housing events and final housing is provided in the next section below. Noted above, a consequence of the delay in securing housing is that a number of treatment families exited the program without being permanently housed.

[25] 2014-15 Interview, Family 8.
[26] 2018 Interview, HH-1.

Table IV.8 Program Engagement and Final Disposition among Treatment Families

Program Engagement and Final Disposition Treatment Families	N	Percent
Total	79	100%
Housed[27]	48	61%
Graduated[a]	37	47%
Housed, became unengaged	2	3%
Housed, new CPS case	2	3%
Housed, no longer eligible	2	3%
Housed, still needs services	2	3%
Housed, reunification terminated	3	4%
Not Housed	31	39%
Never engaged[b]	10	13%
Reunification terminated	15	19%
Became unengaged[c]	3	4%
Incarcerated	1	1%
Moved	1	1%
No longer eligible	1	1%

Exits by Group	Total	Graduated	%
Maintenance, graduated	36	26	72%
Reunification, graduated	43	11	26%

[a] Stably housed for at least 6 months with all child welfare cases closed, engaged at exit

[b] Has fewer than 10 hours of face time and no FTM

[c] Was engaged (has FTM and 5+ hours of face time), but hasn't been engaged for past 6 months

Table IV.9 below provides an overview of the 79 families randomized to the treatment group, and the amount of time they were enrolled program overall, as well as the length of time it took for them to achieve permanent housing. Because for most families permanent housing depended first on securing funding (generally the assignment of a FUP voucher) and then on locating a permanent residence, we show timing for both milestones.

What we see is that overall program duration was lengthy; for all families referred to the treatment group, median duration in the FMF program was 788 days, or just over two years. The time to an initial funding event) was also long. Of the families that had a funding event, it took just over three months for half of them to acquire that funding. It took over six months for 75 percent of families to reach that milestone.

In part, the length of the program is associated with the time it took to locate permanent housing for families even after they had received their FUP voucher. The median time to permanent housing for treatment families who were housed was 303 days – or about 10 months – and 200 days after securing funding. While most families were stabilized in *temporary* housing situations prior to being permanently housed, elements of the program model that were intended to furnished to families in their permanent

[27] 49 of the treatments were housed at some point, but one family's housing was funded through a subsidy, and before that funding stream could switched to a Section 8 voucher, reunification services were terminated for that family, and the family exited the program.

could not be delivered rapidly to the treatment families. If child welfare outcomes were to follow housing, then these durations suggest that it would take nearly ten months to observe those outcomes. The table shows how long families were in the program before getting funding and then leased.

Table IV.9 Duration of Key Program and Housing Processes

Treatment Families	N[a]	Min	Max	Mean	SD	25th Percentile	Median	75th Percentile
Days in program	79	102	1651	812	401	504	788	1110
Days from referral to funding	41[a]	6	1227	182	234	62	104	232
Days from referral to lease	49	2	1337	354	226	223	303	456

[a] Most families in LOSP units do not have a funding event

Disaggregating program referrals by case type (preservation versus reunification) reveals housing outcome differences within the treatment group. Preservation families were both more likely to be housed and were housed faster. Among all preservation families (36), half were housed within one year and 89 percent were housed by the end of the project. Of reunification families (43), 30 percent were housed within one year and only 40 percent were housed by the end of the project.

Table IV.10 Cumulative Percent to Permanent Housing among Treatment Families by Case Type and Time Since FMF Referral

	Within 4 Months	Within 6 Months	Within 8 Months	Within 10 Months	Within 12 Months	Within 14 Months	Within 16 Months	Within 16+ Months
All Families	6%	11%	19%	32%	39%	43%	49%	62%
Preservation	8%	17%	22%	33%	50%	56%	67%	89%
Reunification	5%	7%	16%	30%	30%	33%	35%	40%

Table IV.11 below shows program duration from a different perspective, showing median duration by the ultimate program outcome. This shows program durations were lengthy for all participants, regardless of outcome. Those that were housed (graduated or housed, not graduated) had average durations of well over 900 days. But those that did not or could not complete the program also had lengthy cases and potentially exposure time to case management services. Even those families for whom reunification services were terminated, or who left for other reasons, were enrolled in the program for well over a year, although many may have ceased regular engagement with program.

Table IV.11 Program Duration by Exit Type for Engaged Families

	Family Count	Min	Max	Mean	SD	25th Percentile	Median	75th Percentile
Graduated	37	345	1532	942	307	748	988	1127
Reunification Terminated	15	134	826	471	202	305	441	584
Other[a]	6	109	582	380	194	167	458	504
Housed, not Graduated	11	190	1545	1035	428	745	1071	1452

[a] Other includes families who became unengaged or became ineligible for reasons that included incarceration or moving away.

The delay to permanent housing may have impacted the motivation for some treatment families to persist in the FMF program until they were housed, and likely contributed to dropping out before being housed. During the long wait for housing, families' child welfare care cases progressed. Outcome analysis discusses this further, but what these data show is that some families, despite some engagement in the program prior to permanent housing, had reunification services terminated or became unengaged for other reasons and left the program without the full treatment. Although they were temporarily stabilized, they were not permanently housed and it is not clear what their program outcomes would have been had they been housed earlier.

Did treatment families lose housing and did they remain stably housed?

Only one treatment family, whose housing had been funded through a subsidy, had their reunification services terminated before the funding source could be transferred to a Section 8 voucher. As a result, that family exited the FMF program. As of October 1, 2018, 48 of the 49 total families housed remained in stable permanent housing. These families have been stably housed for a median of 581 days, or 19 months (see Table IV.12). Some families did choose to move with their voucher or subsidy. Among the housed treatment families, families experienced an average of 1.3 lease events (SD=0.6), yet most families only had one lease (see Table IV.13).

Table IV.12 Days in Stable Housing, Treatment Families as of 10/1/2018

Family Count	Mean	SD	25th Percentile	Median	75th Percentile
49	611	385	377	581	828

Table IV.13 Number of Lease Events among Housed Treatment Families

Family Count	Min	Max	Median	Mode	Mean	SD
49	1.0	3.0	1.0	1.0	1.3	0.6

Engagement - Case Management Services

In the next section, we consider the extent to which all families were engaged rapidly following referral, and then persistently over the course of the intervention. Given the delay in securing permanent

housing, case management, service referrals, support services, and housing support that project partners provided following enrollment are the core program elements that contributed to family stability, persistence in the program overall, and progress toward program outcomes.

Did families have initial FTMs? What was the timing? Did they have on-going FTMs?
Did families have regular meetings and facetime with their HPP case managers?
Did housed families have monthly visits?

All referred families should have had their first FTM meeting, including both the child welfare worker and the HPP team within 30 days following referral, and then monthly thereafter until their child welfare case closed.

Of the 79 families referred, 69 went on to have an initial FTM – the critical first meeting during which HPP case managers and SF-HSA child welfare workers determine the next steps for the family to set them up for progress on their child welfare case and simultaneously progress on their housing goals.[28] The program goal was to schedule that first FTM within 30 days of program referral. The table below shows that 82 percent of ITT families had those meeting within 30 days of enrollment, and that the average time to the first meeting was 17 days. Half of the engaged families had that meeting within 12 days (see Table IV.14).

Following the initial FTM, families were expected to have monthly FTMs for the duration of their child welfare care. Most families did not meet this standard; meetings were more likely to occur, on average, every two months. Table IV.14 below shows that only 38 percent of engaged families had the expected number of FTMs during the length of their child welfare case. Because a meeting is only considered an FTM when the child welfare worker is in attendance, this performance does not necessarily mean that families were not engaged with the FMF program.

[28] Two families declined services following the FTM and did not engage with the program.

Table IV.14 Did Treatment Families Receive the Intended Service Process?

Treatment Families	Family Count	ITT	TOT
Total families randomized (ITT group)	79	100%	
Total engaged families (TOT group)	69	87%	100%
Families w/initial FTM in first 30 days	67	85%	97%
Families with monthly FTMs throughout CW case	26	33%	38%
Families with initial ANSA	65	82%	94%
Families with ANSA's every six months during enrollment	34	43%	49%
Families with at least 5 case management hours per month	43	54%	62%
Average CM time per month for enrolled families (hours)		6.9	7.3
Average facetime per month for enrolled families (hours)		3.5	3.8
Housed families	49	62%	71%
Housed graduated families	37	47%	54%
Housed families with monthly home visits	20	41%	41%
Families with an exit interview (among graduated families)	25	68%	68%

Overall, engaged families had on average seven hours of case management per month with their HPP case manager over the course of the open case, about half of which (on average) was face to face meeting time. When considered in tandem with housing timing, it's clear that families had a great deal of contact with case managers prior to procuring permanent housing. Table IV.15 shows that on average, families had three times as much case management support before they were housed compared to post-housing.

Table IV.15 Case Management Hours by Housing Status

Case Management Hours Per Month	Family Count	Min	Max	Mean	Median
All Families Pre-Lease	78	0	39	9	10
Housed Families Pre-Lease	49	0	25	10	12
Housed Families Post-Lease	49	0	13	3	3

Finally, once families moved into housing, they should have had one home visit per month. Among engaged housed families (N=49), 41 percent had at least one home visit per month after they were housed.

ANSA and CANS

Case management services were to be guided, in part by decisions made in the first FTM, and by results of the ANSA assessment, which HPP case managers administered to adult family members during intake and every six months thereafter until the case closed. Results from the ANSA assessment not only guided service referrals and on-going support, but they were also used to determine the point at which families who had been housed could progress through check-in to graduation. ANSAs were to be administered every six months in order to determine when families met the ANSA-related requirement for progression through the program. Table IV.16 shows timing of the first FTM and to the first ANSA. Of

the engaged families, 65 (94%) had a baseline ANSA assessment. It took a median of 51 calendar days from randomization for those families to complete their baseline ANSA.

Table IV.16 Timing of Key Case Management Components

Case Management Services	Family Count	Min	Max	Mode	Mean	25th Percentile	Median	75th Percentile
Weekdays from Lottery to First FTM	69	1	103	5	17	6	12	20
Days from lottery to first ANSA	65	3	216	28	62	28	51	77

The following table indicates the extent to which treatment families showed improvement on the core ANSA domains. Baseline ANSA scores are compared to the most recent follow-up ANSA by family. A total of 59 families completed at least one follow up assessment. If more than one adult in the family had an ANSA assessment, the score for the primary parent is used. The ANSA is scored on a scale from 0-3 where 0 is no need and 3 is immediate need. A score of 2 or 3 on the ANSA is considered "actionable". The vast majority of treatment families had actionable family functioning (83%) and residential stability (71%) needs at baseline. With the exception of medical needs, fewer families had actionable needs at follow-up than baseline.

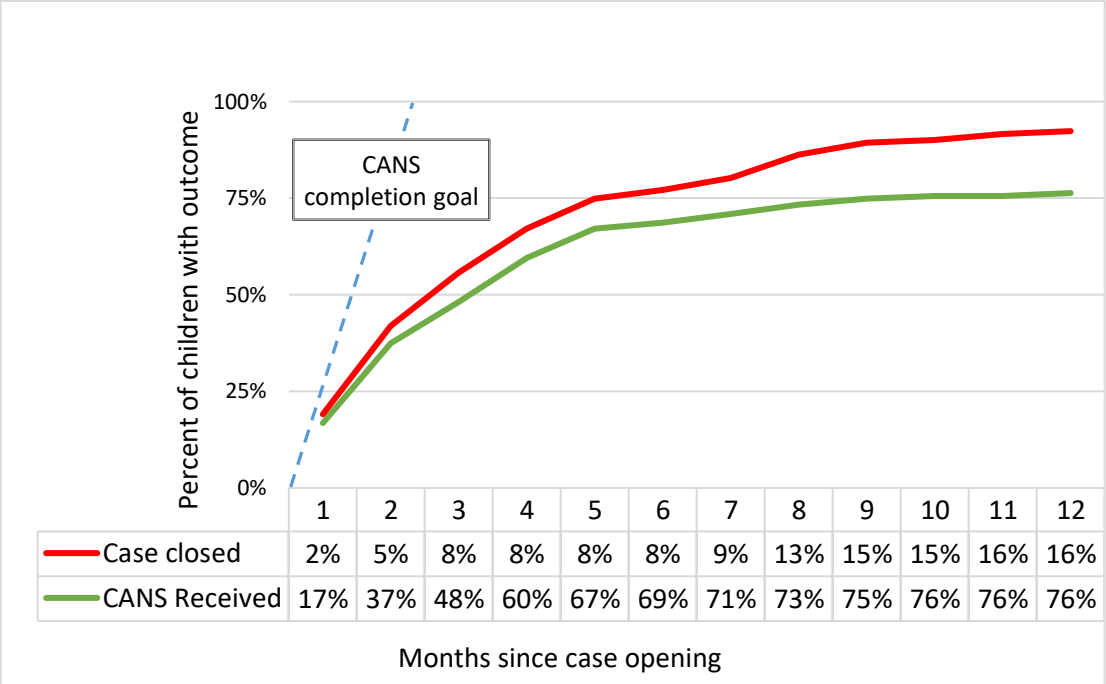
Table IV.17 Baseline and Most Recent ANSA Scores for Treatment Families, Families with Actionable Needs

	Total Families Assessed		Number of Families w/Actionable Needs		Percent of Families w/Actionable Needs	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
Adjustment to Trauma	65	59	36	15	55%	25%
Anxiety	65	59	18	11	28%	19%
Cultural Stress	65	59	11	6	17%	10%
Depression	65	59	23	11	35%	19%
Employment	65	59	17	3	26%	5%
Environment SA	65	59	11	7	17%	12%
Family Functioning	65	59	54	23	83%	39%
Involvement in Recovery	65	59	9	5	14%	8%
Legal	65	59	23	13	35%	22%
Life Skills	65	59	5	6	8%	10%
Medical	65	59	9	9	14%	15%
Residential Stability	65	59	46	15	71%	25%
Severity of Substance Abuse (SA)	65	59	13	6	20%	10%
Stage of SA Recovery	65	59	7	5	11%	8%
Substance Abuse	65	59	19	10	29%	17%
Connectedness Strength	65	59	28	13	43%	22%

The ANSA evidence, discussed further in the Parent/Caregiver Outcomes Chapter of Section IV, suggests that treatment families showed measurable improvements in well-being and functioning after graduating from the FMF program.

As described earlier, children in treatment families were supposed to receive CANS screenings shortly after their referral so that any needs identified would be addressed by the FMF treatment team. Because HPP case managers do not work directly with children, identified services needs would be managed by the public child welfare worker, or in some cases, families with qualifying children five and under would be referred to project partner IPP for dyadic parent-child therapy. Despite early efforts to coordinate with DPH – an initial project partner (see Sec II, "Partners with Less Successful Collaboration") it proved very difficult to meet the project expectation that children in treatment families would receive a CANS screening within two months of referral; in fact, many children in the treatment families did not receive an initial CANS at all or until deep into their child welfare case. This delay triggered a specific study into the CANS process (see Appendix O. Time to CANS), which revealed the median time to CANS assessment (for treatment children enrolled before February 2015) was 107 days.

Figure IV.3 CANS Received and Case Closures



	1	2	3	4	5	6	7	8	9	10	11	12
Case closed	2%	5%	8%	8%	8%	8%	9%	13%	15%	15%	16%	16%
CANS Received	17%	37%	48%	60%	67%	69%	71%	73%	75%	76%	76%	76%

Months since case opening

It was over three months before half of the children in the treatment group had received the initial screening, at which point eight percent had already seen their case closed. By the time 75 percent of this group had the screening, fifteen percent of the cases had closed. While this timing improved over the course of the grant period, many children from the earlier enrolled families were not immediately screened, and therefore that information was not readily available to the treatment team. Further analysis of initial screenings and repeated CANS assessments for children from treatment and control families is included in the results chapter.

Engagement - Services to Children and Families

Children

Although CANS screenings did not occur timely enough for use in immediate case planning, the project did have an active partner in the Infant-Parent Program (IPP) housed at San Francisco General Hospital. IPP partners were alerted when a family with a child five or under had been referred to the program. This allowed them connect immediately with HPP workers and the families to see if they would be appropriate for IPP dyadic services. In total, 85 percent of the engaged treatment families had one or more children under age six. And 18 percent of those families engaged with IPP over time. There were a few reasons for low participation. Anecdotal evidence from family interviews suggest that IPP services somewhat duplicated mandated child welfare services like SafeCare. Other families said that the pressure to find housing and to meet the child welfare case demands made adding IPP on top of all this too much. Finally, the IPP model is a home-based one, which was impractical when families did not yet have homes.

Table IV.18 Treatment Families with Children under Age 6 and Referred to Infant-Parent Program (IPP)

	Family Count	Total Percent
Total treatment families	79	100%
Families with at least one child under age 6	67	85%
Families working with IPP	12	18%

Although IPP worked with a relatively small portion of the treatment families, they provided intensive services to the families they served. On average, families received 141 services from IPP across all family members. The most commonly provided service was mental health followed by parent-child psychotherapy.

Table IV.19 IPP Services Provided per Treatment Family

	Family Count	Min	Max	Mean	SD	25th Percentile	Median	75th Percentile
IPP Services	12	37	327	141	85	68	136	182

Table IV.20 IPP Service Types

Service Type	Service Count	Percent
Total	776	100%
Mental Health	418	54%
Parent-Child Psychotherapy	327	42%
Other	21	3%
Dyadic	7	1%
Physical Health	2	0%
Job Search	1	0%

Referrals and Services

To what extent were families referred for additional services?
How often did they participate in those services?
Did HPP make referrals for outside services?
Did HSA make referrals for outside services?

As part of the FMF intervention, HPP case managers were to be guided by ANSA assessment results, their own interactions with family members, and decisions made during FTM meetings to determine what services families might benefit from. Case managers were able to make service referrals to both HPP and to external providers, as indicated by their case specifics. At the same time, and as part of the effort to support families in the completion of their child welfare case plan, HSA social workers routinely referred treatment families to a range of services. As one HSA worker commented during an interview:

> *…[if] they need therapy, we do a foster care mental health referral. If they need a psychological evaluation, we make that referral. If they need substance abuse assessment, we make the referral. Drug treatment services, usually, homeless prenatal program who has families moving forward refers them or we refer them. Parenting, we refer them. We set up visits. We set up transportation."*[29]

Social workers would then document those referrals and evidence of their uptake in the case record and in court reports. Although evidence from both family and staff interviews suggests that both HSA and HPP referrals were made, as described elsewhere, the process for recording referrals at HPP was somewhat undependable. This issue surfaced during the CQI meetings, and was addressed somewhat during the grant period (this method is being further refined as part of Bringing Families Home).

For the FMF program, a separate study was conducted that involved close scrutiny of case records and documentation to understand the extent to which treatment families were referred for supplementary services. A number of control families were also referred to HPP and received services from non-FMF case managers, thus in that study we compared the documented referrals and services from families from both groups.[30]

In this report, we summarize the results to show the extent to which HPP made referrals and either provided or linked treatment families to services as part of the FMF intervention. We focus on HPP referrals and service to avoid the duplicating counts of referrals and services. As the quotation above suggests, HSA would most certainly have referred FMF families to HPP and would have then documented their receipt in their case notes.[31]

Data were collected from the case opening date for each family through September 30, 2016. HENRI, HPP's case management database, contained direct service notes, referrals to services, program attendance, and housing status over time. Those data were collected through May 30, 2017.

[29] 2018, HSA Interview
[30] Additional details and the preliminary report are available from evaluators upon request.
[31] As the HSA quotation implies, public child welfare workers may have referred any family to HPP, but treatment families referred to HPP would have already been known to them, and their coordinated through their FMF caseworkers. Referrals of other families to HPP as part of the business as usual condition would have been assigned to a different HPP caseworker.

The tables below summarize the number of referrals and service provided to treatment families as recorded by HPP case managers. Table IV.21 shows that HPP made a total of 524 referrals for treatment families, who received 1,948 services, for an average of 24.6 services from HPP during their enrollment.

Table IV.21 Referrals and Services for Treatment Families by Agency

	HPP[a]
Total # of families[b]	79
Total referral count	524
Total service count	1,948
Mean referrals per family	6.6
Mean services per family	24.6
Median referrals per family	6
Median services per family	16.5
Number of events	0-179

[a] HPP referral types were 75 percent external and 25 percent internal
[b] 3 HPP families had no records

Table IV.22 shows the type of referral, with shading reflecting the most common referral types: substance abuse, mental health, housing, and independent living.

Table IV.22 Referral Types for Treatment Families

Category of Service	HPP N	HPP %
Benefits	31	6%
Child centered	16	3%
Domestic Violence	12	2%
Education	16	3%
Employment	19	4%
Housing	70	14%
Independent Living	67	13%
Mental Health	83	16%
Parenting	67	13%
Physical Health	18	4%
Substance Abuse	110	22%
Transportation	0	0%
Visitation	0	0%

Not all families received referrals and services. Table IV.23 below shows for the same categories, the proportion of treatment families who were referred or offered services. Shading indicates when over half of the treatment families received a referral or services.

Table IV.23 Proportion of Treatment Families Who Ever Received a Referral or a Service (N=79)

Types	Referrals	Services
Benefits	24%	25%
Child centered	15%	15%
Domestic Violence	11%	11%
Education	16%	16%
Employment	18%	19%
Housing	46%	50%
Independent Living	50%	50%
Mental Health	44%	47%
Parenting	47%	49%
Physical Health	19%	18%
Substance Abuse	43%	13%
Transportation	n/a	n/a
Visitation	n/a	n/a

Finally, the services study evaluated the extent to which treatment families continued to receive referrals and services after securing permanent housing. Consistent with the decline in case management hours reported above, the results below show a substantial drop in the number of service events, with half (median) of the housed families having five or fewer services in their post- housing phase, compared to 23 in the months prior to housing.

Table IV.24 Service Events Following Housing for Treatment Families

Event	Before Housing	After Housing
Count of Families with Events	47	42
Total Count of Events	1,453	535
Avg. Count of Events	30.9	11.4
Median Events	23	5

Staff and family interviews referred often to the services families were accessing in their efforts to "work" their child welfare case. In addition to working with the HPP housing specialist to complete the tasks necessary to both procure the Section 8 voucher and then locate appropriate housing, families reported attending a range of sessions and services required as part of their child welfare plan. Most frequently however, families reported that the benefits they received from the program were less specifically about services and referrals, and more about two distinct categories of support. The first was assistance with tangible goods: groceries, household items, or child care necessities (stroller, diapers). The second was less tangible – the comfort of having a case manager helping them navigate through the often overwhelming and complex web of decisions, responsibilities, and bureaucracies that they needed to traverse in order to complete the program. As one participant said:

> *So what else? They still help me. They help people a lot find their own place. They help people like, "You can do this. You're not alone." Well, my experience, I'm grateful, like happiness ….They really care about people. They really care about families like coming forward, like, "Come on. You can do it." You know what I'm saying. "We're gonna help*

you. We'll help you. You help yourself. You can do this." You know what I'm saying. "So we're gonna give you a hand," like that. …. It's very important for me because Families Moving Forward helped me to believe in somebody, believe in something…[32]

Monitoring Fidelity

Our fidelity assessment took the form of rapid cycle testing throughout the life of the project, starting during the planning year and persisting through the end of the project. The trigger to each rapid cycle test was a question or concern that emerged from discussion during the monthly CQI meetings with project partners. During those meetings the project team reviewed the monthly dashboard. When questions arose about the extent to which program participants were enrolled, receiving services, housed, and progressing through the program as anticipated, the CQI team would determine if a specific test was necessary. In some cases, raising the issue was enough to attend to a program challenge, other cases demanded more targeted study and specific remedies. The table below summarizes the areas of focus, the method for surfacing concern, and the consequences of the conversation.

[32] 2018 Family Interview, HPP-2.

Table IV.25 Areas of Fidelity, Inquiry Methods and Results

Date	Program Area	Fidelity Activity/Inquiry	Method	Result
Dec-13	Engagement and Intake	Were referrals and enrollments occurring as anticipated	Review of CQI dashboard	Open Enrollment to reunification families
Feb-14	Engagement and Intake	Should referral process consider newborns & infant bypass?	Case Review of newborns	Determined newborn bypass criterial
Jul-14	Engagement and Intake	Were referrals and enrollments occurring as anticipated	CQI dashboard	Added housing events to Henri (Mar 2014)
Sep-14	Case Management	Were FTMS occurring as anticipated with appropriate participants	Coordinated case plan review	Add line tracking FTMs to dashboard
Sep-14	Case Management	Where IPP referrals occurring as anticipated	Met with IPP; reviewed referral protocols	Included IPP in all initial FTM for families with kids under 6??
2016-17	Housing	Housing milestone sub-study	Housing Process map	SFHA Administrative Plan changes; Housing Case Management Model
2016-17	Housing	FUP voucher utilization study	FUP dashboard	Regional work around the housing authority porting process
Oct 2015-Feb 2016	Case Management	Case management effort did not match recorded case management hours	Time Use Study	Improved recording-keeping, and contributed to revision of case management model
Jun-16	Support Services	There were fewer service referrals than we had anticipated	Services study	Deeper study; HPP back entered service hours
Spring 2016	CW/Services	CANS assessments were taking longer than anticipated	CANS study	Devised new approach with DPH
Aug-16	Housing	Where were families being temporarily housed?	Core Database analysis	Learned about reliance on hotels and the challenges their use posed to case progress
Sep 2016 (updated)	Housing	Were families being housed?	Core Database analysis	Holloway House, adapted case management model
Nov-16	Case Management	Case review of families with substance-exposed newborns	Case Review of newborns	Refine targeting strategy
Jan-17	Case Management	Time Use by program status	Core Database analysis	sustainability funding

Exit Interview Results

HPP case managers reached out to all participating FMF families to conduct exit interviews upon their graduation from FMF to see how they would characterize their current housing situation, their overall family functioning and child well-being, and their overall experience in the FMF program. Of the 49 treatment families who obtained housing, 37 graduated from FMF (see Table IV.8), all of whom were contacted by HPP case managers via phone, letters, or house visits and invited to participate in exit interviews approximately 6 months after graduation. Some of these families were harder to reach despite multiple contact attempts, particularly those who had moved out of San Francisco County. In total, 25 families participated in some portion of the exit interview.

The majority (88%) of graduated families who participated in the exit interview still lived at housing that was funded through their FMF housing (See Table IV.26). The remaining 12% (or 3 families) who were interviewed either moved out of San Francisco County with their voucher or relinquished their FMF voucher after finding another type of subsidized housing. Most families were intact and living together; in those instances where some children were no longer with the caregiver, all children were living with family members. Nearly two-thirds of families acknowledged living nearby to social supports (such as immediate family, friends, community members, or service providers).

Table IV.26 Survey Results on Housing Outcomes among FMF Families Who Completed Exit Interview

Question	Answer Choices	Total Respondents	Total Percent
		n=25	100%
Are you still living at your housing through FMF?	Yes	22	88%
	No, I moved with my voucher	2[a]	8%
	No, I'm no longer eligible for my voucher (e.g. income too high)	0	0%
	Other	1[b]	4%
		n=25	100%
Are all of your family members who were originally on the lease still living with you?	Yes, they are all still living with me	22	88%
	No, my partner/spouse is no longer living with me	1	4%
	No, some of my children are no longer living with me	2[c]	8%
	No, none of my children are currently living with me	0	0%
		n=24	100%[d]
Do you have social supports where you're currently living? Check all that apply	Yes, my extended family is nearby	10	42%
	Yes, I have friends nearby	7	29%
	Yes, I participate in the community (e.g. volunteering, religion, cultural events)	5	21%
	Yes, there are local service providers (e.g. HPP) that support me	10	42%
	No, I feel socially isolated where I'm living	9	38%

[a] Both families moved out of county but remained in the Bay Area of California (Hayward, Antioch).
[b] This family moved to Treasure Island, part of San Francisco County, after finding another type of subsidized housing.
[c] All children among these families are living with family members.
[d] This column adds up to more than 100% because respondents were asked to check all that apply.

Graduating families were also asked about their level of satisfaction with their housing in terms of its proximity to public transportation, quality of local schools, personal safety and safety of children, accessibility of nearby resources, sense of community, and overall quality of housing (See Table IV.27). In each domain, over half of all respondents rated their levels of satisfaction as mostly satisfied or very satisfied. Personal safety and safety of children appeared to be a concern for some families; approximately one-fifth expressed being somewhat or very dissatisfied with personal safety (20%) or safety of their children (18%).

Table IV.27 Survey Results on Satisfaction with Housing among FMF Families Who Completed Exit Interview

Question	Likert Scale (%) (n=25)				
How satisfied are you with your current living situation?	Very dissatisfied	Somewhat dissatisfied	Neutral	Mostly satisfied	Very satisfied
Access to transportation	0%	0%	20%	36%	44%
School quality	8%	8%	20%	36%	28%
My personal safety	16%	4%	4%	48%	28%
The safety of my children	12%	4%	4%	44%	36%
Access to community resources (e.g. HPP, other supports)	4%	16%	24%	28%	28%
A sense of community identity and belonging	8%	16%	24%	28%	24%
Quality of the housing itself (structure, appliances, etc.)	0%	12%	4%	40%	44%

Overall family well-being was also assessed (see Table IV.28). Three-quarters of respondents expressed feeling positive or hopeful about their family's future. Regarding mental and physical health needs, the majority of respondents either did not have an issue or were receiving treatment. Few reported legal or domestic violence concerns. Nearly a third reported concern about employment for themselves (32%) or education for their children (41%).

Table IV.28 Survey Results on Well-Being among FMF Families Who Completed Exit Interview

Question	Answer Choices	Total Respondents	Total Percent
		n=25	100%
How are you feeling about your family's future?	I feel positive or hopeful	19	76%
	I feel sad or worried	1	4%
	I feel neutral	5	20%
Do you have any chronic or new significant mental health concerns? If so, are you getting treatment?	No	16	64%
	Yes, and I'm getting treatment	3	12%
	Yes, but I'm not getting treatment	0	0%
	I'm not sure	3	12%
	Not applicable (no history of mental health issues)	3	12%
Do you have any chronic or new significant medical conditions? If so, are you getting treatment?	No	11	44%
	Yes, and I'm getting treatment	9	36%
	Yes, but I'm not getting treatment	2	8%
	I'm not sure	0	0%
	Not applicable (no current or chronic medical conditions)	3	12%
If you're having legal issues, are you or a family member at risk of being incarcerated?	Yes	1	4%
	No	10	40%
	Don't know	1	4%
	Not applicable (no current legal issues)	13	52%
Are you or a family member experiencing, or at risk of experiencing, domestic violence?	Yes, myself and/or my children are currently experiencing domestic violence	0	0%
	Yes, myself and/or my children are at risk of domestic violence	0	0%
	I'm not sure	1	4%
	No	24	96%
Are there any stressors or triggers in your life right now that make you want to use substances? If so, how is this impacting your life?	Yes, and I'm practicing harm reduction	2	8%
	Yes, and it's impacting other areas of my life (work, relationships, etc.)	0	0%
	I'm not sure	2	8%
	No	16	64%
	Not applicable (no history of substance use)	5	20%
Are you experiencing any employment related challenges?	No, I'm happily employed	8	32%
	Yes, I'm having trouble finding work	8	32%
	Yes, I'm worried about losing my job	3	12%
	Yes, I recently lost my job	0	0%

Question	Answer Choices	Total Respondents	Total Percent
	Yes, I'm have issues finding transportation to work	1	4%
	Not applicable, not currently working or looking for work	8	32%
		n=22	100%[a]
Are you experiencing any education related challenges for yourself and/or your children? Check all that apply.	No, my children are attending school and doing well	11	50%
	Yes, I'm having trouble finding a good school	8	36%
	Yes, my children have been truant/dropped out/expelled	0	0%
	Yes, I'm have issues finding transportation to school	1	5%
	Not applicable, my children are not currently in school	4	18%

[a]Column sums to more than 100% because respondents were asked to check all that apply.

Families also rated strengths and challenges in their lives (see Table IV.29). Over 30 percent of the responding families reported that employment, maintaining social connections and support, and maintaining their household, were sometimes or often challenging. On the other hand – sixty percent or more report family relationships, the family's physical and mental health, and their children's education as sometimes or usually a strength – indicating that post-graduation there was clear evidence of both health and stability in the home.

Table IV.29 Survey Results on Strengths and Challenges among FMF Families Who Completed Exit Interview

Question	Likert Scale (%) (n=25)					
For each of the following, to what extent is this a strength or a challenge in your life right now?	Usually a challenge	Sometimes a challenge	Sometimes a strength and sometimes a challenge	Sometimes a strength	Usually a strength	N/A
Family relationships	8%	20%	12%	8%	52%	0%
Physical health of yourself and your children	4%	8%	16%	28%	44%	0%
Mental health of yourself and your children	0%	12%	20%	20%	44%	4%
Education of your children	0%	12%	16%	4%	64%	4%
Employment	12%	28%	12%	4%	32%	12%
Recovery from substance use	0%	4%	8%	0%	36%	52%
Social connections and supports in your community	20%	20%	20%	16%	24%	0%
Maintaining your household (cleanliness, paying bills, etc.)	12%	20%	24%	4%	40%	0%
Handling legal issues	16%	12%	4%	8%	12%	48%

Regarding the areas of challenge, most of those interviewed indicated that they had or would be able to seek assistance from either HPP or a local service resource. Very few suggested that they needed additional assistance, although 3 (12%) reported needing help locating education and employment resources. Additional details are provided in Table IV.30.

Table IV.30 Survey Results on Resources for Challenges among FMF Families Who Completed Exit Interview

Question	Likert Scale (%) (n=25)				
For each of the following challenges, are you currently getting help or do you know where you could get help for yourself or your family if this becomes a challenge?	I'm getting/would get help from HPP	I've identified a local service provider where I'm getting help/could get help	I need help finding a community resource	I'm getting/would get help from friends or family	N/A
Domestic violence	40%	16%	0%	4%	40%
Physical health issue	12%	60%	4%	4%	20%
Mental health issue	16%	68%	4%	0%	12%
Education	24%	40%	12%	0%	24%
Employment	12%	48%	12%	8%	20%
Recovery from substance use	20%	20%	0%	4%	56%
Maintaining your household (cleanliness, paying bills, etc.)	16%	24%	8%	12%	40%
Handling legal issues	24%	28%	8%	4%	36%

Concluding Thoughts

The difficulty obtaining housing at the program outset had a cascading effect on the HPP's ability to deliver the FMF intervention as originally intended. The protracted time to housing may have contributed to the attrition. It certainly prevented HPP case managers from early on providing supportive services in the context of permanent residency, and instead compelled them to focus simultaneously on stabilizing families while also supporting their difficult search for housing.

In the next section, we look more closely at the impact of FMF – both on the entire treatment group, but also on the sub-set of treatment families who remained engaged. What is clear from the implementation study is that there were families who successfully completed the program, closed their child welfare case, graduated, maintained their housing and showed marked improvement in their well-being. For those families, FMF was transformative, as one client said during the exit interview: "[FMF] helped me get to a place in my life where I can help myself." For that client – the program had its intended effect.

Outcome Study Methods, Analyses, and Results

Methods

Outcome Study Questions

The research questions were listed in Table IV.1. This section describes how the evaluation answered the questions and reports the findings.

Data Sources

To track the assignment of eligible families to each treatment condition, and track program events for the intent-to-treat group, the evaluators designed a Core Services database to be housed at Chapin Hall. The lynchpin of this resource was a secure web-based database, hosted at Chapin Hall and accessible to select project partners who documented basic event information for treatment families to whom they delivered services. This was supplemented by a monthly feed from HPP's HENRI database, which provided information on housing and additional services.

The database served two functions. First, it contained a record for each family assigned to either the treatment or control group. The record contained a unique project ID for each family and each family member, the date of enrollment, and an indication of study group assignment. In addition, this database contained identifiers to facilitate matching project families to other administrative data sources.

Secondly, those partners (other than HPP) who provided services to treatment families documented information about service provision to each treatment family. Each time the participating service provider had contact with a participant, they entered names of service recipient(s), date of service, location of service, and type of service received (e.g. mental health, housing). The researchers also collected de-identified service data from SF-HSA and HPP for the control group in order to assess the counterfactual business as usual.

In consultation with the evaluation team, HENRI was augmented to include the collection of services data for treatment families. HPP provided monthly extracts of this database to the evaluation team; those were merged with quarterly extracts of the core services database. Together, these data elements constituted the key source of administrative data for the implementation evaluation, and the monthly CQI meetings.

In addition to the core services database, the evaluation team collected administrative data from a variety of other sources, such as other housing providers, the school district and the California Employment Development Department. These other data sources are described in full in the relevant sections.

Comparative Design

Treatment group families received both (a) rapid intensive case management and housing search assistance with HPP and (b) permanent housing according to their level of need and availability, i.e., shallow rental subsidy, Family Unification Program (FUP) voucher, or on-site supportive housing in San

Francisco's Local Operating Subsidy Program (LOSP).

Families assigned to the control group received service as usual for their child welfare and housing needs. Service as usual could have included referring the family to HPP for help finding housing (although they would not receive a voucher or other housing subsidy) under their existing contract with SF-HSA. On the HPP side there was a clear distinction in the service approach for FMF families relative to other HPP clients. HPP hired designated case managers to work solely with families selected for FMF and these workers carried no other cases. The case management model included ANSA assessments at baseline and every six months and monthly home visits for treatment families as opposed to more sporadic assessments and case management time as-need among other clients. Thus, FMF families received a specific set of services, delivered in a specified manner from a designated work team that differed significantly from the services other HPP families received.

On the SF-HSA side, an ongoing child welfare worker could carry families from both the treatment and the control groups. Any practice modifications this worker may have made in working with treatment families could have carried into her approach with control families. Additional, service providers –IPP and PCG - were asked to enter into the Chapin Hall database contact and service information for any control families that they happened to reach via business as usual.

Baseline Equivalence

Table IV.6 compared the treatment and control groups along their baseline characteristics at the family level. Since a large share of families randomized to the treatment group either never engaged (11%) or disengaged before becoming permanently housed (28%), we supplement the ITT analysis with a TOT analysis. Although treated families likely differed from non-engaged families in unobservable ways, the value of the TOT is to glean insight into whether the intervention appeared to be effective among the types of families who engaged and remained engaged, despite housing delays, which has implications for narrowing the target population in future housing interventions with this population.

CANS and Survey Consents

The Urban Institute (UI) surveyed treatment and control families across sites at baseline and again after one year. The purpose was to gather richer and broader information about how the intervention affected housing and well-being relative to what the administrative data could provide. Like the CANS, the UI survey required family consent which was delivered by the HPP case manager to treatment families and the SF-HSA child welfare worker to control families. All families were offered a $50 incentive to participate in the survey at baseline and again at follow-up. Analyses related to child well-being using these instruments were limited to families who consented (Table IV.31).

Table IV.31 CANS and Survey Consent by Group

		Consented to share CANS data		Consented to survey	
Group	Total Families	Count	Percent	Count	Percent
Control	75	44	59%	42	56%
Treatment	79	72	91%	70	89%

Child welfare workers were tasked with consenting families for research related to a program that the families were not to receive, which probably reduced their motivation, especially in the face of other,

more urgent demands related to the start of a child welfare case. Midway through the study, we began offering grocery store gift cards to child welfare workers for asking control families for their consent, regardless of whether or not the family did, in fact consent. A few control families refused consent but the larger problem was convincing child welfare workers to pose the question.

Since the control group had a relatively low consent rate for both CANS and the survey, we conducted a logistic regression to determine if families and children that consented were observably different than those who did not. There were no statistically significant differences across the covariates included in the regression – ethnicity, primary language, age, case type at randomization, SDM® risk level, and child welfare worker supervisor.

Testing for Program Effects

Refer to Table IV.1 for a listing of statistical approaches by research question. All child-level analyses included a standard error adjustment for clustering of children within families. The modeling approach first examined zero-order effects, then added demographics, then other covariates listed in the descriptive table of the sample, Table IV.48.

Assessing Change over Time, and Handling Attrition and Missing Data

Assessing Change over Time

All analyses relied on the longitudinal database described above. Depending on the question, outcomes were measured using logistic regressions and/or survival models. For questions that involve the timing of housing relative to the outcome, we report descriptive findings because the subsample was too small for inferential methods. For questions about individual change over time (i.e., CANS, education outcomes), we used multilevel growth models. Where available, we report and account for historical exposure to the outcomes that children or families may have had in each area as well.

Handling Attrition

Attrition took several forms. Table IV.32 provides a summary of the engagement and completion level of families randomized into the treatment group. Some families never engaged. These 10 were "non-participants". They were also by definition "non-completers", since "completers" were defined as those that participated in case management, were housed, and completed the requirements to graduate from the program. Another 32 families participated but did not complete the program.

As described earlier, we conducted a TOT analysis that only excludes the non-participants because even those who received case management but dropped out before being housed received some of the prescribed intervention. Since attrition may have been related to housing delays, we examined the effect of time-to-housing on key outcomes, notwithstanding selection bias associated with families who did not receive the full or any treatment.

Table IV.32 Treatment Families, Participation and Completion Status

Treatment Families	Total	Participants/Engaged	Non – Participants/Never Engaged
Total	79	69	10
Completers	37	37	0
Non-completers	42	32	10

Missing Data

Missing data are noted in each analysis.

Results

Table IV.33 summarizes the finding that correspond to the research questions in Table IV.1. It also lists the last date the data were observed. The sections that follow more fully describe each of the analyses and findings.

Table IV.33 Outcomes Summary

RESEARCH QUESTION	ITT FINDING	CENSOR DATE
Percent of treatment families that ever engaged in FMF	87%	9/30/18
Percent that engaged and were permanently housed	62%	
OUTCOMES		
Housing		
1. Were treatment families less likely to enter shelters or use other homeless services?	Yes+	Two years after randomization
2. Were they more likely to obtain stable housing?	Yes**	Varies by group, see notes in Table IV.23
3. Was their housing more stable, of higher quality, more affordable, and safer?	Yes*	One year after randomization
Child Welfare		
1. Were treatment children less likely to be placed into foster care?	No difference	6/30/18
2. Did they avoid foster care placement longer?	Yes within 1 year+	
3. Did they spend less time in foster care?	No difference	
4. Were they more likely to reunify?	Yes within 6 months*, no difference 1 or 2 years	
5. Did they reunify more quickly?	Yes**	
6. Did their cases close faster?	No difference	
7. Were they less likely to be re-abused?	Yes+(preserv.); No difference (reunification)	
8. When they reunified, were they less likely to reenter care?	No difference	
Well-Being		
1. Were treatment families more likely to use public benefits?	No difference	9/1/17
2. Did they increase their earnings more than control families?	No difference	6/30/18
3. Were they more likely to obtain subsidized employment?	No difference	9/14/18
4. Did treatment parents have greater improvements in well-being?	Yes**	10/31/18
5. Did treatment children show greater improvements on the CANS?	No difference	9/28/18
6. Did they have better educational outcomes?	No difference	School year 2017-2018

Significance: *p<.05; **p<.01; +p<.1

Housing outcomes are presented first, followed by child welfare, then well-being.

Housing Outcomes

Background

While both treatment and control families could access the existing array of housing services, treatment families were also eligible to receive the housing assistance described in Section III. In this section, we discuss the extent to which families obtained housing, the time it took to obtain housing, and the type, quality and stability of that housing.

Data Sources and Method

We originally planned to use two main sources of data to understanding housing outcomes – administrative FMF data which was collected only for treatment families, and survey data which was collected for both the treatment and control group. However, response rates were low for the follow up survey (N=66), especially among the control group (N=26). In part, this was because consent rates were low among control families to begin with, but additionally, the survey researchers had difficulty locating some families or they declined to participate even after signing a consent to be contacted by a survey interviewer. We summarize treatment verses control survey responses about several key aspects of housing that speak to the quality, stability, and safety of their housing, although we interpret the findings with caution. All tables in this section source the survey data except for tables 23 and 25 which rely on HMIS and other administrative databases.

We sought to supplement the survey data with other data sources that would allow us to compare housing outcomes between the treatment and control group. First, we matched treatment and control clients to administrative data from other San Francisco agencies that provide housing assistance[33]. Since we could not assume that control group clients that did not match to other housing agencies' administrative data didn't obtain housing at all, we reviewed case records for un-matched control group clients to determine if they obtained housing within the window of time case notes discussed the housing situation of the birth family. We used chi-square tests to assess differences between the treatment group and the control group.

Results

We begin with a description of housing outcomes for both groups that reflects our post-hoc effort to find out what happened to control families, followed by a series of comparative analyses between the groups.

Were treatment families more likely to obtain stable housing?

A condition of the federally funded project was that demonstration sites would identify housing resources for families referred to the treatment group, and that they would rapidly secure permanent housing. As described earlier in the report, the San Francisco project team anticipated that scattered site housing, funded primarily with housing vouchers, would be hard to quickly procure. And as that section documents, the concern proved valid. The housing process consumed a great deal of project attention

[33] Public housing and vouchers administered through San Francisco Housing Authority, rapid rehousing programs administered through CalWORKs, below market units administered through Mayor's Office of Housing and Community Development, and shelter, transitional housing, permanent supportive housing and rapid-rehousing data collected in San Francisco's ONE data system – the coordinated entry administrative database for the Department of Homelessness and Supportive Housing.

during the first 18 months of the intervention, and thus a key question in this section is understanding the extent to which treatment families were able to obtain housing post-randomization relative to the families in the control group.

While treatment families were somewhat more likely to obtain some form of housing post-randomization (treatment=62%, control=44%, p<.03), they were much more likely to obtain housing with a long-term funding source (treatment =59%, control=16%, p<.001), mostly by utilizing FUP vouchers and the 10 LOSP units that only treatment families were eligible to receive. These results are similar to the UI survey responses, which found that at follow-up 55% of treatment families had a house or apartment with their own lease compared to 23% of control respondents (p=0.01).

When control families were able to obtain stable housing, the most common type was permanent supportive housing (n=6). More commonly, control families obtained housing with short-term funding sources, such as rapid rehousing or transitional housing.

Table IV.34 Housing Outcomes

	Last Observed Housing Outcome[a]				
	Count		Percent		
	Treatment	Control	Treatment	Control	p
Total Families Randomized	79	75	100%		
Never Engaged with FMF[b]	10		13%		
Engaged but Not Housed[b,c]	20		25%		
Total Housed	49	33	62%	44%	.03
Long-Term Housing	47	12	59%	16%	<.001
FUP Voucher	29	1	37%	1%	
Supportive Housing	10	6	13%	8%	
Self-Funded	4	2	5%	3%	
SFHA Public Housing	2	1	3%	1%	
Other S8 Voucher	0	2	0%	3%	
SHARE Rental Assistance	1	0	1%	0%	
Below Market Rate	1	0	1%	0%	
Short-Term Housing	1	16	1%	21%	
Rapid Re-Housing	0	10	0%	13%	
Transitional Housing	0	6	0%	8%	
HPP Deep Subsidy	1	0	1%	0%	
Obtained Housing – Type Unknown[d]	0	5	0%	7%	
Lost Housing	1		1%		
Reunification Services Terminated	1		1%		

[a] For the treatment group, last observed housing outcome represents the housing a family was in as of 9/30/2018 or the last time data was collected for the client. For the control group it is the last observed housing type in either the matched administrative data, case review, or survey. We distinguish it as "last" because several families had interim housing (due to long-term subsidies that were not able to be transferred to HA vouchers)

[b] Of these 30 treatment families that were not housed under FMF, 5 were housed in some form of short-term housing and 2 were housed in a long-term setting.

[c] Reasons a family engaged with FMF but were not housed include reunification services being terminated, family moving or becoming ineligible, unengaged, or incarcerated

[d] We were not able to determine the funding source of five families in the control group who were identified as obtaining housing through either the survey or case records.

Shaded areas represent data that are not applicable to the control group

Table IV.35 UI Survey Follow-Up: Do You Have a House or Apartment with Your Own Lease?

	House/apartment with own lease			Total	House/apartment with own lease		p
	Total	No	Yes	Percent	No	Yes	
Total	68	39	29	100%	57%	43%	0.01
Control	26	20	6	100%	77%	23%	
Treatmen	42	19	23	100%	45%	55%	

Were treatment families less likely to enter shelters and receive other homelessness services?

We defined a family as entering a shelter if any of the family members entered a shelter after randomization. We calculated the number of families entering shelters within 12, 18 and 24 months. Treatment families were less likely to enter a shelter at each observed time period at a rate that approached statistical significance (p<.1 at each interval).

Table IV.36 Entries to Shelter after Randomization

	Number of Families			Percent of Families			
	Total	Treatment Group	Control Group	Total	Treatment Group	Control Group	P
Total Families	154	79	75				
Entered SF shelter…							
Within 1 year	21	7	14	14%	9%	19%	0.08
Within 18 months	28	10	18	18%	13%	24%	0.07
Within 2 years	35	13	22	23%	16%	29%	0.06
No entry	119	66	53	86%	84%	71%	

Data Source: HMIS/ONE System

Note: Columns do not sum to 100 percent because categories are not mutually exclusive.

We also calculated the number of families receiving other homelessness services – street outreach and services only at a shelter – within 24 months. Usage of these services were low for both groups, but even lower among the treatment group.

Table IV.37 Other Homelessness Services within 24 Months of Randomization

	Number of Families			Percent of Families			
	Total Families	Treatment Group	Control Group	Total	Treatment Group	Control Group	P
Total Families	154	79	75	100%	100%	100%	
Service Type							
Street Outreach	2	0	2	1%	0%	3%	0.14
Services Only	5	1	4	3%	1%	5%	0.15

Were treatment families more likely to remain stably housed than control families?

Including all moves since randomization, treatment and control families experienced about the same number of moves, with more than half moving 1-2 times (p=0.62). Treatment families were actually more likely to move four or more times, this may be due to moves between hotels and transitional living provided by the intervention. In the longer term, substantially more treatment families (71%) expect to remain in their current housing in 6 months compared to control families (29%, p=0.02). No treatment or control families experienced an eviction.

Table IV.38 UI Follow-Up Survey: Since Randomization, How Many Times Have You Moved?

	Treatment	Control	Treatment	Control	p
Total	42	26	100%	100%	0.62
0 Moves	9	8	21%	31%	
1 Move	11	8	26%	31%	
2 Moves	9	6	21%	23%	
3 Moves	4	2	10%	8%	
4+ Move	9	2	21%	8%	

Table IV.39 UI Follow-Up Survey: Expect to Live in Current Housing in 6 Months

	Treatment	Control	Treatment	Control	p
Total	42	26	100%	100%	0.02
No	12	15	29%	58%	
Yes	30	11	71%	42%	

Did treatment families have higher quality housing than control families?

Treatment families were more than twice as likely to report excellent quality housing at survey follow up, 26 percent compared to 12 percent of control (p=0.01). The vast majority (93%) of treatment families reported that their housing was at least "good" compared to 38 percent of control families. Treatment families also reported less crowded housing—93 percent said their housing was not too crowded with people compared to 77 percent of control families (p=0.06). Treatment and control families reported about the same number of quality issues, with two thirds of both groups indicating no quality issues (p=0.4).

Table IV.40 UI Follow-Up Survey: Quality of Current Living Situation

	Treatment	Control	Treatment	Control	P
Total	42	26	100%	100%	0.01
Poor	3	5	7%	19%	
Fair	0	5	0%	19%	
Good	15	8	36%	31%	
Very good	13	5	31%	19%	
Excellent	11	3	26%	12%	

Table IV.41 UI Follow-Up Survey: Is It (Your Housing) Too Over Crowded with People?

	Treatment	Control	Treatment	Control	p
Total	42	26	100%	100%	0.06
No	39	20	93%	77%	
Yes	3	6	7%	23%	

Table IV.42 UI Follow-Up Survey: Total Number of Housing Quality Issues

	Treatment	Control	Treatment	Control	p
Total	42	26	100%	100%	0.4
0 issues	28	17	67%	65%	
1 issue	9	3	21%	12%	
2 issues	3	2	7%	8%	
3+	2	4	5%	15%	

Did treatment families have more affordable housing than control families?

Treatment families pay much less rent on average than control families, $291 per month compared to $688 per month (p=0.05). Control families are also more likely to be rent burdened with 80 percent reporting that they pay more than 30 percent of their household income to rent compared to 9 percent of the treatment group (p <0.001).

Table IV.43 UI Follow-Up Survey: Monthly Rent Paid by Families

	N	Mean	Std Dev	Std Err	Minimum	Maximum	p
Treatment	31	$291	$349	63	$0	$1600	
Control	16	$688	$979	244	$0	$3000	0.05
Diff (1-2)		$397	$633	195			

Table IV.44 UI Follow-Up Survey: Is Rent More than 30% of Household Income?

	Treatment	Control	Treatment	Control	p
Total	23	5	100%	100%	< 0.001
No	21	1	91%	20%	
Yes	2	4	9%	80%	

Did treatment families have safer housing than control families?

Treatment and control families report about the same number safety issues, with half of each group reporting no safety issues (p=0.84). Treatment and control families also reported similar rates of crime victimization, with three quarters responding that people being attacked or robbed in their neighborhood is not a problem (p=0.39).

Table IV.45 UI Follow-Up Survey: Neighborhood Quality Scale, 0-14

	Treatment	Control	Treatment	Control	p
Total	42	25	100%	100%	0.84
0 safety issues	22	13	52%	52%	
1-2 issues	6	2	14%	8%	
3-5 issues	8	4	19%	16%	
6-8 issues	2	2	5%	8%	
9+ issues	4	4	10%	16%	

Table IV.46 UI Follow-Up Survey: Is People Being Attacked or Robbed in Your Neighborhood a Problem?

	Treatment	Control	Treatment	Control	p
Total	40	25	100%	100%	0.39
Big/some problem	10	4	25%	16%	
No problem	30	21	75%	84%	

Child Welfare Outcomes

Did FMF Improve Child Welfare Outcomes?

Background

FMF was offered to both families whose children had already been removed (reunification cases) as well as to intact families who had in-home child welfare cases (preservation cases). The primary goals of FMF were to prevent placement among children in preservation cases and to facilitate timely reunification among children in reunification cases. The project also sought to expedite case closure, and to prevent re-abuse and reentry to foster care.

Method

All children were observed for at least two years post-randomization. A total of 261 children comprised the ITT analysis – 133 treatment and 128 control (Table IV.47). A TOT analysis follows, which restricts the treatment group to the 69 families who enrolled in FMF and had an initial FTM. The purpose of the TOT analysis is to investigate to what extent families who never engaged with FMF or who left before receiving the full treatment diluted the ITT findings.

Table IV.47 Number of Children Randomized by Year, Case Type, and Treatment Condition

	Number of Children				Percent of Children	
	Total Children	Treatment Group	Control Group	Total Percent	Treatment Group	Control Group
Total Children	261	133	128	100%	100%	100%
Preservation	130	70	60	50%	53%	47%
Reunification	131	63	68	50%	47%	53%

Logit models control for child age, gender, and race. Additional control variables were used in some models based on family characteristics at randomization—caregiver age, caregiver abuse as child, caregiver criminal history, domestic violence, substance abuse, number of children in the family, previous child welfare investigation, homelessness type at randomization. For reunification cases, months in placement prior to randomization and entry cohort were also controlled for. The analysis was conducted at the child level with standard error adjustments for the clustering of children within families.

Results

Table IV.48 provides a descriptive overview of all children in the ITT analysis.

Table IV.48 Descriptive Characteristics (Number and Percent) of Children and Parents by Case Type and Treatment Assignment

	Total Children			Preservation			Reunification		
Category	**Total Children**	**Preservation**	**Reunification**	**Total**	**Treatment**	**Control**	**Total**	**Treatment**	**Control**
Total children	261 (100%)	130 (100%)	131 (100%)	130 (100%)	70 (100%)	60 (100%)	131 (100%)	63 (100%)	68 (100%)
Child age									
Under 1	77 (30%)	27 (21%)	50 (38%)	27 (21%)	17 (24%)	10 (17%)	50 (38%)	25 (40%)	25 (37%)
1 to 5	93 (36%)	42 (32%)	51 (39%)	42 (32%)	23 (33%)	19 (32%)	51 (39%)	23 (37%)	28 (41%)
6 to 12	72 (28%)	47 (36%)	25 (19%)	47 (36%)	22 (31%)	25 (42%)	25 (19%)	10 (16%)	15 (22%)
13 to 17	19 (7%)	14 (11%)	5 (4%)	14 (11%)	8 (11%)	6 (10%)	5 (4%)	5 (8%)	0 (0%)
Child Gender									
F	119 (46%)	62 (48%)	57 (44%)	62 (48%)	34 (49%)	28 (47%)	57 (44%)	29 (46%)	28 (41%)
M	142 (54%)	68 (52%)	74 (56%)	68 (52%)	36 (51%)	32 (53%)	74 (56%)	34 (54%)	40 (59%)
Child Ethnicity									
Black	104 (40%)	54 (42%)	50 (38%)	54 (42%)	25 (36%)	29 (48%)	50 (38%)	25 (40%)	25 (37%)
Latino	90 (34%)	49 (38%)	41 (31%)	49 (38%)	33 (47%)	16 (27%)	41 (31%)	19 (30%)	22 (32%)
White	42 (16%)	15 (12%)	27 (21%)	15 (12%)	6 (9%)	9 (15%)	27 (21%)	9 (14%)	18 (26%)
Other	2 (1%)	12 (9%)	13 (10%)	12 (9%)	6 (9%)	6 (10%)	13 (10%)	10 (16%)	3 (4%)
Child previous investigation									
No	67 (26%)	30 (23%)	37 (28%)	30 (23%)	15 (21%)	15 (25%)	37 (28%)	17 (27%)	20 (29%)
Yes	194 (74%)	100 (77%)	94 (72%)	100 (77%)	55 (79%)	45 (75%)	94 (72%)	46 (73%)	48 (71%)
Months placed before randomization									
N/A	88 (34%)	88 (68%)	0 (0%)	88 (68%)	45 (64%)	43 (72%)	0 (0%)	0 (0%)	0 (0%)
0	162 (62%)	42 (32%)	120 (92%)	42 (32%)	25 (36%)	17 (28%)	120 (92%)	58 (92%)	62 (91%)
1	10 (4%)	0 (0%)	10 (8%)	0 (0%)	0 (0%)	0 (0%)	10 (8%)	4 (6%)	6 (9%)
2	1 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (2%)	0 (0%)
Homelessness type at randomization									
Doubled Up	108 (41%)	66 (51%)	42 (32%)	66 (51%)	34 (49%)	32 (53%)	42 (32%)	21 (33%)	21 (31%)
Residential Treatment	9 (3%)	3 (2%)	6 (5%)	3 (2%)	1 (1%)	2 (3%)	6 (5%)	3 (5%)	3 (4%)
SRO	13 (5%)	4 (3%)	9 (7%)	4 (3%)	2 (3%)	2 (3%)	9 (7%)	6 (10%)	3 (4%)
Shelter	58 (22%)	41 (32%)	17 (13%)	41 (32%)	27 (39%)	14 (23%)	17 (13%)	5 (8%)	12 (18%)

Category	Total Children			Preservation			Reunification		
	Total Children	Preservation	Reunification	Total	Treatment	Control	Total	Treatment	Control
Street	44 (17%)	2 (2%)	42 (32%)	2 (2%)	1 (1%)	1 (2%)	42 (32%)	16 (25%)	26 (38%)
Transition	18 (7%)	11 (8%)	7 (5%)	11 (8%)	5 (7%)	6 (10%)	7 (5%)	4 (6%)	3 (4%)
Vehicle	10 (4%)	3 (2%)	8 (6%)	3 (2%)	0 (0%)	3 (5%)	8 (6%)	8 (13%)	0 (0%)
Sheltered at Randomization									
No	54 (21%)	5 (4%)	49 (37%)	5 (4%)	1 (1%)	4 (7%)	49 (37%)	23 (37%)	26 (38%)
Yes	207 (79%)	125 (96%)	82 (63%)	125 (96%)	69 (99%)	56 (93%)	82 (63%)	40 (63%)	42 (62%)
Domestic Violence									
No	133 (51%)	62 (48%)	71 (54%)	62 (48%)	26 (37%)	36 (60%)	71 (54%)	36 (57%)	35 (51%)
Yes	128 (49%)	68 (52%)	60 (46%)	68 (52%)	44 (63%)	24 (40%)	60 (46%)	27 (43%)	33 (49%)
Caregiver criminal history									
Missing	12 (5%)	2 (2%)	10 (8%)	2 (2%)	0 (0%)	2 (3%)	10 (8%)	5 (8%)	5 (7%)
No	82 (31%)	44 (34%)	38 (29%)	44 (34%)	19 (27%)	25 (42%)	38 (29%)	18 (29%)	20 (29%)
Yes	167 (64%)	84 (65%)	83 (63%)	84 (65%)	51 (73%)	33 (55%)	83 (63%)	40 (63%)	43 (63%)
Caregiver abuse as child									
Missing	12 (5%)	2 (2%)	10 (8%)	2 (2%)	0 (0%)	2 (3%)	10 (8%)	5 (8%)	5 (7%)
No	87 (33%)	44 (34%)	43 (33%)	44 (34%)	26 (37%)	18 (30%)	43 (33%)	14 (22%)	29 (43%)
Yes	162 (62%)	84 (65%)	78 (60%)	84 (65%)	44 (63%)	40 (67%)	78 (60%)	44 (70%)	34 (50%)
Caregiver mental illness									
Missing	12 (5%)	2 (2%)	10 (8%)	2 (2%)	0 (0%)	2 (3%)	10 (8%)	5 (8%)	5 (7%)
No	91 (35%)	58 (45%)	33 (25%)	58 (45%)	23 (33%)	35 (58%)	33 (25%)	18 (29%)	15 (22%)
Yes	158 (61%)	70 (54%)	88 (67%)	70 (54%)	47 (67%)	23 (38%)	88 (67%)	40 (63%)	48 (71%)
Substance abuse									
Missing	12 (5%)	2 (2%)	10 (8%)	2 (2%)	0 (0%)	2 (3%)	10 (8%)	5 (8%)	5 (7%)
No	109 (42%)	61 (47%)	48 (37%)	61 (47%)	35 (50%)	26 (43%)	48 (37%)	23 (37%)	25 (37%)
Yes	140 (54%)	67 (52%)	73 (56%)	67 (52%)	35 (50%)	32 (53%)	73 (56%)	35 (56%)	38 (56%)
Children in family									
1	99 (38%)	42 (32%)	57 (44%)	42 (32%)	23 (33%)	19 (32%)	57 (44%)	29 (46%)	28 (41%)
2	54 (21%)	28 (22%)	26 (20%)	28 (22%)	10 (14%)	18 (30%)	26 (20%)	16 (25%)	10 (15%)
3	45 (17%)	18 (14%)	27 (21%)	18 (14%)	12 (17%)	6 (10%)	27 (21%)	15 (24%)	12 (18%)
4 or more	63 (24%)	42 (32%)	21 (16%)	42 (32%)	25 (36%)	17 (28%)	21 (16%)	3 (5%)	18(26%)

Category	Total Children			Preservation			Reunification		
	Total Children	Preservation	Reunification	Total	Treatment	Control	Total	Treatment	Control
Head of household age									
18 to 24	33 (13%)	13 (10%)	20 (15%)	13 (10%)	6 (9%)	7 (12%)	20 (15%)	11 (17%)	9 (13%)
25 to 34	150 (57%)	68 (52%)	82 (63%)	68 (52%)	33 (47%)	35 (58%)	82 (63%)	34 (54%)	48 (71%)
35 to 44	73 (28%)	46 (35%)	27 (21%)	46 (35%)	29 (41%)	17 (28%)	27 (21%)	17 (27%)	10 (15%)
45 and older	5 (2%)	3 (2%)	2 (2%)	3 (2%)	2 (3%)	1 (2%)	2 (2%)	1 (2%)	1 (1%)
Head of household age									
Under 30	148 (57%)	86 (66%)	62 (47%)	86 (66%)	49 (70%)	37 (62%)	62 (47%)	32 (51%)	30 (44%)
30+	113 (43%)	44 (34%)	69 (53%)	44 (34%)	21 (30%)	23 (38%)	69 (53%)	31 (49%)	38 (56%)

Placement Prevention

Were treatment children less likely to be placed into foster care?

A logistic regression was used to test the likelihood of out-of-home placement within one and two years of randomization among children who began in preservation cases. Due to the small number of preservation children experiencing a placement, the only covariates for child characteristics included are three child age categories and gender.

When controlling for child characteristics, treatment has a marginally significant impact on preventing placement within one year of randomization (OR=0.25, p=0.06). However, at two years out the treatment children had slightly higher odds of placement yet the difference was not statistically significant (OR=1.26, p=0.75).

Table IV.49 Logistic Regression of Placement for Preservation Cases

	Placement within 1 Year				Placement within 2 Years			
	OR	95%	CL	p	OR	95%	CL	p
FMF	0.25	0.06	1.05	0.06	1.26	0.30	5.24	0.75
Infant vs 6+	3.10	0.57	16.74	0.19	4.16	0.63	27.22	0.14
Age 1-5 vs 6+	1.35	0.27	6.87	0.71	1.07	0.22	5.09	0.94
Male	2.73	0.72	10.42	0.14	2.56	0.63	10.44	0.19

Did treatment children avoid foster care placement longer?

The cumulative time to out-of-home placements for those with a preservation case is shown in Table IV.50. Within one year of randomization, 13 percent of treatment children and 18 percent of control children were placed into care. By two years, proportionally more treatment children experienced out-of-home placements compared to control children. At the family level, 11 percent of treatment families and 15 percent of control families had at least one child placed in care within one year of randomization (See Table IV.51).

Table IV.50 Placement among Children in Preservation Cases

	Child Count	6 Months or less	Within 1 Year	Within 2 Years	Within 5 Years	6 Months or less	Within 1 Year	Within 2 Years	Within 5 Years
All Children	130	18	20	29	42	14%	15%	22%	32%
Treatment	70	8	9	18	25	11%	13%	26%	36%
Control	60	10	11	11	17	17%	18%	18%	28%

Table IV.51 Placement among Families with Preservation Cases

	Family Count	6 Months or less	Within 1 Year	Within 2 Years	Within 5 Years	6 Months or less	Within 1 Year	Within 2 Years	Within 5 Years
All Families	69	7	9	14	16	10%	13%	20%	23%
Treatment	36	3	4	9	10	8%	11%	25%	28%
Control	33	4	5	5	6	12%	15%	15%	18%

Time in Care

Did Treatment Children Spend Less Time in Foster Care than Control Children?

Among children in reunification cases, the first half of treatment children (i.e. the median) spent far less time in care overall compared to control children—306 days compared to 426 days across all exit types. The difference in median duration may be related to exit reasons (see Table IV.53). Proportionally more children in the treatment group reunify, which takes less time than other exit types (e.g. guardianship). As we will show, this is also related to the fact that when children reunified, treatment children did so much faster. However, there is not a statistically significant difference between the treatment and control groups for longer term durations in care using survival analysis (p=0.59).

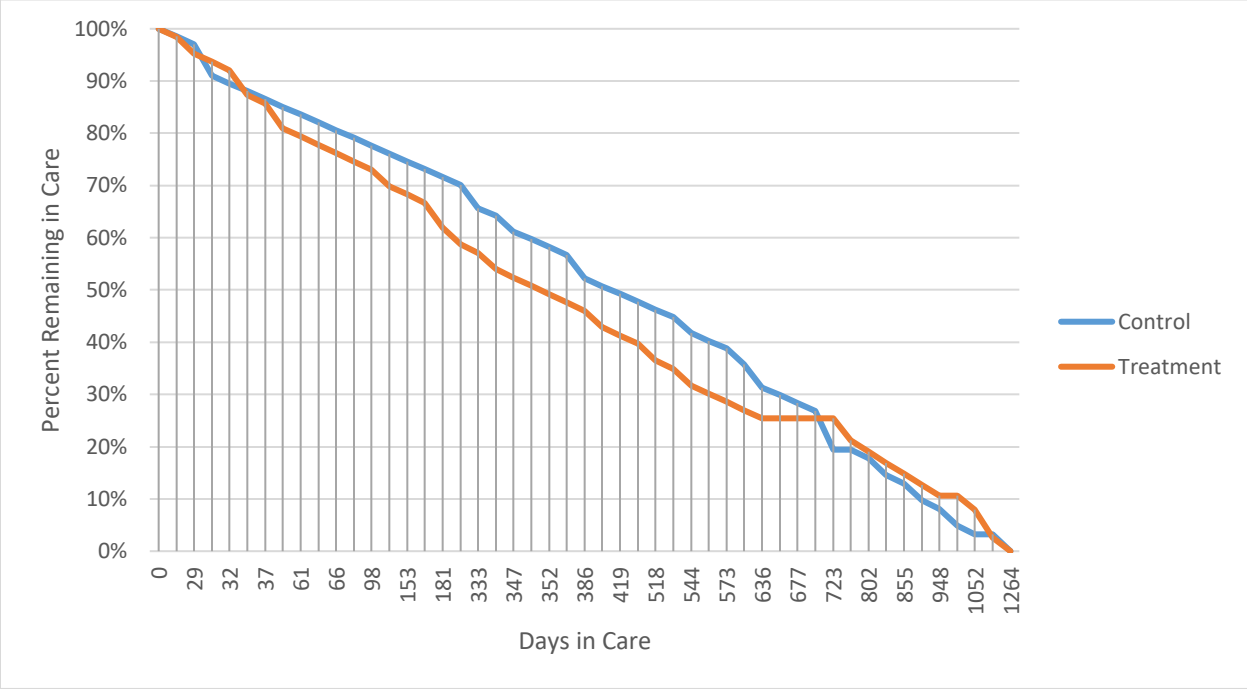
Table IV.52 Overall Durations Days in Care for Reunification Cases

	Child Count	Min	Max	Mean	SD	25th Percentile	Median	75th Percentile	p
Treatment	63	17	1447	455	428	84	306	805	0.59
Control	68	14	1264	471	327	159	426	723	

Table IV.53 Exit Types for Reunification Cases

	Number of Children			Percent of Children		
	Total Children	Treatment	Control	Total Percent	Treatment	Control
Total Children	131	63	68	100%	100%	100%
Completed Adoption	28	13	15	21%	21%	22%
Kin Guardianship	28	10	18	21%	16%	26%
Other Guardianship	3	2	1	2%	3%	1%
Reunified	65	33	32	50%	52%	47%
Still in care	7	5	2	5%	8%	3%

Figure IV.4 Survival Curve by Treatment Condition, all Exit Types



Reunification

Were treatment children more likely to reunify?

Table IV.54 shows that descriptively, slightly more treatment children ultimately reunified with their families than control families (52% compared to 47%), although this was a not a statistically significant difference based on a chi-square test (p=0.55).

Table IV.54 Reunification Outcomes for Children in Reunification Cases

	Number of Children			Percent of Children			
	Total Children	Control	Treatment	Total Percent	Control	Treatment	Pr > Chi-Square
Total Children	131	68	63	100%	100%	100%	0.55
Reunified	65	32	33	50%	47%	52%	
Not reunified	66	36	30	50%	53%	48%	

A logit regression (Table IV.55) shows the likelihood of reunification by treatment assignment, controlling for child age, race, and gender. The treatment effect was marginally significant across all children with a reunification case at referral for reunification within 6 months (OR=2.17, p=0.06). However, this effect was no longer significant at one year (OR=1.34, p=0.45) or two years (OR=1.10, p=0.81).

Table IV.55 Logistic Regression of Treatment Assignment on Reunification within Six Months, One, and Two Years

	Reunification within 6 months 95% Wald				Reunification within 1 year 95% Wald				Reunification within 2 years 95% Wald			
Effect	OR	CL		p	OR	CL		p	OR	CL		p
FMF	2.17	0.97	4.83	0.06	1.34	0.63	2.89	0.45	1.10	0.52	2.32	0.81
Age Under 1 vs (13 to 17)	0.41	0.04	4.88	0.40	0.49	0.04	5.42	0.36	0.49	0.05	5.46	0.43
age 1 to 5	0.41	0.03	4.95	0.40	0.79	0.07	9.03	0.77	0.73	0.06	8.31	0.83
age 6 to 12	0.67	0.05	8.84	0.75	0.62	0.05	7.58	0.79	0.57	0.05	6.86	0.71
Female	0.61	0.27	1.41	0.25	0.69	0.32	1.52	0.36	0.85	0.39	1.84	0.68
Black (vs White)	0.79	0.26	2.43	0.04	0.85	0.30	2.39	0.02	0.73	0.27	1.98	0.01
Latino	1.76	0.57	5.41	0.81	2.84	0.97	8.30	0.18	2.25	0.79	6.42	0.29
Other	4.99	0.94	26.58	0.04	4.60	0.89	23.87	0.10	3.90	0.76	19.96	0.11

Did treatment children reunify more quickly?

When comparing cumulative likelihood of reunification (Table IV.56), our analysis shows that treatment children were more likely to reunify within six months or less. Since the median time to housing was longer than the time to reunification, this effect is not a result of rapid housing (see TOT section below). All children that reunified did so within two years of randomization. Comparing at the family level, proportionally more treatment families reunified in less than six months, about the same percent by one year, and at two years slightly more control than treatment families were reunified (Table IV.57). The difference in the likelihood of reunification at each time point narrows because while treatment families who reunified nearly always did so in the first six months, some control families did as well, while others took one year or more.

Table IV.56 Cumulative Exits to Reunification for Children in Reunification Families

	Child Count	6 Months or Less	Within 1 Year	Within 2 Years	Ever Re-unified	6 Months or Less	Within 1 Year	Within 2 Years	Ever Re-unified
All children	131	49	62	65	65	37%	47%	50%	50%
Treatment	63	30	33	33	33	48%	52%	52%	52%
Control	68	19	29	32	32	28%	43%	47%	47%

Table IV.57 Cumulative Exits to Reunification for Reunification Families

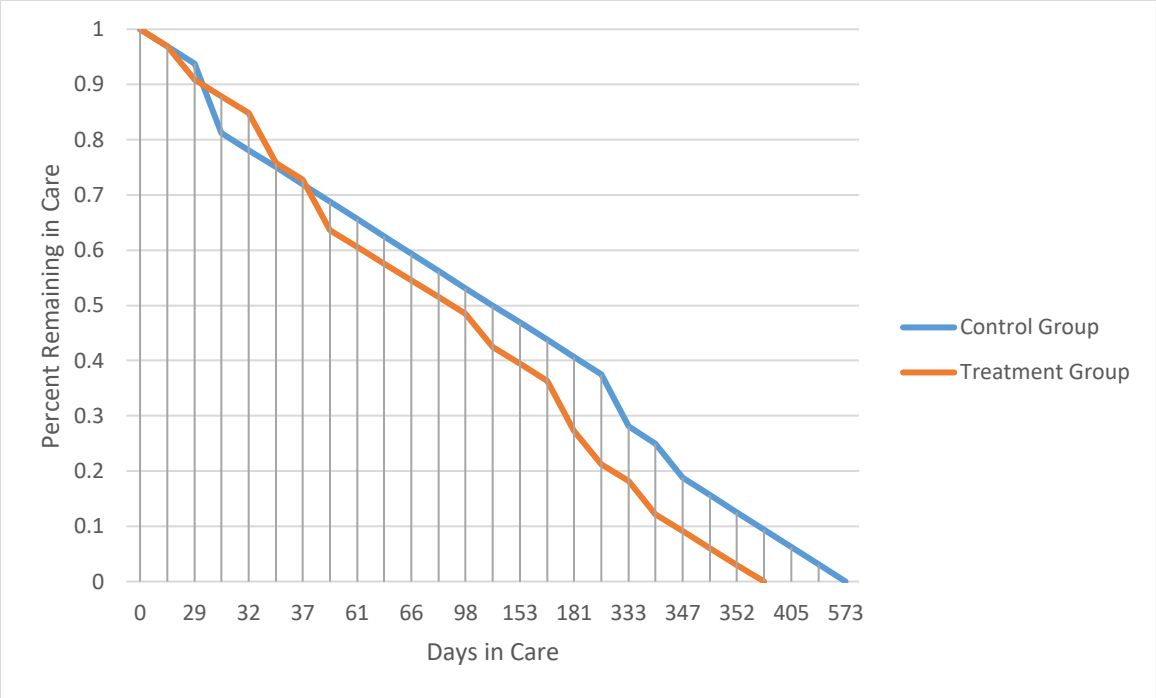
	Family Count	6 Months or Less	Within 1 Year	Within 2 Years	Ever Re-Unified	6 Months or Less	Within 1 Year	Within 2 Years	Ever Re-Unified
All Families	85	33	41	44	44	39%	48%	52%	52%
Treatment	43	19	21	21	21	44%	49%	49%	49%
Control	42	14	20	23	23	33%	48%	55%	55%

When children reunify (Table IV.58), those in the treatment group did so faster, with a median time to reunification of 89 days compared to 150 days for the control group ($p < 0.01$). Survival analysis shows that treatment children reunified more quickly, with most reunifying in well under 200 days.

Table IV.58 Quartile Durations (Days) for Reunification Children Who Reunified

	Child Count	Min	Max	Mean	SD	25th Percentile	Median	75th Percentile	p
Treatment	34	14	329	101	77	38	89	144	0.004
Control	32	14	573	188	160	36	150	344	

Figure IV.5 Survival Curve of Reunification by Group



Case Closure

Did child welfare cases close faster for treatment children?

There was no significant difference in the length of time preservation or reunification cases remained open between treatment and control children using survival analysis. Preservation cases had a median duration of about one year for both treatment and control families. Descriptively, control preservation cases stayed open a month longer than treatment preservation cases—a median of 442 days compared to 412 days. The majority of all cases were closed within two years, and 100 percent of the cases closed within five years.

Table IV.59 Duration of Cases by Group (Days)

		Count	25th Percentile	Median	75th Percentile	p
Preservation	Treatment	70	227	442	587	0.63
	Control	60	196	412	550	
Reunification	Treatment	63	392	641	847	0.93
	Control	68	441	642	865	

Table IV.60 Duration of Cases by Group (Percent in Year)

		Within 1 Year	Within 2 Years	Within 3 Years	Within 4 Years	Within 5 Years	Within 1 Year	Within 2 Years	Within 3 Years	Within 4 Years	Within 5 Years
Preservation	Treatment	33	61	65	67	70	47%	87%	93%	96%	100%
	Control	26	46	49	58	60	44%	78%	83%	98%	100%
Reunification	Treatment	14	39	56	63	63	22%	62%	89%	100%	100%
	Control	14	44	63	68	68	21%	65%	93%	100%	100%

Recurrence of Maltreatment

Were treatment children less likely to be re-substantiated for maltreatment?

For preservation cases, we looked to see whether each child had a new substantiated maltreatment allegation within one year of randomization and within two years of randomization. Table IV.61 shows that treatment children in preservation cases may have been less likely than control children in preservation cases to be re-substantiated for maltreatment within one year (treatment=4%, control=13%), but this gap mostly closed by two years (treatment=23%, control=25%).

We also looked at re-substantiations within one year among children in reunification cases who did in fact reunify to see if there was a cost to the rapid returns home that we saw in the above analysis. Among reunification cases, treatment children may have been less likely to be re-substantiated within one year of reunification (treatment=9%, control=25%).

These promising findings about reduced re-substantiation within one year for both preservation and reunification cases are only marginally significant because while the percentage point differences appear large, the number of children experiencing the event in each group was small.

Table IV.61 Re-Substantiations

	Child Count	6 Months or Less	Within 1 Year	Within 2 Years	6 Months or Less	Within 1 Year	Within 2 Years
Total Preservation Children	130	6	11	31	5%	8%	24%
Treatment	70	2	3	16	3%	4%	23%
Control	60	4	8	15	7%	13%	25%
Total Reunification Children	65	5	11	-	8%	17%	-
Treatment	33	2	3	-	6%	9%	-
Control	32	3	8	-	9%	25%	-

Were treatment children less likely to be re-investigated?

Following from the research evidence demonstrating that substantiation is a weak indicator for whether or not maltreatment actually occurred, and that unsubstantiated reports are often at high risk for future maltreatment, we decided to expand our exploration of re-abuse in the present study.[34,35] We began by looking at new maltreatment **investigations** following randomization for all children in the experiment, reasoning that maltreatment **referrals** cast too wide a net to be a valid marker for maltreatment, (San Francisco screens out approximately half of all hotline referrals) and substantiation, we believe, is too narrow. Investigations are commonly used in the research literature because they indicate that the information presented at the hotline was serious enough to warrant a full, in-person examination.

Treatment children in preservation cases were less likely than control children to be re-investigated for maltreatment, within 1 year (treatment=27%, control=40%), but this difference diminished by two years (treatment=47%, control=45%) of randomization (Table IV.63). Among children in reunification cases, treatment children were about as likely as control children to be re-investigated for maltreatment within one year of returning home.

Table IV.62 Re-Investigations

	Child Count	6 Months or Less	Within 1 Year	Within 2 Years	6 Months or Less	Within 1 Year	Within 2 Years
Total Preservation Children	130	27	43	60	21%	33%	46%
Treatment	70	14	19	33	20%	27%	47%
Control	60	13	24	27	22%	40%	45%
Total Reunified Children	65	16	22	-	25%	34%	-
Treatment	33	10	11	-	30%	33%	-
Control	32	6	11	-	19%	34%	-

[34] Drake, B. (1996). Unraveling "unsubstantiated". Child Maltreatment, 1(3), 261–271.

[35] Drake, B., Jonson-Reid, M., Way, I., & Chung, S. (2003). Substantiation and recidivism. Child Maltreatment, 8(4), 248–260.

Were treatment children less likely to go on to have future child welfare system involvement?

Finally, we attempted to create a more inclusive measure of subsequent child welfare system contact, reasoning that a new investigation signals risk and a new case opening, either in- or out-of-home, would suggest that the child had been re-abused. Cases are sometimes opened quickly under exigent circumstances without a new call to the hotline and a new investigation. The tables above miss those cases. Furthermore, the above tables fail to account for the fact that time spent in foster care removes the child from the risk of re-abuse for the most part. That would not matter if the distribution of placements and time spent in care was equivalent across groups. But we saw that was not the case; among preservation cases, treatment children were less likely than controls to enter in the first year and among reunification cases, treatment children spent far less time in care than control children. Our solution was to capture any significant child welfare event as an indication that the child *may* have been re-abused, i.e., a new investigation (substantiated or not), in-home case opening or out-of-home case opening following randomization for preservation cases and following exit from care for reunification cases. Counting an out-of-home case opening here manages the issue of children leaving the risk set, so to speak, while they are in protective custody.

Table IV.63 displays findings using this broader definition of subsequent system involvement. Among preservation cases, at every interval treatment children were less likely to experience involvement than control children. The difference was significant at 12 months and marginally significant at 18 months. Among reunification cases, the story is less straightforward. At six months post-reunification, more treatment children had become re-involved than control children, although the numbers are quite small and the effect was not significant. By 12 months, the trend reversed, with more control children having been re-investigated or had a new case opened. Again, the counts were small and the effect not significant.

Table IV.63 Re-Investigation or New Case Opening (In- or Out-of-Home)

	Child Count	6 Months or Less	Within 1 Year	Within 2 Years	6 Months or Less	Within 1 Year	Within 2 Years
Total Preservation Children	130	40	57	71	31%	44%	55%
Treatment	70	19	25	36	27%	36%	51%
Control	60	21	32	35	35%	53%	58%
Total Reunification Children	65	17	24	-	26%	37%	-
Treatment	33	10	11	-	30%	33%	-
Control	32	7	13	-	22%	41%	-

We dug further into the finding that the intervention appeared to be somewhat protective against re-involvement for children in preservation cases. Table IV.64 shows a logistic regression model showing the effect of FMF on subsequent child welfare system involvement, adjusting for covariates and clustering of children within families. The main finding is that after controlling for covariates, treatment children remain less likely to become re-involved but the effect is not significant.

Table IV.64 Logistic Regression of Re-Investigation or New Case Opening for Children in Preservation Cases

	Within 6 months			Within 1 year			Within 2 years		
	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p
Treatment	0.61	(0.18, 2.09)	0.43	0.47	(0.16, 1.39)	0.17	0.83	(0.3, 2.31)	0.72
Gender									
Male (Comparison)									
Female	0.76	(0.35, 1.62)	0.47	0.68	(0.32, 1.44)	0.31	0.58	(0.26, 1.26)	0.17
Child Race									
White (Comparison)									
Black	0.81	(0.08, 7.67)	0.85	2.10	(0.3, 14.5)	0.45	3.72	(0.58, 23.83)	0.17
Latino	0.53	(0.06, 5.03)	0.58	0.91	(0.13, 6.45)	0.93	0.80	(0.13, 4.82)	0.81
Other	1.02	(0.07, 14.37)	0.99	1.95	(0.2, 19.08)	0.57	1.27	(0.15, 10.35)	0.83
Child Age									
Under 1 (Comparison)									
1 to 5	0.43	(0.09, 2.12)	0.30	0.70	(0.2, 2.45)	0.58	0.76	(0.2, 2.94)	0.69
6 to 12	0.19	(0.03, 1.05)	0.06	0.48	(0.13, 1.81)	0.28	0.72	(0.16, 3.25)	0.67
13 to 17	0.15	(0.02, 1.12)	0.06	0.19	(0.03, 1.1)	0.06	0.31	(0.05, 1.75)	0.18
Head of Household Age									
Under 30 (Comparison)									
30 and older	0.83	(0.21, 3.27)	0.79	1.54	(0.44, 5.39)	0.50	1.27	(0.38, 4.3)	0.70
Children in Home									
1 (Comparison)									
2	5.91	(0.96, 36.46)	0.06	2.44	(0.5, 11.9)	0.27	1.31	(0.3, 5.72)	0.72
3	14.49	(1, 209.98)	0.05	4.99	(0.59, 42.29)	0.14	5.42	(0.67, 43.73)	0.11
4 or more	5.88	(0.85, 40.79)	0.07	2.93	(0.66, 12.96)	0.16	1.23	(0.25, 5.98)	0.80
Family CPS History	3.11	(0.65, 14.8)	0.15	0.84	(0.22, 3.19)	0.80	0.78	(0.25, 2.44)	0.67
Domestic Violence	0.98	(0.26, 3.75)	0.98	0.91	(0.31, 2.71)	0.87	0.95	(0.31, 2.92)	0.93
Constant	0.28	(0.03, 2.85)	0.28	0.72	(0.1, 5.29)	0.75	1.13	(0.18, 7.25)	0.90

Table IV.65 (below) shows that among reunification children, children in the treatment group were slightly more likely to have child welfare involvement after returning home, but the difference was not statistically significant. Children for whom domestic violence was noted in the home were significantly more likely to experience subsequent child welfare activity.

Table IV.65 Logistic Regression of Re-Investigation or New Case Opening for Reunified Children

	Within 6 months			Within 1 year		
	OR	95 % CI	p	OR	95 % CI	p
Treatment	1.46	(0.2, 10.72)	0.71	1.04	(0.19, 5.79)	0.96
Gender						
Male (Comparison)						
Female	1.47	(0.39, 5.53)	0.57	2.36	(0.63, 8.89)	0.20
Child Race						
White (Comparison)						
Black	2.13	(0.05, 89.35)	0.69	0.21	(0.01, 3.56)	0.28
Latino	1.67	(0.04, 72.2)	0.79	0.22	(0.02, 2.7)	0.24
Other	1.45	(0.01, 258.87)	0.89	0.13	(0.01, 2.1)	0.15
Head of Household Age						
Under 30 (Comparison)						
30 and older	1.25	(0.23, 6.96)	0.80	2.00	(0.41, 9.86)	0.40
Children in Home						
1 (Comparison)						
2	1.31	(0.02, 100.59)	0.90	1.86	(0.03, 106.67)	0.76
3	1.58	(0.17, 14.25)	0.69	4.27	(0.36, 50.86)	0.25
4 or more	1.35	(0.15, 11.89)	0.79	13.60	(1.35, 137.15)	0.03
Family CPS History	2.87	(0.16, 51.11)	0.47	0.35	(0.04, 3.07)	0.34
Domestic Violence	13.69	(1.27, 147.64)	0.03	11.65	(2.15, 63.03)	0.00
Constant	0.01	(0, 3.58)	0.12	0.23	(0.04, 1.47)	0.12

Reentry

When children reunified, were treatment children less likely to reenter care?

Descriptively, more control children reenter care from reunification within one year of exit (19%) compared to treatment children (9%), but this difference is not statistically significant (Table IV.66). There was no substantial difference in the number of children who have reentered care to date.

Table IV.66 Reentries

	Number of Children			Percent of Children			
	Total Children	Treatment	Control	Total Percent	Treatment	Control	p
	65	33	32	100%	100%	100%	
Children Re-Entering in 1 Year							
No	56	30	26	86%	91%	81%	0.26
Yes	9	3	6	14%	9%	19%	
Children Re-Entering Ever							
No	50	26	24	77%	78%	75%	0.72
Yes	15	7	8	23%	22%	25%	

Treatment on Treated Results

What characterized never-engaged families?

An intent-to-treat approach in an RCT requires that all families randomized into the experiment remain in the analysis in order to make causal inferences about outcome differences between treatment and control families. However, we saw a notable amount of attrition in the program and including the never engaged in the analyses may dilute possible effects for families who received some or all of the treatment. Because case management was a key part of the intervention and the time to permanent housing was protracted, our definition of a treated family includes any family who engaged with the program for any amount of time. Those families would have been stabilized, and they would have received both case management and housing support in order to get the full program dose – services and housing. For those reasons, we included all families who ever engaged in the TOT analyses. A total of ten[36] families never engaged with HPP and had no exposure to the intervention, yet they remain in the ITT analyses. We examined these families further to try to understand, if only anecdotally since the group is too small for statistical inference, what distinguished them from families who did engage. Table IV.67 below (copied from an earlier section) describes the treatment families by the participation and program dosage (completion) status. The highlighted box indicates the families included in the TOT analysis.

Table IV.67 Treatment Families, Participation and Completion Status

Treatment Families	Total	Participants/Engaged	Non – Participants/Never Engaged
Total	79	69	10
Completers	37	37	0
Non-completers	42	32	10

[36] One of the ten families had a single FTM, and then declined any further engagement.

All of these families had reunification cases at referral (i.e., no preservation families failed to participate). Out of the 12 children in these 10 families, only one reunified. Nearly all of these families had addicted newborns and reunification services were terminated after a period of failure to engage with the child welfare worker. However, that most unengaged families had addicted newborns does not mean that most families with addicted newborns fail to engage. We examined the court documents for all 79 treatment families. These documents indicate whether the child had prenatal substance exposure.

Table IV.68 shows that families with prenatally exposed infants were less likely to engage (70%) than families without this condition (95%), and the finding was statistically significant (Fisher's Exact Test, $p<.007$). While the counts are small, this finding appears to be entirely associated with reunification rather than preservation cases; 100 percent of preservation families with prenatal substance exposure engaged with FMF, while only 50 percent of reunification families engaged. This picture of the never-engaged group as entirely reunification families, most of whom had addicted newborns provides some context for the TOT analysis that follows.

Table IV.68 Prenatal Substance Exposure and FMF Engagement by Group Assignment

	n			% Engaged		
Prenatal Substance Exposure	Total Families	Preservation	Reunification	Total Families	Preservation	Reunification
Yes	20	8	12	70%	100%	50%
No	59	29	30	95%	97%	93%

Table IV.69 Adult and Child Needs Among Treatment Families by Engagement

	Family Count		Percent		
	Engaged	Didn't Engage	Engaged	Didn't Engage	p
Total	69	10	100%	100%	
Adult Needs					
Substance abuse	49	10	71%	100%	0.05
Mental health[a]	42	8	63%	80%	0.28
Domestic violence	30	3	43%	30%	0.42
Criminal arrest history[b]	42	8	64%	80%	0.31
History of abuse as child[b]	45	8	68%	80%	0.45
Child Needs					
Mental health[b]	19	2	29%	20%	0.56
Diminished physical capacity[c]	7	3	10%	30%	0.08
Diminished mental capacity[d]	8	0	12%	0%	0.26

[a] Two children from the engaged group were dropped from denominator because risk assessment data was missing and they did not receive SDM Safety Assessment Version 3.

[b] Three children from the engaged group were dropped from denominator because missing risk assessment data.

[c] Diminished physical capacity was considered present if any child on the referral had a 'physical disability' or was 'medically fragile or was marked 'failure to thrive' on the risk assessment, or had 'diminished physical capacity (e.g., non-ambulatory, limited use of limbs)' on the safety assessment.

[d] Diminished mental capacity was considered present if any child on the referral had a 'developmental disability' or 'learning disability' on the risk assessment, or had 'diminished mental capacity (e.g. developmental delay, non-verbal)' on the safety assessment.

Treatment-on-treated (TOT) reunification outcomes are included below for the 69 families and 121 children that engaged with HPP, including 51 children in reunification cases at randomization.

Table IV.70 Families and Children, ITT and TOT

	Intent to Treat (ITT)			Treatment on Treated (TOT)		
	All Families	All Children	Percent of children	All Families	All Children	Percent of children
Total	79	133	100%	69	121	100%
Preservation	36	70	53%	36	70	58%
Reunification	43	63	47%	33	51	42%

Proportionally more treatment on treated children reunify than control children. At one year, the difference is 20 percentage points—63 percent compared to 43 percent. Proportionally more treatment on treated families also reunified overall, although the margin is smaller. Based on the logistic regression results in Table IV.71, treatment on treated children are much more likely to reunify within 6 months (OR=3.29, p=0.01). This result is also significant at 1 year (OR=2.35, p=0.05), and approaches significance at 2 years (OR=1.89, p=0.13).

Table IV.71 Cumulative Exits to Reunification for Children in Reunification Families

	Child Count	6 Months or Less	Within 1 Year	Within 2 Years	6 Months or Less	Within 1 Year	Within 2 Years
All Children	119	48	61	64	40%	51%	54%
TOT Group	51	29	32	32	57%	63%	63%
Control Group	68	19	29	32	28%	43%	47%

Table IV.72 Cumulative Exits to Reunification for Reunification Families

	Family Count	6 Months or Less	Within 1 Year	Within 2 Years	6 Months or Less	Within 1 Year	Within 2 Years
All Families	75	32	40	43	43%	53%	57%
TOT Group	33	18	20	20	55%	61%	61%
Control Group	42	14	20	23	33%	48%	55%

Table IV.73 Logistic Regression of Treatment on Treated on Reunification within Six Months, One, and Two Years

	Reunification within 6 months 95% Wald				Reunification within 1 year 95% Wald				Reunification within 2 years 95% Wald			
Effect	OR	CL		p	OR	CL		p	OR	CL		p
FMF	3.29	1.39	7.80	0.01	2.35	1.01	5.48	0.05	1.89	0.83	4.33	0.13
Age Under 1 (vs 13 to 17)	0.71	0.06	8.38	0.79	0.92	0.08	10.70	0.82	0.90	0.08	10.47	0.88
Age 1 to 5	0.64	0.05	7.70	0.63	1.41	0.12	16.95	0.43	1.28	0.11	15.28	0.50
Age 6 to 12	0.86	0.07	11.11	0.86	0.81	0.06	10.18	0.64	0.74	0.06	9.19	0.57
Female	0.65	0.27	1.57	0.34	0.72	0.31	1.68	0.45	0.92	0.40	2.11	0.84
Black (vs White)	0.76	0.24	2.41	0.03	0.80	0.27	2.36	0.01	0.68	0.24	1.94	0.01
Latino	2.23	0.67	7.37	0.39	4.05	1.24	13.23	0.04	3.10	0.97	9.83	0.08
Other	4.18	0.76	23.12	0.10	3.73	0.68	20.36	0.23	3.14	0.58	16.94	0.24

How did the timing of housing correspond to child welfare outcomes for treatment families?

The theory of the intervention was that the combination of rapid permanent housing and supportive services would lead to better child welfare outcomes. Yet we found that the response seemed to precede the dose, i.e., reunification tended to happen quickly for treatment families (well within six months) while most were not housed until well after six months (median 10 months). This led us to more closely investigate the timing of housing in relation to child welfare outcomes. For reunification families, the goal was to understand how often families reunified before they were fully treated (i.e., housed).

Twenty of the 33 “ever engaged” reunification families had their children reunified. Seventeen of those families were also housed, and 14 or 82 percent of those reunifications occurred prior to housing. Only

three of the reunifications happened after families were housed. And among the families that engaged, but were never housed (n=16), there were a small number of reunifications (n=3).

Table IV.74 Reunification by Housing Status for Engaged Reunification Treatment Families

	Number of Families			Percent of Families		
Reunification Families	Total Families	Housed	Never housed	Total Percent	Housed	Never housed
Total Families	33	17	16	100%	100%	100%
Reunified pre-lease	17	14	3	52%	82%	19%
Reunified post-lease	3	3	0	9%	18%	0%
Not Reunified	13	0	13	39%	0%	81%

Thirty-two of the 36 preservation families were housed; and 26 of those families stayed intact, ten families saw a removal. Eight of the ten removals were from families who were housed, two of them prior to housing, and six after the family was in a stable home. Although the counts are small, these analyses show that when preservation families had a removal they were slightly more likely to happen after housing than before. Of the four preservation families that were never housed, two had a removal, and those removals occurred very early in program enrollment. (See Figure IV.1).

Table IV.75 Placement Outcome by Housing Status for Preservation Treatment Families

Preservation Families	Total	Housed	Never Housed	Total	Housed	Never Housed
Total families	36	32	4	100%	100%	100%
Placed pre-lease	4	2	2	11%	6%	50%
Placed post-lease	6	6	0	17%	19%	0%
Not Placed	26	24	2	72%	75%	50%

Five (25%) of the engaged reunification families who reunified also saw a reentry. These counts are very small, so it is difficult to draw any conclusions, but descriptively – the data in Table IV.76 shows that among those families that were ever housed and who also had children reunify, the likelihood of reentering was 18 percent – lower than the overall reentry rate. Thus, it may be true that housing – regardless of when it occurred – may also have had a preventive effect on the likelihood of reentry.

Table IV.76 Re-entries for Children with Reunification Cases in Engaged Treatment Families by Housing Status

	Total Families	Number of Families		Total Percent	Percent of Families	
		Not Housed	Housed		Not Housed	Housed
Total Families	20	3	17	100%	100%	100%
Not re-entered	15	1	14	75%	33%	82%
Re-entered	5	2	3	25%	67%	18%

Implications

In summary, the ITT analysis suggests that despite the fact that most families were not permanently housed early in the program, FMF participation may have had a short-term placement prevention effect, although not a longer-term one. FMF may have diminished the time to reunification although it did not ultimately make it significantly more likely; it did not impact case length; and it did not appear to prevent reentry into care. The findings about recurrence of maltreatment are less clear but trend in the desired direction among preservation cases. FMF appears to have protected children in preservation cases from re-abuse, with the strength and certainty of that finding depending upon how re-abuse was defined. However, we do not find evidence to suggest that FMF was protective among children in reunification cases who returned home.

The TOT analysis amplified the reunification effect on the reunification families – who were the only families that never engaged. Not only was reunification more likely at six months, it was also more likely at one year – and though not significant, that remained true two years out.

The TOT analysis that considers the relationship between child welfare outcomes and housing is illuminating because it suggests that permanent housing itself was not essential to prevent placement or to facilitate reunification. Engaged reunification families were likely to see reunification before being permanently housed. And engaged preservation families (all of them) were likely to remain intact even though the time to housing was protracted. Those results also show that, although the counts are low, engaged families who were never housed may have had a higher likelihood of negative child welfare outcomes. Finally, identifying the TOT families led us to understand that reunification families were less likely to engage with FMF. And nearly all of those unengaged families struggled with substance abuse, failed to engage with the child welfare worker, and saw their reunifications services terminated.

These additional nuances point to broader implications about how to approach serving families who come the attention of the child welfare system with housing needs among their other presenting risks. Families may benefit from the intervention even if they are not housed quickly. The combination of case management, rapid stabilization, and what might be called at-the-elbow assistance in navigating the housing process, along with the *certainty of housing at some point*, may be the vital assistance some families need to move toward functional self-sufficiency.

Those families that do reenter or get placed, despite having the key ingredient of the program also deserve closer scrutiny – especially across sites. Like those who became unengaged, it may be that housing was not their biggest problem – or the one that had to be addressed to introduce safety and stability into the family unit. These too may be addiction cases – but understanding that will help policymakers make better decisions about how and to whom housing opportunities should be provided to troubled families at risk of deeper child welfare involvement.

Well-Being Outcomes

Parent/Caregiver Outcomes

Adult Needs and Strengths Assessment (ANSA)

Background

HPP uses the Adult Needs and Strengths Assessment (ANSA) to inform case planning for adults they serve. All engaged adults in the FMF treatment group received baseline assessments (N=100), and follow up assessments every six months that they remained engaged in the program (N=90). The evaluation did not plan to collect ANSA data for control families because they were to receive service as usual. However, as discussed in the process study section, we discovered that most control group families were in fact referred to HPP for a variety of lighter-touch services under the service as usual condition. We took advantage of that opportunity to analyze their ANSAs as well, although control families were less likely to have follow up assessments. In total, 61 control adults received a baseline ANSA assessment from HPP and 40 had at least one follow up assessment.

The version of the ANSA that HPP uses scores fifteen "needs" and two "strengths" domains. Needs are scored where a "0" indicates no evidence of need, "1" indicated mild need, "2" suggests moderate need, and a score of "3" indicates severe need. For strengths, a score of "0" corresponds to a significant strength and a "3" suggests no strength present.

Methods

Family level IDs were not available for control ANSAs. As a result, treatment and control groups are compared for all adults who had a least one baseline and one follow-up assessment. HPP does not assess all domains for every assessment so the number of responses varied substantially for each domain.

Baseline mean scores are compared for treatment and control groups using their earliest recorded ANSA assessment. If the adult completed follow up ANSAs, the most recent follow up ANSA scores are compared. T-tests are used to determine if there is a significant difference between the treatment and control groups.

Table IV.77. How Many ANSA Assessments Did Adults Receive?

	Total Adults		Treatment Group				Control Group			
	Treatment Group	Control Group	Min	Max	Mean	SD	Min	Max	Mean	SD
Baseline	100	61	1.0	1.0	1.0	0.0	1.0	1.0	1.0	0.0
Follow-Up	90	40	3.0	8.0	4.2	1.2	3.0	9.0	4.5	1.6

Did treatment and control adults have different baseline ANSA scores?

There was very little difference in mean baseline ANSA scores between the treatment and control groups. The only domain with a significant difference is environmental influences for substance use, where the control group had a significantly higher mean score. On average, both treatment and control groups have moderate baseline needs for family functioning and residential stability.

Table IV.78. Baseline ANSA Assessments, Treatment and Control Adults

Domain	Total Adults		Mean		Standard Deviation		p
	Treatment Group	Control Group	Treatment Group	Control Group	Treatment Group	Control Group	
Adjustment to Trauma	98	38	1.2	1	0.8	0.9	
Anxiety Rating	100	38	0.9	1	0.8	1	
Cultural Stress Rating	100	32	0.6	0.5	0.8	0.9	
Depression Rating	100	38	1	1	0.8	0.9	
Employment Rating	71	42	1	0.9	1	0.9	
Environmental Influences Rating	61	24	1	1.6	1	1.3	*
Family Functioning	100	41	2.1	1.8	0.9	1	
Family Strength	100	35	1.3	1.1	0.8	1	
Involvement in Recovery	58	24	0.9	1.2	1	1.1	
Legal Rating	100	42	0.8	0.6	0.9	0.8	
Living Skills Rating	100	33	0.6	0.5	0.7	0.6	
Physical/Medical Rating	97	59	0.5	0.6	0.8	0.8	
Residential Stability	100	58	2	2.2	0.9	0.9	
Severity of Substance Abuse (SA)	64	25	1.1	1.4	1	1.2	
Social Connectedness Strength	100	34	1.2	1	0.8	0.8	
Stage of SA Recovery	61	23	0.9	1.2	0.9	1	
Substance Abuse	86	40	0.9	1	1	1.1	

Significance: *p≤.05; **p≤.01; +p≤.1

How did ANSA Scores Change over Time for Treatment Compared to Control?

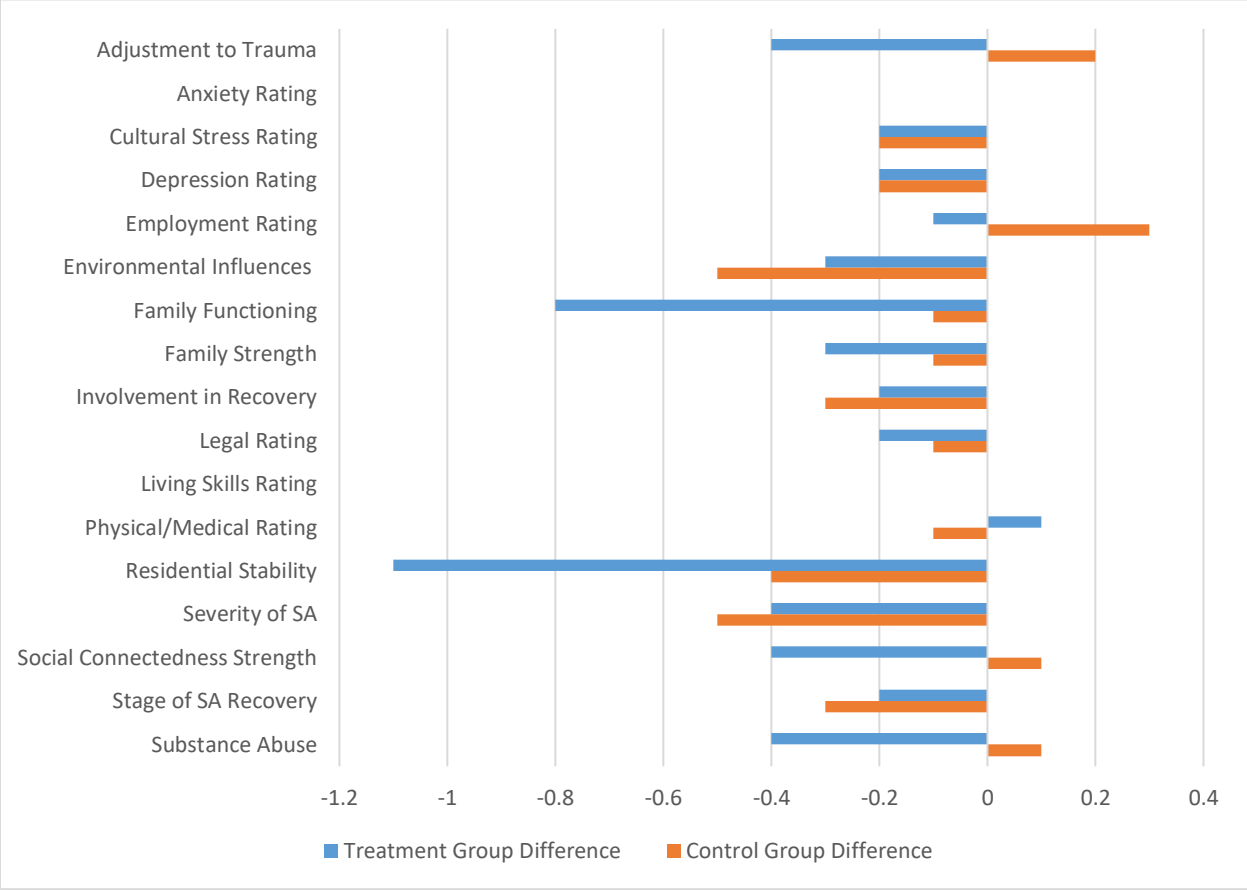
When comparing baseline to follow up ANSAs, the treatment group significantly improved on a number of domains, indicated when the difference between the baseline and follow-up mean score was negative – showing a decline in need. The treatment group has decreased trauma, family functioning, legal issues, residential stability, severity of substance abuse and substance abuse issues at follow up. The treatment group also increased their social connectedness strength. In contrast, the only domain with significant improvement for the control group is residential stability.

Table IV.79. Baseline and Follow-Up ANSA Comparison

	Treatment Group				Control Group			
	Baseline Mean	Follow-Up Mean	Difference Mean	p	Baseline Mean	Follow-Up Mean	Difference Mean	p
Adjustment to Trauma	1.2	0.8	-0.4	***	1	1.2	0.2	
Anxiety Rating	0.9	0.9	0		1	1	0	
Cultural Stress Rating	0.6	0.4	-0.2		0.5	0.3	-0.2	
Depression Rating	1	0.8	-0.2		1	0.8	-0.2	
Employment Rating	1	0.9	-0.1		0.9	1.2	0.3	
Environmental Influences	1	0.7	-0.3		1.6	1.1	-0.5	
Family Functioning	2.1	1.3	-0.8	***	1.8	1.7	-0.1	
Family Strength	1.3	1	-0.3	**	1.1	1	-0.1	
Involvement in Recovery	0.9	0.7	-0.2		1.2	0.9	-0.3	
Legal Rating	0.8	0.6	-0.2	*	0.6	0.5	-0.1	
Living Skills Rating	0.6	0.6	0		0.5	0.5	0	
Physical/Medical Rating	0.5	0.6	0.1		0.6	0.5	-0.1	
Residential Stability	2	0.9	-1.1	***	2.2	1.8	-0.4	*
Severity of Substance Abuse (SA)	1.1	0.7	-0.4	*	1.4	0.9	-0.5	
Social Connectedness Strength	1.2	0.8	-0.4	***	1	1.1	0.1	
Stage of SA Recovery	0.9	0.7	-0.2		1.2	0.9	-0.3	
Substance Abuse	0.9	0.5	-0.4	**	1	1.1	0.1	

Significance: *p≤.05; **p≤.01; +p≤.1

Figure IV.6 Mean Difference between Baseline and Follow-Up ANSA Scores



HPP completed ANSA assessments for both treatment and control adult they served, and both groups had very similar needs and strengths scores at baseline. When follow-up assessments were conducted for families that stayed engaged with HPP, adults in both groups had about four total assessments on average. Yet when comparing baseline scores to their most recent follow-up assessment, treatment adults saw significantly greater improvement than control adults on a number of domains, including adjustment to trauma, family functioning, residential stability, and social connectedness. This suggests that the more intensive case management and housing services provided through FMF have a substantial impact on adult well-being. These improvements may have long term benefits for treatment families beyond the current observation window.

Child Outcomes

Child and Adolescent Strengths and Needs (CANS)

Did treatment children show greater improvements on the CANS than control children?

Background

In addition to stabilizing housing and reducing the need for foster care, FMF was designed to promote child and family well-being. One way of measuring child well-being is the Child and Adolescent Strengths and Needs (CANS) tool, a functional assessment widely used nationally. In 2011, a California settlement agreement mandated that every child at risk of entering foster care be assessed for mental health need. San Francisco's implementation involved working with the Department of Public Health (DPH) to administer CANS screenings to every child entering a child welfare case (in- or out-of-home). Children showing need on the screener were to be fully assessed using a complete CANS instrument and re-assessed at regular intervals including at treatment completion.

We hypothesized that treatment group children screened in for full assessment would exhibit greater improvement in well-being over time compared to control group children.

Methods

FMF involved 203 children who were consented to share CANS information, 123 from 72 treatment families and 80 from 44 control families. Significantly more treatment children were consented than control children. Post-randomization, 72 children from treatment families and 54 children from control families received a CANS screening. There were no significant differences by condition in the number of children screened post-randomization. Sixty-two children from 34 treatment families and 52 children from 30 control families ever received a full CANS assessment or closing summary after randomization to FMF. Significantly fewer treatment children went on to receive a full assessment or closing summary after randomization than control children. Over a period of 4.85 years post-randomization, 259 CANS were administered to treatment children and 195 were administered to controls, making a total of 454 CANS assessments administered through 09/28/2018.

Investigators and practitioners have used CANS in a variety of service settings and the tool has demonstrated good reliability and validity in psychometric studies. In our sample data, CANS assessments and closing summaries for children 0-4 comprised 21 indicators of child needs and strengths, whereas CANS assessments and closing summaries for children 5-18 comprised 50 indicators. Five CANS indicators relating to child psychosocial well-being were common across these CANS documents: anxiety, depression, adjustment to trauma, development, and interpersonal functioning. Each was scored on a four-point scale, representing the level of need in that psychosocial domain (0=no evidence of need, 1=monitoring/prevention, 2=need for action, 3=immediate action).

In order to assess the effect of FMF treatment on child well-being, we developed two composite child well-being measures using the five CANS indicators, and then entered these measures into multilevel models which measured the effects of the treatment on child well-being over time.

Our two composite child well-being measures were: (1) a factor score extracted from a confirmatory factor analysis (CFA), and (2) a mean score. In each case, a higher score indicates worse child well-being whereas a lower score indicates better child well-being. We developed the first measure by using the results of an iterative principal factors analysis to construct and measure a multigroup CFA, from which we extracted factor scores to use in subsequent multilevel models. We developed the second measure by taking the arithmetic mean of the five well-being indicators. As with the factor scores described above, we used mean scores in subsequent multilevel models.

Our multilevel models included each of the two composite child well-being scores individually as the outcome, FMF treatment and years since randomization as predictors, and two random intercepts: one to account for dependence of observations at the family level and the other to account for dependence of observations at the child level.

Results

Descriptive statistics. Of the 454 CANS selected for analysis, 259 involved 62 children from 34 treatment families, while 195 involved 52 children from 30 control families. Sixty-six percent of these children had 3 or more CANS (mean=3.98, sd=2.77). For half of all children, their first CANS was completed within 168 days of randomization (mean=293.63, sd=354.47), and their last CANS was completed within 750 days of randomization (mean=815.56, sd=486.09). The median time between CANS was 140 days (mean= 175.00, sd=159.73). CANS descriptive statistics are displayed in Table IV.80.

Table IV.80 CANS Descriptive Statistics

	Total			Treatment (n=62)			Control (n=52)		
	median	mean	sd	median	mean	sd	median	mean	sd
# of CANS per child	3	3.98	2.77	3	4.18	3.13	3	3.75	2.27
Days to first CANS	168	294	354	153	299	398	172	287	298
Days to last CANS	750	816	486	713	785	497	781	852	474
Days between CANS	140	175	160	131	153	139	161	206	180

Tables IV.81 and IV.82 list for each age group baseline, most recent follow-up, and the difference in means by treatment verses control for the full set of domains and their items. Descriptively, both groups had low baseline needs yet they showed some improvement over time across age groups (i.e., negative values). Young children in treatment families especially showed reduced need on a number of items in the presenting needs and functioning domains.

Table IV.81 Baseline and Follow-Up CANS Comparison: Ages 0-4

	Treatment Group (n=28)				Control Group (n=24)			
Domain	Baseline mean	Follow-up mean	Difference mean	p	Baseline mean	Follow-up mean	Difference mean	p
Current Presentation or Needs								
Adjustment to Trauma	1.50	1.09	-0.59	**	1.46	1.06	-0.47	
Anxiety	1.32	1.23	-0.23		1.04	1.06	0.00	
Attachment	1.32	1.18	-0.32		1.29	1.24	-0.12	
Depression	0.50	0.41	-0.18		0.38	0.29	-0.12	
Failure to Thrive	0.00	0.09	0.09		0.13	0.00	-0.13	
Regulatory Problems	1.33	1.00	-0.50	***	1.17	1.13	-0.19	
Impact on Functioning								
Communication	0.86	0.59	-0.32	*	0.79	0.47	-0.35	*
Developmental/Intellectual	0.57	0.23	-0.32	**	0.33	0.12	-0.18	
Family	1.32	1.14	-0.32		1.75	1.35	-0.24	
Motor	0.39	0.14	-0.32	**	0.17	0.06	-0.18	
Physical/Medical	0.29	0.09	-0.18		0.75	0.24	-0.24	
Sensory	0.39	0.41	-0.05		0.21	0.12	-0.06	
Child Strengths and Supports								
Curiosity	0.33	0.27	-0.14		0.63	0.29	-0.24	
Family	1.29	1.14	-0.32	*	1.46	1.29	-0.06	
Interpersonal	0.89	0.82	-0.14		0.92	0.71	-0.18	
Playfulness	0.26	0.18	-0.09		0.54	0.29	-0.18	
Relationship Permanence	1.43	1.50	-0.14		1.33	1.18	-0.18	

Significance: * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

Note: 14 children had CANS for both age groups over the course of the study.

Table IV.82 Baseline and Follow-Up CANS Comparison: Ages 5-18

	Treatment Group (n=42)				Control Group (n=34)			
Domain	Baseline mean	Follow-up mean	Difference mean	p	Baseline mean	Follow-up mean	Difference mean	p
Current Presentation or Needs								
Anger Control	1.07	0.63	-0.29		1.21	0.76	-0.44	*
Anxiety	1.33	1.08	-0.29		1.44	1.28	-0.20	
Conduct	0.21	0.29	0.08		0.35	0.16	-0.12	
Depression	1.21	1.13	-0.13		1.12	1.16	-0.12	
Impulse/Hyperactivity	0.86	0.67	-0.17		0.94	0.80	0.00	
Oppositional	0.55	0.46	0.04		0.71	0.32	-0.36	**
Psychosis	0.00	0.00	0.00		0.00	0.08	0.08	
Somatization	0.07	0.04	0.00		0.18	0.44	0.24	
Substance Use	0.05	0.13	0.04		0.06	0.12	0.04	
Impact on Functioning								
Developmental	0.26	0.04	-0.33	**	0.15	0.12	-0.04	
Family	1.45	1.21	-0.17		1.71	1.16	-0.40	*
Legal	0.12	0.25	-0.29		0.00	0.04	0.04	
Living Situation	1.14	0.71	-0.29		1.21	0.64	-0.44	*
Physical/Medical	0.17	0.08	0.00		0.35	0.16	-0.20	
Recreational	0.50	0.58	0.00		0.74	0.56	-0.16	
School Achievement	1.00	0.63	-0.50	*	1.18	1.08	-0.16	
School Attendance	0.64	0.42	-0.04		0.59	0.40	-0.12	
School Behavior	0.69	0.83	0.21		0.79	0.72	0.00	
Sexuality	0.07	0.08	0.04		0.09	0.12	0.04	
Child Strengths and Supports								
Family	1.38	1.00	-0.29		1.32	1.08	-0.24	
Interpersonal	0.98	1.08	0.00		0.97	1.04	0.16	
Educational	1.33	1.13	-0.33		0.82	1.08	0.20	
Vocational	0.13	1.00	0.00		0.00	0.00	0.00	
Talents/Interests	1.00	0.88	-0.25		0.91	1.04	0.16	
Spiritual/Religious	1.02	0.88	-0.08		1.59	1.84	0.12	
Relationship Permanence	1.10	1.38	0.33		1.24	1.40	0.16	
Risk Behaviors								
Danger to Others	0.45	0.38	-0.13		0.53	0.36	-0.12	
Delinquency	0.12	0.21	0.13		0.03	0.04	0.04	
Fire Setting	0.02	0.00	-0.04		0.00	0.04	0.04	
Other Self-Harm	0.19	0.04	-0.21	*	0.38	0.24	-0.16	
Runaway	0.19	0.21	-0.08		0.06	0.00	0.00	
Sexual Aggression	0.07	0.04	-0.08		0.03	0.04	0.04	
Sexually Reactive Behavior	0.05	0.13	0.04		0.06	0.12	0.08	
Social Behavior	0.52	0.17	-0.46	*	0.53	0.40	0.00	
Suicide Risk	0.14	0.17	0.04		0.15	0.16	-0.04	

Significance: * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

Note: 14 children had CANS for both age groups over the course of the study.

Iterative principle factors analysis. The iterative principal factors analysis yielded only one factor with an eigen value greater than 1. Results of the analysis suggested that a single factor model of child well-being was sufficient. The correlation matrix of the five well-being indicators is displayed in (table 1 of the Appendix P, Additional CANS Analysis.)

CFA. Based on the results of the iterative principal factors analysis, we loaded the five well-being indicators onto a single latent factor ("MH") for confirmation using CFA. Factor loadings and fit statistics are displayed in table 2 of Appendix P.

Multilevel models. Using the factor scores extracted from the CFA as the outcome, we constructed multilevel models with fixed effects (years since randomization, treatment vs control, and a time-by-condition interaction) and three random effects (a random intercept to account for clustering of time points within children, a random intercept to account for clustering of children within families, and a random coefficient at the family level to account for siblings having similar changes over time in CANS scores). Our multilevel models indicated that treatment children experienced about a fifth of a standard deviation decrease in the factor score (i.e., about a fifth of a standard deviation improvement in well-being) over control children, a decrease that approached significance (b=-0.17, p=0.09). Table IV.83 displays results of the multilevel model using factor scores, including fixed effects and the variances of the random effects (the variances of the child- and family-level random intercepts, the variance of the family-level random coefficient, and the variance of the residual error in the model).

Table IV.83 Mixed-Effects Model Predicting Child Well-Being Factor Scores Up to Five Years Post-Randomization

	b	95% CI
Intercept	-0.08	(-0.38, 0.22)
Year	-0.03	(-0.17, 0.11)
Treatment vs control	0.14	(-0.27, 0.54)
Time by condition interaction	-0.17	(-0.37, 0.03)
var(Family RC)	0.02	(0.01, 0.07)
var(Family RI)	0.13	(0.02, 0.65)
var(Child RI)	0.25	(0.13, 0.50)
var(Residual)	0.59	(0.50, 0.68)

Significance: * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$

Note: N = 454; var(Family RC) = variance of family-level random coefficient; var(Family RI = variance of family-level random intercept); var(Child RI)=variance of child-level random intercept; var(Residual)=variance of residual model error

Using the mean score as the outcome, models indicated that treatment children experienced a 0.08-point decrease in the mean score (i.e., a 0.08-point improvement in well-being) each year over control children, a difference that approached significance (b=-0.08, p=0.08). Table IV.84 displays results of the multilevel model using factor scores.

Table IV.84 Mixed-Effects Model Predicting Child Well-Being Mean Scores Up to Five Years Post-Randomization

	b	95% CI
Intercept	0.93***	(0.80, 1.07)
Year	0.00	(-0.06, 0.06)
Treatment vs control	0.07	(-0.11, 0.25)
Time by condition interaction	-0.08	(-0.16, 0.01)
var(Family RC)	0.00	(0.00, 0.01)
var(Family RI)	0.03	(0.01, 0.12)
var(Child RI)	0.05	(0.03, 0.10)
var(Residual)	0.10	(0.09, 0.12)

Significance: * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$
Note: N = 454; RC = random coefficient; RI = random intercept

We also looked for possible differential effects by case type (maintenance vs. reunification), and the age of the child, hypothesizing that FMF's benefits would be stronger among young children. Results were not significant.

Implications

Results indicate that in comparison to children in the control group, those in the treatment group experienced modest improvements in well-being over time that approached statistical significance, as indicated by both of our child well-being measures. However, one-fifth of a standard deviation improvement is probably not clinically meaningful or actionable.

Other Outcomes

We examined a number of other family, parent, and child well-being outcomes that suggested no meaningful impact of FMF participation. For details see the following appendices:

Research Question	Data Source	Detailed Findings
Did treatment families increase their earnings more than control families?	State of California Employment Development Department	Appendix Q
Were treatment families more likely to initiate and maintain public benefits?	San Francisco CalWORKS (TANF), CalFRESH (SNAP), and General Assistance payment data, Medi-Cal (Medicaid) enrollment data	Appendix R
Were treatment families more likely to obtain subsidized employment?	San Francisco JobsNOW! administrative data	Appendix S
Did treatment children have better educational outcomes?	San Francisco Unified School District administrative data	Appendix T
Were treatment children more likely to use subsidized childcare?	San Francisco Office of Early Childcare and Education administrative data	Appendix U

Cost Study

SF-HSA Participation in Cross-Site Cost Study

SF-HSA collaborated with The Urban Institute (UI) to contribute local information for the cross-site cost study. Via the cross-site cost study, UI sought to analyze the cost and cost-savings of supportive housing initiatives for child-welfare-involved families. Specifically, the UI cost study will answer the following questions:

- What are the programmatic costs and cost savings of such an initiative?
- What are the costs and cost savings of the initiative on the child welfare system?
- What are the costs and cost savings of the initiative on organizations that support the homeless?
- How do up-front costs vary from on-going costs or costs of replicating the program?

SF-HSA efforts centered on strategic support as well as data sharing and analysis.

Strategic Support

SF-HSA Planning staff consulted with UI to offer an orientation to the way child welfare administrative program and payment data are organized in California and in San Francisco City and County. Planning staff made recommendations for the cost study methodology, including ways in which the methodology should be adapted to meet the circumstances in the local child welfare system. For example, UI was encouraged to examine costs for all placement types, regardless of their frequency, since per diem costs vary greatly among placement types in the area.

Analysts also informed UI of externally available sources for California child welfare data, such as the publicly-available web-based CA Child Welfare Indicators Project, where UI could collect counts of children by case type, placement type, age, and other characteristics. Types of measures available on this database, as well as how to use the database, were outlined to UI.

Regarding homelessness costs in the San Francisco Bay Area, SF-HSA Planning staff informed UI of local shelters and introduced UI staff to key stakeholders at these organizations.

Data Sharing and Analysis

Members of the SF-HSA Planning and Fiscal teams provided UI with extracts of administrative and financial data spanning the time period October 1, 2015 to September 30, 2016, per UI's request.

Examples of data shared include:

- Administrative data on the average monthly caseloads of child welfare investigations by preservation and reunification cases and further stratified by out-of-home placement type
- Financial data on payments made to contracted service providers, split by preservation and reunification cases
- Financial data on per diem rates for foster care placements

SF-HSA Planning and Fiscal staff then helped UI map placement types to per diem rates. Fiscal staff also conducted analyses to estimate the average daily cost of the primary care types. The UI cost study team planned to validate the two sources against each other and determine reasonable average per diem estimates by placement type.

Urban Institute Cross-Site Cost Study Methods

For their cross-site cost study, UI estimated the local costs of the program in each of the five demonstration sites, including the FMF site in the consolidated city-county of San Francisco. To sum all costs in San Francisco, UI employed the ingredients method to aggregate all ingredients, or each individual component, of the FMF program. In order to capture the full financial impact of the program, they focused on three domains: the cost of the program itself, the cost to the child welfare system, and the cost of homelessness.

To examine the program costs itself, UI aggregated costs of providing both transitional and permanent housing, given that FMF offered both to its participants. Costs of transitional housing were estimated via discussions with Holloway House, the local partner that provided this interim housing for a number of FMF participants. Additionally, UI gained public access to the U.S. Department of Housing and Urban Development's Pictures of Subsidized Housing database to infer the costs of providing permanent housing vouchers for FMF treatment families.

Child welfare costs were divided into service type: investigations, family maintenance cases, and family reunification cases. SF-HSA's contribution to data sharing, outlined above, was critical to this process and allowed UI to calculate child welfare costs by service type using the ingredients method.

To estimate cost of homelessness in the area, UI reached out to two local homeless providers to gather cost information. UI estimated costs related to the facility (rent, utilities, maintenance, etc.), staffing, materials, and donated time and equipment, and calculated an average cost per family per night. Using the household survey taken by treatment and control families in the FMF study, UI applied the average cost per family per night to the number of shelter days in each group.

San Francisco did not conduct any site-specific cost study beyond participating with the Urban Institute study. Results from UI's cross-site cost study are expected to be published at the end of 2018.

Evaluation Challenges

Challenges and Solutions

1. **Housing availability was the most obvious challenge to the evaluation, impacting both implementation and outcomes.** The CQI framework created mechanisms for quickly detecting and studying implementation problems. A few months after the program's launch, HPP's case managers were overwhelmed, saying their caseloads were full much sooner than expected, even though the number of program enrollments was on pace with expectations. Clients were overwhelmed with their child welfare cases and the crises that brought them to the attention of the child welfare system. It seemed to be keeping them from moving through the program, which the team expected to be relatively quickly once families experienced the stabilizing effects that the Housing First approach was expected to yield. Yet many families were not being housed.

   The evaluation team examined housing event data in HENRI. We identified the sources of the housing delays as partly bureaucratic (administrative requirements) and partly due to the heating housing market in San Francisco. Solutions designed to broaden the supply of housing sources are discussed earlier in this report.

2. **Housing delays translated to delayed onset of the full treatment for most families, making it more difficult to distinguish program effects from usual service.** To be sure, treatment families were ultimately much more likely to become permanently housed than control families. We responded to the delays by examining how and how much case managers were spending their time with FMF families. The information gleaned from that effort informed the FMF casework model which specifies treatment dosage and services phases. The outcomes analysis addressed the housing delays by examining the relationship between the timing of housing and the timing of key child welfare outcomes descriptively.

3. **A large fraction of families either never enrolled or disengaged before being housed, diluting possible treatment effects.** Our effort to target very high-need families and to objectively include all of them in the experiment meant that families may have fatigued from the housing delays, or they may have been so burdened with barriers and disorganized that they were emotionally unable to take the offer of service or persevere after initial engagement. This amounted to about one third of families randomized into the treatment group failing to receive the full program dose. We addressed this by conducting Treatment on Treatment (TOT) analyses. While not causal, we did this to better understand key outcomes among treatment families who had different levels of participation.

4. **Lack of complete information about control families' type and timing of housing post-randomization made it difficult to assess the treatment counterfactual. Across** sites, the evaluations only had systematic access to HMIS data, meaning that other types of homelessness beyond shelters as well as homelessness for control group families who left San Francisco were not tracked. We addressed this in a number of ways. First, we retrieved administrative data from a number of other housing programs in San Francisco, such as below market rate housing and project-based public housing. Second, we reviewed closing court documents for control group children in the child welfare administrative database, which often included narrative information about the family's housing situation at case closure. We checked the reliability of those documents those

families' survey responses and administrative data, where available. The result was a less incomplete picture of the counterfactual.

5. **Obtaining data from relevant organizations – even explicit partners – was challenging.** A San Francisco County court order granted evaluators access to administrative for the treatment group, and the evaluation study was approved by the University of Chicago IRB with a waiver of consent granting us access to individual level administrative data. Partner organizations signed MOUs specifying the nature of the partnership including the expectation that there would be data exchanges. Nevertheless, we were consistently challenged in our efforts to obtain any data not housed at SF-HSA. In large part, this challenge was addressed by delegating some of the key analyses to the SF-HSA team because under court order they could more easily obtain individual level data from outside partners. But even that effort was onerous, and because this was the solution, those data resources could not be merged with core analytic database because the outside evaluation team was not granted access to individual level identifying data from outside partners. This solution was what ultimately enabled the team to access data from SF-DPH, the San Francisco Unified School District (SFUSD), the San Francisco Department of Homelessness and Supportive Housing (HSH), and the Mayor's Office of Housing and Community Development (MOHCD). But each solution had a unique approach, briefly described below:

    - A key project partner was DPH, where data from CANS screening was housed. Despite the pre-existing MOU, the court order, the IRB, and the fact that screened children were in HSA open cases, evaluators were not able to receive the individual level data. We finally addressed that problem by having DPH transfer individual level CANS data from consent treatment and control families directly to HSA, and the CANS analysis was conducted "in-house".
    - For SFUSD, where the education data was housed, the internal SF-HSA evaluation team was permitted to receive individual level data for children once a new court order had been granted from San Francisco County, and families were direct-mailed and given the opportunity to request that their information not be shared.
    - Described earlier, midway through the project a separate SF Department of Homelessness and Supportive Housing was created, breaking out of SF-HSA. This meant all data from HSH managed administrative databases, including HMIS, which had previously been available to the full evaluation team, could no longer be shared. Although efforts to finalize a new data-sharing agreement are underway, they were not completed in time, and as with DPH and SFUSD, the HSH data was shared with the internal SF-HSA team who completed the related analyses.
    - MOHCD quickly and willingly provided data about city housing programs in which study families may have participated, but they preferred to share identifying data with SF-HSA rather than with the evaluators. Again, we relied on the internal SF-HSA evaluation team to prepare analyses using these data.

    A common misunderstanding we encountered was when an organization outside of SF-HSA – whether an explicit partner or not – assumed that the FMF evaluation could be accomplished using either aggregate data from their systems or deidentified individual-level data. In these cases, we clarified with each organization the importance of identifiable data, acquired and protected according to the process outlined above, that could be linked to study families in order to properly assess the effectiveness of FMF compared to control families. While we benefited from having SF-HSA evaluation staff to work with the data internally when necessary, that compromise came with a

cost. The original evaluation plan included a multi-system, longitudinal analytic file containing key events (inputs, outputs, and outcomes in the logic model) that families experienced in all relevant systems. We could not fully develop this file without permission to share identifying client-level data with the outside evaluator.

6. **We were not able to systematically assess the well-being of control group parents.** While we took advantage of the unexpected fact that many control families received ANSA assessments at HPP, this information was not available for everyone or consistently across time points. As a result, while we found that treatment families improved over time and they did so relative to the available control group data, we cannot rule out the possibility that we missed important information about control group families that did not receive ANSAs at HPP.

Limitations

1. **The FMF intervention was deliberately adapted over the course of implementation.** A benefit of a CQI-driven evaluation of a new intervention is that it allows planners to understand more quickly than they otherwise would have what adjustments to the model have to be made so that the targeted clients get the intended treatment. Such adjustments are almost always necessary in a new intervention either because clients are not accessing the intervention fast enough, well enough, or not enough clients are accessing it at all; or early signs show that the intervention is not effective, so model changes are necessary. All of these things occurred in FMF, and the program benefited from the nimble nature of the CQI method to make sometimes substantial program changes. One possible limitation of this approach is that as a function of those changes, the intervention changed significantly enough so that families enrolling at the beginning of the program were delivered a somewhat different intervention from families who enrolled in the later years. The changes were not always discrete or marked clearly in time, which limits the evaluators' ability connect both specific elements and clear dosage of those elements to overall program outcomes.

2. **Housing delays, which may have influenced the attrition rate, meant that the treatment families did not receive a fundamental element of the program – rapid permanent housing.** Because the housing process was protracted in San Francisco, families randomized in received the promise of housing, but not the permanent housing itself, until well into the program. And not all treatment families were successfully housed. While the timing improved over the course of the intervention, this the most significant aspect of the intervention that changed, and thus the evaluation was not able to specifically test the impact of rapid housing with support for all randomized families.

3. **Attrition from the program diminished the already small sample size.** Twelve percent of the treatment families never engaged, shrinking an already small sample. The attrition rate as well as the fact the one third of the treatment families were not housed makes is difficult to be conclusive about the impact of the intervention of the treatment families. The TOT analysis mitigates this somewhat, and points to opportunities to refine the targeting so that families most likely to benefit from the intervention could receive it. Urban Institute's cross-site evaluation also remediates the concern that small sample place on the intervention's external validity.

4. **The follow-up time was relatively brief for well-being outcomes.** Raj Chetty and colleagues examined children's outcomes two decades after their parents moved to low-poverty neighborhoods using Section 8 vouchers found strong effects that were not apparent in the short-term. If families moved to higher-opportunity neighborhoods before children were teenagers, those

children increased their adult earnings for each year they were exposed to the new neighborhood[37]. The FMF evaluation was not designed to capture long-term outcomes, although the Urban Institute received a grant from the Robert Wood Johnson Foundation to continue to track housing, child welfare, and well-being outcomes from all five grantee sites for nearly five years after randomization.

5. **A related limitation was that HPP is an adult service provider, making it difficult to tie services to specific expectations for child well-being improvements.** The program included treatment team members whose particular focus was on housing and adult well-being (HPP staff), and on child welfare outcomes (SF-HSA child welfare worker). Without an SF-DPH partner as part of the treatment team, the model lacked deliberate, ongoing attention to specific child needs that are measured on the CANS.

6. **Matching administrative data across systems without a common client identifier is inherently imperfect.** A number of analyses required matching study clients to other administrative data sets using probabilistic matches, which may not identify clients with complete accuracy. This may have led to undercounts of participation in programs beyond child welfare. However, this error would be equally likely to occur in both the treatment and control groups, which somewhat mitigates the concern.

[37] Chetty, Raj and Nathaniel Hendren. (2015). The Impacts of Neighborhoods on Intergenerational Mobility: Childhood Exposure Effects and County-Level Estimates. Harvard University Working Paper.

Section V. Dissemination

Families Moving Forward (FMF) dissemination activities to date have primarily involved academic conference presentations, practitioner webinars, workshops, and a podcast, contributing to federal dissemination documents and producing key programmatic tools. The content has been focused on implementation lessons and program design. Beginning in 2018, evaluators submitted outcomes findings to academic conferences and they plan to continue to disseminate findings via presentations and publications over the next several years. Appendix L lists those presentations, as well as Master of Social Welfare (MSW) student research projects conducted under the supervision of San Francisco Human Services Agency's (SF-HSA's) Research Director.

Major products related to program design and operations include:

- Structured Decision Making® (SDM®) targeting package: The planning team prepared hard- and electronic copies of San Francisco's expanded definition of homelessness for child welfare workers, a modified investigative narrative document in the child welfare administrative data system that captures homelessness type and eligibility criteria, and continuous quality improvement (CQI) review procedures that describe how SDM® data can be used to regularly confirm that all eligible families have been referred to the program and all referred families are eligible. We distributed this to the Children's Bureau.
- Case management model: Homeless Prenatal Program (HPP) staff, with help from the Corporation for Supportive Housing (CSH) and the planning and evaluation team, produced a written manual describing FMF's program theory, policies, and procedures. It was distributed to other demonstration sites, to California's Bringing Families Home (BFH) grantees, and was used as a template for other HPP programs.
- Caseload model: Evaluators developed a model for planning case management caseloads using data collected about the volume and program duration of eligible families (See Appendix V). The model uses SDM® information about the average number of eligible children with case openings each month, the fraction of families that never engaged, the typical amount of time families spent in the different service intensity phases of the program, the overall average program duration, and the maximum desired caseload per case manager to estimate the number of full-time case managers needed to serve the stock and flow of families. The model was later used to plan FMF's sustainability grant under California's BFH program, other programs at SF-HSA, and was disseminated to grantees at a BFH statewide meeting.
- Federal Information Memorandum: At the national level, FMF was recognized for its promising practices in Appendix B of *Information Memorandum ACYF-CB-IM-17-03* by the U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Administration for Children and Families, Children's Bureau. The memorandum directed to state, tribal, and territorial child welfare agencies describes efforts by child welfare agencies, local communities, and federal agencies to end family and youth homelessness. The FMF program was acknowledged for its use of administrative data for targeting and screening for housing needs.
- Bringing Families Home (BFH) Grant: The Supportive Housing for Families grant cluster informed the State of California's Assembly bill 1603 which appropriated $10M in 2016 for 12 counties to implement supportive housing and rapid rehousing programs in child welfare on order to reduce the use of foster care. FMF formed the basis for San Francisco's successful application and award of $1.9M to sustain and scale up under the BFH program (http://www.cdss.ca.gov/inforesources/CDSS-Programs/Housing-Programs/Bringing-Families-

Home-Program). In 2018, the California Department of Social Services allocated an additional $26,000 to the San Francisco evaluation team, including Chapin Hall, in part to disseminate FMF lessons learned to the other 11 BFH counties.

Section VI. Sustainability

Families Moving Forward (FMF) substantially impacted the way in which San Francisco serves its vulnerable populations. The program itself continues, renamed Bringing Families Home (BFH) to align with state funding sources. Early indications are that this is likely to become a permanent program for San Francisco Human Services Agency's (SF-HSA) child welfare department sustained through a combination of state and local funding, and supported by Family Unification Plan (FUP) vouchers in partnership with San Francisco Housing Authority (SFHA). Homeless Prenatal Program (HPP) continues to be SF-HSA's main partner in running the project. The partnerships and innovations that emerged as a result continue to be felt across systems.

SFHA Partnership

A close working relationship evolved between SF-HSA and SFHA leadership over the course of the FMF project, nourished by annual grantee meetings and other offsite time. This bore rich fruit both for FMF and for other initiatives. SFHA leadership has gone to bat for FMF and BFH families. As San Francisco's FUP vouchers hit full utilization, SFHA is freeing up new vouchers: moving long-since-stabilized FUP families to regular housing choice vouchers so that more families can be referred to the FUP program. The ability to do this on an ongoing basis is codified in SFHA's Administrative Plan. When SFHA suspended all voucher referrals due to financial challenges, SFHA advocated for (and was granted) an exception for BFH families already in the housing pipeline. More broadly, the FMF model of assigning a housing broker to help each SFHA client find and lease a property has now become a city-wide model. SFHA changed their Administrative Plan so that vouchers are allocated to agencies. In return these agencies agree to provide support as clients navigate the housing process.

Close collaboration also characterizes the day-to-day work of housing vulnerable families, as SFHA and HPP form an integrated team to navigate the family through the application process and are in immediate contact to address any hiccups that occur. This strong working relationship has persisted even after the recent departure of HPP's lead housing specialist. This is a promising sign that the coordinated response is becoming structured in to the organizations, rather than the result of one personal working relationship.

Department of Homelessness and Supportive Housing

In 2016 SF-HSA's Homeless Services Division spun off to become the Department of Homelessness and Supportive Housing (HSH) its own city agency. After a period of adjustment, SF-HSA and HSH began collaborating closely on a number of initiatives, among them SF-HSA's FUP voucher program. Discussions are currently underway to integrate HSA's BFH families into San Francisco's Coordinated Entry system, ensuring that they receive the highest level of housing support for which they qualify. BFH Families who qualify for on-site supportive housing will receive it. Families who qualify for rapid rehousing subsidies (typically still necessitating that the family move out of San Francisco to afford rent) will be given a FUP voucher, if they are eligible. Early conversations are also seeking to help homeless parents whose children are removed: these individuals often fall between systems (not qualifying for family housing, but needing a safe space to begin to reunify). Together the two agencies are looking for options to support these parents.

San Francisco Human Services Agency

At the outset of FMF, SF-HSA hoped that by the project's end an awareness of the importance of housing would be fully integrated into San Francisco's child welfare system, with avenues to housing

explicit in case plans and relationships with housing agencies robust and fruitful. While work remains, anecdotal evidence suggests that the FMF project has had a tremendous impact on how workers address homelessness. Prior to the project, workers perceived homelessness as a contributor to patterns of abuse and neglect, but often saw it as being beyond their ability to address. FMF introduced a systematic approach to identifying homelessness and to referring families for help. Routine data screening allowed the team to pinpoint workers who were not referring homeless families for housing support and initiate a discussion as to why. Over time, referrals directly from workers increased.

Many components of the project, such as early assessment of homelessness, rapid referral of all children for mental health assessment, coordination of benefits, and a "teaming approach" for supportive case management are being honed for all families in the child welfare system. FMF has been able to produce operational efficiencies that will apply to these wider efforts.

Homeless Prenatal Program

HPP continues as SF-HSA's main partner in implementing the BFH Program. Key elements of the program have endured, including

- A streamlined intake and referral process
- Rapid engagement and case coordination utilizing a "teaming" approach for supportive case management both during the family's child welfare case and after it closes
- Holloway House and its supportive environment
- The use of FUP vouchers for the BFH program
- 'Bridge funding' to enable families to hold units during the SFHA's inspection & leasing process
- Housing broker and housing search services
- Housing and general support for at least one year post-lease
- Coordination across counties – both through interagency relationships and inter-county partnerships - when families move to the wider Bay Area

For HPP, experiences with FMF and continuous quality improvement (CQI) enriched their practice, leading them to clarify the FMF logic model and grow their culture to be more data informed. The BFH logic model incorporates some of the lessons learned from FMF implementation. Participants are referred for housing search after the initial court process, once their case plans are better understood. And HPP's case management services focus on housing support and stability; BFH relies on child welfare workers to provide general case management and service referrals. Close coordination between these two support systems remains an essential element of the program. HPP has also broadened its housing team, offering housing support services to clients across the agency.

Close implementation monitoring and a robust CQI process continue to be core to BFH.

Sustainability Lessons Learned

It is challenging to offer universally applicable lessons around sustainability, because the FMF initiative was the benefit of a huge windfall when the State of California funded the BFH program, allowing the project to continue without interruption. However, several factors increased the likelihood of sustained success:

1. Collaboration was structured into the program design and sustained for the life of the program: this ensured that a diversity of stakeholders felt invested in FMF families and would do what they could to help the project succeed.

2. A CQI approach supported and guided the program through early implementation, ensured that the program adapted to changes in the environment, stayed relevant to families' needs, and fostered and measured cross-system collaboration, and
3. Having a public entity as the lead agency helped embed practice change, secure funding, and institutionalize project success.
4. As circumstances changed, the project adjusted its services, winnowing out elements that proved ineffective or impractical.

Section VII. Conclusion and Discussion

The purpose of the Supportive Housing for Families grant cluster was to test permanent supportive housing models with child welfare involved families who were homeless at the time of their referral. The theory to be tested posited that safe and stable housing would facilitate remediation of the problems that led to impaired parenting and child maltreatment. Expected outcomes included a reduced need for foster care and improved child and family well-being, but by how much remains a question. The Children's Bureau issued clear direction to sites to locate and deliver the program to highly challenged families – to avoid creaming – and in doing so also managed expectations around the magnitude of success in favor of learning and disseminating important lessons about how to collaborate across systems to design and deliver a complex program for complex families.

San Francisco's Families Moving Forward (FMF) program adhered to these federal directives, using empirical information about child welfare history and family risk factors to target families identified as homeless during a child welfare investigation who were at heightened risk for placement or who were unlikely to reunify. The targeting theory was nuanced; hard-to-serve families were not necessarily the same as families who were likely to benefit the most from the program. Our targeting criteria identified families who fit both conditions and we established baseline expectations about their likelihood of achieving reunification or avoiding placement. We also carefully excluded a specific group of families who the program theory was not designed to help, i.e., parents who had a newborn removed and who had permanently lost custody of all prior children.

Baseline expectations were low. For example, depending on the constellation of risk factors, a child in a program-eligible family before FMF began was over six times more likely to be placed into foster care than children in the general San Francisco child welfare population. By this measure, program families were fairly unlikely to succeed had we not intervened. The objective of FMF was to safely reduce that probability, and to promote timely reunification, but by how much in order to conclude that the program was successful? When considering broader policy implications, it may be useful to keep in mind that even small improvements among this particularly challenged population may be worth relatively large investments if they provide future cascading benefits, particularly in the out years beyond this evaluation window. The Urban Institute's upcoming research on the well-being of SHF families across the five sites for at least five years after baseline will begin to address this question.

As expected, implementation was complex, fragile, and required ongoing monitoring. Just under half of the referred families were housed and graduated (two were on pace to graduate around the end of 2018). In the preceding sections, we outline some of the barriers that limited the success for all 79 families. Some of the design limitations are addressed in the sustainability discussion. These include: refined targeting and enrollment procedures; a tightened path to housing including a more salutary stabilization option; and a clearer case management model with partner roles and responsibilities greatly clarified.

Having addressed those barriers, we are left to ascertain the extent to which the FMF program was successful in introducing stability, well-being, and improved family functioning to child welfare involved homeless families contending with additional significant challenges. What we find is limited evidence of success in the short or medium term, knowing that long-term success remains too distal to be determined.

That said, relatively few child welfare interventions have measured longer-term outcomes. Recent program instruction for the Family First Prevention Services Act described how the Children's Bureau will categorize evidence-based programs according to their level of sustained effect. Programs will be distinguished according to whether or not they demonstrate effectiveness for less than six months, six to 12 months, or more than 12 months.[38] The present study contributes to the base of evidence by measuring most outcomes at least two years post-randomization for all study families.

Targeting

Clients were automatically screened into the program almost as soon as their cases were promoted from the child welfare investigation to an open case. To ensure that the program truly reached a representative sample of the hardest to serve, no meeting occurred with the family to determine their readiness or willingness to be part of the program prior to their referral to the FMF lottery. Similarly, to ensure that the project was not 'creaming' the families most likely to succeed, no input was accepted from the child welfare worker regarding a family's likelihood of successfully engaging in the program and finding housing. A family's slot was held open for up to six months, even if they did not initially engage with the program or if their engagement was sporadic. This accommodating program design can lead to extended enrollment time.

However, the result was that about one-third of families randomized into the treatment group either never engaged or became disengaged before becoming housed, raising the possibility that some families – at least during the beginning stages of a child welfare case – may be too disorganized or their circumstances too acute and chaotic to participate in a program that is essentially a blunt instrument. The families who never engaged were all reunification families, and many reunification families who initially engaged did not receive the full intervention before their reunification services terminated. Yet there were also reunification families that did receive and benefit from the intervention. This suggests that refinement to the targeting strategy is called for to better identify reunification families who will benefit from the intervention.

Child and Family Impact

Housing

As described in our findings, securing rapid permanent housing for treatment families, a vital ingredient of the intervention and a hypothesized driver of the outcomes, was a consistent challenge. This increased our interest in understanding the experience of control families. We made a special effort to search for housing outcomes among control group families in order to understand the extent to which they eventually managed to resolve their homelessness without the help of FMF.

Although nearly one third of the treatment families left the program without housing, we did find that overall treatment families were more likely to secure any form of housing than control families – and preservation families were more likely to secure housing the reunification families. For both referral types, obtaining permanent housing was slow-going, averaging 10 months, but ultimately treatment families were more likely to become permanently housed than control families. And once housed,

[38] U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau (USDHHS). (2018). Program instruction (ACYF-CB-PI-18-09), Attachment C. HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the Title IV-E Prevention Services Clearinghouse, November 30.

treatment families remained stably housed for the full observation window. Additional housing findings included:

- FMF appears to have generated more stable and higher-quality housing among treatment families as well. One year after the baseline survey, substantially more treatment families expected to remain in their present housing than control families. They also were much more likely to report that their housing was of excellent quality, and nearly all felt their housing was at least "good". Finally, treatment families nearly always reported that their housing wasn't too crowded, while a handful of control families said that it was.
- Treatment families were less likely to subsequently enter a shelter than control families.
- Results suggest that work remains to address challenges that often accompany low-cost housing: about half of the treatment families reported one or more safety issues, and about one-quarter reported that assault and robbery was a problem in the neighborhood. These rates were similar to those reported by control families.
- Treatment families were much less rent burdened than control families.

Child Welfare

The child welfare outcomes associated with FMF programs were variable over time, and due to the challenges in providing early permanent housing for the treatment families, they cannot be directly connected to the receipt of permanent housing. It is possible that the promise of housing motivated families to persist in the FMF program, and the combination of motivation and the expectation of housing may be associated with the some of the short-term benefits of the program. But the evaluation did not directly test that. We do make the following observations about child welfare outcomes for families referred to FMF.

FMF may have had a short-term placement prevention effect, although not a longer-term one, and the outcome was not quite significant. The FMF program appeared to decrease the time to reunification (this was especially pronounced in the TOT analysis). The intervention did not ultimately make reunification significantly more likely for treatment families, nor did it impact case length. And although the counts are quite small, it did not appear to prevent reentry into care.

The findings about recurrence of maltreatment are less clear but trend in the desired direction among preservation cases. FMF appears to have protected children in preservation cases from re-abuse, with the strength of that finding depending upon how re-abuse was defined. We do not find evidence to suggest that FMF was protective among children in reunification cases who returned home, although the slightly elevated re-abuse rate observed for that group was not statistically significant.

The TOT analysis showed that reunification families that engaged with and persisted in the program, despite the housing delays, were more likely to reunify in the first year of program enrollment. Descriptive analysis looking at the timing of housing for treatment families alongside the primary child welfare outcomes shows that prevention families were likely to become housed (89 percent), that relatively few families experienced child removals, and that when those removals happened, they tended to happen after the family leased-up. Reunification families were less likely to get housed (40 percent), about half of the families did see a reunification outcome, and when those reunifications occurred, they were well in advance of the family's being housed.

Taken together, the ITT and the TOT child welfare results, in combination with what we learned from the targeting efforts, suggests that some child welfare involved homeless families may become less likely to have to have prolonged contact with the child welfare system, but that the supportive housing intervention as designed may not have produced those outcomes. The housing delay meant that many families dropped out before receiving the full treatment, although those that persisted were stabilized in temporary settings, and received case management services. Families who took that path, and subsequently completed the program, may have had the fortitude necessary to support their persistence in the program, and that facilitated both their child welfare outcomes and their eventual permanent housing. We cannot say if families that failed to engage or to stay engaged would have had different outcomes had they received the full program dosage earlier. They may well have; alternatively, it is possible that the struggles that prevented them from persisting in the FMF program may have also contributed to both their homelessness and their child welfare case, and would have continued to plague them even with the benefit of earlier permanent housing.

Parent/Caregiver Well-Being

Our analysis for parent/caregiver outcomes took advantage of the evaluation team's access to administrative data records containing information about both control families and treatment families over time. Analysis considering the change in condition between adults in treatment and control families over time revealed the following:

- Treatment families had lower average need scores on multiple ANSA domains relative to those in the control group, including significant improvements in family strength and family functioning, residential stability, social connectedness, and substance abuse.
- We examined a variety of outcomes related to financial stability and found no meaningful effects. Earnings tended to be low across groups and over time; about half of families had no reported earnings in any observed year. Very few adults from either group participated in San Francisco's subsidized employment program, so we could not draw conclusions from that analysis. There were no differences in the use of public benefits or in subsidized childcare participation rates.

Although we did not find many significant differences between treatment and control group families from these analyses, we note that FMF case management and support services did appear to improve the functioning of adults from the treatment families, despite the delays in receiving the complete FMF treatment intervention. This suggests that families did benefit from the support offered to them as they navigated through the FMF program, working on both their child welfare case and pursuing stable housing.

Child Well-Being

Our primary means of assessing child well-being, apart for the child welfare outcomes discussed above, relied on analysis of CANS screenings and assessments which were to occur shortly after referral, and then repeated as needed during the course of the child welfare case. At the program's outset, CANS screening were not delivered as intended by the project partner. As a result, a number of families saw their child welfare case close before their initial CANS screening was scheduled. After that delay we remedied, we were able to receive the results and CANS screenings for children from consented treatment and control families. Our analysis showed no strong evidence of improved child well-being. Descriptively, we did see statistically significant improvement in the average mean scores of younger

children from treatment families in a range of areas including: adjustment to trauma, regulatory problems, and several functional domains including communication, development, and motor skills, and improve strength in families. For older children from treatment families, there were a couple of areas of significant improvement, including diminished need in developmental areas, and improved school achievement.

Our efforts to use San Francisco public school data did not show meaningful effects on a range of education outcomes.

As indicated above, the evaluation team had access to administrative data records for children from both the treatment and control families that allowed for some analyses of short-term change in outcomes. However, the study cutoff date for all of these analyses was June 30, 2018, permitting no more than five years of follow up time for some children of families referred earlier to the program and as little as two for later referrals. This window of time did not allow for a full appraisal of the intervention's impact on children who even now are still developing. We do know that a number of treatment families received some of the program benefits, and 39 families with children graduated or are on pace to graduate and receive the full FMF intervention. The future prospects of these children may be better than those in the control group, although that is obviously not yet known.

Impact on Partner Organizations

Cross-System Collaboration

FMF attempted to integrate service delivery among many organizations, an ambitious goal considering the bureaucratic nature of several of the partner agencies. The intention was to learn as we went along, and to refine the model accordingly. This required a collective governance and steering process that far exceeded the normal contractor relationship in San Francisco government. The Steering and Continuous Quality Improvement committees enabled the individuals and institutions involved to operationalize their shared vision and to resolve questions and challenges either independently or as a whole. The approach proved effective and was replicated in other collaborative efforts between the two core agencies (SF-HSA and HPP) and elsewhere at SF-HSA.

The CQI process also changed HPP's internal operations and practices. Through monthly meetings, CQI team members engaged in lively discussions about implementation and outcomes (i.e., review of progress captured in the FMF monthly dashboard, evaluation efforts and service delivery). Over time the approach to problem solving became embedded as each CQI stakeholder increased their comfort with using data evidence. The steady and deep commitment to this approach enriched HPP's practice, leading them to clarify their broader organizational logic model and to change their culture to rely much more on data evidence.

Involvement in FMF enhanced IPP's already established commitment to collaboration. Having a formalized process and structure for collaborative meetings with SF-HSA and HPP workers confirmed and heightened the benefits of provider collaboration on behalf of families involved in the child welfare system. Meeting regularly and separately from Family Team Meetings promoted clarity and consistently among providers, ensuring that families were not inadvertently receiving conflicting messages and were unanimously supported to succeed. The formal partnership afforded by FMF encouraged child welfare workers to view the IPP mental health worker as an integral team member.

FMF had no perceivable impact on the San Francisco Department of Public Health.

FMF was well underway when HSH split from SF-HSA, but the program's continuation as well as the launch of the BFH (the state-funded sustainability grant) required the two agencies to forge an effective working relationship which was easily layered onto pre-existing internal relationships. The full range of collaborative work between the two agencies continues to be under development – ranging from working together at the case level, developing system resources that can be directed toward child welfare involved families, and developing data resources that are more easily linked across systems.

Fundamentally, this development and implementation of this initiative reveal to project partners the essential important of treating collaboration itself as a project goal. As described earlier, when it became clear that the systems integration that was the intended result from FMF partnership was not fully realized, the evaluators developed a hypothesis about the necessary ingredients of true systems collaboration. That hypothesis, and opportunities to refine, test it, and specify the ingredients necessary for effective collaboration and system integration to continue are on-going beyond the FMF project.

Impact on Child Welfare System

The demonstration project's implementation lessons learned contributed to California's Bringing Families Home legislation, which funded public child welfare agencies in 12 California counties to house homeless families in an effort to improve child welfare outcomes. Other ways in which FMF affected the local child welfare system include:

- SF-HSA formalized the child welfare practice expectation of assessing for housing instability and homelessness at investigation and increased recognition of the role that housing plays in family stability. It also better delineated the child welfare worker role in relation to the housing case manager role.
- The project articulated the importance of working with community-based agencies specializing housing case management to support families in the search, lease up (application and inspection completion) acquisition (move in) and retention (annual re-certification process).
- The project identified an effective and reliable strategy for improving access to housing choice vouchers (Section 8 FUP) for child welfare families.
- FMF highlighted the need to more carefully consider the possibly unique needs of families who are homeless, child welfare involved, and struggling with serious and persistent substance abuse addictions.
- The project enhanced collaboration at the management level with the department of Supportive Housing and Homelessness.

The SFHA / SF-HSA relationship has spurred other collaborations for the benefit of children in the child welfare system. Over breakfast at a Children's Bureau convening, the Director of Program Development for child welfare and SFHA's Director of Leased Housing hatched a plan to provide housing choice vouchers to potential foster care families who agreed to expand their foster care capacity for at least five years. Aimed at expanding capacity to keep foster children in the city of San Francisco, this initiative is the first of its kind. Although funding constraints at SFHA have temporarily prevented program launch, the initiative is ready to launch as soon as vouchers become available. In another innovation, SFHA has agreed to allow SF-HSA to use a handful of its FUP vouchers preventatively. HPP is in the process of launching Jelani House – a residence for homeless pregnant women who would likely qualify for risk of entry into the child welfare system as soon as the children

were born. The goal is for these mothers to graduate to stable housing in San Francisco, a goal that will be possible with SFHA's assistance in using SF-HSA FUP vouchers.

Impact on Supportive Housing System

The close working relationship among SFHA, SF-HSA and HPP that emerged through FMF impacted the way supportive housing is provided in San Francisco. It led to a voucher roll-over mechanism: as San Francisco's FUP vouchers hit full utilization, SFHA is moving stabile FUP families to regular housing choice vouchers, freeing up FUP vouchers so that more families can be referred to program. This is codified in SFHA's Administrative Plan. When SFHA suspended all voucher referrals due to financial challenges, SFHA secured an exception for BFH families already in the housing pipeline. More broadly, the FMF model of assigning a housing broker to help each SFHA client find and lease a property has now become a city-wide model. SFHA changed their Administrative Plan so that vouchers are allocated to agencies. In return these agencies agree to provide support as clients navigate the housing process.

In 2016 three Bay Area housing authorities submitted a rent reasonableness study and succeeded in increasing HUD's fair market rents to a viable amount. Prior to this adjustment, the majority of FMF families were forced to move out of San Francisco with their vouchers, a lengthy and bureaucratic process known as "porting". Attempts to ease the burden for families led to a regional, HUD-funded initiative to streamline porting among Bay Area housing authorities. Now being championed by the housing authorities themselves, this initiative could become the basis for similar work across the nation.

Similarly, SF-HSA manages a state-funded program that provides two-year rent subsidies to homeless families receiving TANF. To help families locate and settle into housing, SF-HSA contracts with one of the city's largest community-based organizations that services homeless families, Hamilton Families. As with the pre-2016 Housing Choice Voucher program, many of the families receiving rent subsidies are forced to relocate out of county to communities that are more affordable.

The FMF project created a space for San Francisco to examine family homelessness in a more regional context and begin developing protocols with surrounding counties to ensure families' stability and success across jurisdictional lines. In the last year, SF-HSA has developed a pilot with Hamilton that focuses on Contra Costa County (a common destination for homeless families moving out of the city) and aims to develop specific processes and partnerships to support families. Goals of the pilot include:

- Expedited case transfers between county TANF offices.
- Developing neighborhood resource guides that are specific to communities and that provide newly arriving families with a complete list of all needed connections, from grocery stores to school special education offices. The colorful, easy-to-read packets contain maps, public transportation guides, contact lists, and tips for new arrivals.
- Instructions for Hamilton case managers on how to connect their clients to new Health Maintenance Organizations in their communities.
- Improved linkages with employment programs and resources in the new counties, as well as regular case conferences between Hamilton case managers and SF-HSA employment specialists to review the employment and other needs of parents placed out of county.
- Facilitated transfer of child care subsidies between counties.

The pilot is still young, and the two agencies will be reviewing implementation challenges and client outcomes next year.

The enhanced profile of the FUP project has also helped foster collaboration between SF-HSA and San Department of Homelessness and Supportive Housing (HSH). SF-HSA and HSH are collaborating closely on a number of initiatives, among them SF-HSA's FUP voucher program. Discussions are currently underway to integrate HSA's BFH families into San Francisco's Coordinated Entry system, ensuring that they receive the highest level of housing support for which they qualify. BFH Families who qualify for on-site supportive housing will receive it. Families who qualify for rapid rehousing subsidies (typically still necessitating that the family move out of San Francisco to afford rent) will be given a FUP voucher, if they are eligible. Early conversations are also seeking to help homeless parents whose children are removed: these individuals often fall between systems (not qualifying for family housing, but needing a safe space to begin to reunify). Together the two agencies are looking for options to support these parents.

Section XIII. Recommendations

Recommendations to Administrators

Building a successful program for complex families requires complex service planning across systems. That complexity introduces challenges. In anticipation of those challenges, we offer the following recommendations to administrators considering a supportive housing model for child welfare-involved families.

1. Treat cross-system collaboration as distinct goal. Budget for a project manager whose job it is to cultivate the collaboration and measure its progress.
2. Consider that adding process and team-based approaches generally adds rather than reduces the time it takes to accomplish tasks.
3. Have a clear logic model that maps the theory of change, uses analytics to monitor fidelity, and have a structure in place to review analytics and adjust implementation as necessary (it will be necessary).
4. Cultivate inter-agency relationships at all levels of the organization: line staff to leadership
5. Consider deposits and move-in costs when budgeting for housing.
6. Carefully consider the definition of homelessness adopted, whether that of the Department of Education or that of the McKinney-Vento Homeless Assistance Act, and train workers on the definition so that in planning and operations, there is a consistent understanding of what is meant by saying that a family is homeless.

Recommendations to Children's Bureau

1. Include a substantial planning period for any complex initiative. At minimum, that planning period should be six to nine months, but if it is a newly developed initiative, the planning period should be a least one year.
2. Consider structuring the evaluation into a least two discreet discrete stages: The implementation evaluation, if designed with an explicit CQI framework, should start during the project-planning year. The outcome evaluation should follow full implementation, and should include a modest process focus that monitors program fidelity.
3. Consider funding a separate demonstration focused specifically on creating a housing first model specifically designed to serve families who have longer timelines to reunification.
4. Use annual convening and cross-site visits so that implementers can exchange knowledge.

Recommendations to the Child Welfare and Housing Felds

1. Refer families as early as possible, given the theory of change, i.e., if the intervention seeks to prevent deeper involvement with particular systems, it must be delivered well in advance of the outcomes to be avoided. However, a multi-system, team-based approach to complex families requires a great deal of coordination and information sharing, particularly in the beginning, in order to understand the family's needs and circumstances. We believe that families are best set up to succeed when that coordination of baseline information has been established prior to bringing the family into the intervention. What that means in terms of timing along the child welfare case process will vary by jurisdiction. In many places in California, the right time might

be after the initial court process is complete and the case moves to an ongoing child welfare worker.

2. Develop data use agreements and begin sharing information across systems early, during the planning phase so that each partner understands the collective picture and so that any difficulties with data sharing, legal or practical, are identified early. “Early” cannot be overstated. For this project, we began seeking data sharing agreements in the 2013 planning period and by the end of 2018 not all agreements were achieved.
3. Based on FMF’s analysis of sequence, homelessness often precedes child welfare involvement. Given the difficulties of mobilizing multiple systems once a homeless family is engaged in the child welfare system, it would be advantageous to use research evidence and administrative data from child welfare to focus local prevention resources – housing and family support -- on those homeless families with the greatest risk for child welfare involvement.
4. Consider efforts to more clearly understand intersections and distinctions in the sub-population of families who are homeless, child welfare involved, and struggling with serious and persistent substance abuse addictions. These families may benefit from a more targeted intervention that include an explicit partnership with an entity focused on combating addiction. Child welfare jurisdictions with a drug court option may be especially good candidates for this recommendation.
5. Specify clear role distinctions among the family’s team members – child welfare worker, housing case manager, housing specialist, etc. Understand that it does not work to have the same person play more than one of these roles. That said, the child welfare worker can help gather vital documents for the housing application process. Separate the housing-search function from the case management, recognizing that the challenges of finding housing are consuming.
6. In the Bay Area, the frequency of families taking local housing vouchers or subsidies and using them in other communities and jurisdictions compounded the difficulties in providing aftercare. The aftercare support system needs to be geographically flexible, and able to follow families or provide warm-handoffs to providers in the new community that can provide intensive services.
7. Given the challenges of finding housing in high-rent communities, consider bridging families to their permanent housing with interim apartments, not creating a new transitional housing program, but providing a wholesome, safe place for families while they search for permanent housing.
8. If relying on Family Unification Program Housing Choice Vouchers, work with the local housing authority to understand how they might modify their Annual Plan to lower barriers for program families.

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Appendices

Appendix I. FMF Evaluation Report Appendices

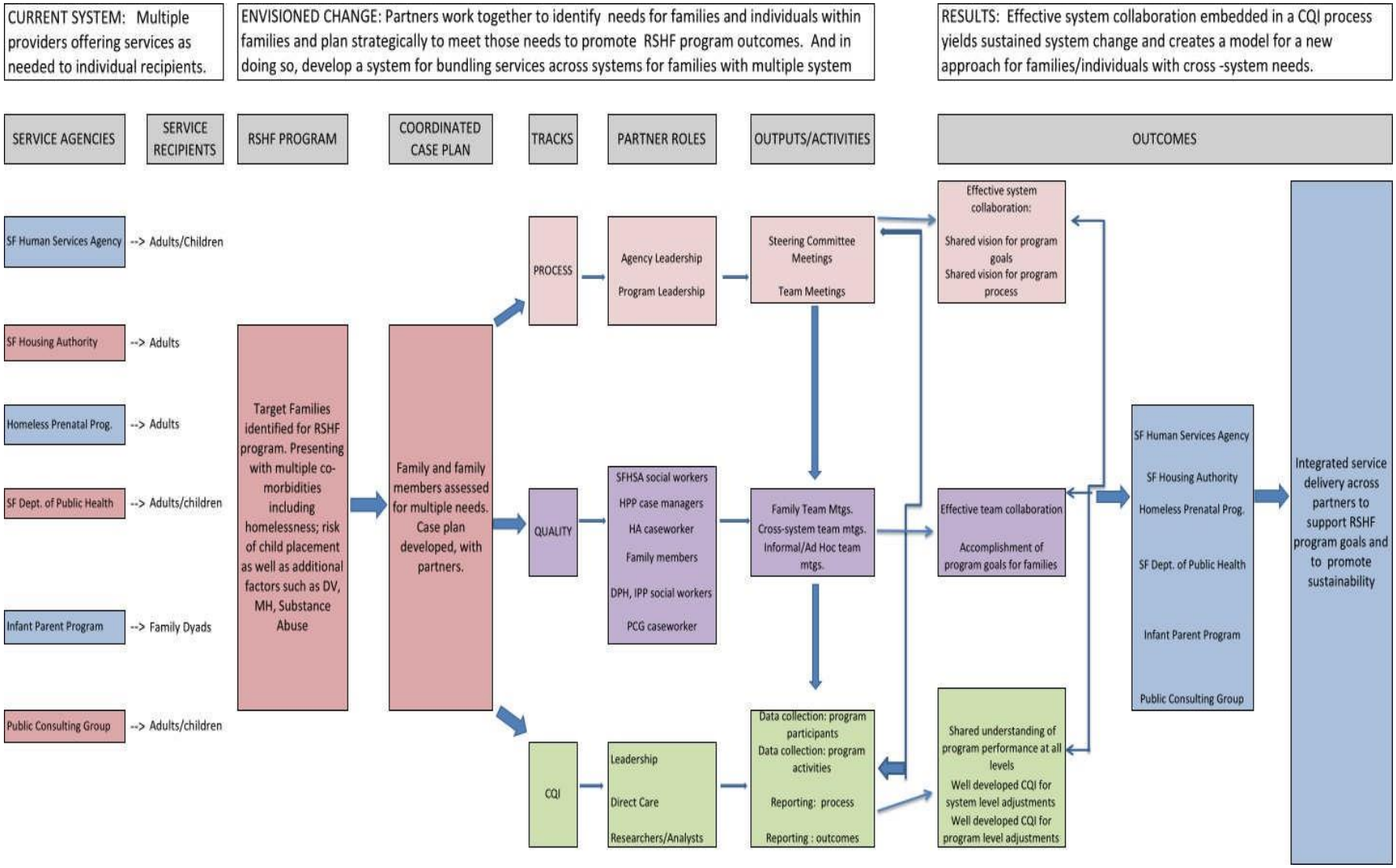
Appendix A. City and County of San Francisco Definition of Homelessness

City and County of San Francisco Definition of Homelessness

The term "homeless" includes individuals or families who lack a fixed, regular, and adequate nighttime residence and who have a primary nighttime residence in one or more of the following categories:

1. Shelter
   - Anyone staying in a mission or homeless or domestic violence shelter, i.e., a supervised public or private facility that provides temporary living accommodations.
   - Anyone displaced from housing due to a disaster situation.
2. Street
   - Anyone staying outdoors; for example, street, sidewalk, doorway, park, freeway underpass.
3. Vehicle
   - Anyone staying in a car, van, bus, truck, RV, or similar vehicle.
4. Make-Shift
   - Anyone staying in an enclosure or structure that is not authorized or fit for human habitation by building or housing codes, including abandoned buildings ("squats") or substandard apartments and dwellings.
5. Doubled-Up
   - Anyone staying with friends and/or extended family members (excluding parents and children), because they are otherwise unable to obtain housing, or
   - Any family with children staying in a Single Room Occupancy (SRO) hotel room –whether or not they have tenancy rights, or
   - Anyone staying in temporary housing for less than 6 months, and the accommodations provided the person are substandard or inadequate, for example, garage, small room, overly crowded space.
6. Transitional
   - Anyone staying in a Single Room Occupancy (SRO) hotel room without tenancy rights, or
   - Anyone formerly homeless (formerly in one of the above categories) who is now incarcerated, hospitalized, or living in a treatment program, half-way house, transitional housing or
   - Anyone formerly homeless (formerly in one of the above categories) who has obtained supportive housing or permanent housing for less than 30 days. While we recognize that the issues that brought people to homelessness may take a lifetime to overcome, we believe that at a minimum, 90 days of wrap-around aftercare services should be provided for individuals exiting homelessness into permanent housing.

Appendix B. Systems-Level Logic Model



Appendix C. Housing and Engagement Challenges

Families Moving Forward (FMF) had the initial goal of serving 160 families over five years - enrolling 32 families a year into the FMF treatment group. This goal eroded in the face of unforeseen complexities: some inherent to program design, others due to external forces, all described below. Ultimately only 59 families were permanently housed. There were three main reasons for this: program design, systemic barriers to housing search, and caseload challenges.

Program Design

The first was an inevitable byproduct of intentional program design. FMF based its housing goals on the number of families referred to the program, assuming that most families referred would be housed. In reality, there was substantial attrition between selection as part of the FMF project and the end goal of housing and supportive services. Clients were automatically screened into the program almost as soon as their cases were promoted from the child welfare investigation to an open case. To ensure that the program truly reached a representative sample of the hardest to serve, no meeting occurred with the family to determine their readiness or willingness to be part of the program prior to their referral to the FMF lottery. Similarly, to ensure that the project was not 'creaming' the families most likely to succeed, no input was accepted from the child welfare worker regarding a family's likelihood of successfully engaging in the program and finding housing. A family's slot was held open for up to six months, even if they did not initially engage with the program or if their engagement was sporadic. This accommodating program design can lead to extended enrollment timeframes, delay housing in service of other goals, and lead to a higher rate of program exits

The combination of FMF's rapid referral and tolerant enrollment process meant that some families, dealing with the fresh shock of their entry into the child welfare system, took longer to meet with their FMF case managers, despite diligent outreach attempts by HPP. FMF's practice of referring all families to the lottery with no prior readiness assessment also meant that families entered the project with competing priorities. A number of clients entered the program mandated to residential treatment. FMF was initially operating under the hypothesis that families were being referred to residential treatment as a substitute for available housing. However, although it is difficult to know the counterfactual, the availability of housing did not change the fact that some families needed the structure and retreat of residential treatment and needed to complete treatment prior to beginning the housing search. A small number entered the program while simultaneously involved with the criminal justice system and needed to complete jail sentences prior to beginning the search for housing.

FMF's intentional strategy of referring all families without creaming and without regard to their probability of success meant that not all families engaged with child welfare and / or FMF in a timely enough fashion to reunify with their children. Serving all families allowed the demonstration project to better understand the families most likely to benefit from the Families Moving Forward approach, and it strengthened the randomized control treatment aspect of evaluation. An initial component of FMF program design was that parents would no longer qualify for the program once their Family Reunification Services had been terminated.

Systemic barriers to housing search

Even families actively engaged in housing search faced substantial time to housing. Mental health needs, substance use, and chaotic lives continue impacted the capability of some families to obtain necessary documentation (leading to delays in the application process) or to conduct housing search. Those that were able to engage in housing search faced daunting odds. Between 2011 and 2013 the average rent for a vacant unit in San Francisco, already extremely expensive, rose by 41%. The median price for a two-bedroom apartment in San Francisco in fall of 2013 was $4,000. HUD payment standards initially did not keep pace.[1] In 2013, 75% of families leaving shelter in San Francisco ended up resettling in communities 10 – 15 miles away. FMF's FUP voucher holders joined the outward migration to the wider Bay Area.

Initially hesitant, the FMF team began to help families consider the wider Bay Area for housing options from the outset. For the team this was a painful reckoning with the realities of San Francisco's rental market. Many project families considered San Francisco their home and did not want to look outside of the city until they had exhausted other options. For those families who were amenable, FMF worked to make the process as smooth as possible. The program's housing search approach made use of deep subsidy funding to pay the rent, acting as a 'bridge' to a FUP voucher. Even if a family had a FUP voucher in hand when they began their housing search, they would still have to port the voucher to the county in which they found housing. This made it difficult to know where to focus the housing search. Because housing was so hard to find, the team wanted to cast a wide net and look in many counties at once, but couldn't start the porting process until they knew where the housing would be. This was compounded by the complexity of keeping track of different payment standards, unit sizes, and regulations (such as how to handle reasonable accommodations) across different housing authorities. At the project's urging, the SFHA adopted more lenient admissions criteria for our FUP families. Although a neighboring housing authority cannot reject a portability request, they can rescreen a family using their own admissions criteria during the RTA process. Some families were rejected by the receiving housing authority at this late stage. Finally, communication challenges occurred when the team ventured outside of the successful, established relationship with the SFHA intake department. Lack of close contacts in other departments and at other housing authorities made it more difficult to track the status of individual vouchers and proactively intervene if difficulties arose. To help manage this complexity, FMF hired first one housing specialist and then a second.

Caseload challenges

The two factors above contributed to the third: FMF found itself with insufficient case managers to serve the originally projected caseload. The original project estimates for both the amount of time clients would be working with HPP (less than two years) and number of active clients per case worker (20) both proved inadequate for this very complex work. Only after the project launched did the team discover that existing, successful practice models have lower caseloads (12 – 15) and a longer time to work with families (5 – 7 years). Compounded by turnover among HPP staff, the FMF model as originally designed wasn't sustainable.

In November of 2015, the team paused intake of any new families into the program. HPP caseloads were at the maximum optimal levels and families were not yet graduating from the program. That situation

[1] In 2016 three Bay Area housing authorities submitted a rent reasonableness study and succeeded in increasing HUD's fair market rents to a viable amount.

was about to become much more acute because 3 of the 4 HPP case managers were transitioning to other jobs. November and December were seen as good months to pause the lottery because they were fairly slow enrollment months. In addition, the project was about 6 families ahead of its expected pace in its goal of enrolling 32 families a year. The process of hiring new case managers was underway and the case load challenges seemed temporary.

Program intake resumed in February of 2016, but in May it halted again, this time permanently. In making the decision, the team carefully considered available case management resources given the number of families currently enrolled and the levels of their need.[2] As of the end of May, 2016, 79 families had been randomized into the treatment group. Of those, a few never engaged or had exited, leaving 46 enrolled families served by three full-time case managers at HPP. The levels of need in the families was very high, particularly for the 23 families not yet housed. Had the caseloads grown to be unreasonably high, each family would have received less case management than they needed, on average. This was particularly problematic for families not yet housed, because as the demonstration project model posited, they are unlikely to benefit from efforts to help them make progress in their case plans while in a state of intensive distress due to homelessness. This translates to a bottleneck whereby families do not progress, step down in case management need, and eventually exit. The caseloads were unsustainable and would only continue to increase. The team made the difficult decision to devote their time to housing currently enrolled, homeless families as quickly as possible, followed by tending to their intensive case management needs. The hope was that adhering to this program model would lead to better outcomes for the families in the treatment group. The team felt that it was more important to allow currently enrolled families to get the dosage they deserve than to admit more families, diluting the dosage for all.

[2] The team also considered the impact that pausing the lottery would have on statistical power. Statistical power can come from either increasing the sample or increasing the effect size. If increasing the sample, large increases are needed in order to improve power. The rate of qualified families presenting to the lottery each month was too slow (about 5 families per month) to boost the sample enough to increase power by the end of the demonstration. Stopping enrollment allowed the team to focus on increasing the effect size, i.e., the number of families with positive outcomes. If the team could effect change (fewer placements, more and faster reunifications) for more families, the project would need fewer families to demonstrate program effectiveness.

Appendix D. Newborn Exclusion Rationale and Criteria

We further clarified our targeting criteria with respect to reunification cases. The intent was to only target families for whom the intervention was intended, i.e., prevention and reunification families. The logic was as follows.

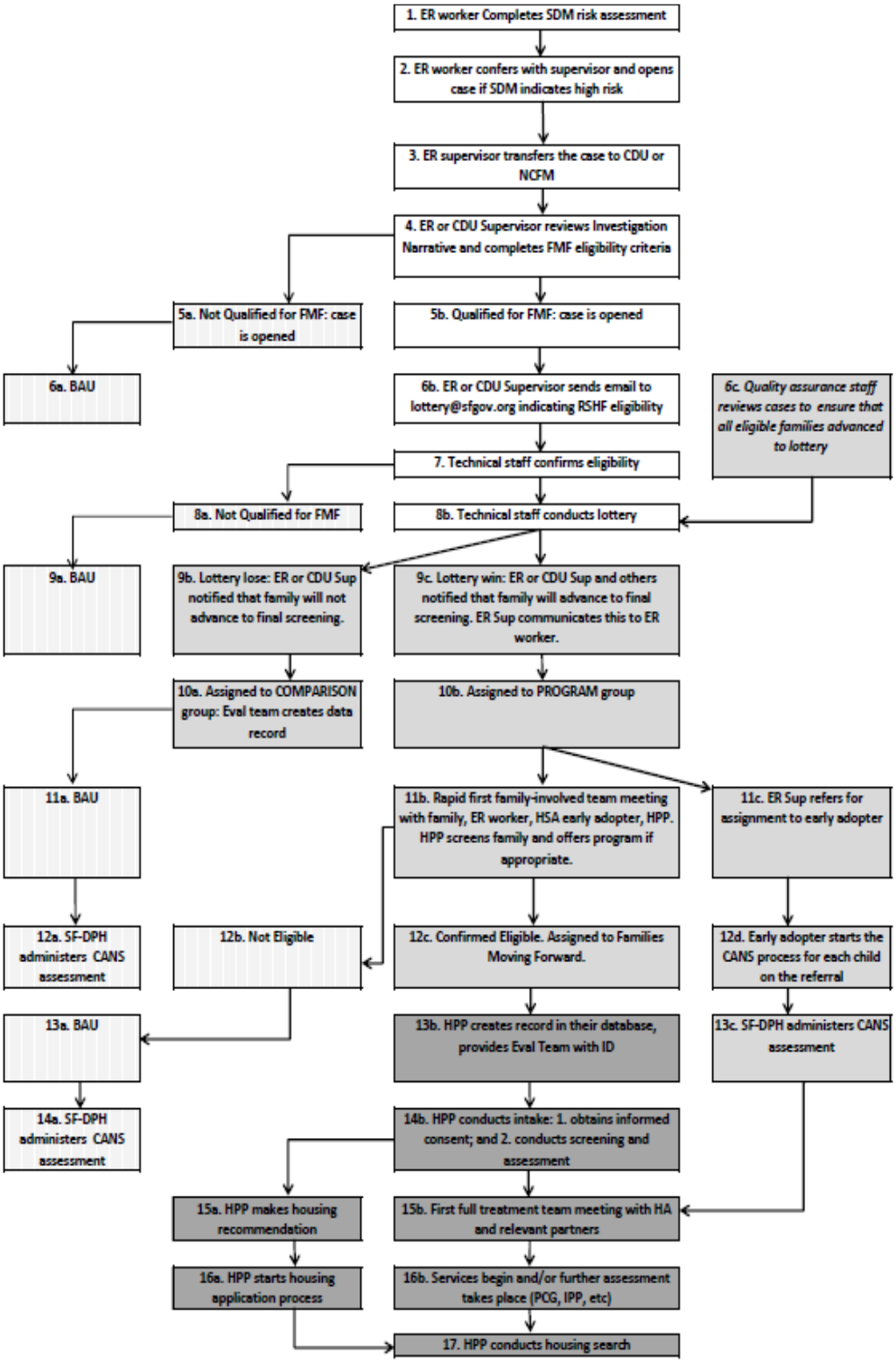
An in-home case signifies that a family is eligible for prevention because the children have not yet been placed into foster care. Similarly, a reunification case signifies that a family is eligible for reunification. However, during regular CQI reviews of homeless referrals to child welfare, we discovered that a small number of families were effectively unqualified for reunification but had not yet been formally designated as such in the administrative data. Under Welfare and Institutions code 361.5, these cases are typically tracked quickly to adoption, and reunification services are bypassed after relatively brief efforts fail. We also conducted a case review of 31 infants removed from home and randomly sampled from a five-year cohort of children who would have met FMF targeting criteria between 2008 and 2012. Together, the set of FMF referrals and cases reviewed revealed that these unqualified reunification cases were nearly always newborns removed soon after birth, and for whom all prior maternal siblings were permanently removed.

Such cases are initially designated as reunification and later changed to a case status indicating that reunification services had ended – once the court approves the plan. The FMF program sought to target families rapidly, within 30 days of the maltreatment investigation, so we could not wait until the case was formally transitioned out of reunification status. Instead, we chose to screen these cases out during the regular FMF screening phase. We identified and screened them out of the experiment according to the following two criteria, which are specified under the Welfare and Institutions 361.5 referenced above:

1. Newborn removed within the first 30 days of life AND
2. All prior maternal siblings have been permanently removed.

By these criteria, firstborn newborns were not excluded. Nor were newborns for whom siblings are in foster care in reunification status.

Appendix E. Referral Process Diagram



Appendix F. Lottery Protocol

People will conduct QA and run the lottery in the following order:
xxxx

Any member of the group is responsible for communicating to the rest of the group when they are out of the office.

Upon receipt of a new Families Moving Forward referral, complete the following:

Step	Tool
To Access the Lottery Spreadsheet: 1.) Open Explorer 2.) If not already, go to the HSA Intranet 3.) Click the "Web Mail" box on the upper left hand side of the page 4.) Login using your Outlook email/password 5.) When you have logged into your web based outlook, click the "Outlook 365" Box at the top. 6.) Click on the "OneDrive" box 7.) Open the Lottery Spreadsheet file 8.) Click "Edit Workbook" You have the option of working in Excel, or in browser, either one will work	OneDrive
1. Make sure that family has not already been submitted for FMF Eligibility	FMF Lottery Database
2. Make sure there is a program slot available	FMF Lottery Database
3. Check that case / referral numbers and names match	Safe Measures Database or CWS/CMS
3a. Make sure the referral ID is the same as the "initiating referral". If not, use the referral associated with the risk assessment. This should be the initiating referral. Use this ref ID for the lottery sheet as instructed in step 12 below. Add a comment with the ref ID sent by the ER sup for tracking purposes.	Safe Measures
4. Check that family was correctly categorized as homeless	The Investigative Narrative & SDM® (N12)
5. If the case is FR, there is only one child in the case, and the child was removed within the first 30 days of life, check to see if all prior children have been permanently removed (In CA or out of state). If yes, the family is not eligible for FMF.	CWS / CMS
6. Check that this is a new case	Safe Measures Database or CWS/CMS
7. Check that at least one of the children referred has had no prior cases (in CA or out of state).	Safe Measures Database or CWS/CMS
8. Check to make sure that there are no duplicate notebooks in CWS / CMS for this family	CWS / CMS
9. If there are duplicate notebooks, verify that there is still one child that has had no prior cases	CWS / CMS
10a. Ensure that a case has been opened.	Safe Measures or CWS/CMS
10b. Ensure that one or more risk factors is checked on the SDM® (Includes: N6, N9, N10, N11, A6, A7, A11 and Supplemental Question #2b or c.)	SDM® Reports
11. Check sex offender registry for names of all adults in the case	http://www.nsopr.gov/en/Search/Verification
12a. Enter the family into the Lottery Database tab. If the family is eligible, Create a sequential id for the family and enter information for each client. The mother should be listed first, as client #01. If there is no mother, create a #01 dummy row with the referral date. The mother will not have a case id. The father should be client #2. If there is no father, there is no #2. The father will not have a case id. Any additional guardian (not father or mother) should be #3**.** If there is a same-sex partner use #99. The children should be listed next in birth order, each with their separate case id. Each client name should be listed.	
12b. Enter the family into the Lottery Database tab. If the case is not eligible, do not assign ids to the family. Enter a single record into the Ineligible tab with the date and time of submission, a lottery result of "NA" and enter the reason for ineligibility.	
12c. Enter the other known fields in the Database tab. For DOB, make sure to use the format mm/dd/yyyy.	
Note: If this is not a referral by email, here's how to find the supervisor so that you can ask them clarifying questions. Pull up the referral and ensure that you are on the ID tab. Go to 'Action' and 'Client Disposition'. Select the client and hit 'ok'. On the next screen, select 'Approval'. On the approval screen, look to see who submitted the approval.	CWS/CMS
13. If everything looks ok (i.e., family appears eligible), run the lottery. Enter the family id that you just created for the family in the Lottery Database. Enter the case ids for children only into Random Assignment tool. Once you have submitted the family, enter the lottery result in the database.	https://secure.urban.org/SHARP

Appendix G. Evidence-Based Practices by Service Component

Intervention	Rationale	Evidence	Citations
Family Team Meeting			
The family team meeting uses the principles of family engagement, an evidence-based approach focused on building effective family participation and ensuring sustainable engagement.			
Family Team Meeting	The FTM accomplishes both outcomes-related and operational goals for RSHF. Evidence suggests that family engagement creates deeper and more sustained involvement on the part of families, thus increasing the likelihood that they will avoid negative outcomes such as separation or re-abuse and achieve positive outcomes such as housing stability, increased school attendance, and improved social and emotional functioning. From an operational perspective, it enables interdisciplinary teams to mobilize quickly and effectively. It promotes regular and open communication. It also builds on a process already in place at SF-HSA, and will thus be familiar to the child welfare case worker, ensuring that implementation will be as smooth as possible.	According to the U.S. Department of Health and Human Services Child Welfare Information Gateway, "a qualitative analysis … found that child and family involvement in case planning was correlated with (1) active engagement of noncustodial and incarcerated parents, (2) family-centered and strength-based approaches (e.g., team meetings, mediation) effective in building working relationships, and (3) strong rapport developed between workers and parents. (U.S. Department of Health and Human Services, 2009)." The Gateway also suggests evidence that parental involvement leads to more rapid reunification and to permanency in other ways (Tam & Ho, 1996; Merkel-Holguin, et al., 2003). Finally, it suggests that "Working collaboratively, caseworkers and families are better able to identify a family's unique needs and develop relevant and culturally appropriate service plans that address underlying needs, build on family strengths, and draw from community supports. A better fit in services often leads to a more effective use of limited resources (Doolan, 2005)."	-Doolan, M. (2005). The family group conference: A mainstream approach in child welfare decision-making. Presentation retrieved February 20, 2009, from www.americanhumane.org/assets/docs/protecting-children/PC-fgdm-conf-fgc2004.pdf -Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. Protecting Children, 18(1-2), 2-11. Retrieved March 1, 2009, from www.americanhumane.org/assets/docs/pprotectin-children/PC-pc-article-fgdm-research.pdf -Tam, T. S., & Ho, M. K. W. (1996). Factors influencing the prospect of children returning to their parents from out-of-home care. Child Welfare, 75(3), 253-268. -U.S. Department of Health and Human Services (HHS), Children's Bureau. (2009). *Results of the 2007 and 2008 Child and Family Services Reviews* cited in Child Welfare Information Gateway (2010).

Intake and Assessment			
Rather than just focusing on the adults or the children in isolation, the project's intake and assessment process allows case managers to look at the needs of the entire family. This will give those serving the family a broader perspective and allow them to establish service goals from different angles, and it provides a baseline of family functioning that permits the measurement of progress. The intake and assessment tools are the Adult Needs and Strengths Assessment (ANSA) for adults and the Child and Adolescent Needs and Strengths (CANS) assessment for children. They are the standard tools used by SF -DPH. The SF-DPH and HPP staff is trained on administration and the data are entered into existing databases, maximizing sustainability and minimizing cost and the potential for error.			
ANSA	The ANSA provides a framework for clinicians to work collaboratively with consumers to assess family stability (health, employment, mental health, residential stability, family functioning, social connectedness, substance abuse), and generates consistent, measurable data regarding efficacy across all programs. Client-level data that is captured over time is used to determine whether improvements at the item- and domain-levels have occurred. Measurement of change at the domain-level will involve development of a "reliable change index" to capture statistically significant changes in overall domain scores.	The Adult Needs and Strengths Assessment (ANSA) is based on the Severity of Psychiatric Illness (SPI) scale, but in addition to the psychiatric vulnerabilities measured by the SPI, the ANSA assesses client and caregiver strengths (Shaw 2007). The SPI has research supporting its validity and reliability for measuring psychiatric and social characteristics to determine service needs, level of care, and measure outcomes, with an inter-rater reliability of 0.87-0.89 (Lyons et al 1995). The ANSA has a reliability of 0.75 with vignettes, 0.84 with case records, and 0.90 with live cases (The Praed Foundation). An abbreviated version of the ANSA was used to assess 272 psychiatric patients over a 2 year period, and correctly determined the level of care needed with a predictive validity of 85.9% (Nelson and Johnston 2008). The ANSA has been used to assess and develop service plans for adults who have co-occurring mental disorders and homelessness (Foster et al 2010).	-Foster, S., LeFauve, C., Kresky-Wolff, M., & Rickards, L. (2010). Services and Supports for Individuals with Co-occurring Disorders and Long-Term Homelessness. *Journal of Behavioral Health Services & Research, 37*(2), 239-251. doi: 10.1007/s11414-009-9190-2 -Lyons, J. S., Colletta, J., Devens, M., & Finkel, S. I. (1995). Validity of the Severity of Psychiatric Illness rating scale in a sample of inpatients on a psychogeriatric unit. *International Psychogeriatrics, 7*(3), 407-416. -Nelson, C., & Johnston, M. (2008). Adult Needs and Strengths Assessment-Abbreviated Referral Version to specify psychiatric care needed for incoming patients: exploratory analysis. *Psychological Reports, 102*(1), 131-143. -The Praed Foundation (accessed 7/19/2013). About the ANSA. http://www.praedfoundation.org/About%20the%20ANSA.html -Shaw, M. F. (2007). *After the Insanity Defense: When the Acquitted Return to the Community*. New York: LFB Scholarly Pub. LLC. -Sieracki, J. H., Leon, S. C., Miller, S. A., & Lyons, J. S. (2008). Individual and provider effects on mental health outcomes in child welfare: a three level growth curve approach. *Children and Youth Services Review, 30*(7), 800-808.

CANS	The Child and Adolescent Needs and Strengths Assessment is a standardized tool that provides multi-system partners with understandable information about child and youth needs, as well as treatment recommendations that can be tracked. The CANS is administered to nearly all children entering foster care placement in San Francisco, and will soon be extended to all children in an open child welfare case, per a recent California legal settlement mandating improved screening of mental health needs among children in the child welfare system. The CANS is widely accepted as a reliable tool to determine service needs and strengths over time.	The CANS assessment (was developed to assess the service needs of children with behavioral and/or emotional health concerns and has been used with children in the child welfare system (Sieracki et al 2007). The CANS was used to assess children in the Illinois child welfare system who had caregiver-related trauma, finding that the CANS is a better predictor of placement disruptions than exposure to complex trauma related to caregivers alone (Kisiel et al 2009). A study of delinquent youth found that the CANS has moderate concurrent validity with the Child and Adolescent Functional Assessment Scale (CAFAS), a similar assessment tool with substantial research evidence supporting its validity and reliability (Dilley et al 2007). Yet another study found that the CANS has strong concurrent validity with the CAFAS, and trained CANS assessors have an average inter-rater reliability of 0.80 (Lyons 2009). Another study of the CANS-MH (mental health) found an inter-rater reliability of 0.85 (Anderson and Lyons 2003).	-Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale. *Journal of Child & Family Studies, 12*(3), 279. -Dilley, J. B., Weiner, D. A., Lyons, J. S., & Martinovich, Z. (2007). The Validity of the Child and Adolescent Needs and Strengths Assessment: Online Submission. -Johnson, T. (2012). Mapping the critical service needs of adolescent children of prisoners. *Social Work in Public Health, 27*(1-2), 45-68. -Kisiel, C., Fehrenbach, T., Small, L., & Lyons, J. S. (2009). Assessment of complex trauma exposure, responses, and service needs among children and adolescents in child welfare. *Journal of Child & Adolescent Trauma, 2*(3), 143-160. -Lyons, J. S. (2009). *Communimetrics : a communication theory of measurement in human service settings*: Springer. -Lyons, J. S., Anderson, R. L., & Estle, G. (2001). Child and Adolescent Needs and Strengths--Mental Health. *Predicting level of mental health care among children served in a delivery system in a rural state, 17*, 259-265. -Sieracki, J. H., Leon, S. C., Miller, S. A., & Lyons, J. S. (2008). Individual and provider effects on mental health outcomes in child welfare: a three level growth curve approach. *Children and Youth Services Review, 30*(7), 800-808.

HPP Case Management			
HPP's case management model integrates three main evidence-based practices: Motivational Interviewing, Solution-Based Casework and Signs of Safety. It also employs peer mentoring.			
Motivational Interviewing	Motivational Interviewing is a client-centered intervention technique that emphasizes relationship-building between client and practitioner and utilizes cognitive-behavioral strategies in order to elicit a client's verbalized motivation for change and create a framework for comparison with current behavior, drawing on the client's own vision for herself. Through Motivational Interviewing, HPP staff members hope to enhance internal motivation to change, to reinforce this motivation, and to develop a plan to achieve change.	Motivational Interviewing has been found effective in both reducing negative behaviors (e.g., problem drinking) and promoting positive health behavior changes (e.g., medication adherence) (Miller & Rose, 2009). A meta-analysis of studies involving Motivational Interviewing found that its effect increased when the intervention is paired with another treatment and the efficacy of these interventions did not fade significantly over time after treatment (Burke, Arkowitz & Menchola, 2003). Research also indicates that Motivational Interviewing can increase change motivation for female victims and male perpetrators of domestic violence (Hughes & Rasmussen, 2008 & 2010; Crane & Eckhardt, 2013). The research literature suggests that interventions incorporating motivational interviewing can improve retention in child and parent mental health programs (Ingoldsby, 2010).	-Burke, B. L., Arkowitz, H., & Menchola, M. (2003). Journal of Consulting and Clinical Psychology. 71(5), 843–861 -Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. Journal of Counseling Psychology, 60(2), 180-187. -Hughes, C. A. & Rasmussen, L. A. (2008). Applying Motivational Interviewing in a Domestic Violence Shelter: A Pilot Study Evaluating the Training of Shelter Staff. Journal of Aggression, Maltreatment & Trauma, 17(3), 296-317. -Hughes, C. A. & Rasmussen, L. A. (2010). The Utility of Motivational Interviewing in Domestic Violence Shelters: A Qualitative Exploration. Journal of Aggression, Maltreatment & Trauma, 19(3), 300-322. -Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. Journal of Child and Family Studies, 19(5), 629-645. -Miller, W. R. & Rose, G. S. (2009). Toward a theory of motivational interviewing. American Psychologist, 64, 527–537.

Solution-Based Casework	Solution-Based Casework focuses on the specific, everyday events that have caused difficulty for the family and prevented the accomplishment of goals. According to the California Evidence-Based Clearinghouse for Child Welfare (CEBC) "This model combines the best of the problem-focused relapse prevention approaches that evolved from work with addiction, violence, and helplessness with solution-focused models that evolved from family systems casework and therapy. By integrating the two approaches, family, caseworkers, and service providers can develop partnerships that account for basic needs and restore the family's pride in their own competence" (CEBC 2013). HPP's goal is to ensure families feel valued and competent to do their own work. Developing partnerships that lead to identifiable solutions in everyday family life is the best way to prevent future relapse.	Two retrospective case review studies found that Solution-Based Casework (SBC) resulted in and case workers more actively involved with case planning and service acquisition and significantly more families compliant with casework requirements and achieving goals and objectives. It additionally found that the approach was especially effective for families with a long history of involvement with the child welfare system (Antle, B. F., Barbee, A. P., Christensen, D. N. & Martin, M. H. 2008). A pretest-posttest control group study tracking child maltreatment recidivism for 6 months among 77 participants found that those assigned to the SBC treatment group had significantly fewer recidivism referrals when compared to the control group (Antle, B. F., Barbee, A. P., Christensen, D. N., & Sullivan, D. J. 2009). A recent retrospective review of select public welfare cases in Kentucky found that use of the SBC model was associated with better scores on the state's Continuous Quality Improvement tool and on federal outcomes related to Safety, Permanency, and Well-Being. Higher degree of use of the SBC model was associated with exceeding these federal standards (Antle, B. F., Christensen, D. N., van Zyl, M. A., & Barbee, A. P. 2012).	-Antle, B. F., Barbee, A. P., Christensen, D. N. & Martin, M. H. (2008). Solution-Based Casework: Preliminary evaluation research. *Journal of Public Child Welfare, 2*(2), 197-227. -Antle, B. F., Barbee, A. P., Christensen, D. N., & Sullivan, D. J. (2009). The prevention of child maltreatment recidivism through the Solution-Based Casework model of child welfare practice. *Children and Youth Services Review, 31,* 1346-1351. -Antle, B. F., Christensen, D. N., van Zyl, M. A., & Barbee, A. P. (2012). The impact of the Solution-Based Casework (SBC) practice model on federal outcomes in public child welfare. *Child Abuse and Neglect, 36,* 342– 353. - Solution-Based Casework. The California Evidence-Based Clearinghouse for Child Welfare. From http://www.cebc4cw.org/program/solution-based-casework/ (Accessed July 2013)

Safety Organized Practice	Safety Organized Practice *(Signs of Safety)* is used by both SF-HSA's child welfare workers and HPP. It is described as "a relationship-grounded, safety-organized child protection framework designed to help families build real safety for children by allowing those families to demonstrate their strengths as protectors over time... Central to this approach is meaningful family engagement and, in particular, capturing the voice of the child." (CEBC 2013)	A review of Minnesota administrative data found some evidence to suggest that Signs-of-Safety may be associated with a reduction in out-of-home placements for new cases and fewer children re-entering foster care. Qualitative findings from stakeholders in the same study reported a positive increase in family involvement, lower recidivism and increased safety and permanency, and increased use of evidence-based or research driven practices (Rothe, M.I., Nelson-Dusek, S., & Skrypek, M., 2013). A study in England found a number of strengths and opportunities with the model (Bunn, A., 2013).	-Bunn, A. Signs of Safety ® in England : An NSPCC commissioned report on the Signs of Safety model in child protection. National Society of the Prevention of Cruelty to Children at http://www.nspcc.org.uk/Inform/research/findings/signs-of-safety-pdf_wdf94939.pdf -Signs of Safety. The California Evidence-Based Clearinghouse for Child Welfare. From http://www.cebc4cw.org/program/solution-based-casework/ (Accessed July 2013) - Rothe, M.I., Nelson-Dusek, S., and Skrypek, M. (2013). Innovations in Child Protection Services in Minnesota *Research chronicle of Carver and Olmsted Counties.* Wilder Research.
Peer parent outreach and support	HPP's peer case managers are former clients or other members of HPP's target demographic (low-income, formerly homeless, involved, etc.). They work within an organizational context that values authenticity of experience: almost one third of all HPP staff are former clients. Over the past 24 years, HPP has found that peers are uniquely equipped to engage families in sustained relationships. These relationships help families overcome their isolation and connect them to housing, family resource centers, and trauma-informed services. The peer-to-peer connection inspires trust while modeling proof that success is possible, resulting fuller engagement in HPP services.	Research indicates that peer mentors can provide a model for communication with social service professionals, help parents secure additional assistance from social service programs, and may also support relapse prevention for parents struggling with substance abuse (Berrick, Young, Cohen & Anthony, 2011). Research has also found that individuals receiving services through Kentucky's Sobriety Treatment and Recovery Teams (START), an integrated service program that relies on parent peers with at three years in recovery, had twice the sobriety rates and less than half the child placement rates than parents receiving typical practice (Huebner, Willauer & Posze, 2012). A recent child welfare study in Washington also found that parental trust in child protective services and engagement with the court process increased in parents who participated in a peer support program (Summers, Wood, Russell & Macgill, 2012).	-Berrick, J. D., Young, E. W., Cohen, E., & Anthony, E. (2011). 'I am the face of success': Peer mentors in child welfare. Child and Family Social Work, 16(2), 179-191. -Huebner, R. A., Willauer, T. T., & Posze, L. L. (2012). The impact of sobriety treatment and recovery teams (START) on family outcomes. Families In Society: The Journal Of Contemporary Social Services, 93(3), 196-203. -Summers, A., Wood, S. M., Russell, J. R., & Macgill, S. O. (2012). An evaluation of the effectiveness of a parent-to-parent program in changing attitudes and increasing parental engagement in the juvenile dependency system. Children and Youth Services Review, 34(10), 2036-2041.

Housing Assistance			
Homeless families tend to have multiple and interlocking issues that require comprehensive and holistic approaches, but they are not able to productively utilize the support services offered by child welfare while their housing is in chaos. The very experience of homelessness is deeply traumatic, and for families involved in the child welfare system, many of whom struggle with resilience, homelessness can be debilitating and magnify the family's underlying vulnerabilities. To prevent foster care placements, the child welfare system needs to mobilize more quickly to secure permanent housing and engage families in services that respond rapidly to their needs. Families that require housing assistance will vary in their needs, with housing assistance provided ranging from time-limited rental assistance through permanent supportive housing.			
Housing First Model	The Housing First philosophy holds that homeless individuals require stable housing before they can effectively address other treatment needs such as addiction and mental illness. It is intended to address housing needs from a consumer perspective, rather than requiring treatment programs as a condition for receiving housing. Positive results from Housing First programs demonstrate the value of being stably housed while offered supportive services. Most existing studies focus on single adults. One benefit of the RSHF project will be to contribute an understanding how Housing First models can support families.	Studies evaluating Housing First models have demonstrated promising results. A recent study evaluated a residential support facility for families with a history of foster care involvement. The model included case management and social support. The study found that it significantly reduced entry into the foster care system. (Lenz-Rashid 2013). An 18-month evaluation of a pilot for 518 families and individuals with extensive histories of homelessness and multiple complex issues found that participants experienced significant improvement in housing stability and lesser gains in health and well-being. Participants increased access to mainstream services, especially preventative care and use of prescription medications (National Center on Family Homelessness, 2009). A study comparing a Housing First treatment group with a traditional Continuum of Care control group concluded that Housing First results in better housing outcomes while providing the same treatment outcomes with lower service provision. (Tsemberis, Gulcur & Nakae 2004). A study of HUD's Veterans Affairs Supportive Housing found that, twelve months into the program, veterans in Housing First programs were eight times more likely to have maintained housing stability than a treatment-first control group (Montgomery, Hill, Kane & Culhane 2013). A study of a small program that works with homeless individuals who have a serious medical illness and a history of reliance on emergency medical care / sobering centers found that the treatment group had substantially lower emergency service utilization (Srebnik, Connor, and Sylla 2013).	-Lenz-Rashid, S. (2013) Supportive Housing for Homeless Families: Foster Care Outcomes and Best Practices. Sierra Health Foundation. -Montgomery, A. E., Hill, L. L., Kane, V., & Culhane, D. P. (2013). Housing chronically homeless veterans: evaluating the efficacy of a housing first approach to HUD-VASH. Journal of Community Psychology, 41(4), 505-514. doi: 10.1002/jcop.21554 -The National Center on Family Homelessness (2009) The Minnesota Supportive Housing and Managed Care Pilot Evaluation Summary -Srebnik, D., Connor, T., & Sylla, L. (2013). A Pilot Study of the Impact of Housing First-Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services. American Journal of Public Health, 103(2), 316-321. doi: 10.2105/AJPH.2012.300867 -Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health, 94(4), 651-656. doi: 10.2105/AJPH.94.4.651

Infant-Parent Program			
The Infant-Parent Program clinicians assigned to this Project will provide treatment to approximately 10 young children (0-5) together with their primary caregivers (biological and/or foster parents) in the first full year of the Project's implementation. Therapy will be offered though weekly visits that will take place primarily in the home, shelter or visitation site in order to gain a better understanding of the child's daily circumstances and to be heighten the likelihood that families are consistently seen. An essential component of dyadic treatment is the clinician's ongoing attempts to understand the influences on the adult-child relationship. Acknowledging the contribution of both partners, the intervention examines the interaction rather than exclusively focusing on the individual and addresses the transactions created between them (Fraiberg, 1980; Lieberman & Pawl, 1993; Lieberman, Silverman, & Pawl, 2000; Pawl & Lieberman, 1997). In treatment, the therapist tries to trace parental perceptions, attributions and actions toward the infant to origins in the parent's past or present circumstances. The baby's contributions, such as constitutional and physical characteristics, are examined with equal intensity for the meaning they hold for parent.			
Infant-Parent Program	By treating parents together with their infants, toddlers or preschoolers, the pattern of intergenerational transmission of trauma can be interrupted. The overarching goals of treatment are to enhance parenting capacities and improve the quality of the parent-child relationship thereby avoiding the recurrence of abuse or neglect and relational disruptions that led to the family's involvement in the child welfare system. By turning the tide of developmental difficulties as early as possible, young children's healthy development is optimally supported and the possibility of permanency is heightened.	IPP's treatment method is trauma-informed and evidence-based. Efficacy for this approach has been empirically documented in randomized trials with a high-risk group of infants and toddlers at IPP (Lieberman, Weston & Pawl, 1991). Findings from this National Institute of Mental Health-funded study and several that followed show that this treatment approach results in reduced child and maternal symptoms; more positive attributions of parents toward themselves and their children and their relationships with each other; improvements in the child-mother relationship and the child's attachment security (Cicchetti, Rogosch, & Toth, 2000; Lieberman, Van Horn & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen and Van Horn, 2006) Families- in these studies included maltreated preschoolers in the child protection system, and those exposed to domestic violence as well as infants and toddlers of depressed and/or traumatized mothers. At least seven published randomized outcome research studies now show that young children's functioning improves when treatment focuses on the parent-child relationship.	-Cicchetti, D., Rogosch, F.A. & Toth, S.L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers, 28(2), 135-148. -Lieberman, A.F, Ghosh Ippen, C. & VAN Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 45(8), 913-918. -Lieberman, A.F, VAN Horn P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry, 44(12), 1241-1248. -Lieberman, A.F, Weston, D.R. & Pawl, J.H. (1991). Preventative intervention and outcome with anxiously attached dyads. Child Development, 62(1), 199-209.

Available Programs and Services
Studies show that families living in poverty are often isolated from larger communities, often due to geographic disenfranchisement, community violence, language barriers, inaccessibility to education and employment (Coulton & Pandey, 1992; Wilson, 1987). The extensive roster of programs and services available through HPP and its partner organizations helps clients build a community and assists all case managers in establishing trusting relationships with clients in order to increase the likelihood of them accepting and participating consistently in support services. Clients will have access to a wellness center, which offers prenatal care and classes, alternative health services (e.g., acupuncture, massage, doula support), infant massage classes, and postpartum care for new mothers. They will have access to emergency food, shelter, transportation, household, baby and child needs, and financial services including tax preparation and filing, financial and legal counseling, and financial literacy training. Clients may use a drop-in childcare center with trained staff to observe and report on age-appropriate child development. They will have access to Five Keys Charter School to assist with obtaining a high school degree or a GED. They can attend classes in art, English as a second language, quilting, sewing, and writing as well as computers and internet job searches. This broad array of programs is evidence-based and serves a variety of purposes. Among these are parenting classes, psychotherapy for parents and children who have experienced trauma and/or are in crisis, and education support. We particularly wish to highlight these as key to RSHF.
Parenting Classes: HPP's 8-week *Positive Parenting* class is taught by a child development specialist and is a collaboration between HPP and City College of San Francisco. The class offer basic knowledge of parent and child growth and development designed to strengthen the family by providing alternative parenting methods (ages 0-18). Through class activities and discussion, participants learn positive behaviors that promote, motivate and support development of self-esteem in their children and affect appropriate, cooperative and healthy home environments. The course is open to all HPP clients, but includes slots for parents and caregivers who are mandated to participate by the child welfare services. An SF-DPH study of HPP's parenting class outcomes from July 2010 to June 2012 found that the class was achieving comparable results to other evidence-based programs in use by the City of San Francisco. Other FRC's in San Francisco use the *Incredible Years* and *Triple P* parenting programs. It is possible that parents may have an existing relationship with another FRC. As such, they may attend one of these other parenting programs as part of their comprehensive case plan.

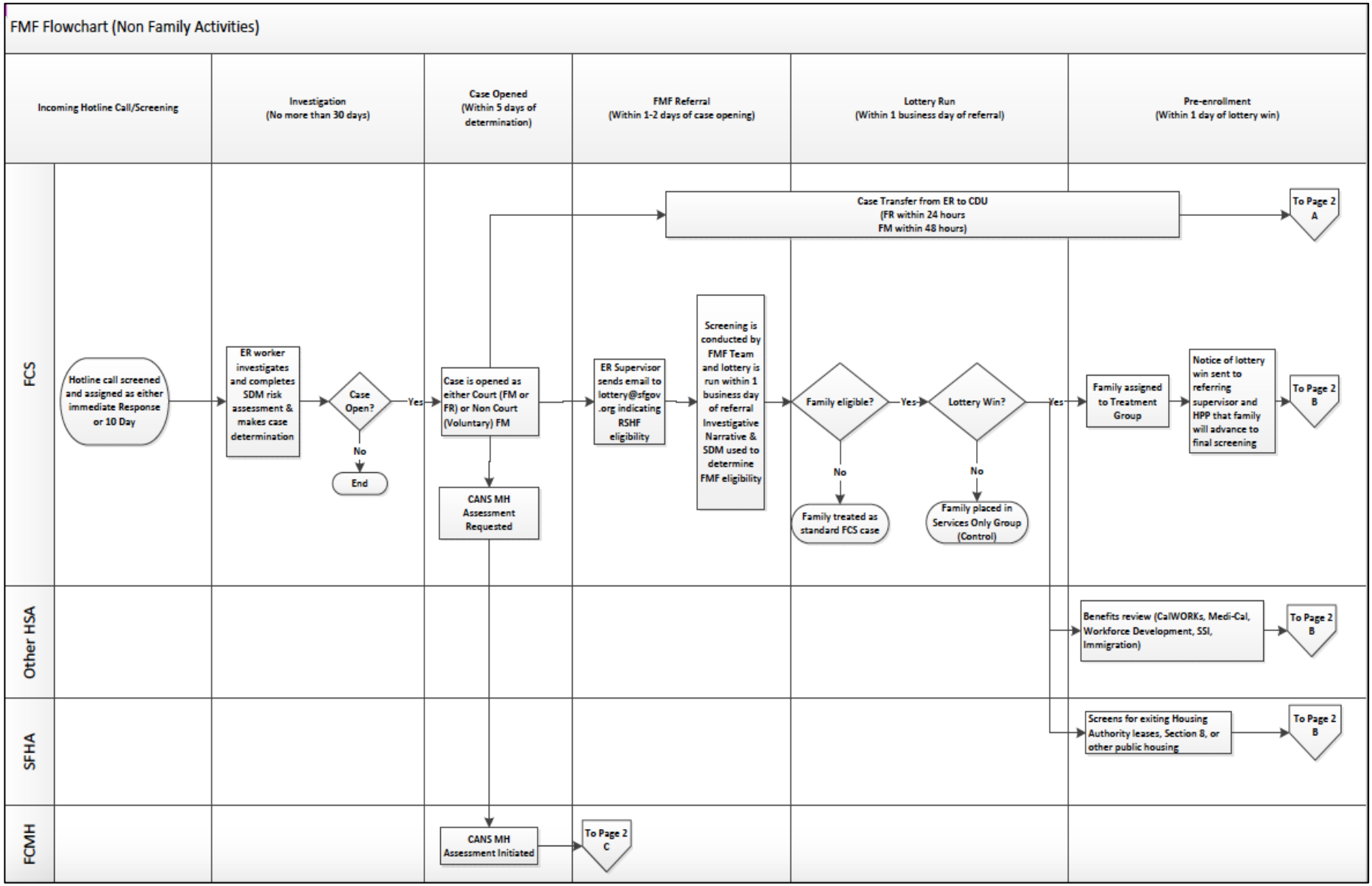
Positive Parenting Program	Positive Parenting Program (Triple P) is a worldwide model that gives parents access to parenting support and information regardless of socio-economic status. Triple P has been shown in a number of experimental studies to decrease problem behavior and increase academic performance in children while simultaneously decreasing rates of child abuse.	Evaluation results suggest that the program reduces over-reactivity and stress in parents, and improves child behavior (Romney & Zlatevski, 2011). A randomized control trial with approximately 85,000 participants involved families with children under the age of 8 with substantiated child maltreatment cases. It found that after 12 months, those assigned to the Triple P treatment group had significantly lower rates of substantiated child maltreatment, child out-of-home placement, and child maltreatment related emergency room visits or hospitalizations than the control group. (Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R., 2009). A separate study involving 3000 children between the ages of 4 and 7 who were making the transition to school compared the results of a Triple P treatment group to a group that did not receive the intervention. They found that the treatment group showed significantly greater reductions in the number of children with clinically elevated and borderline behavioral and emotional problems. Similarly parent reported stronger declines in depression, stress, and coercive parenting. (Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. 2008).	-Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009) Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial. Prevention Science, 10(1), 1-12. doi: 10.1007/s11121-009-0123-3 -Romney, S. & Zlatevski, D. (2011) Parent Training Institute: Triple P Evaluation. -Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., & Bidwell, K. (2008). A population approach to reducing behavioral and emotional problems in children making the transition to school. Journal of Primary Prevention, 29(3), 197-222.

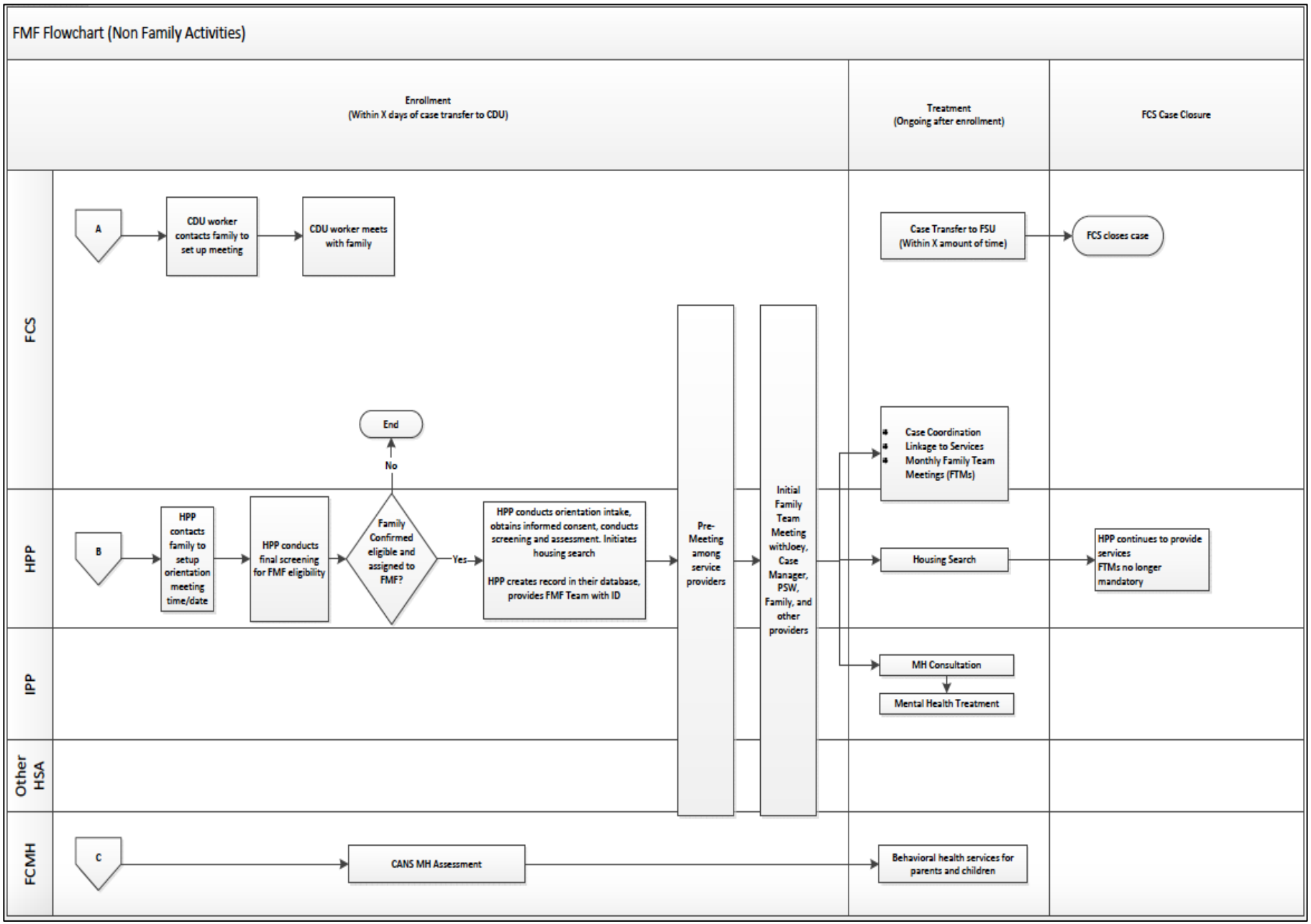
Incredible Years	The Incredible Years is a series of three programs designed to promote young children's emotional and social competence and to prevent and treat emotional and behavioral problems. It has been the subject of a number of randomized-control trial studies leading to articles in peer-reviewed journals. In particular it has been found to be effective with individuals with some of the complex issues (e.g. mental illness, substance abuse, trauma, domestic violence, etc.) prevalent among the high-risk population that is at the heart of RSHF.	A randomized control trial involving a low-income sample of African American, Hispanic, Asian and Caucasian mothers with children enrolled in Head Start found that mothers in the treatment group were "observed to be more positive, less critical, more consistent, and more competent" than those in the control group. Similarly their children exhibited fewer behavioral problems (Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. 2001). A later study found that parents with mental health risk factors (anger, depression, substance abuse or a history of abuse as a child) demonstrated equally positive engagement with and response to the program as those with no risk factors (Baydar, N., Reid, M. J., & Webster-Stratton, C. 2003). A later study with the same participants found that families initially recorded as having problems at baseline were those that benefited the most from the program and that mothers with the greatest involvement benefited the most (Reid, M. J., Webster-Stratton, C., & Baydar, N. 2004). A separate study found that the program was most effective with boys and those with more highly depressed mothers. It was at least as effective for parents with high-risk factors (such as being a teen or single parent or very low income) as for those without those risk factors. A change in positive parenting skill was predictive of a change in behavioral outcomes for the child (Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. 2010). According to the U.S. Department of Health and Human Services Child Welfare Information Gateway, Incredible years is cited by six separate registries of child welfare practices, more than any other evidence-based or evidence-informed practice.	-Baydar, N., Reid, M. J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. Child Development, 74(5), 1433-1453. -Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does It work? Moderators and mediators of outcome in an effectiveness Trial of a Parenting Intervention. Journal of Clinical Child & Adolescent Psychology. 39(4), 568-580. -Reid, M. J., Webster-Stratton, C., & Baydar, N. (2004). Halting the development of conduct problems in Head Start children: The effect of parent training. Journal of Clinical Child and Adolescent Psychology, 33(2), 279-291. -Reid, M. J., Webster-Stratton, C., & Beauchaine, T. P. (2001) Parent training in Head Start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. Prevention Science*, 2*(4), 209-227. - U.S. Department of Health and Human Services Child Welfare Information Gateway (2008). Parent Education: Evidence-Based and Evidence-Informed Programs retrieved 2013 from https://www.childwelfare.gov/pubs/issue_briefs/parented/programs.cfm

Psychotherapy for parents and children who have experienced trauma and/or are in crisis: SF-DPH and, in some cases, IPP will provide psychotherapy on a referral basis for those families for whom this is identified as a need. The exact location and provider for the service will be determined on a case-by-case basis.			
Trauma-Informed Cognitive Behavioral Therapy / Seeking Safety	As judged by SF-HSA's case file review, homeless families have very high levels of trauma, including domestic violence and child maltreatment. These interfere with their ability to mobilize themselves to meet their families' basic needs, such as housing, as well as the emotional well-being and safety of their family. Trauma-informed therapy is increasingly being used with children and adolescents who have experienced a spectrum of traumatic events that can adversely impact their development (Tishelman & Geffner 2010). Several models of trauma-informed therapy have been developed to treat co-occurring trauma and substance abuse, of which Seeking Safety (Najavits 2002) has been the most broadly applied and studied. Seeking Safety is intended to improve coping skills on cognitive, behavioral, and interpersonal, and case management domains.	The American Psychological Association recognizes "strong research support," for Seeking Safety as an effective treatment for adults with post-traumatic stress disorder (PTSD) and substance abuse. Similarly, the California Evidence-Based Clearinghouse identifies Seeking Safety as evidence based model for adults and a promising model for adolescents. A flexible approach, Seeking Safety has been used to address a variety of different types of trauma, including child abuse, domestic abuse, and neglect. Seeking Safety has also been successfully implemented in a variety of settings, including residential, domestic violence shelters, and homeless shelters. A scientific study found that women in a condensed Seeking Safety program have higher retention rates than treatment as usual (Ghee et al 2009). Improved program retention rates are associated with reduced relapse rates. Another study found that Seeking Safety reduces post-traumatic stress disorder PTSD (Wolff et al 2012). A sample of incarcerated women with a history of trauma was assigned to Seeking Safety treatment. The treatment group had a 67 percent completion rate. Participants were assessed with the PTSD checklist (PCL) at baseline and post-treatment. Overall, participants experienced an 8.5 point or 22 percent decrease on the PCL post-treatment. Participants with a higher PCL score pre-treatment experienced an even larger decrease of 22.8 points.	-Ghee, A. C., Johnson, C. S., Burlew, A. K., & Bolling, L. C. (2009). Enhancing Retention through a Condensed Trauma-Integrated Intervention for Women with Chemical Dependence. North American Journal of Psychology, 11(1), 157-172. -Najavits, L. M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In K. A. -Najavits, L. M., Gallop, R. J., & Weiss, R. D. (2006). Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. The Journal of Behavioral Health Services & Research, 33, 453-463 -Najavits, L. M. (2002). 'Seeking Safety' Therapy for Trauma And Substance Abuse. Corrections Today, 64(6), 136. -Tishelman, A. C., & Geffner, R. (2011). Child and Adolescent Trauma across the Spectrum of Experience: Research and Clinical Interventions. Journal of Child & Adolescent Trauma, 4(1), 1-7. doi: 10.1080/19361521.2011.545982 -Wolff, N., Frueh, B., Shi, J., & Schumann, B. E. (2012). Effectiveness of cognitive behavioral trauma treatment for incarcerated women with mental illnesses and substance abuse disorders. Journal Of Anxiety Disorders, 26(7), 703-710. doi:10.1016/j.janxdis.2012.06.001

Housing Support			
A major goal of this project is to help homeless families find and maintain safe, permanent housing. For some families, this home may be their first. This project aims to ensure long term success, and therefore offers housing support from the HPP case management team. The peer case manager will offer practical support (i.e. paying related bills on time, taking out the garbage, keeping a home safe and clean, how to be a good neighbor, etc). Continuous services will be provided weekly and bi-weekly both in the office and at the family's home, depending on the need of the family. The purpose of frequent contact is to identify early threats to stability and provide clients with support or guidance needed to remain stably housed. Engagement of and contacts with clients will happen via phone calls, as well as office and home visits to assess the client's need for food, furniture, household essentials (dishes, pots and pans, linens), baby supplies, etc. Staff will also continue to offer general support to determine if the clients are taking steps to improve their lives, such as payment of rent and utilities, meeting with doctors, getting to work on time, and getting their children to school. These visits can also provide clients with a support system to help them overcome issues such as depression and isolation that might curtail their progress.			
Home Visiting	The lives of homeless families are chaotic, and the functioning of the household has been undermined by the tumult and trauma of the experience that led to becoming homeless. HPP will utilize home visiting techniques to ensure that families are able to practice suggested behavior changes in their homes.	Meta-analysis of studies addressing the effectiveness of home visiting found that home visiting does help families with young children, but was unable to identify the consistent effects of specific program characteristics (Sweet & Appelbaum, 2004). A randomized trial of a home visiting program in Arizona found that the program had an effect on violent parenting behavior, parenting attitudes and practices, parenting support, mental health and coping, and maternal outcomes (LeCroy & Krysik, 2011). Scholars disagree about the effectiveness of home visiting: while some research suggests that there is little evidence that home visiting programs directly prevent child abuse and neglect (Howard & Brooks-Gunn, 2009), other research shows that home visiting programs can prevent child abuse, reduce low birth weights and the health of young children (Peacock et al, 2013) improve family functioning and prevent placement of children in at risk families (Scannapieco, 1994).	-Howard, K & Brooks-Gunn, J. (2009). The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect. Future of Children, 19(2), 119-146 - Peacock, S., Konrad, S., Watson, E., Nickel, D.; Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. BMC Public Health, 13(1), 17. -LeCroy, C. & Krysik, J. (2011). Randomized Trial of the Healthy Families Arizona Home Visiting Program. Children and Youth Services Review, 33(10), 1761-1766. -Scannapieco, M. (1994). Home-based Services Program: Effectiveness with at Risk-Families. Children and Youth Services Review, 16(5-6), 363-377. -Sweet, M. & Appelbaum, M. (2004). Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families with Young Children. Child Development, 75(5), 1435-1456.

Appendix H. FMF Intake Flowchart




FMF Flowchart (Non Family Activities)
Enrollment
(Within X days of case transfer to CDU)
Treatment
(Ongoing after enrollment)
FCS Case Closure
FCS
HPP
IPP
Other HSA
FCMH
A
CDU worker contacts family to set up meeting
CDU worker meets with family
Case Transfer to FSU
(Within X amount of time)
FCS closes case
End
No
B
HPP contacts family to setup orientation meeting time/date
HPP conducts final screening for FMF eligibility
Family Confirmed eligible and assigned to FMF?
Yes
HPP conducts orientation intake, obtains informed consent, conducts screening and assessment. Initiates housing search
HPP creates record in their database, provides FMF Team with ID
Pre-Meeting among service providers
Initial Family Team Meeting withJoey, Case Manager, PSW, Family, and other providers
Case Coordination
Linkage to Services
Monthly Family Team Meetings (FTMs)
Housing Search
HPP continues to provide services
FTMs no longer mandatory
MH Consultation
Mental Health Treatment
C
CANS MH Assessment
Behavioral health services for parents and children

Appendix I. Lottery Suspension Justification

The FMF program and evaluation teams jointly decided to suspend the lottery for a second time as of the end of May, 2016. Before doing so, we carefully considered available case management resources given the number of families currently enrolled and the levels of their need. We also considered the impact that pausing the lottery would have on statistical power.

As of the end of May, 2016, 79 families were randomized into the treatment group. Of those, a few never engaged or exited, leaving 46 enrolled families served by three full-time case managers at HPP. The levels of need in the families were very high, particularly for the 23 families that were not yet housed. Unreasonably high caseloads meant that each family received less case management than they need, on average. This was particularly problematic for families not yet housed, because as the demonstration project model posited, they were unlikely to benefit from efforts to help them make progress in their case plans while in a state of intensive distress due to homelessness. This translated to a bottleneck whereby families cannot not progress, step down in case management need, and eventually exit. Therefore, current caseloads were unsustainable and would only continue to increase if the lottery were to remain on.

Statistical power can come from either increasing the sample or increasing the effect size. If increasing the sample, large increases are needed in order to improve power. The rate of qualified families presenting to the lottery each month was too slow (about five families per month) to boost the sample enough to increase power by the end of the demonstration. Stopping enrollment allowed us to focus on increasing the effect size, i.e., the number of families for whom we see positive outcomes. If we could affect change for more families (e.g., fewer placements, more and faster reunifications), we would not need as many total families to demonstrate that the program was effective.

We reasoned that our effort was best spent devoted to housing currently enrolled, homeless families as quickly as possible, followed by tending to their intensive case management needs. Adhering to this program model should lead to better outcomes for the families in the treatment group. We determined that it was more important to allow currently enrolled families to get the dosage they deserved than to admit more families, diluting the dosage for all.

Appendix J. Examples of an Early and a Mature Implementation Dashboard

Early Implementation Dashboard (October 2015)

		Treatment		Pilot	
#	Component	Current Active Total	New in Report Month	Current Active Total	New in Report Month
1	Families randomized to FMF	**73**	3	**12**	
2	Families in referral > 30 days with no FTM[1]	7	2	0	
3	Families Enrolled in FMF (First FTM held)[2]	**62**	2	**8**	
4	Families in referral > 30 days with no FTM, >10 service hours[1]	2	1	4	
5	Families for whom initial ANSA is complete	57	4	12	
6	Program Graduations[3]	0	0	1	0
7	All other exits that had at least one FTM	7	1	1	0
8	Exits that never engaged	1	0	0	0
9	Families Currently Enrolled[4]	**55**		**10**	
10	Families in Inactive Status[4]	5	1	0	0
11	Families in Check-in Status	4	0	7	0
12	Families Currently Active in FMF (subtracting inactive and check-in)	**46**		**3**	
13	FMF Active Families for whom all Child Welfare Cases are closed	14	0	3	0
14	Enrolled Families with Subsequent Child Welfare Cases Opened[5]	0	0	2	0
15	FTM's Indicated (not including Initial Team Meetings)[6]		29		
16	FTM's Held (not including Initial Team Meetings)[2]		21		0
17	Families with at least 5 hours of HPP direct services[7]		28		0
18	Active Housed Families	**20**	**0**	3	0
19	Active Families with at least one home visit this month		21		0

20	Active Housed Families with at least one home visit this month		8		0
21	Families in adult inpatient treatment facilities	7	0	0	0
22	Families currently using shallow subsidies	1	0	0	0
23	Families currently using deep subsidies	10	1	0	0
24	Families currently housed in Holloway				
25	Families currently holding FUP voucher	17	0	12	0
26	Families using LOSP	7	0	0	0
27	Families housed with a lease (deep or shallow subsidy funding)	8	1	0	0
28	Families housed with a lease (FUP, LOSP, or public housing)	16	3	11	0
	Total families housed	**24**	**1**	**11**	**0**
26	Families housed outside of SF	9	0	4	0
27	Families working with IPP	6	6	0	0
28	Families with a JobsNOW!! Position	0	0	0	0
29	Families with a CALWORKS caseload	27	1	5	0
30	Families that are CalFresh or MediCal only	19	0	6	0
31	Families in SafeCare	19	0	2	0
32	Families referred to PCG	75	0	12	0
33	Individuals referred to PCG	104	0	17	0
34	Individuals screened by PCG	46	0	17	0
35	Families selected for outreach from PCG	75	0	17	0
36	Claims Under Development	0	0	0	0
37	Applications filed with Social Security Admin. (SSA)	3	2	2	0
38	Claims Denied by Social Security Admin. (SSA)	0	0	1	0
39	Appeals filed to Reconsideration Level	0	0	1	0
40	Individuals granted SSI/SSDI	0	0	0	0
41	Individual cases closed without receiving SSI	90	7	15	0

1) Does NOT include families who have exited FMF
2) Includes only FTMs where face_time > 0

3) Graduations are defined as exits from check-in status
4) Includes ONLY families who had at least one FTM for treatment families or an ANSA for pilot families
5) Includes any cases who were ever enrolled
6) Equals active families - families newly enrolled this month - families for whom all child welfare cases are closed
7) Families are counted only if there have been at least 30 days since referral. HPP's "total time" is used.

Mature Implementation Dashboard (September 2018)

			Treatment	
#	**Component**	**New in Report Month**	**Active**	**Cumulative**
1	Families randomized to FMF	0		**79**
2	Families enrolled in FMF (First FTM held)[1,2]	0	70	70
3a	Program graduations[3]	6		36
3aa	Graduates with a completed exit interview	12		36
3b	*Housed exits that are not graduations**	*1*		*11*
3c	*Exits that had housing and lost it prior to exiting**	*0*		*1*
3d	Exits where reunification services were terminated	0		19
3e	Exits that never engaged or became uengaged	0		15
3f	Partially met goals	1		5
3g	Exits for ineligibility	0		1
3e	Exits for other reasons (e.g. incarceration)	0		2
4	Families in check-in status	0	1	
5	Re-opened FMF cases	0	0	2
6	Families currently active in FMF (subtracting check-in families, includes re-opened cases)		0	
7	Families with at least 5 hours of HPP direct services[7]		2	
8	Active housed families	0	0	
9	Active housed families with at least one home visit this month		2	
10	Active families currently searching for housing	0	0	
11	Families currently housed at Holloway	0	0	0
12	Families housed with temporary funding (deep or shallow subsidy funding)	0	0	1

13	Families housed with long-term funding (FUP, LOSP, public housing, self, or other)	0	1	47
14	Families housed outside of SF	0	0	23
15	Families currently working with IPP	0	0	12
16	Families with a JobsNOW!! position			
17	Families with a CalWORKS case	0	0	65
18	Families that are CalFresh or MediCal only	0	0	12

Notes

1 This counts all families that had at least one FTM where face_time >1.

2 Equals all families who ever enrolled (ONLY families who had at least one FTM) - [(Program Graduations + Housed Exits that are not Graduations + Exits who were housed, lost housing and then exited+All Other Exits (25;not shown))]+Reopened FMF Cases

3 Graduations are defined as housed exits from check-in status

* These exits are double counted below

Appendix K. Justification to Include Reunification Cases

During the first year of implementation the planning team decided to open the FMF eligibility criteria to include reunification cases. We analyzed data on homeless referrals over the first three months of implementation, as well as similar data for the prior five years. What we learned is that the small number of FMF referrals in the first quarter of implementation may have been due in part to the fact that when San Francisco does place children, we tend to place them soon after referral. Two-thirds of children who would have been eligible for the program over the past five years were placed within 30 days of the maltreatment report. That was too fast for the FMF program to identify and screen in families because the targeting criteria relied upon a full investigation that could take up to 30 days.

Therefore, programmatically, it made sense to open the FMF program to reunification cases. It was difficult to predict how many additional eligible referrals would occur with this change because the monthly counts were low with significant fluctuations. However, we estimated that it would increase the number of monthly referrals to the lottery, on average, allowing us to fill our 32 slots per year and develop our control group to be of similar size.

We maintained our criteria that at least one child in the family must have had no prior cases or placements, and all FMF families were to be enrolled at the beginning of their cases. As such, we remained true to our intent to intervene as early as we can with families in order to alter their course towards more positive outcomes.

We recognized the possibility that splitting the target group into two – preservation and reunification – could yield not enough families in one or both groups to detect the specific prevention effects we were looking for.

Like the preservation group, the reunification group was high-need and at elevated risk for poor long-term outcomes. Specifically, about one-third of placed children over the past five years who would have been eligible ultimately returned to their families. This was compared to approximately half of children in the broader placement population.

Appendix L. Dissemination Products

REPORTS, MANUAL, AND PODCAST

Lery, B. & Haight, J. (2018). Case vignette: Designing information systems for effective project implementation. In James Bell Associates, Guide to Data-Driven Decision Making: Using Data to Inform Practice and Policy Decisions in Child Welfare Organizations. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Everroad, J. & Woodall, K. (2018). Housing's Critical Connection to Child Welfare. Child Welfare Information Gateway podcast.

Everroad, J., & Lery, B. (2017). Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System: Lessons from San Francisco, CA. Administration on Children, Youth, and Families and United States Interagency Council on Homelessness brief.

Milton, L., Bowersox, D., Roberts, C., Fishleder, M., Nedelko, Y. Woodall, K. (2017). Families Moving Forward Case Management Model: Policies & Procedures. Homeless Prenatal Program, San Francisco, CA.

MANUSCRIPT UNDER REVIEW

Lery, B., Haight, J., & Roscoe, J. Skills for collaboration: Training graduate students in homelessness intervention research. Journal of Social Work Education, Special Issue on Advancing Social Work Education to Meet the Grand Challenge of Ending Homelessness.

FMF-RELATED RESEARCH COMPLETED UNDER THE NATIONAL CHILD WELFARE WORKFORCE INITIATIVE STUDENT TRAINING PROGRAM

Ness, T. (2018). School Outcomes Among Children in the Families Moving Forward Experiment. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

Agnew, E., Kopp, A., & Seuylemezian, Ani. (2018). Analysis of Public Benefits Uptake in the Families Moving Forward Program. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

Cheung, B. & Tuomi, C. (2018). Families Moving Forward: Family Resource Center Use. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

Galan, M. (2017). The Impact of Families Moving Forward on Access to Referrals and Services. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

Abramson, D., Wapman, M., & Wright, H. (2017). Families Moving Forward: A Descriptive Analysis of Child Well-Being. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

Becerra, M., Gerber, A., & Thompson, D. (2016). Tracking Mental Health Screenings for Homeless Families in a Child Welfare Program. Final paper for MSW requirement, UC Berkeley School of Social Welfare.

PRESENTATIONS AND TRAININGS

Lery, B., & Haight, J. Skills for Collaboration: Training Graduate Students in Homelessness Intervention Research. Submitted for presentation at the Society for Community Research and Action annual meeting, Chicago, June 2019.

Haight, J., Lery, B., & Rhodes, E. Outcomes from a Supportive Housing and Child Welfare Experiment. Submitted for presentation at the National Conference on Child Abuse and Neglect, Washington, DC, April, 2019.

Milton, L. Everroad, J., & Lery, B. Reshape Foster Care as a Support for Families. Submitted for presentation at the National Conference on Child Abuse and Neglect, Washington, DC, April, 2019.

Haight, J., Lery, B., Rhodes, E., Thompson, D. The Effects of a Supportive Housing Program on Reunification from Foster Care. Accepted for presentation at the Society for Social Work and Research annual meeting, San Francisco, CA, January, 2019.

Lery, B., Haight, J., Roscoe, J., Thompson, D. Child Well-Being Effects of a Supportive Housing Program for Families Involved with Child Welfare. Accepted for presentation at the Society for Social Work and Research annual meeting, San Francisco, CA, January, 2019.

Everroad, J. & Lery, B. FUP Yeah! Housing Vouchers and Child Welfare in the San Francisco Bay Area. Day-long technical assistance to King and Snohomish Counties. Seattle, WA, November 5, 2018.

Haight, J., Lery, B., Rhodes, E., & Packard-Tucker, L. Speaking Evidence to Power: Balancing client self-determination, service equity, and rigorous evaluation. Presented at the American Evaluation Association annual meeting, Cleveland, OH, October, 2018.

Lery, B., Haight, J., Implementation Findings from a Housing and Child Welfare Cross-System Collaboration. Presented at the European Scientific Association on Residential and Family Care for Children and Adolescents biannual meeting, Porto, Portugal, October, 2018.

Lery, B., Everroad, J., & Milton, L. CQI Tips and Tricks for Smarter, Faster, Better BFH Implementation. Technical assistance webinar, August, 2018.

Lery, B. What Families Should be Living in Supportive Housing vs. Rapid Re-Housing? Invited panelist at Bringing Families Home: Serving the Most Vulnerable Families Convention, San Francisco, CA, October, 2017.

Lery, B. Making Use of What's Here: Linking CWS/CMS and SDM® Data to Fuel a CQI Process. Presented at the California Child Welfare Council, Data Linkage and Information Sharing Committee, San Francisco, CA, September, 2017.

Lery, B. Roadmap to Child Welfare and Supportive Housing Partnerships. Panel presented at the Corporation for Supportive Housing Summit, Denver, CO, May, 2017.

Lery, B., Haight, J., Rhodes, E., & Thompson, D. Implementation Findings from a Housing and Child Welfare Cross-System Collaboration. Presented at the American Public Human Services Association National HHS Summit, Baltimore, MD, May, 2017.

Lery, B., Haight, J., Feldman, S., & Alpert, L. Setting up for Success: Principles of Big Data Practice and the Science of Implementation. Presented at the Society for Social Work and Research annual meeting, New Orleans, LA, January, 2017.

Protection Involvement Among Young Adults Receiving Homeless Services. Presented at the California Child Welfare Council, Data Linkage and Information Sharing Committee, Sacramento, CA, December, 2016.

Lery, B. CQI in a Supportive Housing Program: What We Thought, What We Learned, What We Did. Presented at the National Council on Crime & Delinquency annual meeting, Garden Grove, CA, October, 2016.

Johnson, K., & Lery, B. Strengthening Social Service Agency CQI Efforts. Presented at the National Council on Crime & Delinquency annual meeting, Garden Grove, CA, October, 2016.

Lery, B., Haight, J. Triage: Who, When, and How Much. Presented at the National Conference on Child Abuse and Neglect, Washington, DC, September, 2016.

Haight, J. & Lery, B. Cross-System Collaboration as a Child Welfare Intervention and Outcome. Presented at the National Conference on Child Abuse and Neglect, Washington, DC, September, 2016.

Lery, B., Haight, J. & Fowler, P. Cross Systems Collaboration: A Framework within Child Welfare and Supportive Housing. Presented at the Society for Prevention Research annual meeting, San Francisco, CA, June, 2016.

Lery, B., Haight, J., Alpert, L., & Putnam-Hornstein, E. Cross-System Collaboration as a Child Welfare Intervention and Outcome. Panel presentation at the Society for Social Work and Research annual meeting, Washington, DC, January, 2016.

Putnam-Hornstein, E , Lery, B., Hoonhout, J., & Curry, S. A Retrospective Examination of Child Protection Involvement Among Young Adults Receiving Homeless Services. Paper presentation at the Society for Social Work and Research annual meeting, Washington, DC, January, 2016.

Lery, B. Targeting High Need Families for Supportive Housing. E-class presented for the Center for Supportive Housing, May, 2015.

Lery, B. Targeting: Who, When, and How Much? Presented at the National Council on Crime & Delinquency annual meeting, San Diego, May, 2014.

Lery, B. Supportive Housing as a Platform for Child Welfare Reform: Perspectives on System Change from Five National Demonstration Projects. Presented at the National Conference on Child Abuse and Neglect biannual meeting, New Orleans, May, 2014.

Lery, B. Using Administrative Data to Target Children for a Homelessness Intervention. Presented at the National Conference on Child Abuse and Neglect biannual meeting, New Orleans, May, 2014.

Lery, B., Feldman, S., & Torrevillas, T. Moving the Needle: A New Look at Targeting as a Way to Achieve Results at Scale. Presented at the National Association for Welfare Research and Statistics, Chicago, August, 2013.

Lery, B. Aligning Housing Needs with Housing Options. Presented at the National Alliance to End Homelessness annual meeting, Washington, DC, July, 2013.

Lery, B. Targeting: Who, When, and How Much. Presented at the National Alliance to End Homelessness annual meeting, Washington, DC, July, 2013

Appendix M. Family and Staff Interviews

Family Interviews – Round 1

Experience with service process

Please think back to when you first heard about Families Moving Forward.

- How did you first find out about the program (i.e. HSA or HPP)? How was the program explained to you? Did it make sense? Was there any information you wish you had known about the program earlier?
- What was your experience with the first family team meeting and follow-up FTMs (if applicable)?
    - Did you feel comfortable? Were the right people in the room? Do you feel that your needs were heard and addressed?
- Have you ever had a home visit? If so, how would you describe your experience with the home visit(s)?
- Did you receive an assessment (CANS, ANSA, HAM) at any point?
    - If so, did you think the assessment was relevant and a good use of your time?

Satisfaction with HPP

Next, I'd like to talk about your experience working with your HPP case manager.

- What were your expectations for working with HPP?
    - Were you familiar with HPP before joining FMF?
- What is your relationship like with your HPP case manager?
    - Is s/he helpful? Is there anything you think s/he could do better, or that you wish s/he did differently?
    - Do you feel like [name] is good at meeting your needs? Does [name] meet you where you're at?
    - Has your relationship with [name] changed over time? How so?
- How frequently do you interact with [name]? Would you prefer more or less interaction?
    - How do you interact with [name]? (For example, over the phone, in person at the HPP offices, in person at your home, etc.)
    - Has how or how much you interact with [name] changed over time since you became involved with this program?
- What has [name] helped you with directly through HPP?
    - Probe for: finding a job, applying for benefits, HPP programs
- Did your HPP case manager [name] [or anybody else on your case management team] ever refer you to services at an organization other than HPP?
    - If so, what did they refer you to (probe for IPP, mental health)?
    - Did you follow through on the referral and if so were these referrals were helpful? If you did not follow up the referral, why not?
- Overall do you think HPP has helped you? How could they help you more?

The path to housing

Next, I'd like to talk about the part of the program related to finding you housing.

- When you first became involved with this program, what were your expectations for what the program would do for you in terms of housing?

- Could you tell me about your experience with the process of getting (or trying to get) a **housing voucher**?
    - How was the process explained to you? Did you end up with a voucher/subsidy that is a good fit for your family?
- How [was *or* is] your experience with the **housing search**?
    - What [were *or* are] you looking for with regards to housing? What are your considerations (eg location, space, schools etc)?
    - What [worked *or* is working] well? What [were *or* are] the challenges? Is there anything that anyone on your team could [have done *or* do] differently to improve the process?
    - Who supported you in the process of searching for housing? (E.g. housing broker). Would you have liked more support from anyone?
- [IF THE RESPONDENT HAS NOT BEEN HOUSED]: What are the next steps that you and your team will take in order to get you housed?
    - How has your team responded to challenges in getting you housed?
- [IF THE RESPONDENT HAS BEEN HOUSED]: How was your experience with the process of **moving in**?
    - What types of supports did you get to move in (eg deposit, furniture, moving, etc)?
    - Would you have liked more support?
- Is there anything else that I should know about your experience with the housing process?

Coordination between service providers

Next, I'm going to ask about how the people from different organizations worked together to support you, especially in relation to your child welfare case.

- How well do you feel like your HSA case worker understands the FMF program? Has [HSA name] ever talked to you about the FMF program? Did they help explain the program to you?
- Did [HSA name] and [HPP name] coordinate with each other?
    - From what you could tell, how well do/did [HSA name] and [HPP name] work together?
        - Were they consistent in what they told you?
        - Do you think they're talking to each other?
- How did [HSA name] and [HPP name] work together to help close your case? What could they have done to make this process smoother?
- Are you receiving services from IPP? If so, what has your experience been?
- Has PCG helped you apply for SSI? If so, how have they been able to help you?

Is there anything else you think we should know about the program? Do you have any questions for me?

Thank you very much!

Family Interviews – Round 2

Experience with service process

Please think back to when you first heard about Families Moving Forward.

- How did you first find out about the program (i.e. HSA or HPP)? How was the program explained to you? Did it make sense? Was there any information you wish you had known about the program earlier?
- What was your experience with the first family team meeting and follow-up FTMs (if applicable)?
    - Did you feel comfortable? Were the right people in the room? Do you feel that your needs were heard and addressed?
- Have you ever had a home visit? If so, how would you describe your experience with the home visit(s)?
- Did you receive an assessment (CANS, ANSA, HAM) at any point?
    - If so, did you think the assessment was relevant and a good use of your time?

Satisfaction with HPP

Next, I'd like to talk about your experience working with your HPP case manager.

- What were your expectations for working with HPP?
    - Were you familiar with HPP before joining FMF?
- What is your relationship like with your HPP case manager?
    - Is s/he helpful? Is there anything you think s/he could do better, or that you wish s/he did differently?
    - Do you feel like [name] is good at meeting your needs? Does [name] meet you where you're at?
    - Has your relationship with [name] changed over time? How so?
- How frequently do you interact with [name]? Would you prefer more or less interaction?
    - How do you interact with [name]? (For example, over the phone, in person at the HPP offices, in person at your home, etc.)
    - Has how or how much you interact with [name] changed over time since you became involved with this program?
- What has [name] helped you with directly through HPP?
    - Probe for: finding a job, applying for benefits, HPP programs
- Did your HPP case manager [name] [or anybody else on your case management team] ever refer you to services at an organization other than HPP?
    - If so, what did they refer you to (probe for IPP, mental health)?
    - Did you follow through on the referral and if so were these referrals were helpful? If you did not follow up the referral, why not?
- Overall do you think HPP has helped you? How could they help you more?

The path to housing

Next, I'd like to talk about the part of the program related to finding you housing.

- When you first became involved with this program, what were your expectations for what the program would do for you in terms of housing?
- Could you tell me about your experience with the process of getting (or trying to get) a **housing voucher**?

    - How was the process explained to you? Did you end up with a voucher/subsidy that is a good fit for your family?
- How [was *or* is] your experience with the **housing search**?
    - What [were *or* are] you looking for with regards to housing? What are your considerations (eg location, space, schools etc)?
    - What [worked *or* is working] well? What [were *or* are] the challenges? Is there anything that anyone on your team could [have done *or* do] differently to improve the process?
    - Who supported you in the process of searching for housing? (E.g. housing broker). Would you have liked more support from anyone?
- [IF THE RESPONDENT HAS NOT BEEN HOUSED]: What are the next steps that you and your team will take in order to get you housed?
    - How has your team responded to challenges in getting you housed?
- [IF THE RESPONDENT HAS BEEN HOUSED]: How was your experience with the process of **moving in**?
    - What types of supports did you get to move in (eg deposit, furniture, moving, etc)?
    - Would you have liked more support?
- Is there anything else that I should know about your experience with the housing process?

Coordination between service providers

Next, I'm going to ask about how the people from different organizations worked together to support you, especially in relation to your child welfare case.

- How well do you feel like your HSA case worker understands the FMF program? Has [HSA name] ever talked to you about the FMF program? Did they help explain the program to you?
- Did [HSA name] and [HPP name] coordinate with each other?
    - From what you could tell, how well do/did [HSA name] and [HPP name] work together?
        - Were they consistent in what they told you?
        - Do you think they're talking to each other?
- How did [HSA name] and [HPP name] work together to help close your case? What could they have done to make this process smoother?
- Are you receiving services from IPP? If so, what has your experience been?
- Has PCG helped you apply for SSI? If so, how have they been able to help you?

For Families Living at Holloway

- What was your previous situation? How did you end up at Holloway?
- How long do you expect to be at Holloway?
- What do you want to happen next? What are you doing to find permanent housing?
- Do you understand the different roles of staff—HPP, HSA, Hamilton?
- What would you have liked to have been done differently for housing and services? How can the program serve other families better?

Is there anything else you think we should know about the program? Do you have any questions for me?

Thank you very much!

Staff Interviews

This list contains all questions that may be asked during an interview. There are separate lists of questions depending on the role of the administrator. Two or more respondents will be asked each set of questions.

Background (for all respondents)

1. What is your position and title?
    a. How long have you held this position?
    b. What services does your agency provide? How many staff do you have?
    c. What is your agency's role in FMF? What is your role?

Ongoing Implementation

a. How are (housing/other) services you provide through FMF different from the (housing/other) services your agency regularly provides?
    a. Housing, supportive services
b. How is the model specifically different (probe for supportive housing, housing first, harm reduction)?
    a. How does housing first guide decision making about the services you provide?
    b. What steps do you take to secure housing?
c. What is the target population for your program? How is this different, if at all, from the target population for FMF?
d. Please describe the process participants go through when they are first referred to the program. How are they screened and assessed? Have there been changes in how families are referred to FMF/ your program or their willingness to enroll?
e. How do project partners work together to identify the needs of participants and connect them to services? What tools/protocols have been developed to support this process? How is the process different from your non-FMF work? How can this process be improved?
f. Describe any specific practices (eg motivational interviewing) your agency uses when working with participants. How receptive have FMF participants been to these practices? Have you needed to adapt these practices for the FMF project or adopt any new practices? Can you tell me about how you use motivational interviewing techniques when you work with clients?
g. How does the clients' involvement in the child welfare system, if at all, change how you deliver services? For FR families, does the housing impact their ability to reunify?
h. How does your program meet the cultural and language needs of families in your program?
i. How receptive are FMF clients to enrolling in your program and receiving services? How does your staff work with at-risk families who are hard to engage in services? Differences for FM vs. FR?
j. How do you make referrals to other services and supports for families in the community? How do you coordinate these referrals with project partners (i.e. HPP?) How well do families understand the reason for these referrals and how likely are they to follow-up? Are you able to follow-up to find out if families who are referred actually get the services they are referred to?
k. In your experience, what have been the biggest challenges your program faces in serving families? What kind of assistance have you received, and from whom, to meet these challenges?
l. What challenges/barriers have you faced and how have implementation procedures been improved over time? How do you think they can be improved further moving forward?
m. For HSA PSWs: did you participate in case coordination meetings to transfer FMF cases between units (e.g. ER and CDU)? If so, were these meetings helpful and how could they be made more useful?

Ongoing Services, Monitoring, and Improvement (skip for HSA PSWs)

How are ongoing services reviewed?

a. Is there an effective process in place to assess the implementation process, discuss information on program operation, and identify opportunities for improvement? If so, how is information about program operation used to inform and improve the implementation process?
b. Do you use a database as part of regular program? Is this different for FMF? How do administrators interact with the database? How do practitioners use it? Have practitioners received any new trainings or certifications to improve practice?
c. How have early findings been used to improve the implementation process? Have new collaborations developed to facilitate quality improvement?

Systems Change

a. Has FMF changed how you collaborate with (HSA/HPP/DPH/HA/IPP/PCG)?
b. Are there any new or revamped systems in place to support this collaboration (e.g. referral processes, data sharing, etc)?
c. What resources were needed to support this collaboration or system (e.g. planning, people, data infrastructure, etc.)?
    a. What additional resources could help strengthen this collaboration/system?
d. How does this collaboration/systems change impact your ability to serve families?

Sustainability

e. Does your agency have a plan to sustain FMF (or components of FMF) beyond the grant period?
f. Have you identified resources to maintain the program beyond the grant period?
g. What components of FMF do you think should be sustained/replicated? Are there other program components you do not think should be sustained/replicated?
h. Looking back, do you have suggestions for how the pre-implementation planning and implementation processes can be improved for a program like FMF?

Wrap Up

We appreciate your time in talking with us. Is there anyone else you think we (the local evaluators) should make sure to interview? Is there anything else you would like to say regarding FMF?

Thank You!

Appendix N. Qualitative Summaries

Draft Interview Data Summary & Analysis

Interview Process & Methods
The evaluation team at Chapin Hall has reviewed and analyzed interview data collected from FMF project partners between June 2014 and March 2015. Analysis of these interviews with Families Moving Forward (FMF) staff, including both direct service and administrative staff, revealed that ongoing and emerging challenges are addresses even progress with full implementation continues. In total, 15 interviews with FMF staff —7 with the Homeless Prenatal Program (HPP) and 8 with the Human Services Administration (HSA)—were conducted and subsequently analyzed using ATLAS.ti software. The major themes covered in interviews were stages of implementation/planning, development of the FMF program model, and systems change/collaboration.

FMF Program Model
Below is a discussion of the development and adaptation of the FMF Program Model, Based, in part, on HPP's current case management framework.

Engagement and Assessment
A central feature of the FMF program model is the engagement with and support of high-needs families. Responses indicated that the program continues to reach high-needs families facing complex, multi-system challenges. They also indicated that the families participating in FMF are often highly appreciative of the intensive support they are receiving from the program.

The family's first engagement with the program is through the ER worker who fills out the investigative narrative to determine program eligibility. A respondent from HSA reported that the timeframe in which emergency response (ER) workers are required to complete the ER investigative narrative is too short, as they do not have the information (eg criminal background) necessary to complete it as quickly as the specified timeframe dictates. An ER supervisor also expressed concern that some of the FR families randomized into the program may never reunify with their families, making housing the entire family an unrealistic goal. Regarding potential improvements to engagement, one HSA staff respondent suggested that the program develop a system for tracking the strategies used to try to initially engage with clients. A system of this kind would make it possible to measure engagement over time and also understand the relative success of different engagement strategies.

With regards to assessment, FMF clients are slated to receive a set of assessments that are used to gauge their needs from multiple angles. Respondents reported that the mini-HAM (Housing Assessment Matrix) was used to score the family's level of housing-related need, and this score was then aligned to FMF's housing options in order to determine "what type of housing might best suit that particular family's needs." Responses from early interviews suggested that the use of the HAM had been adapted over time; in fact, since the time of these interviews, FMF has stopped using the HAM assessment tool because housing type has become less important—most families use a FUP and other assessment tools help able to identify families that qualify for a LOSP unit.

Adult clients are also assessed using the Adult Needs and Strengths Assessment (ANSA). Respondents indicated that they understood that the ANSA was supposed to be completed within a week of the family's first FTM, and then at 6-month intervals after that. The ANSA is used to develop a picture of

clients' histories and needs in order to determine what supportive services would be appropriate for him or her. In the words of one respondent, the ANSA "gives us the opportunity to really get a good perspective of the family and things that they need help with so that we can move forward in the program." While adults in client families are assessed using the ANSA, children in client families are supposed to receive the child version of the tool, the Child Assessment of Needs and Strengths (CANS), soon after their child welfare case opens. However, some respondents indicated that this process has encountered some delays. In addition to these assessments that are currently in use, one respondent suggested that the program would benefit from adopting a family assessment that considers the strengths, needs, and dynamics of the family unit as a whole.[3] Staff were in the process of identifying an appropriate family assessment at the time our interviews were being conducted.

Team Collaboration

Overall, direct care staff respondents reported high degrees of communication and contact between case team members across agencies. One major vehicle for interpersonal and interagency contact and communication is the Family Team Meetings (FTMs). FTMs are a central feature of the FMF program model, providing a consistent point of contact between frontline staff from all involved agencies, and establishing strong, multidimensional support for families. Interview respondents spoke highly of the FTMs, emphasizing the way in which they allow for cross-system coordination on a family's case and provide opportunities to build supportive relationships with the clients. Respondents also indicated that it was beneficial for both caseworkers and families to have a consistent team involved with a given case, as that provides a sense of stability and facilitates the ongoing development of collaborative relationships.

Respondents also mentioned certain challenges associated with the FTMs. First, multiple respondents from HSA indicated that the timeline within which caseworkers are supposed to hold the first Rapid Team Meeting is too short. Staff members reported that it was challenging to coordinate with all relevant parties so quickly, and felt that the limited timeframe did not allow them enough time to become fully familiar with the case. Similarly, respondents indicated that families were sometimes overwhelmed by the attempt—in the words of one frontline staff member—"to do everything all at once in that first meeting." Other respondents described that in the early phases of the case relationship, "families can be reluctant to bring their own family members to the FTMs" because they are not yet comfortable with the service team.

The complexities of case assignment also posed a challenge for case team collaboration. Many HSA staff indicated that there were insufficient procedures in place for making sure that FMF cases get assigned to early adopters—staff who are familiar with and trained on the FMF program model, and who volunteered to be involved with the FMF program. Both HSA and HPP respondents reported that families' progress can be stymied when their cases are assigned to staff who are unfamiliar with the program. HPP respondents discussed the challenges associated with working with someone who is unfamiliar with the program; this imposes an added burden on the HPP worker of having to explain the highly complex program to both the clients and the other staff members, and requires extra effort to

[3] This came from HSAR5. The expressed reason for adding a family assessment is that, while the CANS and ANSA provide strong clinical, individual information, a family assessment would be useful in trying to determine the needs of the whole family as a unit and address whole family dynamics/strengths/needs. The other argument is that a family assessment will be helpful before, during and after the CW case. They said that they haven't yet identified the family assessment to add, but they were actively looking at some, including the Family Decision Matrix (that First Five utilizes), the North Carolina Family Assessment Scales as well as others.

make sure that everybody is on the same page and working in tandem. Additionally, some respondents noted that some non-early adopters appeared to be guided by personal attitudes, ideologies or preferences rather than the program model. Respondents suggested that this lack of familiarity with the program stalls communication and can also stall progress on the case. HPP respondents also pointed out that there appeared to be insufficient measures in place to make sure that FMF cases go to early adopters, because they are often going to non-early adopters. Respondents also noted a related system barrier: the transfer of cases between child welfare workers, which typically happens twice during the first 60 days of an open case and can cause a great deal of delay for both interagency collaboration and family progress.

Since the initial interviews, the project leadership, acting through both the Services and the CQI committee, has refined the referral, case assignment and case transfer process within HSA, as well as the timing for the initial FTM. These refinements were made as part of the project's on-going implementation review and will be discussed in more detail in a subsequent evaluation report.

Supportive Services

A key aspect of the program model is the process of service partnership, wherein multiple San Francisco agencies form a service network—or a "consortium of providers"—provide supportive services that meet the various needs of the FMF clients. Respondents widely acknowledged the importance and utility of these service partnerships working together in the FMF program. Respondents also made some suggestions for improving the service partnership aspect of the program.

Some respondents suggested that FMF would benefit from clarifying the program's connections with CalWORKs and JobsNow, and making sure that the Linkages case coordination meetings are being held within a reasonable timeframe for all CalWORKs-involved clients. Another respondent suggested that FMF create a checklist of the resources and services (from this service network) that may be available to FMF clients for case managers to use for reference.

Respondents emphasized the utility of the supportive services provided to FMF clients as a result of these service partnerships. In particular, a number of respondents spoke highly of IPP's involvement in FMF, reporting that IPP had been very helpful in serving children and families, despite the fact that its services are limited to families that have a child under the age of 6. Respondents also noted that clients may attend supportive services programs within HPP, such as parenting classes, or through community organizations, such as outpatient treatment programs.

Furthermore, interviewees described how HPP staff provided clients with intensive, personalized support via workshops and one-on-one meetings targeted towards strengthening life skills necessary for the housing search, such as resume writing, interviewing with landlords, using Craigslist, and managing credit. However, respondents also indicated that it could be difficult for families to dedicate the required time and energy to supportive services while they are embroiled in the housing search process. As such, respondents suggested that case managers should manage the tension between the demands of the housing search and the dedication required to engage in supportive services. Several HPP staff indicated that this tension is heightened for FR families, where "everything is an immediate crisis".

Housing Search, Placement, and Advocacy

Housing families swiftly is the central element of the FMF program model; however, interview responses indicated that the program has encountered obstacles to achieving this programmatic goal in a rapid timeframe. Specifically, respondents indicated that the original goal of providing families with rapid

housing placements in San Francisco has proven to be very difficult, and FMF has had faced substantial challenges finding housing in San Francisco. Not only is the housing market in San Francisco very competitive, but the cost of housing in the city has also increased dramatically in recent years, such that housing vouchers based on past years' costs are now below the market rate.

Frontline staff emphasized that finding available housing for families was a significant challenge, as they were faced with limited housing options for which vouchers could apply, a limited supply of public or subsidized housing, and few landlords who were willing to take in "risky" tenants in exchange for below-market-rate vouchers and complicated program requirements. Respondents described how the program has built strong relationships with a small number of landlords who are enthusiastic about the FMF program and have housed several families. Nevertheless, relationships such as these require uniquely open-minded and willing landlords, and as one respondent noted, "finding landlords to build relationships with has been a little bit trickier." Some respondents suggested that the program would benefit from greater, more systematic engagement with and education of landlords. A more recent interview suggests that increased outreach to landlords is helping. Effective outreach includes explaining the section 8 voucher payment process, advocating for the families, and letting landlords know the families have the support of the program should there be any issues.

In light of the housing market challenges, FMF administrative staff have refocused on finding housing outside the city of San Francisco. While staff will continue their efforts to work with landlords to house FMF families in the city, HSA has also funded housing broker services through a separate grant with the Hamilton Family Center. The housing broker, who can assist two families at a time, works with HPP to find housing outside of the city for qualified families. Ideally, the housing broker identifies housing options based on families' needs and specifications, HPP staff shows these options to families, and then families make the choice. As of September 30, 2015, no families have been housed through the housing broker. HPP respondents reported that this was because the broker hadn't located any units that were eligible for section 8.

Due to these challenges and others, the program has struggled to achieve rapid housing for families. The delays caused by the difficult housing search are compounded by the need to coordinate various timeframes—such as the timing of a family's "lottery win" and entry into the program, the timeframes built into voucher agreements, and the narrow windows of availability of supportive housing units, etc.—with clients' needs. In the face of these many system constraints, respondents reported that the process of housing a family, while typically initiated early in the case, could take six to eight months or more, and even longer for families with very high levels of need.

Because of this extended period between a family's entry into the program and their housing placement, the program has faced the challenge of providing families with temporary, transitional placements. According to interview respondents, these placements are often in motels of a very low quality which, though generally an improvement over the family's former housing situation, can be counterproductive for family functioning. Furthermore, families may struggle to participate in services while in temporary, unstable housing situations. In response to these challenges, the program has been working to find or create additional temporary housing resources and opportunities, and in the process has identified the Holloway House.

The Holloway House formerly served as transitional housing for emancipated foster youth, but when California passed a law extending the age that youth could remain in foster care to 21, the facility became obsolete as transitional housing. The Holloway House subsequently became available to HSA,

and HSA decided that the facility could, in the words of one HSA administrator, serve as a good "way station for families who were moving out of county so that they could be in a safe environment rather than a stigmatizing one" (a reference to motels). Nonetheless, some respondents stressed the need for the program to develop additional relationships with temporary housing sources and family shelters, as demand for temporary housing continues to outweigh the supply, and the Holloway House was not yet open. [4]

In response to the challenges of finding permanent housing in San Francisco, respondents noted that the program is increasingly placing families in other counties, where more housing is available. Although this deviates from the original program plan, respondents report that it is proving to be much more feasible. However, placing families in other counties involves its own set of challenges. For example, caseworkers noted that families are often hesitant to leave San Francisco, which is the location of their social networks, relatives, children's schools, and services. Thus, for many families, leaving San Francisco makes it difficult for them to access whatever resources they have already developed. Furthermore, it can be challenging for caseworkers to continue engaging with families in a manner consistent with the program model protocols when those families have been placed outside of the county.

Despite these obstacles, interviewees suggested that the program would increasingly focus on placing families outside of San Francisco; thus, the program would need to continue to address the challenges that placing families out of county present. Adaptations that have already been made to account for increasing out-of-county placements include the acquisition and use of Holloway House as transitional housing (instead of motels) for families preparing to move out of county, the use of HPP's van for far away home visits, and the potential substitution of some home visits with a "check-in" via telephone when an in-person home visit isn't possible. [5]

Ongoing Housing Support

Once a client has been housed, FMF provides the family with ongoing support consisting primarily of home visits. Respondents' comments regarding home visiting were limited in number and scope, but took three forms: First, some respondents expressed dissatisfaction with HPP's home visiting protocol, describing the home visiting checklist as overly general and insufficient. Second, a few respondents indicated that families are sometimes uncomfortable with home visits and experience them as punitive or judgmental. Third, some respondents said that it has been challenging and time-consuming to conduct home visits with families that have been placed in different counties. As mentioned above, one respondent indicated that families placed outside the city could receive phone call check-ins rather than home visits.

Challenges with the Principles of FMF

In addition to discussing specific elements of the program model, interview respondents also reflected on how program implementation was measuring up to the principles of FMF, or the concepts undergirding the project.

Housing First

The "housing first" approach posits that the best way to support homeless individuals with comorbidities is to provide them with stable housing as soon as possible and then address their service

[4]Holloway House is expected to be available for project family use in early November 2015.

[5] The technical aspect of porting vouchers different counties in which local Housing Authority may have slightly different rules is an issue project leadership expects to focus on in spring 2016.

needs, with interventions such as substance abuse treatment or individual therapy. The housing "ready" perspective takes a different view, positing that families cannot be expected to maintain permanent housing until their most significant barriers are addressed and they have achieved relative stability.

The concept of "housing first" is a driving force for FMF and figured prominently in the interviews. Nonetheless, respondents said that the average time it is taking families to find housing is five months to one year. Some families have found housing within two to three months. Respondents describe that those families who did find housing more quickly were families who "present well" (in the words of one respondent), or those who decided that moving out of county was a feasible choice for them.

Though respondents generally agreed that FMF is driven by a housing first philosophy, (rather than "housing ready"), they also identified ways in which FMF has run up against obstacles that prevent it from fully achieving the housing first ideal. The most significant obstacle discussed was the lack of available housing, which makes it impossible for families to be housed rapidly and thus ensures that families will be held in a period of limbo during which the program cannot function as originally conceived. For example, respondents suggested that many clients found it quite difficult to participate in supportive services while they were in transitory, unfamiliar situations (such as motels, etc.)—which is consistent with the key tenets of the housing first philosophy. One respondent shared an example of a family who was placed in a hotel and was participating in services with
s (IPP): after participating in services for a short while, the mother expressed that "I'm not ready for this—I don't want to do it—I need to find a house." The family stopped participating in services and focused entirely on the housing search, which resulted in the family finding housing in the city within 1 to 2 months. In this situation, the supportive services aspect of the program appear to have been incompatible with the housing search—which, given the nature of the housing market, required intensive effort. Overall, interview respondents repeatedly conveyed their sense that implementing a housing first model in a context in which very little housing is available asks a great deal of the workers, families, and communities involved.

Furthermore, some respondents expressed the concern that the program's emphasis on housing first was leading to an under-prioritization of families' other needs. While all respondents agreed that it made sense to provide families with stable housing so that they can tackle their other issues, responses suggested that the program's prioritization of housing sometimes came at the expense of a timely response to the other needs and challenges facing the families. For example, interview responses indicated that, although many families achieved stability and began to thrive after finding housing, some of the high-need families that have been housed have been encountering issues that may result in their not maintaining housing, despite receiving supportive services.

Family Self-Determination and Choice

Respondents also indicated that program goals were not always congruent with client goals. While FMF strives to follow the guiding principle of "family self-determination and choice" (FMF manual working copy, FMF guiding principles, p. 12), respondents described that client families' desires sometimes run counter to the program's elements, such as intensive engagement and providing families with housing and supportive services based on assessment results. Respondents reported that not clients wanted to be placed in what the program would view as appropriate permanent housing, for example one family was reported as preferring to live in a mobile home. Others weren't interested in participating in the supportive services that the program designated for them. In instances such as these, honoring client self-determination and choice would require the abandonment or alteration of key features of the

program model. When client goals and program goals are incompatible in this way, the program is caught in a tension between two of its driving principles.

Supporting Families with Complex Needs

Respondents suggested that incongruence between program and client goals may relate to tensions between clients' multiple, complex needs, which the program struggles to deal with simultaneously. Homelessness, child welfare involvement, and serious mental health and/or substance abuse-related comorbidities place competing demands on the clients that sometimes prevent full participation in the many facets of the FMF program. Families with the added burden of an active CPS case are often embroiled in those cases and court requirements, leaving them with less time and energy to engage with the housing search or supportive services. However, respondents also noted that it could be challenging to maintain engagement with families whose CPS cases had been closed, as they may feel that they no longer need to participate. Similarly. FMF families who are preoccupied with the housing search may have a hard time participating in supportive services (for the six to eight months it might take them to find housing), but some families that have been housed lose motivation to participate in services. Though the multifaceted nature of the program design is intended to address clients' multiple needs, the complexity of their needs and the many demands on their time may mean that clients simply are not inclined or able to do everything all at once.

Furthermore, respondents highlighted some structural incongruities in the program design that may hinder its ability to engage and serve families with complex needs. The respondents reported instances in which the program's efforts to address certain client needs were incompatible with other client needs. For example, open child welfare cases reportedly could conflict with the program's housing process: respondents noted that in instances in which families have had children removed, that change in family status could have an impact on their housing voucher. Additionally, uncertainty about where children are going to be can complicate the housing search, potentially delaying the onset of housing and the family's uptake of the full program model. A second example relates to mandated treatment programs. When parental participation in residential treatment is mandated by the court for FMF client, this can be a structural barrier to rapid housing since parents must complete the program before they can be permanently housed. The original program model did not take residential treatment into account, and HPP has adjusted to this reality by treating it like other types of transitional housing, and working the families to start the housing process while they are still in treatment.[6]

Communication and Staff Understanding

FMF's program design relies on frontline staff from multiple agencies collaborating to intensively engage high-need families and help them navigate several complex, intersecting systems in order to meet their multiple needs. By this design, all frontline staff must manage multiple competing priorities in order to help their clients achieve desired outcomes. As such, the success of the program depends on effective communication and thorough staff understanding of the program model. However, interview respondents suggested that there were some gaps in communication and staff understanding.

Given the innovative nature of FMF, the project requires many of its staff to make changes to their routines. For example, as the program is guided by a housing first philosophy, it is important that this philosophy is effectively communicated to all staff involved in any way with the FMF program. According

[6] Mandated residential treatment and its impact on the onset of housing will be considered in more detail in a subsequent evaluation report.

to some interviewees, some HSA case workers who were not early adopters demonstrated a lack of understanding of the program model and overall confusion about the program's goals and scope, and seemed to be more comfortable with a "housing ready" or traditional approach to service provision rather than a housing first approach. These staff sometimes fell back on what they were used to when working with FMF families, rather than adopting the FMF program model. As a multisystem program navigating many moving parts, FMF requires careful training and demands attention to detail and ongoing communication and support for its staff. When that is not provided, it becomes very difficult to adhere to the program model.

Collaborations/Systems Change

Inter- and intra-agency collaborations, however, continue to work to facilitate systems change. Respondents discussed how the relationship between the Housing & Homeless Services and Family & Child Services (child welfare) programs within HSA has vastly improved, and continues to develop as mutual understanding grows. In the words of one HSA administrator:

> *Not everybody in child welfare [Family & Children's Services] understands Housing & Homeless [Services], but we are sprinkling expertise in that program so that there is knowledge within reach. And Housing & Homeless still has some myths about child welfare families, thinking that they are different from other families they are serving, and they are really not, and I think that's been important for them to learn.*

With respect to inter-agency collaborations, respondents indicated that the relationship between HSA, HPP, and the San Francisco Housing Authority (HA) has also continued to develop and improve. In the initial interviews, HPP staff indicated that the collaboration with HSA has been strong and fruitful, and that the committee structure has been useful and responsive to issues that arise. As an example, one administrator respondent recounted that, in recognition of the fact that many families have arrests and/or credit problems in their backgrounds, the HA included in their renewed annual administrative plan a clause that indicates that "they are assuming that this program is for exactly those kinds of families that have credit and other issues and we are going to expedite their applications for vouchers accordingly." The HA also helped FMF administrators develop the idea of dedicating FUP (Family Unification Program) vouchers to FMF program families and transitioning existing FUP recipients to regular section 8 vouchers as they stabilized. According to an administrator interviewee, this was considered a "huge breakthrough for FMF because it restored control to HSA, so that HSA could be identifying the families already receiving FUPs who had stabilized and didn't need them anymore." These changes constitute notable successes that were only made possible through inter-agency collaboration.

Finally, the monthly FTMs were described as being used increasingly by all workers to maximize the communication between CPS, FMF staff and the family, and to document what services need to be in place to meet the family's needs. HSA staff shared that the FTMs provide a structured way for all of the different partners working on behalf of families to come together in a more collaborative, less adversarial manner, and to be accountable to each other and to families.

Sustainability

In more recent interviews, some direct service as well as administrator interviewees shared their thoughts regarding what aspects of the program warrant attention for program sustainability beyond the funded project period.. One administrator felt that the idea of dedicating the FUP vouchers to FMF

program families and transitioning existing FUP recipients to regular section 8 vouchers as they stabilized represented a "real strategy for sustainability" because as each family is transitioned from a FUP voucher to a section 8, room is made for a new FMF family to enroll in the program. In addition, as FUP vouchers go outside the county with families, the program receives a new FUP voucher to be used within the city. Both direct care and administrative staff participate in the conversations with HA and "are getting excited about the possibilities of working more collaboratively with HA," which "has the effect of generalizing to other work we're doing."

The sustainability of the program will also depend on the continuous integration of new knowledge gained through program experience. Staff talk about their experiences serving FMF families and how they have been surprised at times at how families react to being housed or receiving services by the program. One case manager put it this way: "what would seem ideal to you is not really ideal to them, and they're just not as excited as you would think. To me that says something also about us having to really look at – how do we serve these families?" Similarly, other staff stressed the importance of considering the stage of change families are in with respect to their risk behaviors when determining the most useful services and housing type for families.

Summary and next steps

This preliminary analysis of our interview findings revealed both strengths in the program's initial installation as well as several challenges that program participants and providers confront as they work with and child welfare system-involved FMF families. The different perspectives from HSA case workers, HPP staff, and HSA administrators reveal how the program is being implemented at different levels. Respondents discussed how the program model is being administered, the challenges of implementation, and how the program model is being adapted to address these challenges.

Appendix: Family Interview Summary (First 9 Families)

Housing Experiences

According to the family members interviewed, five families are housed in permanent or semi-permanent housing, and four families are not yet stably housed. The families who have not yet been housed are staying in temporary living situations including residential treatment programs and transitional housing shelters. Despite the diversity of the housing experiences of these nine families, their accounts shared some key themes which we touch on below.

FMF support in housing search: Among the housed families, two found housing on their own, either before enrolling in FMF or shortly afterwards. One family was able to find housing within San Francisco using a Section 8 voucher before winning the FMF lottery. This family member said that HPP provided furniture, assistance moving into the home, and payment of past bills. The other family member that found housing independently reported that s/he had found housing without help from HPP using a city subsidy. HPP helped the family move in and faxed the necessary paperwork; however, HPP provided no furniture or food – assistance that the family perceived had been provided to other families. The other three housed families reported that the FMF program supported them in their housing search processes, including helping them to complete housing applications, get housing vouchers, and find landlords/housing options. However, only one of these families reported that FMF provided them with furniture.

Non-housed interviewees report varying degrees of housing search support from FMF. While most of them indicate that FMF has been helpful in some ways, most of them also feel that FMF is not as responsive as they wished they would be – for example, following up with landlords or giving them accurate information about the vouchers and subsidies. Some housed families also indicate that they did not receive as much support for similar services as they had wished.

Location: Housing location was a significant factor for all nine interviewees. Of the five housed families, four live in San Francisco – in low-income or below market rate (BMR) housing or rental housing secured via Section 8 vouchers – and one lives outside of the city. All of the non-housed families report that they are concentrating their housing searches outside of San Francisco – some because they prefer it, and some because they feel that they will not be able to find housing in the city. All interviewees, including those who have been housed, remarked on the challenges associated with finding affordable and accessible housing within San Francisco.

The location of private SRO/hotel housing options also played a significant role for some families. One respondent in particular noted that his/her emergency housing's location in an area with heavy crime facilitated his/her return to crime, which s/he had not participated in for more than two years and which resulted in the re-removal of his/her child. Although this respondent expressed concerns about the hotel's location to the FMF team before s/he was placed there, it was the only option available at the time and s/he understood that s/he needed to be housed in order to be reunified with her/his child. For this respondent, and others, the location of the temporary housing was counterproductive to the larger goals of addressing families' complex needs. Respondents that spent time in hotels also expressed that hotels required them to move periodically, which was stressful and disruptive.

Child welfare case: Though there was a great deal of diversity in the child welfare cases of the nine families interviewed, all of the families indicated that their child welfare cases were major concerns and strong motivators for obtaining housing and achieving stability. Of the families interviewed, five have Family Maintenance cases, two have Family Reunification cases, and two have cases that have been closed. All of the respondents with open cases emphasized that achieving reunification and/or resolving their child welfare cases was a top priority. Both of the families with Family Reunification cases have not yet been housed. Several respondents remarked that they understood that a lack of stable housing is a barrier to reunification, which compounded many families' frustrations with the slow and arduous housing search process.

Nonetheless, some families without permanent housing have their children in their care: the other two non-housed families have Family Maintenance cases, and their children live with them in temporary living situations like residential treatment programs and transitional living shelters. Respondents varied with regards to their outlook on their child welfare cases and the support from HPP and HSA to resolve their cases: some interviewees felt that involved parties from both agencies were doing everything they could, while others felt that they were being held to unreasonable (or untenable) expectations without receiving the support they needed to achieve them. Furthermore, some family members indicated that HPP staff were involved in their child welfare cases, while other respondents portrayed HPP staff as exclusively involved with the housing search rather than child welfare.

Experience with Service Process

Most of the family members who were interviewed said that HPP staff were supportive and helpful in their efforts to help families find housing, close their child welfare cases, and generally provide what they needed around moving, such as funding for deposits, furniture, and assistance on moving day.

Most interviewees reported that they had strong relationships with their caseworkers; relationships which were developed through family team meetings, home visits, accompaniment to court, and frequent informal contact and support. Some respondents emphasized how helpful HPP has been in providing services, a safe space, and a supportive and affirming community.

Nonetheless, most of the families also had critiques of how FMF and HPP managed their cases, particularly with regard to responsiveness. Several family members felt that HPP staff had been less helpful than they could have been and even unresponsive in a couple of cases. Numerous respondents mentioned that they received slow or inadequate responses from the FMF team, especially around housing help. One interviewee shared that s/he had been placed in a hotel and lived there as a resident with his/her child without incident for more than half a year, at which point the family was evicted due to new ownership of the hotel. This interviewee expressed frustration that HPP did not provide support related to the eviction, or assist in the search for more permanent housing. Other interviewees note that the FMF team is slow to respond to requests and are often unable/unwilling to acquire or provide the things they ask for (such as a playpen for the toddler and emergency housing for an interviewee's homeless partner). Several of the families interviewed struggle with the tension between being grateful for what FMF has helped them with, being aware that they have been told that they are supposed to be able to ask the FMF team for anything, and feeling like the FMF workers think that families ask for too much support. Moreover, several families indicated that FMF/HPP staff gave the impression that they did not have the time to give them the support they needed.

Summary and next steps

This preliminary analysis of family interview findings revealed implementation strengths and challenges of the FMF program. While child welfare system-involved families face multiple challenges and often a high degree of trauma in their lives, and these circumstances are evident in the interviews, it seems clear that with the thoughtful provision of services and supports, families can begin to rely on themselves and make changes in their lives that have the potential to last. The research team will continue to examine trends related to how families are experiencing FMF program services and how FMF staff perceive they are providing these services.

Interview Process and Methods

The evaluation team at Chapin Hall conducted two rounds of interviews with families participating in the Families Moving Forward (FMF) program as well as FMF program and administrative staff members. The first round, which took place in September 2015, included interviews with a total of nine adults from participant families and nine FMF staff members. The interviews were coded, reviewed, and analyzed (using ATLAS.ti software) between October 2015 and April 2016. The primary themes covered in interviews were experiences with housing, satisfaction with the Homeless Prenatal Program (HPP), experiences with the service process, and coordination between service providers.

The second round of interviews took place in late March of 2016, and involved interviews with four adults from three families living in Holloway House and six interviews with FMF program and administrative staff members. The interviews were coded, reviewed, and analyzed (using ATLAS.ti software) between April and July 2016. The family and staff interviews covered the same themes as the first round of interviews; however the family interviews included an additional focus on the unique experiences related to Holloway House. In total, the Chapin Hall evaluation team interviewed thirteen adults from twelve families participating in the FMF program and fifteen FMF staff members.

In this summary, our analysis focuses on the second round of family and staff interviews. Analysis of the family interviews overall revealed that families living in Holloway House viewed it as a welcome and supportive resource. They also discussed some challenges and stresses associated with living there. Analysis of the staff interviews revealed an evolving FMF program model and changing staff roles; continuing challenges such as the difficult San Francisco housing market and families struggling, for various reasons, to engage in the housing search; and successes such as families who were housed quickly and locally, and a developing collaborative relationship between HPP, SF-HSA, and the Hamilton Family Center (the Hamilton Family Center is the contractor that provides 24/7 staff coverage in the form of Residential Counselors, who oversee safety and provide supplies, among other services, for Holloway House residents).

Family Interviews: Experiences with Holloway House

Interview participants moved into Holloway starting in the late fall of 2015, and had been living in Holloway for approximately two to four months at the time of the interviews. In this section, we discuss what these families had to say about their experiences in Holloway House.

Life in Holloway House

All of the interviewees agreed that living in Holloway House was a significant improvement over their previous living situations, which included living on the street, moving between short-term hotels, and staying in various other temporary living situations or programs (including residential treatment programs), as well as living with family. All of the families also indicated that they and their case managers worked hard to get into Holloway House, and all of them expressed appreciation for the safety and stability that it provides. As one respondent described living at Holloway, "it's like you can breathe... You can sleep right. You can shower every day. You can eat some food. My experience is like a dream."

The families described that Holloway House provides them with access to shared kitchen space and groceries. Holloway House staff go on monthly grocery runs, and one resident indicated that his/her case manager provides bags of food and/or food cards when the client needs them.
Nonetheless, the communal nature of Holloway House posed some difficulties for the families living there. Specifically, respondents noted that sharing space with other families can be stressful and challenging, especially with regard to cleanliness and chores. Furthermore, some families noted that there have been certain interpersonal problems and conflicts between families in Holloway, which adds stress to their already stressful lives. All of the interviewees indicated that they try to keep to themselves, spending time primarily in their rooms rather than the communal spaces, and have limited interactions with other families. So notwithstanding the considerable benefits of having secure shelter and food, Holloway residents still expressed some dissatisfaction with living in a temporary communal setting where many decisions about the structure and substance of their daily life remained out of their control.

Tensions with Program Goals

In discussing the complexities of life at Holloway House, interviewees illuminated some tensions related to establishing a functioning communal living situation that is not counterproductive to FMF's central goal of supporting child welfare involved families with complex needs. First, interviewees noted that there have been some issues related to the space being safe for young children. One family's SafeCare

worker brought up concerns about child-proofing in Holloway House, including the fact that the cabinets did not have child locks and chemicals were not appropriately locked away. This respondent also indicated that s/he had to "fight" to get a baby gate.

Relatedly, Holloway House residents described some instances in which health issues were exacerbated by the conditions in Holloway House. One family had an asthmatic child who was experiencing significant asthma flare-ups while in Holloway House, and the parents attributed these flare-ups to their small, dusty room and neighbors' use of aerosol sprays and perfumes. The parent's initial strategies to increase airflow (i.e. opening the balcony door) were forbidden by Hollow House staff, and the parent's requests for window fans were denied. The parent continued to advocate for changes, including bringing in several doctor's reports and having a SafeCare nurse attest to the health risks, and the family was eventually moved to a larger room with greater airflow. In the parent's words, it initially "felt like nothing was getting answered; they were just denying me and acting like it was nothing"; but, eventually "it did get resolved, it just took a while and I'm persistent."

As this last example suggests, the interviews indicated that the rules at Holloway House sometimes came into conflict with FMF's goals of empowering its clients and helping them to make progress on their various areas of need. For example, respondents mentioned that house rules can be strict and punitive: one respondent described being written up for misunderstandings like forgetting to sign their name on a chore sheet, despite having completed the chore. Furthermore, family respondents alluded to miscommunications between and moments of inconsistent communication from Hamilton staff and HPP staff about the rules in Holloway, especially early on. This was most notable in relation to rules about visitors to Holloway House, which was an area of confusion and tension. Rules against visitors to Holloway made it difficult for some of the residents to comply with some elements of their child welfare case plan and/or coordinate with their partner/co-parent.

One family was in the middle of SafeCare services (as part of their child welfare case) when one parent moved into Holloway with their child, at which time the rule against visitors prevented the other parent from participating in the SafeCare sessions, which involve supervised visits between parents and child. This led the family to have to halt their SafeCare services until the second parent could move into Holloway. The parents expressed frustration about this forced lapse in their SafeCare services, saying that "you guys (FMF) are supposed to be coordinating with us to do these things," and that these policies were "not right" for something that is "supposed to be a family program." Other issues with visitors included one client's mother from out of town and another client's child and co-parent being prevented from visiting Holloway House – both clients indicated that this took an emotional toll on them.

While some challenges (such as the rules about visitors) have persisted over time, respondents indicate that many of the tensions with life at Holloway were the most severe at the very beginning, and have been getting better over time as the program has taken steps to address and correct the early problems. In the words of one respondent:

> *Here, Holloway, it's gotten better. It's gotten way better now that they're trying to get things straight and they're adding more things... We knew we were the guinea pigs of the program. You know what I mean? … As they weeded out what the issues were, it's been getting a lot better.*

Overall, although the families identified certain areas of tension in life at Holloway House, they recognized the efforts being made to address the issues raised, and they valued the opportunity to live there.

Housing and Permanent Housing Search at Holloway

All of the families interviewed expressed the understanding that Holloway House was supposed to serve as a temporary but stable living situation where they could stay while they searched for permanent housing. However, respondents varied somewhat in their understandings of how long they could stay at Holloway: one understood that they could stay for 6 to 12 months, one understood that they could stay for as long as they needed to (with no specified limit), and one did not know how long they could stay.

The interviewees also differed in how they described their experiences searching for permanent housing from Holloway. One resident who had not received a Section 8 voucher indicated that the housing search was just as difficult from Holloway House as it was from anywhere else, and involved the "same process" and the "same conversations." Over the course of the client's year-long search, before and after moving into Holloway, the client reported that it was consistently difficult to find housing options, subsidies were insufficient to cover housing costs, and the search process overall demanded a great deal of effort without producing positive results. This respondent had not worked with HPP's Housing Specialist, but rather worked with his/her HPP case manager.

Another family at Holloway had recently initiated their permanent housing search, and was primarily focused on finding a living situation that could accommodate the client as well as the client's partner/co-parent and child, who were not currently living in Holloway. This client had a Section 8 voucher, and expressed frustration about not being able to find housing options that accept Section 8. Nonetheless, the respondent was very grateful for the support of his/her case manager, who, in the client's words, has "helped me so much [that] I can't ask for nothing else. S/he is working so hard, s/he is helping me so much." This respondent also had not worked with the HPP Housing Specialist.

The third family at Holloway had worked extensively with the Housing Specialist, and had recently secured housing outside of San Francisco, where they were planning to move within a couple weeks of the interview. The respondent described that the process of getting a housing voucher, and then porting that voucher out of county, was effort-intensive but understandable – especially with the support from the Housing Specialist, who the family described as a huge resource. Over the course of the family's seven-month housing search, the Housing Specialist had: "explain[ed] everything," accompanied the family to appointments and apartment visits, helped the family talk with landlords, developed a phone log to assist with talking to landlords on the phone, developed an email template for communicating with landlords via email, helped the family develop an "about me" introduction paper, and personally vouched for the family to landlords. According to the interviewee, the fact that the Housing Specialist personally vouched for them was the reason the otherwise hesitant landlord became convinced to accept them: "If it weren't for her, we wouldn't have gotten the place."

Staff Interviews: Housing and the Service Process

In the second round of staff and administrator interviews, we spoke with five HPP staff members and one SF-HSA staff member. In this section, we highlight what staff members shared with us about the processes involved in the evolution and refinement of the FMF program model, the impact of integrating Holloway House into the array of FMF housing options, the remaining challenges facing staff

and families, and the successes experienced by staff and families. Overall, staff express optimism and satisfaction with the program changes that have taken place to adapt to the fluid needs of families and the changing dynamics of San Francisco's housing market.

Evolution and Refinement of the FMF Program Model

Role Changes

Staff and administrators discussed in interviews how the FMF program model has evolved over time to best meet families' needs as well as to establish which tasks are most appropriately the responsibility of HPP or SF-HSA staff. Many staff talked about how HPP's responsibilities have been re-defined to focus on engaging families and helping them find and maintain housing, and SF-HSA's role has become that of primary case coordinator; helping link families with mandated services and benefits. While HPP and SF-HSA program staff both remain case managers, HPP case managers will now be called housing case managers. This new title distinguishes their role from SF-HSA case managers, or child welfare workers, in that the housing case managers "function primarily as the family case managers who help families stabilize in housing.

Housing case managers are the main contact for the family, focusing on engagement, supporting them in other areas, like recovery growth areas, for their child welfare cases, and they will continue to coordinate the FTMs. One HPP staff member further explains that changing the position name of HPP from case managers to *housing* case managers will hopefully "work toward an understanding of the two organization's roles." In the words of one HPP case manager, "we were working all over the place and I think it impacted the housing piece." HPP case managers previously worked with families to find housing and then felt as if they'd stabilized them (i.e., they felt like their obligation to the family was done or at least paused); they would then check in with them via phone and home visits. HPP and SF-HSA case managers are continuing to consider how best to work out the HPP versus SF-HSA case managers' roles. In addition, one SF-HSA interviewee talked about the importance of "bringing SF-HSA leadership on board with support as well as resources" during this transition process.

HPP and SF-HSA staff and administrators also discussed the issue of the period of time when families have been referred to the FMF program but are not yet housed. Several HPP case managers questioned what their role should be during this interim period. One HPP case manager stated, "with housing first, it's supportive housing when they are in permanent housing." In other words, the way the housing first model is designed to work is that once a family is housed in permanent housing, they begin to receive supportive services. This case manager goes on to say that supportive services that are provided before families find housing "is (in the form of) a lot of engagement with the families, getting them ready, building up trust, helping them with the other elements of their case, and then working with the housing specialist to acquire the housing, to do all the applications, all of that stuff." HPP case managers also state that before families are housed can also be a time to connect them to appropriate benefits and services, and that this should be the responsibility of SF-HSA child welfare workers.

Housing First Model

As the FMF program model has evolved to better meet the needs of families, and staff roles are also changing to meet needs, the way that SF-HSA and HPP staff have interpreted and understood the housing first model has evolved as well. One HPP case manager said that when s/he joined the program

s/he observed FMF's program model to be

> *in part focused on stabilizing the families enough so that they were able to focus on the search for housing and on the application for the voucher and so on; this model didn't necessarily line up with the housing first philosophy, which I took to mean really buckling down and focusing on the housing and relying on collateral and external supports for the larger issues.*

Relatedly, one interviewee raised the issue of some clients not being "housing-ready," despite what the housing first model says should happen. The housing first model says that families should first be housed and secondly provided supportive benefits and services, once they no longer have to worry or be preoccupied with being homeless or in transitional housing. S/he explains that in his/her experience, some clients have not been "cognitively or psychosocially prepared to engage in the process of acquiring a voucher, thinking about how much money they have available for support or from child subsidy, and connecting that idea to a search for a unit," for example. Another HPP staff member adds that

> *it's unclear early in this transition process to HPP and SF-HSA workers who should provide the case management at this point. It isn't clear to HPP housing case managers that if they don't work with families who are not ready to engage in the housing search process, that they will get the supportive services they need from SF-HSA workers in order to ready them for engaging in the housing search.*

Several other staff we interviewed talked about how many staff didn't understand the housing first model in the beginning of the program and that many are "just fully grasping what it means this year (HPP case manager)." S/he goes on to explain:

> *We had the hotels that we were putting families in because we couldn't put them in a shelter – that took a long time. We had this money that we could put them in the hotels, but literally, you had the case managers moving families weekly because you couldn't stay more than a week or two in a hotel. Moving them from one hotel to the next, to the next, to the next. Meaning that they spent a lot of time coordinating that type of housing – crisis housing.*

In addition, a few staff said that it had been unclear to them until this year how the housing first model could be integrated with the work of both SF-HSA and HPP, rather than just functioning as additional case management services and support for families. One HPP staff member describes it this way:

> *…part of the challenge in the life of this grant has been taking what we've been doing, what we do at HPP, which is really that advocacy piece and that support piece and in connection with child welfare having that external person that you can go to for support, where the families can go to for support. Integrating that into the housing first has been a challenge in the sense that it hasn't been clear. How do we put these things together? How do we provide that advocacy and get our clients to connect it to the certain things that they need while also focusing on housing first, and as immediately as possible finding permanent housing?*

Now that they feel they have a better understanding, SF-HSA and HPP staff are continuing to have conversations about how to refine their roles to better collaborate in order to provide more of the necessary case management and support for families. It is becoming clear to HPP and SF-HSA case managers, per our conversations with them, what each of their roles should be in a housing first model,

which resources and services each family needs most appropriately at each stage of their recovery, how Holloway House fits in a housing first model, and how flexible the housing first model can be.

Interviewees talked about the new more specific housing focus of the HPP case managers (while continuing to coordinate the FTMs and be responsible for engaging families in the beginning of the process), acknowledging that many families are not psychosocially or cognitively ready to immediately engage in a housing search. HPP case managers (i.e., housing case managers), have learned that case management provided during the period when families are not yet housed and are struggling with the search for housing, can take the form of rapport-building, addressing other elements of the child welfare case as possible, identifying service needs, and familiarizing families with the available housing search resources and personnel available. In addition, the more specific focus of SF-HSA child welfare workers on providing benefits and supportive services has already and will likely continue to help both HPP case managers and SF-HSA child welfare workers more efficiently and adequately meet the often complex needs of families. Finally, the hiring of one additional (bilingual) housing specialist will also serve to lessen the burden on the HPP case managers and further help meet the needs of families.

The Integration of Holloway House

Most interviewees agreed that while Holloway House is temporary housing rather than permanent housing, it still fits with the housing first model in that it's a safe place for families to live while they're receiving services and searching for permanent housing. Other staff said that while it doesn't really fit the housing first model of finding permanent supportive housing quickly in that it's equivalent to them to a drug treatment facility or a shelter, Holloway House does represent "a safe place for families to be while we stabilize them (HPP staff member)." Furthermore, several staff discussed how much better Holloway House is as a transitional housing option than hotels, shelters, or drug treatment facilities, because it gives residents the experience of living in a safe, structured environment in which they have some typical household responsibilities while they participate in services and search for permanent housing.

An HPP staff member is now working at Holloway House and s/he states that communication and knowledge between HPP and Hamilton has greatly improved as a result of this staff member's co-location. In addition to helping residents search for housing, this staff member coordinates programming with and for the families, and is responsible for case managing all Holloway House resident families. S/he states that "the communication has been great since I've been here. In the beginning a lot of our families was staff splitting between us and it seemed like we weren't together as one, but we are. We all share the same common goal to serve the families."

Remaining Challenges

One of the biggest challenges facing the FMF program currently is the high number of families who need housing and services. The FMF lottery has been turned off to give staff the chance to meet the needs of families; however, while the stress of new referrals has abated, at the time of the interviews and currently, many families continue to search for housing.

Interviewees discussed the status system in place now, which has helped the program keep track of and meet the needs of families. The statuses are active, inactive, and check-in (after families are housed). One interviewee shared that staff "seem prepared to expand the definition of active to be longer, so that families can be stabilized in housing longer."

Another important challenge is the number of families that have now been housed outside San Francisco. FMF's model and a level of resources that were not designed to provide weekly home visits to families housed so far away, according to many of the staff we interviewed. Several staff say that monthly home visits are just not enough to establish and maintain relationships with families. In addition, one HPP staff member said that because of the number of families—and an increasing number living out of county— staff have to "just do the basics", like the family team meetings (FTMs). To address these factors, one respondent suggested that instead of pushing families to move to check in status, "It seems like the team is prepared to expand the definition of active to be longer, so we can stabilize families in housing longer. I think everyone would be excited to do that, just like me, we just need less families coming in the door (i.e. turning off the lottery)".

An additional challenge noted by several staff is that with families who are not yet reunified with their child(ren), it's often hard to focus on a housing search because there are complex problems that have to be addressed first. While families do not have to be reunified while they're looking for housing, the lack of assured housing can be a barrier to reunification. For example, judges and/or child welfare workers are sometimes reluctant to reunify families unless they are living in stable, permanent housing, or if they are assured that the family will be in permanent housing imminently. In these cases, HPP makes efforts to communicate with child welfare and let them know the family is taking necessary steps to find permanent housing. One staff member expressed a concern that (although this had not happened at the time of the interview), a family that has not yet reunified may only qualify for a voucher for a one-bedroom apartment; then, if the parent subsequently is reunified with a child(ren), they may need to find the family a different living option. However, another staff member indicated that they are able to include children on a FUP voucher even if the children have not yet been reunified.

Successes

To date the FMF program has seen notable successes. One of the successes of the program and its staff and administrators is that while it has long been known that lack of housing is one of the "key things hurting families," what was not known was very much detail about the magnitude of family homelessness and its consequences. The program has called attention to the severity of the problem. There is also now "overwhelming agreement," according to several interviewees, that families should get housed as soon as possible. In addition, several staff members mentioned that through the FMF program's experience, they've "figured out a way to move Section 8 vouchers quicker than anybody." One interviewee shared that the program could "write a manual based on how to conduct a housing search just based on the program's experience searching for housing for families and training families on how to manage the process."

Another important success of the program noted by an HPP staff member is that it has been able to engage "really hard to serve families, and get them to utilize the Section 8s." According to several staff, Holloway House has so far proven to be a successful platform from which families can find permanent housing. A collaborative and supportive relationship is developing between HPP and Hamilton Center staff. One HPP staff member puts it this way: "I've worked with a lot of dedicated staff before, but I've never been with a staff that's really poured their heart into their work. We do what we have to do to support our families. From Hamilton to HPP, we all share that goal genuinely. We sense that with each other and that's what makes us work well."

The housing specialist at HPP has also been able to facilitate considerable success with both the housing search and with engaging landlords. S/he states that s/he has reached out to several landlords who have been receptive to both FMF's program model and to giving clients a chance to be successful in housing. Landlords have in particular responded positively when the housing specialist has assured them that they can call the specialist directly if they encounter any issues or problems with clients. One technique that the housing specialist discussed using that has worked well is simply asking clients if they know anyone: "I also ask the clients – do you guys have friends or family members that would find any landlord and see if they can make calls through them. And that actually usually is a really good trigger for clients to think about people who they can call and use as a resource."

The FMF program has also been successful with moving away almost completely from housing families in hotels. The program recognized that hotels were time-limited, dangerous, unpleasant, expensive, often counter-productive to clients getting better, and required a lot of time and effort from families and staff. Holloway House represents a very good alternative. Hotels are now reserved almost exclusively for emergency situations.

> *What I like about the model is that I think what it's trying to do is address families who have been affected by CPS because of homelessness. They wouldn't have had a case if they probably had not been homeless. There was maybe not any other mitigating factors. I think due to the homelessness other things started to come up for families, and of course CPS gets involved. How do you return a child to a parent who don't really have a place to take them? I understand CPS' point of view as to – we need to find housing for this family. I really like that. I think that it's great that we have the Section 8 vouchers, we have Housing Authority on board. We have a subsidy pot of money that we can pay for especially our families that are undocumented who can't get Section 8 vouchers. It's harder for them… (HPP staff)*

Conclusion

It is clear over the course of FMF implementation, and through its attendant successes and challenges, staff and leadership at both SF-HSA and HPP have built a great deal of actionable knowledge about how to meet the complex needs of homeless families involved in the child welfare system. Additionally, through collaboration between the two organizations, SF-HSA and HPP have learned and continue to learn how to work together to best meet families' needs. Evidence of that is how the two organizations have recently reevaluated their case managers' roles as they relate to the FMF program and believe they've come up with a structure that may work to secure housing for families faster and overall serve their needs more efficiently and effectively.

HPP's case managers are now called housing case managers and focus primarily on engaging families and finding housing for families quickly – be it permanent supportive housing in or outside the city, or the safe and homelike transitional housing of Holloway House – as well as collaborating with SF-HSA child welfare workers and others to convene FTMs. SF-HSA's child welfare workers are focused primarily on connecting families with necessary benefits and supportive services, and they're ready to facilitate these services before and after families are housed. With their roles re-specified, HPP and SF-HSA staff seem to have found more clarity as to when it is most appropriate and useful to provide certain resources and services, and they are in better communication with each other as they work out the timing and sequence of those services.

While the FMF program has faced formidable challenges - most notably, the difficult housing market in San Francisco and the high number of families who have been referred to the program, they've been able to come up with some promising solutions. It is likely that program leadership will need to continually reevaluate and adjust their approaches. Keeping the FMF responsive to the needs of families, attending to the changing dynamics of the housing market; and continuing to provide support and guidance to program staff will remain important going forward.

Family interviews (3) summary, August 2018

Family 1

Learned about FMF from HPP at the FTM. At the time, the family (mom/dad/5 year old child) was living at a friend's house in Richmond (SF), but described themselves as homeless. The police came to the friend's house looking for the child since the child should have been in school at that age. The family thought he was to begin school at age 6. "We went through CPS and all that and that's how I got involved here." Neither parent was addicted to drugs.

HPP found the family housing in hotels in San Rafael. They lived in hotels for about a year, switching hotels every 30 days as required by the hotels. After living in hotels, HPP was able to get the family into Holloway House in SF. The interviewee speaks very highly of the social worker with HPP who helped him and his family with various needs along their journey – like vouchers for food. The family stayed at Holloway House for about six months. The interviewee described Holloway this way:

> *It was…well, you have to comply with rules, which I understand that. At a certain time, you had to go to sleep. It wasn't…I don't know what to say of it…a normal place, like home, like a regular home. It did its job. It helped us move forward as far as waiting for that opportunity to come up for the apartment. So it was a godsend basically*

While at Holloway House the interviewee conducted a housing search on his own, using the computer room. The interviewee said he received a little assistance from the staff at Holloway. After much searching, the interviewee was able to find an apartment in the city, and he has been there now for about a year and a month. He says it's a nice place and it's low-income, so he can afford to pay his rent. He said that HPP helped move him into the apartment and provided a van and furniture as well as kitchen supplies to get him and his family started. He describes his housing in the city this way:

> *Yeah, I feel safe here. It's a safe place. It's like a modern building. It's three or four years old, I imagine. I don't know, maybe eight, but I'd say it's pretty modern. It's pretty clean. It's healthy for my son and for the family. So it's okay. There's not transactions of illegal drug users or nothing like that. It's just families living there. So it's a comfortable place basically. It's a nice place to raise your kids.*

There's a school about a block away from the apartment, but his child wanted to continue to go to the school he's been going to while in the city, so he has to take a bus, which dad says isn't that bad.

Interviewee states repeatedly that he has no idea what he would have done or where he'd be without the staff at HPP, and his social worker in particular.

Interviewee also states that while he lived at Holloway House check-ins with his social worker occurred once a week or every two weeks. Now, as he nears graduation, he comes in to HPP if he needs help from his social worker and to say hi and that is it. He is reluctant to end his time with FMF and the HPP staff and especially his social worker.

He says this about his social worker:

> *She's always been, like I said, a godsend. She's always been a wonderful person as far as she helps a lot. Everybody, all the case managers, from the first time that I started here, they've all been very nice people. They'll give you a helping hand. I just don't know what else to say as far as how grateful. If it wasn't for this program, Homeless Prenatal, I don't know what would be going on right now with my life*

Family 2

At the time that interviewee two was accepted into the FMF program he was in a drug treatment program. Prior to the program, interviewee had been homeless "20-something" years. He was homeless when his daughter was born and that's how CPS got involved.

Interviewee found out at the FTM that he'd been accepted into the program. He stayed in the drug treatment program for about 10 months and was told that if he could find housing he could get custody of his daughter. His daughter was placed in foster care while dad was in the program. HPP then put him in Holloway House.

As soon as dad was placed at Holloway House his daughter was returned to him and the search for permanent housing began. Dad started attending housing workshops and started getting prepared for interviews with landlords. Dad mentioned his "really cool housing specialist" – Kylie. Dad says that he looked on his own and got assistance from Kylie. He finally found an apartment in Oakland.

Interviewee says the Oakland apartment was great, with a bus stop and grocery stores nearby. Interviewee says he lived at Holloway House about 3-4 months while looking for permanent housing. He liked Holloway a lot:

> *I liked Holloway. I liked it a lot. It's a shelter in a way, but I would recommend anybody, whoever wants to go to Holloway, I would strongly recommend them to go. Staff is cool there. They treat you with respect*

Interviewee reports that he could call his case manager anytime and he came in to HPP to do check-ins. He came for his fatherhood group once a week anyway, so it was easy to talk with case manager then. About his case worker he says: "But if I ever needed anything, all I had to do was call my case manager and she made it happen."

Home visits (once a month) began as soon as he was housed in Oakland.

Interviewee reports that Kylie would often act as an intermediary with the landlord whenever issues arose just because whenever he was in the HPP office Kylie would ask how things were going and if there was an issue, she'd offer to call.

Interviewee's daughter is doing well and he says that they (HPP) helped him get daycare for her. He also reported that the Infant/Parent program worked with him beginning at the time of his daughter's birth as he had anxiety related to handling a baby.

Interviewee states that he's feeling stable as he gets close to graduating from the program.

Great quotes about participation in FMF:

> *Yeah, it's a whole different ballgame now. But if they every mention that, I've heard people mention it in my fatherhood group that they got accepted. The first thing I say is "you ain't got to*

worry about nothing now, pretty much," because they're gonna help people with the housing and stuff

They're pretty much – how could I say it? They'll help you, hold your hand through it, say, It'll be okay. This is how we're going to do it. We'll get this application and I'll help you do it. I'm bad with computers so that was helping me. They will help you do your application online. When I got the interview for the apartment, they took me there

When asked at the end of the interview if he had any questions, he said no, "just give everybody a raise."

Appendix O. Time to CANS

Introduction

As of 2012, all children entering California's child welfare system were expected to quickly receive mental health screenings. In the county of San Francisco, the Department of Public Health (specifically the Foster Care Mental Health (FCMH) Program) has been contracted to administer mental health screenings for children in contact with child welfare. FCMH clinicians use the Child and Adolescent Needs and Strengths (CANS) assessment tool to screen mental health needs. Through this assessment, it is hoped that children with mental health needs can be identified and receive treatment.

As the essential gateway to services, it is important that the CANS be administered in a timely fashion, especially for homeless children who are at particularly high risk for experiencing adverse mental health outcomes. We analyzed administrative data to determine how long it takes children in FMF (control and treatment groups) to receive CANS screenings, and what factors are associated with the length of time it takes to receive the screening.

Methods

Our sample included children in both the treatment and control groups of the Families Moving Forward research project. Participants have been randomized into treatment and control groups prior to this research project as part of a larger evaluation of FMF. We observed the 239 children randomized into the program between November 1, 2013 and January 30, 2015.

Data pertaining to the length of time it takes to complete the CANS was collected through collaboration with the Foster Care Mental Health division of the San Francisco Department of Public Health (DPH). Data pertaining to the independent variables was collected from child welfare administrative data, and then cleaned and coded. The independent variables examined in the study include treatment/control, Family Maintenance (FM)/Family Reunification (FR) case status at case opening, date of case opening, age, ethnicity and language.

Descriptive statistics were collected pertaining to the percentage of children who had and had not received the CANS as of 3/1/2016, and how this varied across the independent variables described above. Subsequently, amongst the children who had completed the CANS, descriptive statistics were collected pertaining to how many days it took the children to receive the CANS.

Next, competing risk regression models were used to assess the impact of the independent variables on the time to CANS completion. A competing risk regression model is similar to a cox regression model, except that in addition to analyzing the time to an event of interest, it also takes into account whether or not an alternative event occurred that would prevent the event of interest from occurring. For our competing risk regression model, the primary event of interest was completion of the CANS, and the alternative event was identified as a case closure.

Results

Descriptive statistics. The descriptive statistics are summarized in Table 1 below. As of the time at data collection, 83% of children had received the CANS, 14% had their case closed before receiving the CANS,

and 3% had a case still open but had not received the CANS. Among children who had received the CANS, mean time from case opening to receiving the CANS was 106 days.

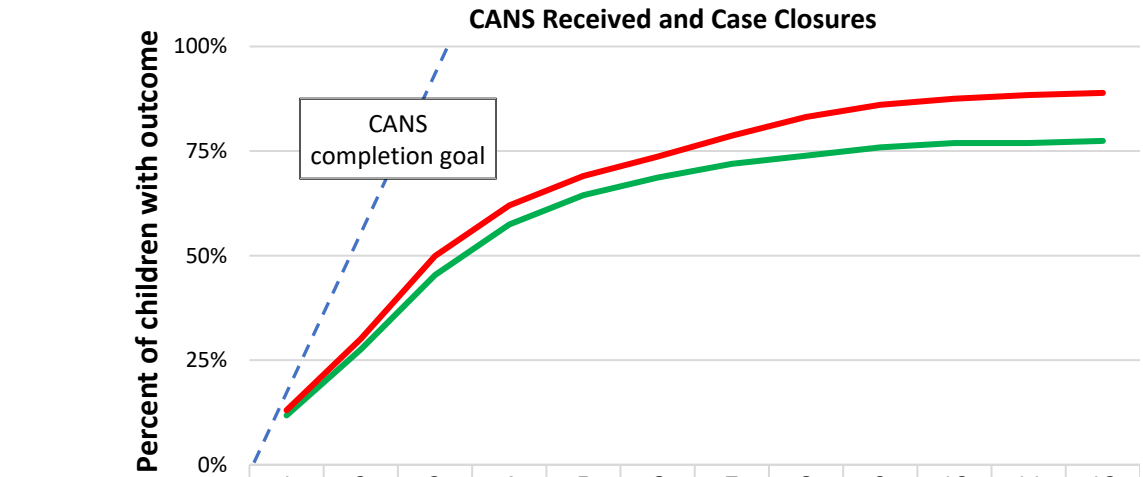
Table AI-O.1 Descriptive Statistics of Time to CANS

	Total	% of total sample	Received CANS	Case closed before CANS	Case is still open	*Mean time to CANS	*SD of time to CANS	*Median time to CANS
Total	239		198(83%)	34 (14%)	7 (3%)	106	100	79
FMF enrollment								
Treatment	122	51%	92 (75%)	25 (21%)	5 (4%)	107	107	76.5
Control	117	49%	106 (91%)	9 (8%)	2 (2%)	105	95	79
Case Status								
FM	118	49%	89 (75%)	26 (22%)	3 (3%)	115	120	75
FR	121	51%	109 (90%)	8 (7%)	4 (3%)	98	80	79
Age Category								
Less than 1	74	31%	64 (87%)	6 (8%)	4 (5%)	126	120	93.5
1 to 5	81	34%	66 (82%)	13 (16%)	2 (2%)	102	88	79
6 to 12	66	28%	55 (83%)	11 (17%)	0	92	78	79
13 to 17	18	8%	13 (72%)	4 (22%)	1 (5.6%)	84	126	54
SDM® Risk Level								
Medium Risk	21	9%	17 (81%)	4 (20%)	0	114	135	77
High Risk	98	41%	79 (81%)	18 (18%)	1 (1%)	87	83	72
Very High	120	50%	18 (18%)	12 (10%)	6 (5%)	119	104	90
Date of maltx report								
Nov 2013 - April 2014	57	24%	44 (77%)	13 (23%)	0	148	126	108
May 2014 - Oct 2014	72	30%	60 (83%)	12 (17%)	0	113	121	77
Nov 2014 - April 2015	54	23%	47 (87%)	4 (7%)	3 (6%)	74	49	57
May 2015 - Jan 2016**	56	23%	47 (84%)	5 (9%)	4 (7%)	90	63	79
Ethnicity								
White	47	20%	41 (87%)	3 (6%)	3 (6%)	138	115	109
Black	98	41%	83 (85%)	13 (13%)	2 (2%)	115	115	79
Latino	60	25%	49 (82%)	9 (15%)	2 (3%)	76	40	69
API	20	8%	14 (70%)	6 (30%)	0	114	100	86.5
Native American	5	2%	5 (100%)	0%	0	39	22	32
Primary Language								
English	205	86%	173 (84%)	26 (13%)	6 (3%)	114	103	85
Spanish	23	10%	18 (79%)	4 (17%)	1 (4%)	43	20	36.5
Other	2	1%	1 (50%)	1 (50%)	0	235	.	.

*Among those that received CANS

Competing Risk Regression

The cumulative incidence function of CANS being received and a case closing before receiving the CANS is shown in the figure below. A line showing what 100% of CANS completed within 2 months is also included in the figure, to show what the CANS completion cumulative incidence function line would look like if the agency was meetings its goals for CANS completions.



	1	2	3	4	5	6	7	8	9	10	11	12
Case closed	1%	3%	5%	5%	5%	5%	7%	9%	10%	11%	11%	11%
CANS received	12%	28%	45%	57%	64%	69%	72%	74%	76%	77%	77%	77%

Months since case opening

Discussion

As the results indicate, even though most children are receiving the CANS and the speed at which children are receiving the CANS has increased over time, there is still room for improvement. For example, while it is the agency's goal to administer the CANS for all children within 60 days of a case opening, 9% of children with case openings between May 2015 and January 2016 did not receive the CANS before their case closed, and the average time to receive the CANS amongst those that did was 90 days.

While this research project only examined a small subset of the total population of children involved in the San Francisco Human Services Agency (SF-HSA) child welfare system, the disparity between the agency's goals and what was happening in practice prompted a larger examination of the CANS administration process across the agency. The process of administering CANS was mapped out, aspects of this process that may lead to CANS being completely slowly or not at all were identified, and these findings were presented to SF-HSA child welfare management.

On another note, the process by which the CANS completion data was obtained from FCMH for the purpose of this research was a laborious one, suggesting that outcomes could be improved through a more streamlined process of tracking. A process of receiving data on CANS completions for all children is in the process of being developed as of the writing of this report, and in the meantime, FMF evaluators

are working with FCMH to identify a point person to provide CANS data on an ongoing basis moving forward.

Appendix P. Additional CANS Analysis

Table AI-P.1 Correlation Matrix of Five CANS Child Well-Being Indicators

		1	2	3	4	5
1	Anxiety	1				
2	Depression	**0.31**	1			
3	Developmental	**0.12**	0.06	1		
4	Adjustment to Trauma	**0.38**	**0.21**	**0.12**	1	
5	Interpersonal	**0.21**	**0.21**	**0.17**	**0.24**	1

Note: Bolded correlations significant at p=0.05

Table AI-P.2 Multigroup CFA of Five CANS Child Well-Being Indicators

	b	95% CI
anxiety		
MH	0.64***	(0.53, 0.75)
intercept	1.83***	(1.68, 1.98)
depression		
MH	0.44***	(0.33, 0.55)
intercept	1.23***	(1.10, 1.35)
developmental		
MH	0.21***	(0.10, 0.33)
intercept	0.49***	(0.40, 0.59)
adjtrauma_m		
MH	0.57***	(0.46, 0.67)
intercept	1.84***	(1.69, 1.99)
interpersonal		
MH	0.40***	(0.29, 0.51)
intercept	1.38***	(1.25, 1.50)
mean(MH)	0.00	
var(e.anxiety)	0.59	(0.47, 0.74)
var(e.depression)	0.81	(0.72, 0.90)
var(e.developmental)	0.95	(0.91, 1.00)
var(e.adjtrauma_m)	0.68	(0.57, 0.81)
var(e.interpersonal)	0.84	(0.76, 0.93)
var(MH)	1.00	

Note: Overall model n=454, SRMR=0.03, CD=0.62; years 0-1 n=156, SRMR=0.07, CD=0.62; years 1-2 n=141, SRMR=0.11, CD=0.66; years 2-3 n=91, SRMR=0.11, CD=0.63; years 3-4.85 n=66, SRMR=0.09, CD=0.62

Appendix Q. Other Outcomes: Earnings

Did treatment families increase their earnings more than control families?

Background

If stable housing provided a platform for families to focus on their other needs, increasing income might have become a priority for families. We hypothesized that treatment families would experience a larger increase in earnings than control group families, particularly in the out years, once housing stabilized.

Methodology

We obtained quarterly earnings of families from the State of California Employment Development Department (EDD). Data were matched on SSN and DOB; any families where both parents were missing at least one of these fields were dropped. We calculated the mean, minimum, 25th percentile, median, 75th percentile and maximum earnings for families for the year before randomization (this included the quarter earnings of the quarter a family was randomized), and the two years following randomization.

Results

Earnings tended to be low for both groups. About half of families had no reported earnings in any observed year. Among the top quartile, which only represents about 19 treatment and 17 control families – treatment families on average increased their earnings by nearly $2,800 from the first to second year after randomization, while control families on average experienced almost no change during that period.

Table AI-Q.1 Family Yearly Earnings Before and After Randomization, by Group

	Year Before Randomization		First Year After Randomization		Difference (First Year After - Year Before)		Second Year After Randomization		Difference (Second Year After-First Year after Randomization)	
	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control
N	74	67	74	67	-	-	74	67	-	-
Min	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
p25	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
p50	$47	$0	$0	$0	-$47	$0	$0	$0	$0	$0
p75	$3,550	$2,892	$3,004	$3,529	-$546	$636	$5,777	$3,496	$2,773	-$33
Max	$72,119	$38,921	$75,583	$41,654	$3,464	$2,733	$75,706	$52,559	$123	$10,905

Average earnings across families, even broken out by quartile, may wash out any meaningful growth among some families if others counterbalance that growth with declined earnings. We examined this by asking how many families increased their income, how many decreased, and how many had no change (Table AI-Q.2). In the year following randomization, about one-quarter of families in both groups had higher earnings in the year following randomization. Nearly all of the roughly half in both groups who had no change had $0 earnings in either year. Slightly more treatment families decreased their earnings during this period.

Table AI-Q.2 Number and Percent of Families with Increased, Decreased, or No Change in Yearly Earnings from One Year Prior to Randomization to One Year Post Randomization

	Treatment	Control	Treatment	Control
Total	74	67	100%	100%
Decrease	24	18	32%	27%
Increase	17	17	23%	25%
No Change	33	32	45%	48%

The picture improved somewhat between the end of the first year and the end of the second year following randomization. While about half in both groups still had no change (i.e., no earnings), slightly more treatment families experienced an increase and slightly fewer experienced earnings loss.

Table AI-Q3. Number and Percent of Families with Increased, Decreased, or No Change in Yearly Earnings between One and Two Years Post Randomization

	Treatment	Control	Treatment	Control
Total	74	67	100%	100%
Decrease	12	17	16%	25%
Increase	24	18	32%	27%
No Change	38	32	51%	48%

Appendix R. Other Outcomes: Public Benefits

Were treatment families more likely to initiate and maintain public benefits than control families?

Background

Part of the expected effect of a Housing First approach is that once stably housed, families may have the time and energy to pursue and maintain public benefits. In turn, those benefits should contribute to improved well-being in the form of greater cash and in-kind resources. The evaluation team took advantage of the database resources available within the Human Services Agency, the lead agency for FMF, linking the experimental data to an administrative database containing enrollment and benefit information on CalWORKS (California's TANF program), CalFRESH (California's SNAP program), General Assistance, and Medi-Cal (California's Medicaid program). We hypothesized that treatment families were more likely than control families to initiate an episode of public benefits following randomization.

Methods

Sample. Of the 79 treatment and 75 control families, most received at least one of the three benefits of interest at some point – either before, during, or after randomization to FMF (see Tables 1-3).

Measures. The administrative data indicated the beginning and end dates of Medi-Cal enrollment and the monthly dollar amount of CalWORKS, CalFRESH, and General Assistance disbursed to each family. From these data, we generated benefits episodes, where we interpreted more than one month between benefits disbursements as the end of one episode and the beginning of another. We then generated dichotomous variables for indicating whether each family initiated a CalWORKS, CalFRESH, General Assistance or Medi-Cal benefits episode before, during, and after randomization.

Analysis. We used logistic regression to test for the likelihood of initiating a benefits episode. We also examined whether length of post-randomization benefits episode differed by condition. We controlled for whether each family had ever initiated a benefits episode prior to randomization.

Results. Post-randomization, 23 treatment and 31 control families initiated an episode of CALWORKS benefits, 35 treatment and 39 control families initiated a CALFRESH episode, 17 treatment and 22 control families initiated a General Assistance episode, and 22 treatment and 26 control families initiated a Medi-Cal episode. Table 1-4 display descriptive statistics for each benefit type.

Table AI-R.1 Percent of families who had a spell of CalWORKS benefits before, during, and after randomization to Families Moving Forward

	Before			During			After			Ever		
Condition	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No
Treatment	100%	49%	51%	100%	47%	53%	100%	29%	71%	100%	87%	13%
Control	100%	43%	57%	100%	41%	59%	100%	41%	59%	100%	77%	23%
Total	100%	46%	54%	100%	44%	56%	100%	35%	65%	100%	82%	18%

Note: Total n = 154, Control n = 75 Treatment n = 79; a benefits spell is any period of time during which a family received consecutive benefits payments no more than 31 days apart

Table AI-R.2 Percent of families who had a spell of CalFRESH benefits before, during, and after randomization to Families Moving Forward

	Before			During			After			Ever		
Condition	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No
Treatment	100%	67%	33%	100%	66%	34%	100%	44%	56%	100%	95%	5%
Control	100%	55%	45%	100%	65%	35%	100%	52%	48%	100%	89%	11%
Total	100%	61%	39%	100%	66%	34%	100%	48%	52%	100%	92%	8%

Note: Total n = 154, Control n = 75 Treatment n = 79; a benefits spell is any period of time during which a family received consecutive benefits payments no more than 31 days apart

Table AI-R.3 Percent of families who had a spell of General Assistance benefits before, during, and after randomization to Families Moving Forward

	Before			During			After			Ever		
Condition	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No
Treatment	100%	39%	61%	100%	5%	95%	100%	22%	78%	100%	52%	48%
Control	100%	25%	75%	100%	3%	97%	100%	29%	71%	100%	44%	56%
Total	100%	32%	68%	100%	4%	96%	100%	25%	75%	100%	48%	52%

Note: Total n = 154, Control n = 75 Treatment n = 79; a benefits spell is any period of time during which a family received consecutive benefits payments no more than 31 days apart

Table AI-R.4 Percent of families who had a spell of Medi-Cal before, during, and after randomization to Families Moving Forward

	Before			During			After			Ever		
Condition	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No
Treatment	100%	96%	4%	100%	96%	4%	100%	28%	72%	100%	97%	3%
Control	100%	93%	7%	100%	92%	8%	100%	35%	65%	100%	97%	3%
Total	100%	95%	5%	100%	94%	6%	100%	31%	69%	100%	97%	3%

Note: Total n = 154, Control n = 75 Treatment n = 79; a benefits spell is any period of time during which a family received consecutive benefits payments no more than 31 days apart

After randomization, relative to control families, treatment families were less likely to initiate CalWORKS, more likely to initiate CalFRESH, and less likely to initiate General Assistance. When all three benefits were combined, treatment families were less likely to initiate any of the three, though none of these differences was significant. Both treatment and control families had high enrollment in Medi-Cal at time of randomization, and the control group was more likely to have a new episode initiated. There were no differences by condition with respect to length of post-randomization benefits episode.

Implications. Results provide no support for our initial hypothesis that treatment families would be more likely than control families to initiate episodes of public benefits. A possible explanation is that it is common for child welfare families to be referred to a worker that will connect families to the benefits they qualify for, and when relevant, help align the child welfare case plan and requirements of the CalWORKs program. Both groups were subject to these practices, and it is possible FMF does not provide any additional benefit beyond the business as usual condition.

Appendix S. Other Outcomes: Subsidized Employment

Were treatment families more likely to obtain subsidized employment?

Background

We anticipated that families housed through a housing first program would have more time and energy to pursue public benefits that improve financial stability. One such public benefit, JobsNOW!, provided access to employment opportunities and training for participants in one of a variety of other public service programs (e.g., CalWORKS). The evaluation team linked experimental data to an administrative database containing JobsNOW! employment information. We hypothesized that treatment families were more likely than control families to be hired through JobsNOW! following randomization.

Methods

Sample. Of the 79 treatment and 75 control families, 25 treatment families and 16 control families had parents who were hired at least once through JobsNOW! either before or after randomization.

Measures. The administrative data indicated the hire date, dollars per hour, and hours worked per week for each job that a parent obtained through JobsNOW!. From these data, we generated dichotomous variables indicating whether any parent in the family was hired through JobsNOW! ever, before randomization, and after randomization.

Analysis. We conducted chi-square tests that examined differences by condition in the number of families with parents hired through JobsNOW! post-randomization. Next, we used logistic regression to examine differences by condition in the odds of a parent being hired through JobsNOW! post-randomization.

Results. Only 20 percent of treatment families (n=16) and 15% of control families (n=11) were hired at least once through JobsNOW! following randomization. Table 1 displays the overall and by-condition percentage of families who were hired through JobsNOW! ever, before randomization, and after randomization. Chi-square tests indicated there were no significant differences by condition in the number of families hired through JobsNOW! after randomization.

Table AI-S.1 Percentage of Families Hired Through JobsNOW! Ever, Before Randomization, and After Randomization

	Overall % (n = 154)	Treatment % (n = 79)	Control % (n = 75)
Ever	27	32	21
Before Randomization	14	16	11
After Randomization	18	20	15

Note: Ever chi2(1) = 2.09, p = 0.148; before randomization chi2(1) = 1.09, p = 0.30; after randomization chi2(1) = 0.83, p = 0.36

Results from logistic regression analysis (see Table 2) indicated no significant difference in the odds of hire through JobsNOW! post-randomization.

Table AI-S.2 Logistic Regression Results: Differences by Condition in Odds of JobsNOW! Hire Post-Randomization

	OR	95% CI
Treatment vs control	1.48	(0.64, 3.43)
Intercept	0.17***	(0.09, 0.33)

Implications. Results provide no support for our initial hypothesis that parents from treatment families would be more likely than control families to be hired through JobsNOW! post-randomization. As in the case of our public benefits analysis, a possible explanation for this finding is that both treatment and control families would have been equally as likely to be directed by their child welfare worker to California's Linkages program, which connects families to the benefits for which they qualify. As a result, both groups may have been equally as likely to be hired through JobsNOW!

Appendix T. Other Outcomes: Education

Did treatment children have better educational outcomes?

Background

The evaluators hypothesized that FMF enrollment and the provision of permanent, supportive housing would lead to greater family stability, which would allow for caregivers to better meet the educational needs of their children by ensuring their enrollment and attendance in local schools. Increases in attendance would subsequently lead to improved rates of graduation and academic performance measures.

We tested this hypothesis by matching children in the FMF study to San Francisco Unified School District (SFUSD) administrative data which tracks – for each student enrolled in any SFUSD school – various educational outcome measures, including: student enrollment days, absences, drop outs, graduations, grade point averages (GPAs) and standardized test scores, among others. For students in grades kindergarten through 12th grade, SFUSD provided complete outcome data during the study period (2013-2014 through 2017-2018) and solely attendance data for three school years prior to the study period. For the pre-kindergarten students, SFUSD provided solely absence data for the school years during the study period (2013-2014 to 2017-2018). All SFUSD data included outcomes for both treatment and control children, which allowed for a comparative analysis.

Methods

Sample. Of the 133 treatment and 128 control children, over half (59% in each group) were enrolled in an SFUSD school at some point during the study period (See Table AI-T.1). Among those children enrolled in SFUSD schools, few were enrolled in pre-kindergarten (9 treatment and 8 control), whereas the remainder were enrolled in kindergarten through 12th grade (70 treatment and 67 control).

Table AI-T.1 Children in SFUSD School during School Years (2013-2014 to 1027-2018), by Condition

Total Children in Study (n)		In Any School (n)		In Pre-K (n)		In K-12 (n)		In Any School (%)	
Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control
133	128	79	75	9	8	70	67	59%	59%

Pre-K children were observed for either one or two years. K-12 children were observed between one and five years, and we were able to track half of this group for three years. Across all grades, not all children were observed during school years before randomization, at school year of randomization, or after randomization. We assume that some children may have been enrolled in another non-SFUSD school in San Francisco. Others may not be enrolled in any school.

Measures. Results were analyzed at the child level, separately for pre-K and K-12, and comparisons were made between treatment and control groups.

Year since Randomization. Results were further examined across time since randomization into FMF (pre-randomization, at randomization, and post-randomization). All data provided by SFUSD aggregated outcomes at the school year level, thus we compared outcomes over school years. We defined time

since randomization by the school year, with the beginning of the year starting on the first day of SFUSD instruction and the end of the year finishing on the last day of summer before the following school year start date. Therefore, we considered baseline data as occurring during the school year and subsequent summer during the year in which the child was randomized into FMF. The first year post-randomization was defined as the first school year entry date that occurred after randomization.

Absences. Among children in pre-kindergarten, total absences per child per school year were provided by SFUSD data. Among children in kindergarten through 12th grade, absences included a sum of unexcused absences, excused absences, and suspensions. We aggregated unexcused absences, excused absences, and suspensions as this is the SFUSD standard when examining overall absences and chronic absences (defined below).

Enrolled Days. Among children in pre-kindergarten, total enrolled days per child per school year were provided by SFUSD data. Among children in kindergarten through 12th grade, most students entered school at the school year start date and finished at the school year end date, thus being enrolled for the full school year. Total school days in the district was either 176 or 180 days, depending upon the year.

When a student started the year late, we adjusted the school entry date to be the school year start date, assuming that children in both the treatment and control groups were living in the San Francisco area and likely enrolled in another school beforehand. We made this assumption because the data received from SFUSD only recorded the most recent school entry date even in situations where students were enrolled in another SFUSD school earlier in the year. Total enrolled days were then calculated by subtracting a student's school leave date by the student's school entry date and adjusting for weekends and holidays. When school entry date was missing, we assumed the student enrolled on the first day of instruction. When school leave date was missing, we assumed the student completed school on the last day of instruction.

Percent Absent. Among children in all grades, we compared the percent of enrolled days absent between treatment and control groups. Percent absent was defined as a fraction of total days absent in a school year over total days enrolled in a school year.

Chronic Absence. Among children in kindergarten through 12th grade, we also examined counts of chronic absenteeism across treatment and control groups. Chronic absenteeism was defined as a dichotomous variable, where a student was considered chronically absent if he/she has an absence rate of 10% or more.[7]

Suspensions. Among children in kindergarten through 12th grade, we examined days suspended from school. Because the mean days suspended was quite low (0.4 days), the median days suspended was zero, and the range of suspensions was narrow (0 to 19 days), we defined suspensions as a dichotomous variable and compared students who ever had any suspensions to those who had none.

Grade Point Average. Grade point average (GPA) was provided for students 6th through 12th grade GPA is based on a 4-point scale where 0 represents a failing average (F), 1.0 represents a D average, 2.0 represents a C average, 3.0 represents a B average, and 4.0 represents an A average among all classes.

[7] Our definition of chronic absence differs slightly from the SFUSD definition, which defines chronic absence only among students who have been enrolled in at least 45 days of school and have an absence rate of 90% or less.

Standardized Test Scores. Among all grades that participate (3rd through 8th and 11th), we examined State of California standardized test scores in English Language Arts and Math. Scores for both subjects were examined by achievement levels which ranged from 1 to 4, where 1 is defined as state standard not met, 2 is state standard nearly met, 3 is state standard met, and 4 is state standard exceeded. Scores of 3 or 4 indicate a student is "proficient" in the subject.

Graduations. Among children in 12th grade, we examined the number of students who graduated high school compared to those who did not.

District Transfers. Among children in kindergarten through 12th grade, we examined the number of student transfers to a school outside of the SFUSD. We compared the date in which a student left school with his/her randomization date to identify if a student moved to a school out-of-district before or after randomization. We compared students who transferred to those who did not.

Analysis. Descriptive statistics were examined for each outcome using two-way t-tests or chi-squared tests. To assess individual student changes over time, we included only students who had data both at school year of randomization and some school year after randomization. Pre-kindergarten outcomes were ultimately not analyzed because the number of children (9 treatment and 8 control) was small. There were also too few 12th graders over the period to examine graduation rates.

Kindergarten through 12th Grade Results

We analyzed student behavioral outcomes, student academic achievement, and school stability. The table below details research questions by theme.

Table AI-T.2. Research Questions

Student Behavioral Outcomes	Student Academic Achievement Outcomes	Student Stability Outcomes
• *Absence:* Are treatment children absent less than control children? • *Chronic Absence:* Are treatment children chronically absent less than control children? • *Suspensions:* Are treatment children suspended less than control children?	• *Grade Point Average:* Do treatment children perform better than control children in terms of Grade Point Average? • *Standardized Test Scores:* Do treatment children perform better than control children on standardized tests? • *Graduations:* Do treatment children graduate on time more than control children?	• *District Transfers:* Do treatment children move out of the school district less than control children?

Descriptively, there were some differences across treatment and control groups post-randomization. Tables AI-T.3 and AI-T.4 show these differences, where Table AI-T.3 includes all continuous variables and Table AI-T.4 includes all dichotomous variables.

Table AI-T.3. Post-Randomization Differences in Continuous Outcomes

	Overall		Treatment		Control	
	n	mean	n	mean	n	mean
Mean Percent Absent	67	16%	36	18%	31	14%
Grade Point Average	41	2.37	21	2.65	20	2.05
Standardized Test Scores						
English Language Arts	49	1.41	24	1.5	25	1.35
Math	48	1.37	23	1.47	25	1.3

Table AI-T.4. Post-Randomization Differences in Dichotomous Outcomes

	Overall		Treatment		Control	
	n	%	n	%	n	%
Chronic Absenteeism	42	63%	23	64%	19	61%
Suspensions	14	15%	5	10%	9	20%
Graduations	8	88%	6	86%	1	100%
School Moves	20	17%	15	24%	5	9%

School Behavioral Outcomes

Did treatment children have fewer school absences than control children?

A total of 70 treatment children and 67 control children were enrolled in an SFUSD school in kindergarten through 12th grade during the observation period. Mean percent absences were calculated at time of randomization and averaged across post-randomization years. Table AI-T.5 results show no significant difference across groups, although descriptively, treatment children were on average more absent than control children over the post-randomization years.

Table AI-T.5. K-12 Mean Percent Absent at and Post-Randomization

	School Year of Randomization		School Years Post-Randomization	
	Treatment	Control	Treatment	Control
Total Children	36	31	36	31
Mean Percent Absences	12%	11%	18%	14%
p-value	0.72		0.44	

Mean percent absences were also calculated each year post-randomization to allow for a more nuanced examination across time for the 36 treatment and 31 control group children who were in school during the year their families entered the experiment (See Table AI-T.6). The fourth school year post-randomization, the mean percent absenteeism among treatment children was two percentage points less than that of control children; however, this difference is not statistically significant. Treatment children tended to be absent more than control children during the first, second, and third school years

post-randomization, though these differences were not statistically significant. A regression analysis corroborated the finding.

Table AI-T.6. K-12 Percent Absent Outcomes at and After Randomization by School Year

	School Year Randomized		Post-Randomization							
			1st School Year		2nd School Year		3rd School Year		4th School Year	
	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control
Total Children	36	31	35	28	25	24	16	20	11	11
Mean Percent Absent	18%	14%	22%	17%	14%	11%	25%	16%	7%	9%
p-value	0.44		0.42		0.51		0.31		0.79	

Were treatment children less likely than control children to be chronically absent?

Chronic absenteeism was calculated at time of randomization and averaged across post-randomization years. The difference was not significant (Table AI-T.7).

Table AI-T.7. K-12 Chronic Absenteeism Pre-, At, and Post-Randomization

	School Year at Randomization		School Years Post-Randomization	
	Treatment	Control	Treatment	Control
Total Children (n)	36	31	36	31
Children Chronically Absent (n)	16	14	23	19
Percent (%)	44%	45%	64%	61%
p-value	1.00		1.00	

Chronic absenteeism was also calculated for each year post-randomization for the 36 treatment and 31 control children in school when their families entered the experiment (See Table AI-T.8). After the first year, the rate declined for both groups but no important differences emerged when we examined the issue in a regression context.

Table AI-T.8. K-12 Chronic Absenteeism Outcomes at and after Randomization by School Year

	School Year Randomized		Post-Randomization							
			1st School Year		2nd School Year		3rd School Year		4th School Year	
	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control
Total Children (n)	36	31	35	28	25	24	16	20	11	11
Children Chronically Absent (n)	16	14	18	17	10	8	7	8	4	4
Percent (%)	44%	45%	51%	61%	40%	33%	44%	40%	36%	36%
p-value	1.00		0.61		0.77		1.00		1.00	

Were treatment children less likely than control children to be suspended from school?

We examined whether or not a student had been suspended during the year of randomization and averaged across post-randomization years in Table AI-T.9. The suspension rate increased for both groups but the difference between the groups was not significant.

Table AI-T.9. K-12 Suspensions at and Post-Randomization

	School Year Of Randomization		School Years Post-Randomization	
	Treatment	Control	Treatment	Control
Total Children (n)	36	31	36	31
Children with Any Suspensions (n)	2	3	7	10
Percent (%)	6%	10%	19%	32%
p-value	0.66		0.41	

Again, we examined the outcome by year (See Table AI-T.10). For all school years post-randomization, treatment children were consistently less likely than control children to be suspended; however, these differences were not statistically significant.

Table AI-T.10. K-12 Suspensions Outcomes at and After Randomization by School Year

	School Year Randomized		Post-Randomization							
			1st School Year		2nd School Year		3rd School Year		4th School Year	
	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Control
Total Children (n)	36	31	35	28	25	25	16	21	12	12
Children with Any Suspensions (n)	2	3	4	5	1	5	1	3	1	3
Percent (%)	6%	10%	11%	18%	4%	20%	6%	14%	8%	25%
p-value	0.66		0.49		0.19		0.62		0.59	

School Academic Achievement Outcomes

Did treatment children perform better than control children in terms of Grade Point Average?

At SFUSD, Grade Point Averages (GPAs) are calculated from grades 6 through 12. These GPAs were examined at time of randomization and post-randomization. Table AI-T.11 shows that treatment children as a group had higher mean GPA, and the difference approached significance (p=0.06).

Table AI-T.11. 6-12 Grade Point Averages at and Post-Randomization

	At Randomization		Post-Randomization	
	Treatment	Control	Treatment	Control
Total Children (n)	12	8	21	20
Mean GPA	1.84	2.15	2.65	2.05
Standard Deviation	1.20	.99	.92	1.08
p-value	0.55		0.06	

Did treatment children perform better than control children on standardized tests?

Standardized tests in both English and Language Arts and Math are taken by students in grades 3 through 8 and grade 11. These tests were compared at time of randomization and averaged across years post-randomization. Post-randomization, treatment children do not significantly outperform control children in both subjects (Table AI-T.12). All treatment and control children performed less than "proficient" across both time periods and in both subjects.

Table AI-T.12. 3rd-8th, 11th Grade Standardized Test Scores at and Post-Randomization

	At Randomization		Post-Randomization	
	Treatment	Control	Treatment	Control
Total Children (N)	4	7	24	25
Mean English Language Arts Score	1.25	1.71	1.5	1.35
Standard Deviation	.5	.95	.75	.62
p-value	0.31		0.45	
Total Children (N)	4	7	23	25
Mean Math Score	1.25	1.43	1.47	1.30
Standard Deviation	.5	.53	.77	.43
p-value	0.59		0.34	

School Stability

Did treatment children have greater school stability (fewer district transfers) than control children?

Table AI-T.13 examines whether or not children ever moved to a school out of district, either in the observation years before randomization or after. One quarter of treatment group children moved out of district following randomization while only 12 percent of control group children did; however, the difference was not significant. This may be because many treatment families left San Francisco County to use their housing voucher in more affordable counties.

Table AI-T.13. District Transfers

	Post-Randomization	
	Treatment	Control
Total Children	68	59
Children who Moved Out of District (n)	17	7
Percent (%)	25%	12%
p-value	0.12	

Implications. We were not able to assess many school outcomes because of low numbers of children. Among those we could examine, there were no significant treatment effects except for GPA among 6th to 12th graders which approached significance.

Appendix U. Other Outcomes: Subsidized Childcare

Were treatment children more likely to use subsidized childcare than control children?

Background

The evaluators hypothesized that FMF enrollment would lead to higher uptake of other public services, including subsidized child care. We tested this hypothesis by linking children in the FMF study to San Francisco's Office of Early Care and Education (OECE) administrative data which tracks the delivery of public child care subsidies in San Francisco, and compared differences in uptake and stability of subsidized child care.

Methods

We defined a positive child care outcome as either a) not in child care at time of randomization and began child care by 6/30/2018 or b) in child care at time of randomization, and having subsidized child care authorized for at least 9 of the 12 months following randomization. We limited the sample to children 12 and younger because only children of that age were eligible to receive subsidized child care through OECE. We also did a sub-group analysis on children who were and weren't old enough to be enrolled in Kindergarten at time of randomization.

Results

Children in the control group were more likely to have a positive child care outcome (Control=40 percent; Treatment=32 percent) but the difference was not statistically significant. Children in the control group were also more likely to have a positive child care outcome in both of the sub-groups analyzed, although again the difference was not statistically significant.

Table AI-U.1 Children with Positive Child Care Outcome

	Total Children (n)		Positive Outcome (n)		Positive Outcome (%)		
	Treatment	Control	Treatment	Control	Treatment	Control	p
Total	120	121	38	49	32%	40%	0.15
Age							
Pre-K	86	77	32	39	37%	51%	0.08
K to Age 12	34	44	6	10	18%	23%	0.58

Note: P-value for Chi-Square Test

Implications

Results provide no support for our hypothesis that treatment families would have higher uptake of subsidized child care. A possible explanation is that treatment and control families were equally likely to be referred to this service by their child welfare worker, and the case management and housing support of FMF offered no additional benefit beyond this business as usual condition

Appendix V. Caseload Model

Parameters:

Monthly Homeless Admissions (Families)[1]	5.0
CM weekly hrs/family intake/engagement, phase I (mo 1-9)[2]	2.5
CM weekly hrs/family stabilization phase II (mo 10-13)[3]	1.4
CM weekly hrs/family maintenance, phase III (mo 14-19)[4]	0.5
Weekly non-CM hrs[5]	16.0
Phase I length (months)[6]	9.0
Phase II length (months)[7]	4.0
Phase III length (months)[8]	6.0

	Total Caseload					Total Weekly HOURS				Total FTEs			
	Admits	Phase 1	Phase 2	Phase 3	**Total**	Phase 1	Phase 2	Phase 3	Total	Phase 1	Phase 2	Phase 3	**Total**
Jan	5	5			**5**	12.7	0.0	0.0	12.7	0.5	0.0	0.0	**0.5**
Feb	5	10			**10**	25.4	0.0	0.0	25.4	1.1	0.0	0.0	**1.1**
Mar	5	15			**15**	38.1	0.0	0.0	38.1	1.6	0.0	0.0	**1.6**
Apr	5	20			**20**	50.8	0.0	0.0	50.8	2.1	0.0	0.0	**2.1**
May	5	25			**25**	63.5	0.0	0.0	63.5	2.6	0.0	0.0	**2.6**
Jun	5	30			**30**	76.2	0.0	0.0	76.2	3.2	0.0	0.0	**3.2**
Jul	5	35			**35**	88.9	0.0	0.0	88.9	3.7	0.0	0.0	**3.7**
Aug	5	40			**40**	101.6	0.0	0.0	101.6	4.2	0.0	0.0	**4.2**
Sep	5	45			**45**	114.3	0.0	0.0	114.3	**4.8**	0.0	0.0	**4.8**
Oct	5	45	5		**50**	114.3	6.8	0.0	121.1	4.8	0.3	0.0	**5.0**
Nov	5	45	10		**55**	114.3	13.6	0.0	127.9	4.8	0.6	0.0	**5.3**
Dec	5	45	15		**60**	114.3	20.4	0.0	134.8	4.8	0.9	0.0	**5.6**
Jan	5	45	20		**65**	114.3	27.3	0.0	141.6	4.8	**1.1**	0.0	**5.9**
Feb	5	45	20	5	**70**	114.3	27.3	2.7	144.2	4.8	1.1	0.1	**6.0**
Mar	5	45	20	10	**75**	114.3	27.3	5.3	146.9	4.8	1.1	0.2	**6.1**
Apr	5	45	20	15	**80**	114.3	27.3	8.0	149.5	4.8	1.1	0.3	**6.2**
May	5	45	20	20	**85**	114.3	27.3	10.6	152.2	4.8	1.1	0.4	**6.3**
Jun	5	45	20	25	**90**	114.3	27.3	13.3	154.8	4.8	1.1	0.6	**6.5**
Jul	5	45	20	30	**95**	114.3	27.3	15.9	157.5	4.8	1.1	**0.7**	**6.6**

[1]Based on annual estimates from SDM® risk assessments, 2013-2015 3-year average.
[2]All data are from HPP's Henri database. Hours are based on mean monthly pre-lease hours.
[3]Hours are based on mean monthly post-lease hours.
[4]Hours are based on mean monthly check-in hours.
[5]Includes traveling to out-of-county clients, training, time off, admin and other duties.
[6]Phase length is based on median time to housing for 46 families housed as of January, 2017. Time to housing has not accelerated in recent months/years.
[7]Progression to Phase II is marked by reduced need on ANSA's adjustment to trauma domain. CM hours decrease accordingly.
[8]Progression to Phase III requires child welfare case closure and no moderate or severe needs on the ANSA.

Families Moving Forward Year 1
Interim Implementation Evaluation Report, July 2014

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Six Month Interim Implementation Evaluation Report

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Introduction

The San Francisco Human Services Agency (SF-HSA) is one of five sites awarded a five-year federal grant to provide housing and supportive services to child welfare-involved homeless families in San Francisco. SF-HSA's federally funded demonstration project is the Families Moving Forward (FMF)[8] initiative. Under this initiative, homeless families who are at risk of having their children removed (or who have had them recently removed) by child welfare workers receive placement into subsidized housing along with intensive, multi- disciplinary case management and rapid connections to community-based services and supports to improve family functioning and well-being.

Establishing housing first is hypothesized to have a stabilizing effect on families by providing a platform to support the provision of ancillary services that are matched specifically to each family who have co-occurring mental health and/or substance abuse issues (Padgett and Tsemberis 2006). Together the mix of housing and services is expected to keep the family together, while also improving family-functioning as well as individual family member well-being.

Project Description

SF-HSA is partnering with several community-based partners to implement the project. The Homeless Prenatal Program (HPP) is the lead agency administering the program. SF-HSA has contracted with HPP to conduct intake assessments, coordinate housing and ancillary services, and provide case management for all of the treatment families selected into the program. Other key project partners are Public Consulting Group (PCG), the San Francisco Housing Authority (SF-HA), the San Francisco Department of Public Health (DPH), and the Infant Parent Program (IPP).

The project will serve a randomly selected treatment group of approximately 150 families over the course of the five-year grant period with a randomized control group of approximately 150 families. Additionally, the project participants also include the twelve pilot families who were enrolled prior to the October 1, 2013 official implementation start. Since these families were not randomized, they are not considered part of the experiment but receive the same programming as the treatment group.

[8] The project was known as Rapid Support and Housing for Families (RSHF) prior to implementation

The control group receives treatment as usual from SF-HSA and other service providers while the treatment group is placed in subsidized housing with an array of supportive services. For the control group, treatment as usual means that while their child welfare case is open, they receive case management services from SF-HSA. This could include referrals for assessment and services, as well as linkages to community supports and housing assistance. The treatment group is referred directly to HPP. There, a designated case management team ensures that they have immediately secured temporary housing, as a bridge while the family and treatment team work to locate permanent housing. In addition, the case management team conducts assessments and intake, and works closely with the family to ensure that they are linked with specific support services.

Anticipated outcomes of treatment include: a decreased rate of placement of children in out-of- home care; a decrease in the rate of re-abuse of children; increase in housing stability; increase in school attendance; increase in employment participation or securing of SSI benefits; and improved social and emotional functioning of children and parents.

Evaluation Overview

The FMF initiative was launched on October 1, 2013 and the first annual evaluation report will be produced in November 2014. This report serves as the first interim evaluation report for the project and is intended to be preliminary with a primary focus on pre and early implementation activities. This review first provides an overview of the Process/Implementation Evaluation approach. We describe pre-implementation activities, and then early program implementation activities focusing first on program launch activities, second on data collection activities to date, and finally on the ongoing CQI activities which connect closely to both program implementation and data collection, as well as to overall project oversight and implementation.

At the end of the first quarter in Year 3, we will submit a final, more comprehensive evaluation report that will elaborate and expand upon the areas included in this interim report, and include detail about the pilot families as well as the treatment and control families.

Implementation Process Evaluation

Evaluation Design

The purpose of the Process/Implementation Evaluation is to examine the extent to which program planning and implementation activities unfold consistent with the logic model and with the intervention design. Because the evaluation is explicitly embedded in a Continuous Quality Improvement (CQI) framework, it also designed to promote regular feedback to project partners. Evaluators use the key concepts of implementation science that are in-line with CQI as a framework for evaluating the planning and implementation process. This approach reflects the growing current in social policy design, implementation, and evaluation that calls for programs to be designed with rigor, implemented with fidelity, and evaluated with empiricism and in prescribed intervals during the performance period (Carman 2007; Carrilio 2008; Ethiraj 2009; Lee et al 2007; Wulczyn 2007).

Continuous Quality Improvement Framework

Sometimes called CQI – other times referred to as "Plan-Do-Study-Act", this approach combines rigorous evaluation methods with the real world contingencies associated with implementing complex social programs such as FMF. The figure below illustrates the full CQI cycle of improvement.

During the ten-month planning period from November 2012 to October 2013, the work of the project partners, including the evaluators, largely focused on refinements to the "Plan" box. Partners further refined the theory of change and clarified the process, quality and capacity investments that were necessary to fully launch the intervention on October 1, 2013. The "Study" box is where the primary evaluation activities unfold over the course of the project and is the focus of the program service delivery section of this report.

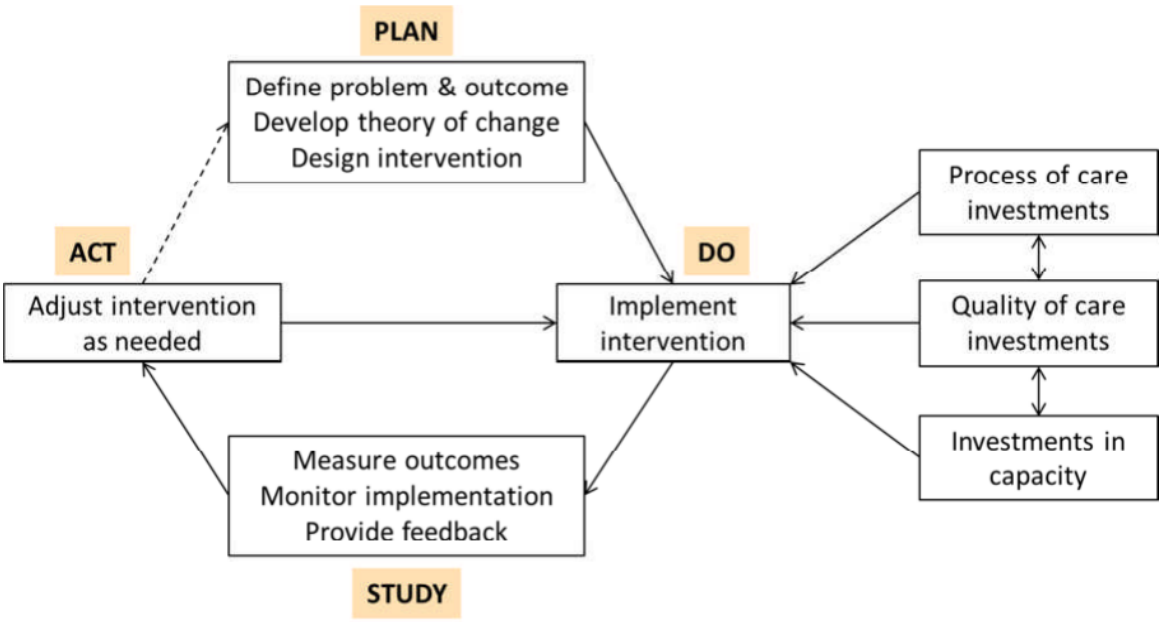

Figure 1. Continuous Quality Improvement (CQI) Process

Because evaluation activities occur at regular intervals following project implementation, preliminary results from both the process and the outcomes are fed back to project partners. In cases where adjustments are necessary -- represented by the "Act" box – those adjustments are developed, implemented, and evaluated to continue the feedback loop that characterizes both the CQI process, and the overall approach to the local evaluation.

Implementation Evaluation Questions

As described in the project Implementation Plan, the process/implementation evaluation draws from the field of implementation science with particular reliance on the Stages of Implementation Completion (SIC). This tool was developed specifically for child welfare programs and is designed to cohere to the CQI process by giving organizations feedback on their progress toward effective implementation. The SIC framework is divided into three phases with a total of eight stages. The first phase—pre-implementation—involves engagement, consideration of feasibility, and readiness planning. The second stage is implementation, characterized by staff hiring and training, creating an adherence monitoring system, beginning to provide services and consultation, and ongoing activities (service provision, consultation, fidelity monitoring and feedback). The third and final stage is sustaining implementation by establishing competency through licensing and other formal mechanisms.

Accordingly, the research questions for the process/implementation evaluation are defined by the three stages of pre-implementation, implementation, and sustainability, and the evaluation is designed to address the following questions, which relate back to the process, quality, and capacity investments:

Pre-Implementation planning

- How were key project partners identified and engaged in collaboration?
- How did project partners conduct implementation planning?

Implementation of the program model

- Did project partners adhere to the process of care as described in the rationale for those families selected into the treatment group?
- To what extent are the treatment families having the intended process of care experience?
- To what extent were the partners prepared and able to make the process and quality changes associated with project implementation?

Sustainability of the program model

- What processes/procedures were put in place to ensure the sustainability of the program model?

To organize our approach to address these questions, we rely on the framework outlined in Figure 2 below[9], which depicts the Implementation Phase, corresponding Implementation Stage, and the research tools and resources that support evaluation of these activities.

This six month interim report begins to answer these questions using the methods described above to document implementation process activities associated with pre-implementation planning and early implementation of the program model (as it is too early in the implementation process to evaluate sustainability). The annual evaluation report, due at the end of November 2014, will consider in more depth the implementation process and the extent to which it is consistent with implementation science research.

Implementation Science Phase	Implementation Stage	Research Tools and Resources
Pre-implementation	1- Engagement	Interviews, RFP response
	2- Consideration of feasibility	Interviews, RFP response, Key Decisions
	3 - Readiness Planning	Interviews, RFP response, Implementation Plan, Implementation Checklist
Implementation	4 -Staff hired and trained	Interviews, Implementation Plan, Implementation Checklist, Key Decisions, Training and Meeting Tracker
	5- Adherence monitoring in place	Interviews, Key Decisions, Training and Meeting Tracker, Monthly Dashboard, Core Services Database, Core Analytic Database
	6- Services and consultation begin	Interviews, Key Decisions, Training and Meeting Tracker, Monthly Dashboard, Core Services Database, Core Analytic Database
	7 - Ongoing services, consultation, fidelity monitoring, and feedback	Interviews, Key Decisions, Training and Meeting Tracker, Monthly Dashboard, Core Services Database, Core Analytic Database
Sustainability	8 - Competency	Interviews, Training and Meeting Tracker, Evaluation Reports

Figure 2. Implementation Science Evaluation Framework

[9] This framework is based on a review of implementation science literature. The main phases and stages of implementation are taken from the Stages of Implementation Completion (SIC) framework that was created to track the implementation of an evidence-based child welfare program (Chamberlain, Brown, and Saldana 2011). The SIC was also cross-referenced with a synthesis of critical steps in the implementation process (Meyers, Durlak, and Wandersman 2012) that reviews the frequency of key implementation phases and stages in 25 implementation frameworks.

Pre-Implementation Planning

The process of engaging partners has been documented through a systems change logic model and is reflected in the committee structure that governed implementation planning, implementation, and ongoing monitoring. A core strength of the FMF initiative has been this committee structure and its regular meetings, which allowed for a relatively seamless transition from pre implementation activities to actual implementation. Supporting both committee process and the transition to implementation is the documentation of key decisions, as well as the development of working policy papers that describe core program decisions.

Finally, a recent project launch event also demonstrates project engagement and cross-systems collaboration, and the transition from planning to implementation. Further qualitative information on engagement and pre-implementation planning has been gathered from interviews with administrators and project staff, and will be analyzed in greater detail for the annual evaluation report.

How were key project partners identified and engaged in collaboration?

Systems Change Logic Model

The project is built on cross-system collaboration model (see Figure 3). The current system in San Francisco is described as providing services on an as needed basis to individual clients. FMF is intended to more effectively serve clients across systems by facilitating collaboration across project partners to combine resources and strategically meet clients' service array. Early in the implementation planning process, SF-HSA formally partnered with both public and private organizations with a history of working collaboratively and effectively with SF-HSA. These included: Infant Parent Program (IPP), Public Consulting Group (PCG), Housing Authority (SF-HA), SF-HSA, HPP, and DPH.

Figure 3. Systems change logic model

Implementation Planning Committees

Project partners formally began implementation planning in November 2012. A steering committee comprised of the project partners was formed to facilitate the implementation process.[10] The steering committee met monthly during implementation planning and continues to meet monthly now that the project is implemented to discuss ongoing project management needs.

The steering committee formed three standing subcommittees to address housing, support services, and CQI. These committees met semimonthly during pre-implementation and both the CQI and the Support Services sub-committees have continued to meet on a regular basis to generate policy or program clarifications that support on-going program services. For example, the Support Services sub-committee drafted a working description of project partner roles and responsibilities services to guide program activities and to clarify partner responsibilities. Similarly, the CQI sub-committee documented the notification process for families referred to the program lottery. This document permits program stability through staff transitions, and is key to ensuring continuity through the full implementation period.

Project Launch Event

The committee structure allowed FMF to transition from pre-implementation to implementation. Focus on decisions associated with project implementation segued smoothly into refinements to be completed during implementation. The transition was well represented in early June when SF-HSA hosted a public event formally introducing the FMF project to the local community. SF-HSA hosted this project launch event for staff and leadership of project partners and other local service providers in an effort to both provide education about the initiative as well as to foster cross systems collaboration. Approximately 176 individuals attended and 41 agencies were represented. Guest speakers included JooYeun Chang, the Associate Commissioner of the Children's Bureau, and Dr. Carmela DeCandia, Director of National Center on Family Homelessness at the American Institutes for Research. Each speaker addressed current housing and policy research and attendees had the opportunity to ask questions.

[10] A comprehensive list of steering committee membership will be provided in the annual report.

How did project partners conduct implementation planning?

Targeting Strategy

Prior to the program start date, the steering committee, in consultation with Federal project officers, developed the targeting criteria that determined how families would be recruited into the FMF program.[11] Since the outcome evaluation has an experimental design, the strategy had to be implemented in a manner that supports random assignment. As discussed later in the CQI section, the targeting criteria were adjusted several times to reflect operational contingencies. The current targeting and referral process is described briefly below.

Families are referred to the lottery by an Emergency Response (ER) Supervisor at SF-HSA. Eligibility is determined through the Structured Decision Making (SDM) risk assessment. Families are considered eligible if they meet the following criteria documented on the Investigative Narrative:

1. Are considered homeless based on the established definition of homelessness[12]
2. A child welfare case will be opened—either family reunification (FR)[13] or family maintenance (FM) court or non-court.
3. At least one child on the referral has no prior open child welfare case.
4. One or more of the following risk factors are present based on the SDM:
    a. Caregiver: domestic violence, substance abuse, criminal history, mental health problem
    b. Child: medically fragile, developmental disability, physical disability, physical disability, mental health problem

If the family meets all of these criteria, the ER supervisor emails the FMF lottery (i.e., randomization system) within 2 days of case promotion.

SF-HSA CQI staff then reviews the referral to ensure the family is in fact eligible. If the child welfare case is FR, the case will be excluded from the lottery if:

1. Newborn removed within the first 30 days of life AND
2. All prior maternal siblings have been permanently removed.

If the review shows that the family is eligible, the family will be entered into the lottery within 30 days of the maltreatment referral to allow time for the child welfare investigation. The lottery is conducted by the national evaluator (the Urban Institute) using randomization software. If the family "loses" the lottery, they are considered part of the control group and will receive business as usual from SF-HSA. If a family

[11] See the Implementation Plan for a detailed description of the targeting approach and the quantitative evidence that was used to develop the specific criteria.
[12] See the Implementation Plan for the definition of homelessness.
[13] Note: the program began accepting FR cases in December 2013. See the CQI section for more detail.

"wins" the lottery, they are considered part of the treatment group and the subsequent process of care is described below.

Coordination of Care/Service Timeline

Following a lottery "win", families are expected to have their first Family Team Meeting (FTM) with the SF-HSA child welfare Caseworker, HPP Case Manager, and the HPP meeting facilitator within 5 days (see Figure 4). At this first meeting, the program is explained and families sign voluntary consent forms to participate in the program and release their data for evaluation. At the second FTM, more extensive case coordination begins. In the first 30 days of project enrollment prior to the second FTM, HPP conducts the ANSA to determine service need of adults in the family. HPP also uses the Housing Assessment Matrix (HAM) to assess the level of housing need for the entire family. While HPP is conducting these family assessments, DPH workers are alerted by the SF-HSA child welfare worker that a family has been referred to the FMF program. The DPH worker is then expected to conduct a Child and Adolescent Needs Survey (CANS) assessment, ideally within three days, for all children in the treatment family.

The treatment team then works together to create a coordinated case plan based on assessed need. At this time, HPP would begin making referrals for service needs including referrals to project partners IPP (for families with children under age 5) and PCG if Social Security Income (SSI) advocacy is needed. The family will also begin the housing search process, supported by their HPP case manager and the HPP Housing Specialist.

Monthly team meetings are expected to continue as long as the family remains in the program and requires supportive services. The extent to which the service timeline is completed within the desired timeframe will be evaluated in greater detail in the annual evaluation report. Early results included in this report suggest that treatment families are receiving their first FTM and completing Adult Needs and Strengths (ANSA) and HAM assessments. Service contact data also suggests that families are receiving regular case management through HPP.

However, the process associated with scheduling timely CANS assessments and securing the CANS assessment has been less successful. The processes associated with alerting DPH workers about the enrollment of treatment families, the scheduling of the assessments, and the transmittals of the assessments themselves have been inconsistent. These issues have been the subject of CQI and steering committee meetings, and efforts are underway to remediate this challenge. However, as of June 30, only 13 of the 35 children in the treatment families actually had completed a CANS, and many fewer of those CANS assessment had actually be transmitted to SF-HSA.

There are several CANS implementation delays related to the broader context of the Katie A. court case[14] that have to do with the expansion of the population from children in foster care to children at imminent risk of foster care (i.e., all open cases). First, DPH staffing has not scaled up in pace with the mandate to screen all children in the class. Second, the process by which Katie A. class children are referred from SF-HSA to DPH for CANS screening is not consistent or timely for this expanded population. Third, the 3-page CANS tool is in hardcopy only (not yet electronic), necessitating different data transmission procedures for the 3-page vs. the full CANS, which is stored electronically. Together, these challenges contribute to the delays in CANS screening for families in both the FMF treatment and control groups. As such, the evaluators do not yet have baseline CANS data to analyze, although the process to procure the CANS data once it becomes available to SF-HSA has been finalized and seems to be operating smoothly.

Housing Process

Based on HAM and ANSA results, families are assigned a housing subsidy. The subsidies available to program participants are:

1. A shallow subsidy for bellow market rate rent
2. Deep subsidy where rent is set at approximately 30 percent of income
3. Family Unification Program (FUP) vouchers (i.e. Section 8) that can be used for private market rental units that meet federal regulations
4. Local Operating Subsidy (LOSP) for permanent supportive public housing

Additionally, discretionary project funds are available to pay for incidentals such as security deposits and furniture. SF-HSA deep rental subsidy funds from outside of the project can be used to rapidly move families into hotels while they search for permanent housing. Once a family has been assigned a subsidy or voucher, they can begin the housing search with support from HPP's housing staff.

[14] A recent class action lawsuit in California resulted in a settlement agreement (referred to here as Katie A., in reference to the plaintiff) which sought to improve mental health services to all children in the identified class, i.e., those in or at imminent risk of placement in foster care. County child welfare agencies must now screen such children for mental health needs. DPH created an abbreviated 3-page CANS screening tool intended to accomplish this task quickly for the full population of children entering a child welfare case. Children go on to a full CANS assessment if the screening tool indicates the need.

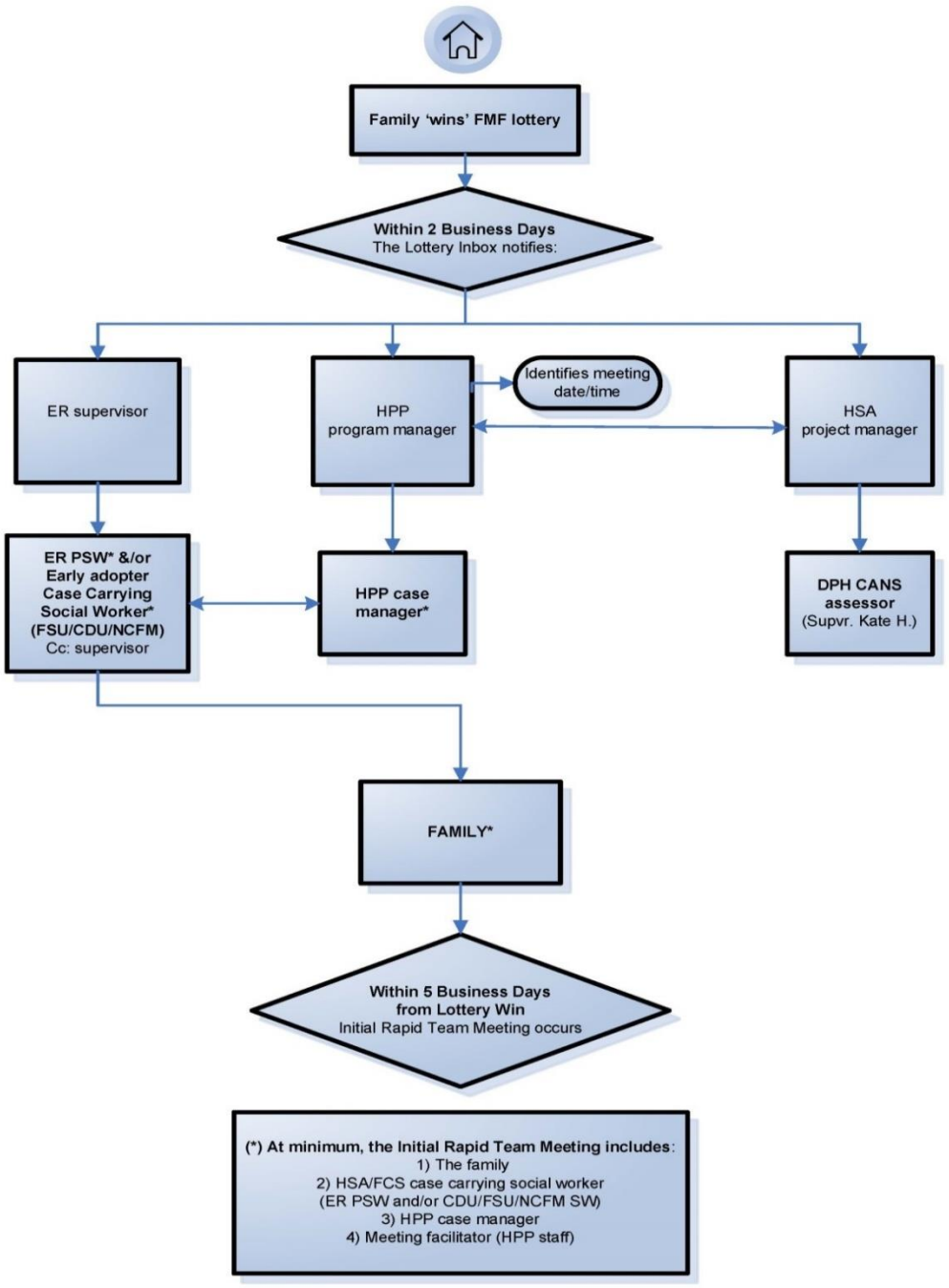

Figure 4. FMF Lottery Process

Program Implementation Activities

For this first interim report, it is too early to determine if partners are adhering to the full process of care for treatment families. However, preliminary data analysis does show that after referral to the treatment group, families do receive the assessments and participate in the family team meetings that are prescribed as part intake process. Additional information about early program experiences, summarized from the first round of staff interviews, indicates that staff have a good awareness of the program and its fundamental purposes. Finally, project partners, in particular HPP, have invested resources to refine their process of collecting and transmitting program data. This core capacity is critical to supporting program implementation and to identifying where adjustments are necessary, and is thus closely connected to program implementation as well as being vital to the evaluation itself. Both the quantitative and qualitative information that will be used to evaluate the process of care in subsequent reports is also briefly discussed in this section.

Did project partners adhere to the process of care as described in the rationale for those families selected into the treatment group?

Early implementation experiences from interviews

In June 2014, evaluators conducted baseline interviews of project staff involved in program implementation. Eleven HPP staff and four SF-HSA staff were interviewed for approximately one hour each. Interview questions were open-ended to allow respondents to share their individual perspectives on the implementation process. A combination of supervisors and front line staff were interviewed at both agencies.

Interview questions were aligned with implementation science domains of pre-implementation planning and program implementation. Questions related to pre-implementation planning included how the respondent became engaged in the project, and how they collaborate with project partners. Questions on program implementation asked the respondents to explain the FMF program model and how it is similar or different from other services their agency provides. Respondents were also asked to describe the

target population and challenges with serving this population. Additionally, respondents were asked about training, service practices, and data utilization used to serve treatment families.

The results of baseline interviews and follow up interviews will be analyzed in the annual evaluation report. Emerging results from the baseline interviews indicate that front line workers at SF-HSA who are early adopters understand the program model and its potential to help their clients. However, there were two instances where SF-HSA workers indicated some confusion with the program. A front line worker who was not an early adopter expressed frustration that neither she nor her supervisor had sufficient information about the program. Additionally, an Emergency Response supervisor described FMF as "another housing program" and did not recognize the supportive service aspect. FMF has provided multiple presentations and trainings about the project, as well as newsletter profiles and all-staff emails, but child welfare workers are generally uninformed about housing options for families, and one of the broader culture changes the project hopes to achieve is that the child welfare system will be more knowledgeable about the housing and homeless system for clients. The project has scheduled follow-up presentations to catch all out-stationed offices and any workers not yet engaged.

However, all SF-HSA respondents who are front-line workers valued the close collaboration with HPP the program's ability to help clients navigate services required for their child welfare case. The regular family team meetings were also valued by SF-HSA front line workers as a way to coordinate service delivery for their clients. Additionally, SF-HSA workers reported communicating with their HPP counterpart outside of FTMs.

HPP workers shared experiences working with both pilot and treatment families. At HPP, housing staff, case managers, and a program director were interviewed. The housing staff described the challenges of finding affordable housing in San Francisco and landlords who are willing to rent to low-income tenants. Housing staff also described how they have been able to engage landlords and assist families with the housing search. Case managers also described the process of assessing clients' needs, as well as early success and challenges of providing wrap around services.

Data Collection: Core Services Database

HPP Database

The first source of administrative data to evaluate service delivery is provided by HPP, who collects assessment, services, and contact data for treatment families referred to the FMF program. On a regular basis, HPP transfers extracts containing individual level data from their database, called Henri, to

Chapin Hall for inclusion in the project database. Those data, related only to treatment families, is a key source for the implementation evaluation.

Core Project and Services Database – Chapin Hall Data Collection

Secondly, Chapin Hall hosts a secure website housing the Core Project and Services Database (CSD). This database is accessible to trained project partners who have been assigned a unique user name and password. The combined Core Project and Services Databases have two functions. First, it tracks the assignment of eligible families to each treatment condition. Secondly, it tracks service and contact events provided by partners other than HPP to families in the treatment group.

1. Assignment Function:

SF-HSA project partners are trained to input data related to case assignment. Each time a family is assigned to either the treatment or the control group, the SF-HSA representative creates a record for the family and each family member in the database. The record contains the FMF project unique IDs for each family and each family member, first name and last name of each family member, birthdates, the date of enrollment, the date of program completion, and an indication to which group they are assigned - treatment or control. These data are linkable to the Core Analytic Database. Once linked, all identifying information is stripped from the Core Analytic Database.

2. Services/Contacts Function:

The second function of the Core Project and Services Database is to collect ongoing service and contact information for program participants receiving services from providers other than HPP, such as PCG and IPP. Those providers are offering services to pilot and treatment families in the FMF program under an MOU with SF-HSA which requires regular reporting of service provision.

Chapin Hall's web-based component of the CSD was launched in December 2013 to collect client referral information and to track service contacts with project partners to whom HPP refers clients. Prior to IRB approval in December 2013, the database was developed at Chapin Hall by an internal web programmer and tested by evaluators. Following IRB approval in December 2013, the database was shared with—and tested by—SF-HSA. Revisions were made to the database allowing SF-HSA to enter information for clients referred to the program that was being collected in an internal SF-HSA "lottery spreadsheet". This information includes ineligibility and exit reasons, whether the case is family maintenance or reunification, consent collection or refused dates, and IDs for HPP and SF-HSA allowing evaluators to easily link data.

These updates were complete in February 2014 and SF-HSA transferred referral data to Chapin Hall to enter. Chapin Hall then conducted trainings for the project partners who use the database to track

service events: the Infant Prenatal Program (IPP) and the Public Consulting Group (PCG). PCG is currently entering service data for clients referred for Social Service Income (SSI) advocacy from HPP. IPP is in the process of clearing Chapin Hall's IRB with UCSF before they can begin entering data in Chapin Hall's web database. In the meantime, IPP is entering service information in a spreadsheet that mirrors the database. Data from the CSD is currently being used to generate dashboards for the national evaluation, steering committee, and summarize enrollment for this report (see tables 1-6).

To what extent are the treatment families having the intended process of care experience?

Early descriptive information on the process of care has been analyzed from the CSD. Information on project enrollment over time, including basic demographic information is included from the Chapin Hall database. HPP service data on direct services, service referrals, ANSA, and housing events is also included. Since the treatment family sample size at this point in the project is too small to be statically significant (N=15), all of the data reported below is descriptive and should not be considered diagnostic. Data is current through May 31, 2014.

Enrollment report

As of May 31, 2014 there were 15 families in the treatment group and 13 in the control group. Some basic information on 12 pilot families enrolled in April-June 2013 is also included, although evaluation consent has not yet been collected on 2 pilot families that are excluded from descriptive data. The number of referrals have fluctuated some since the project "went live" in October 2013, yet the number of families in the treatment and control groups is comparable. The program began accepting family reunification (FR) cases in addition to family maintenance (FM) cases in December 2013, and the proportion of FM cases in the program is currently higher--approximately 60 percent of families are FM and 40 percent are FR. Treatment family size (including children and adults) ranges from 2-12, and every family has at least one child under age 5.

Family Level Data

Table 2 Referral Types by Year and Month

	Total Families	2013-APR	2013-MAY	2013-JUN	2013-OCT	2013-NOV	2013-DEC	2014-JAN	2014-FEB	2014-MAR	2014-APR	2014-MAY
Total	52	10	1	1	1	3	4	5	9	4	10	4
Pilot Group	12	10	1	1								
Ineligible	12				1	1	1	2	1	1	3	2
Control Group	13					1	1	1	3	2	4	1
FMF Treatment Group	15					1	2	2	5	1	3	1

Table 3 Referral Types by Child Welfare Status

	Total Families	Family Maintenance	Family Reunification	Total %	Family Maintenance	Family Reunification
Total	38	27	11	100%	71%	29%
Pilot Group	10	10		26%	100%	
Control Group	13	8	5	34%	62%	38%
FMF Treatment Group	15	9	6	39%	60%	40%

Table 4 Family Size by Referral Type

		Min	Max	Median	Mode	Mean
Pilot Group	**Full Family Size**	2	5	3	3	3
	Children per Family	1	4	2	1	2
	Children Under Age 5	1	3	2	1	2
Control Group	**Full Family Size**	2	7	3	2	4
	Children per Family	1	5	2	1	2
	Children Under Age 5	1	4	2	2	2
FMF Treatment Group	**Full Family Size**	2	12	3	2	4
	Children per Family	1	11	1	1	2
	Children Under Age 5	1	5	2	2	2

Client Level Data

Table 5 Client Referral Type by Month and Year

	Total Clients	2013-APR	2013-MAY	2013-JUN	2013-NOV	2013-DEC	2014-JAN	2014-FEB	2014-MAR	2014-APR	2014-MAY
Total	137	30	2	2	14	11	9	27	14	18	8
Pilot Group	34	30	2	2							
Control Group	47				2	6	3	12	12	7	5
FMF Treatment Group	56				12	5	8	15	2	11	3

Table 6 Referral Types by Family Membership

	Total Clients	Child	Mother	Father	Total %	Child	Mother	Father
Total	137	84	37	16	100%	61%	27%	12%
Control Group	47	28	13	6	34%	60%	28%	13%
FMF Treatment Group	56	35	15	6	41%	63%	27%	11%
Pilot Group	34	21	9	4	25%	62%	26%	12%

Table 7 Children Referred by Age Group

	Total Clients	Under 1	1 to 5	6 to 12	13 to17	18 to21	Total %	Under 1	1 to 5	6 to 12	13 to17	18 to21
Total	84	13	26	35	8	2	100%	15%	31%	42%	10%	2%
Control Group	28	5	10	12	1		33%	18%	36%	43%	4%	
FMF Treatment Group	35	7	10	13	5		42%	20%	29%	37%	14%	
Pilot Group	21	1	6	10	2	2	25%	5%	29%	48%	10%	10%

HPP service contacts report

HPP collects direct service data on family team meetings (FTMs), case management contacts, and "collateral" services where the case manager acts on behalf of the client (e.g. to contact SF-HSA). The data suggests that 14 of the 15 treatment families have had their first FTM. The number of monthly team meetings conducted with treatment families ranges from 0-5, although these numbers do not account for how long families have been enrolled in the program. Families

are receiving multiple service contacts, with all families experiencing an average of 23 case management contacts, 18 collateral services, and one home visit. Since these are early numbers for families with a range of enrollment times, these data are not conclusive.

Table 8 First and Monthly Family Team Meetings Conducted by Month

	Total	FMF Treatment Group						
		2013-NOV	2013-DEC	2014-JAN	2014-FEB	2014-MAR	2014-APR	2014-MAY
Total	43	1	2	5	4	10	8	13
First FTM	14	1	1	3	2	2	2	3
Monthly FTM	29		1	2	2	8	6	10

Table 9 Family Team Meeting Statistics

		Family Count	Min	Max	Median	Mode	Mean
Pilot Group	**Monthly Family Team Meetings**	6	0	5	2	0	2
	First Family Team Meetings	6	1	1	1	1	1
FMF Treatment Group	**Monthly Family Team Meetings**	14	0	5	2	2	2
	First Family Team Meetings	14	1	1	1	1	1

Table 10 Direct Service Statistics

		Family Count	Min	Max	Median	Mode	Mean
FMF Treatment Group	**Collateral Services**	15	3	65	14	9	18
	Case Management	15	1	58	23	7	23
	Home Visits	15	0	4	0	0	1
Pilot Group	**Collateral Services**	9	28	135	48	28	60
	Case Management	9	84	239	122	84	124
	Home Visits	9	0	20	2	2	4

HPP referrals report

HPP makes referrals for internal services and provides in-house and external referrals to project partners IPP and PCG and other specialized providers (e.g. mental health). Families may receive multiple referrals depending on their specific needs, and Henri (HPP's database) is designed to

capture each referral made for each family. Data displayed in Table 10 suggests that to date, 11 referrals have been made for treatment families in FMF, about half of which are internal and half of which are external. HPP is in the process of implementing database updates that will provide more detail on the type of referred service and referral status for future reports. At that time evaluators will examine timing of referrals and how that relates to uptake. Baseline interviews suggest that families in the initial stages of project engagement often have so much flux and uncertainty in their lives that it may be best not to brace them with too many service referrals at the outset.

Table 11 Treatment Group Service Referrals

	Total	FMF Treatment Group				Total %
		2014-JAN	2014-MAR	2014-APR	2014-MAY	
Total	11	3	4	3	1	100%
FMF Referral	4	3	1			36%
External Referral	5		3	1	1	45%
HPP In-House Referral	2			2		18%

ANSA data summary

Among the 15 treatment families, first ANSA assessments have been conducted for 14 adults as of May 31, 2014. The ANSA collects data on client demographics, and scores client needs and strengths on various domains. Race information and highest level of education at the individual adult level are summarized below, although the sample size is currently too small to draw any conclusions about client characteristics. Early data suggests that clients receive income from a variety of sources including TANF, SNAP, and SSI. ANSA scores on various domains are summarized, yet no conclusions can be drawn at this point due to the small sample size and missing data for clients. ANSA scoring is as follows:

For needs:
0 = No evidence
1 = Watchful waiting/prevention
2 = Action
3 = Immediate/Intensive Action

For strengths:
0 = Centerpiece strength

1 = Strength that you can use in planning
2 = Strength has been identified-must be built
3 = No strength identified

A score of 2 or 3 on the needs assessment suggests that action is needed. Preliminary data suggests that families are the most likely to need action on family functioning and residential stability.

Table 12 ANSA Assessments Conducted by Month

	Total	First Assessments Conducted by Year and Month								
		2013-APR	201-3JUN	2013-SEP	2013-NOV	2013-DEC	2014-JAN	2014-FEB	2014-MAR	2014-MAY
Total	23	4	1	1	3	1	4	1	2	6
Pilot Group	9	4	1	1	3					
FMF Treatment Group	14					1	4	1	2	6

Table 13 Race from ANSA Assessments

	Total	Race/Ethnicity							
		Multi-racial	African American	White	Hispanic Latino	Other	Asian	Missing	Native American
Total	23	3	3	4	3	1	7	1	1
Pilot Group	9	1	2	3	1	1	1		
FMF Treatment Group	14	2	1	1	2		6	1	1

Table 14 ANSA Needs Assessments for Treatment Group

	Count	Missing	Min	Max	Median	Mode	Mean
Adjustment to Trauma	13	1	0	2	1	0	1
Anxiety	14	0	0	2	1	1	1
Cultural	14	0	0	3	1	0	1
Depression	14	0	0	2	1	0	1
Employment	13	1	0	3	0	0	1
Environment	9	5	0	2	0	0	1
Family Functioning	14	0	1	3	2	2	2
Involvement in Recovery	9	5	0	3	0	0	1
Legal	14	0	0	2	0	0	1
Life Skills	14	0	0	2	1	1	1
Medical	12	2	0	3	0	0	1
Residential Stability	14	0	0	3	2	1	2
Severity of SA	9	5	0	2	0	0	1
Stage of SA Recovery	9	5	0	1	0	0	0
Substance Abuse	14	0	0	2	1	0	1

Table 15 ANSA Strengths Assessments for Treatment Families

	Count	Missing	Min	Max	Median	Mode	Mean
Social Connectedness	14	0	0	2	2	2	1
Family Involvement	14	0	0	2	2	2	2

Housing Stages and Assessment Data

HPP collects housing stages data on housing situation at intake, assignment of housing funding, non-lease housing moves (e.g. moves into a hotel), and lease events. About half of the treatment families, each of whom met the definition of being homeless, were living with family or friends when they first enrolled in the program. The second most common housing situation, associated with about one quarter of clients, is “other”.

Through May, HAM assessments have been completed for 9 treatment families. The HAM was developed by Hamilton Family Center, the organization that manages the city’s largest homeless family shelter, and is scored based on the correlation of family characteristics with success in 7 types of housing: market rate (no assistance needed), short-term rental subsidy (1-3 months), medium-term rental subsidy (1-18 months), transitional housing, affordable housing, deeply subsidized, and

permanent supportive housing. The sample size (N=9) is currently too small to draw conclusions about housing assessment results.

HPP also collects housing stages data on housing funding assignment, temporary housing event (e.g. moves into hotels), and lease events, yet there is not enough data at this point in the program to include tables. Based on their most recent housing funding event, three families have been assigned deep housing subsidies and one family postponed a subsidy to enroll in a residential treatment program. For most recent lease and non-lease housing events, two families have moved into hotels, and one has been permanently housed in San Francisco. It should be noted that ten of the twelve pilot families have been housed, and that one of those not housed is incarcerated and not engaged, and the other has been working on housing intermittently. This suggests that while the project families are able to find housing, it takes an extended time.

Table 16 Housing at Intake

	Total	FMF Treatment Group						Total
		2013-NOV	2013-DEC	2014-JAN	2014-FEB	2014-APR	2014-MAY	
Total	13	1	2	2	4	3	1	100%
Family/Friends	6	1	2	1	1		1	46%
Other	3			1	1	1		23%
Shelter	1				1			8%
Hotel at intake	1				1			8%
Vehicle	1					1		8%
SRO	1					1		8%

Table 17 HAM Assessments Completed by Month for Treatment Group

	Total	HAM Assessments Conducted by Year and Month			
		2014-JAN	2014-FEB	2014-MAR	2014-MAY
Total	9	1	4	1	3
Percent	100%	11%	44%	11%	33%

Continuous Quality Improvement: To what extent were the project partners prepared and able to make the process and quality changes associated with project implementation?

Throughout the implementation process, the steering committee as well as subcommittees for housing, supportive services, and CQI have continued to meet regularly (usually monthly) to address issues as they arise and make adjustments to the implementation process as necessary. The committees also plan for future implementation issues, such as the case closure process. Major issues and the response to these issues are tracked in a "key decisions" document. Several key decisions that demonstrate how project partners have made process and quality changes are described below.

Eligibility Criteria

As described in the Implementation Plan, the initial targeting strategy focused on families in newly opened cases for which there was no removal (FM) case, and at least one child in the household who never had a prior open case. This latter restriction was intended to reflect one of the core goals of the initiative – early intervention with families who had not developed lengthy child welfare histories.

Early into project implementation, and as a consequence of on-going CQI review, the steering committee members realized that restricting referrals to FM cases was limiting the project's access to families for whom a quick removal may have been necessary for safety reasons. Without this removal, in all other respects, these families would meet program criteria. In December 2013, the steering committee, after consultation with the Federal Project Officer and the National Evaluators, decided to broaden the referral process to include Family Reunification cases (FR) when all other program criteria were met (see targeting strategy for criteria)[15]. This adjustment did generate more referrals to the experiment, and is subject to on-going review by the CQI committee.

As a quality check on the exclusionary criteria of the subgroup of newborns described in the previous section, the CQI team recently reviewed all FR cases referred to the lottery through May. Among the seven that were excluded, five continued on the track to permanent placement status (i.e., reunification bypass). The remaining two were new cases that had not yet reached the court's six-month review. None

[15] As noted in the targeting criteria, when this change was implemented, it was with two FR sub-groups excluded – newborns removed rapidly, and children when any prior maternal siblings had been permanently removed. These two groups were associated with children who bypass reunification and move straight to court-ordered permanent placement, which would render them ineligible for project participation.

of the FR cases that were admitted to the experiment had gone on to permanent placement status by the end of May. Thus the review found that so far the new, broader eligibility along with the specific exclusions are operating as intended.

Housing First

The project is based on the Housing First model that was developed by Pathways to Housing in New York, and is currently being used to address chronic homelessness among veterans in the U.S. and nationwide in Canada. In the Housing First model, the objective is to permanently house clients who have a multiplicity of needs so that stable housing serves as platform enabling the client families to more directly benefit from services designed to ameliorate their co-morbidities (Padgett and Tsemberis 2006). Yet implementing Housing First in San Francisco has proved challenging.

The city has a very expensive, competitive housing market and landlords are reluctant to accept housing vouchers. As a result, many families have been housed temporarily in hotels. In many cases, these hotels may represent an improvement over the family's housing situation at intake, yet they are not a stable permanent housing solution. The steering committee and housing committee have been working to find better solutions. For example, partners are in the process of obtaining transitional housing for families in partnership with Hamilton Family Center that would represent an alternative to hotels while families are searching for permanent housing. Additionally, SF-HSA leadership is negotiating with the SF-HA to increase the value of the housing voucher, which will make those vouchers more attractive to potential landlords.

HPP Database Development

Chapin Hall received preliminary data extracts from HPP's Henri database in December 2013, including preliminary Adult Needs and Strengths Assessment (ANSA) data for adults from the Pilot Families. Preliminary extracts revealed that there was a notable amount of missing or incomplete data entry. Since then members of the evaluation team have been working closely with HPP staff to improve both staff data entry and Henri's ability to collect robust longitudinal data. Henri has been updated to track multiple service contacts over time. It has also been revised to collect distinct service and referral types that can be aggregated. Additionally, Henri can now track changes in housing status (i.e. living situation, receipt of voucher, obtaining and losing a lease) that will be used to populate the housing section of the monthly dashboard report. The "go live" date for these updates was April 23, 2014,

although data for families receiving services prior to that date will need to be back entered before an extract can be analyzed

Conclusion

During pre-implementation planning, project partners created a formal structure and process for collaboration and established targeting and process of care procedures. During the first months of program implementation, project partners further refined the program model (e.g. the targeting strategy), identified strategies for improving collaboration (e.g. coordinated case planning), fostered cross-systems collaboration (e.g. project launch event), and engaged in CQI to establish data collection procedures and ensure data quality. Yet some process and program challenges remain. A key challenge is associated with rapidly locating and securing permanent housing for families. In addition, accurate provision and/or documentation of all service referrals remains a challenge as does the timely completion of CANS assessments for children.

The CANS process challenge also underscores some of complexities involved in generating sustainable system change. However, many successes in other aspects of the project are indicative of the potential to accomplish sustainable system change. Chief among these are the efforts that HPP, SF-HSA, and the SF-HA are exerting to surmount some of the challenges associated with securing housing for the treatment families. Additionally, the project launch event, beyond publicizing the FMF initiative, inspired collaboration across the partners and created increased opportunity to generate sustainable cross system change.

Early program data also suggests that treatment families are receiving their first FTM, although the timeframe for FTMs will be evaluated further in the annual report. Families are also experiencing multiple contacts with their HPP case manager including home visits. Yet the data suggests that families are receiving few referrals for external or internal services at this point in the program, and improvements to HPPs database to collect information on the type of referred service (i.e., mental health) hat not yet been realized. Additional data on referrals for the annual report will allow for a better understanding of how the pace of referrals is related to program uptake.

Families are also receiving ANSA assessments through HPP for case management coordination. However, there are still process and systems challenges with conducting and collecting CANS assessments quickly. DPH, SF-HSA, and Chapin Hall did successfully establish data sharing and consenting procedures, yet DPH has experienced a systems change barrier with conducting the CANS assessments in the established time frame. In turn, project partners have been unable to use the CANS

for treatment planning in the process of care. Project partners are continuing to work together to resolve this issue.

The main current program challenge is permanently housing families. HPPs housing data suggests that families are being assessed for housing need, assigned subsidies, and temporarily housed in hotels. Yet only one treatment family has been permanently housed as of May 2014. The housing committee is taking steps to find better solutions for both transitional and permanent housing, and the process of housing families will be further evaluated in the annual report.

The annual implementation evaluation report due in November 2014 will include more thorough analysis of the pre-implementation and implementation processes. The report will draw from a variety of sources including both quantitative and a range of qualitative data sources. In advance of that, this interim process/implementation evaluation report on FMF development, targeting, referral and early processes shows that there are notable strengths in the organization and delivery of early program activities to families referred to the program in its first year. The challenges identified are known to the program managers and are the subject of improvements efforts. Together, the findings of progress to date, along with the efforts to continually improve the FMF initiative are indicative of a promising start.

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Families Moving Forward Case Management Model Policies & Procedures

Homeless Prenatal Program

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This demonstration could not have succeeded as it did if not for the wisdom, tenacity, and unyielding strength of the families who participated. This model is, in large part, a product of the invaluable programmatic feedback the families provided throughout their engagement in the process of connecting with services, securing permanent housing, and establishing stable patterns of independence. We thank the families first because, as experts in their own experiences as consumers, they have been our true teachers.

As we reflect on the contributions of the FMF case managers, housing specialists, and interns, we find that we are initially at a loss for words. These brilliant individuals have made it their collective mission to imbue this model with life, constructively and directly advocating for a model that most appropriately addresses the needs of the families being served, and putting that model into practice with an enduring commitment to serving our families with passion, grace, and integrity.

Our partner agencies were crucial in the development of this model. It has been, in part, through the integration of existing resources, such as the broader FMF Program Manual (2014), that this manual has come into being. We extend our gratitude to the formidable programmatic structures developed by Jocelyn Everroad, Bridgette Lery and their colleagues at the *Human Services Agency of San Francisco*. The extensive technical knowledge shared by Sarah Ramler, Lily Duong, Allyn Hayes, and the whole *San Francisco Housing Authority* team have been indispensable to our development of a model that can truly operationalize the Housing First approach. In our efforts to equally maintain a trauma-informed lens to address the complex needs of our families, we owe a debt of gratitude to the *Infant Parent Program* for the opportunities to dive more deeply into the work, to explore the impact it has on us as service providers, and to identify the clear need to incorporate these considerations into our model.

We also wish to thank the organizations who have provided indispensable Technical Assistance and project guidance throughout the grant, and in the development of this model: Emily Rhodes and Jennifer Haight at *Chapin Hall,* Alison Harte and Leah Rhea at *CSH;* Erin Ingoldsby at *James Bell Associates;* and Dori Sneddon at the *Administration for Children and Families.*
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Contents

Part 1: Program Description

Introduction

Homeless Prenatal Program's Families Moving Forward Case Management Model integrates clinical case management and housing search and placement, while fostering interagency partnerships and engaging in collaborative case planning. Building upon HPP's success with engaging and supporting families, the project aims to implement a structured model of crisis stabilization and ongoing supportive housing. HPP's case management model is strengths- based and client-centered, integrating three main evidence-based practices: Motivational Interviewing, Solution-Based Casework, and Safety Organized Practice.

FMF embraces an approach to housing families that eliminates barriers typically facing high- need families in the housing process. In some instances, families have immediate goals that do not include becoming housed. In these cases, as neutral advocates for the families, FMF case managers support families in meeting these goals while maintaining a Housing First focus through coordination with Housing Specialists.

We understand that the families who need supportive housing are those who by design, cannot obtain or sustain housing on their own without services. We understand that obtaining housing consists of multiple smaller objectives, and that clients will most likely not demonstrate the ability to effectively carry out the steps needed to meet those objectives. FMF families are intentionally targeted to be those who no other provider can help. As a result, the role of the FMF case manager is extremely challenging and unique. FMF case managers go beyond the office hours and their desk. The core practice components of the FMF case manager are: Engage, Team, Collaborate and Advocate. Please see the grid below for a summary of tasks associated with these core components:

Figure 1: Critical Practice Components

Engagement, Team Collaboration & Assessment	**Service Partnership Engagement & Advocacy**	**Housing Search, Advocacy & Placement**	**On-going Housing Stabilization & Maintenance Services**
1. Develop initial "plan of care" 2. During 30-day assessment period, CM meets with family at least once weekly 3. Arrange Rapid Team Meeting; secure informed consent from family 4. Identify family strengths 5. Prioritize needs and goals of family and assign action steps to team members. 6. Determine outcomes and indicators for each goal. 7. Determine potential serious risks; develop safety plans. 8. Finalize plan. 9. Complete documentation and logistics.	1. Connect family with initial services, provide treatment recommendations, advocacy. 2. Orient family to supportive housing program and case management services 3. Identify any immediate concerns and stabilize crises. 4. Engage other team members 5. Elicit information from child welfare about concerns and potential crises 6. Explore family strengths, needs, culture 7. Discuss the family's previous experiences with and current view of seeking help	1. Work with head of household to gather all documents needed for housing applications. 2. Once applications have been submitted, follow-up with each housing option with periodic phone calls. 3. Provide contact information for appointed case manager on all housing applications so PHA/other housing entity have someone to contact. 4. Refer family to FMF Housing Clinic or provide 1-on-1 Housing Search appointment for families unable to participate in Housing Clinic.	1. Conduct regularly scheduled home visits, matched with level of need, (see Part 2 for detail) 2. Carry out action steps, track progress, evaluate success. 3. Celebrate family successes 4. Revisit and update the plan: consider new strategies 5. Maintain and build team cohesiveness, trust, "buy-in". 6. Complete necessary documentation and logistics 7. Create a transition plan for reducing intensity of case management, including post-transition crisis management 8. Document the team's work 9. Celebrate success 10. Conduct regular check-ins

Utilizing the program's historical knowledge about housing placement and client need, HPP works to improve client processes and integrate services so that they are optimal and efficient. This document is intended for use at Homeless Prenatal Program, as well as for integration with the broader FMF Program Manual (2014) developed in conjunction with Human Services Agency of San Francisco and other project partners.

Practice Profile

This section focuses on the services component of Families Moving Forward, and is specifically designed to be applied to the programmatic approaches of the family Supportive Housing Case Managers and Housing Specialists. The document:

1. Provides a brief rationale for the approach, using a logic model,
2. Describes the values that guide all interactions between FMF staff and family members,
3. Presents the core components and operational definitions of those practices, and
4. Provides ways to measure those practices performed by FMF staff.

The model is informed by human services work in general and grounded in the practices of family supportive housing programs, including those developed as part of the Administration on Children, Youth and Families' *Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System.*

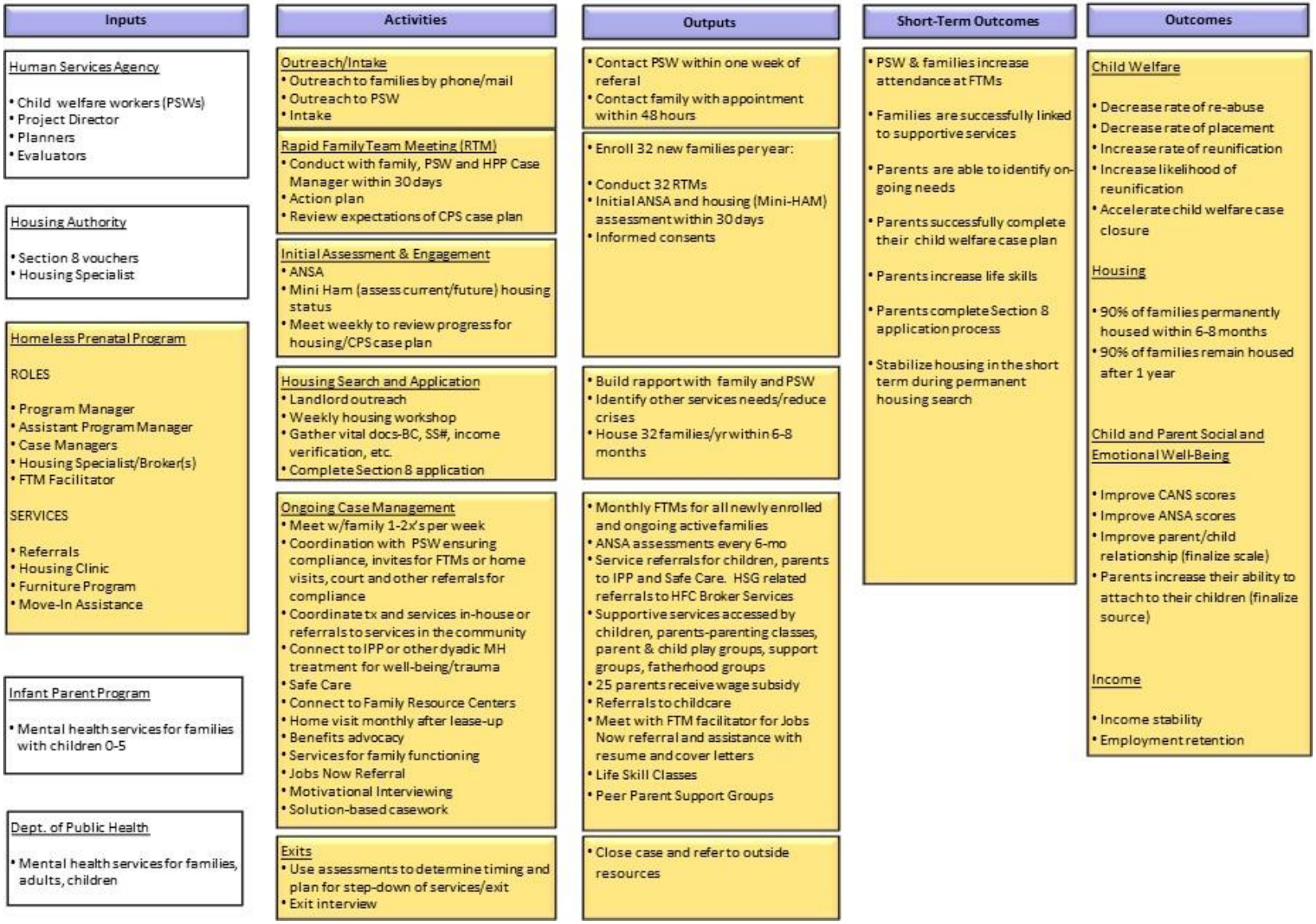
Rationale and Logic Model

Case management services for families participating in a supportive housing program, defined as *non-time limited subsidized housing*, are voluntary. The case manager works in partnership with family members, meeting with family members at their home or in the community to assess the family's strengths and needs, set goals, and coordinate services. Case managers are hired, trained, supervised, and supported to offer the following:

1. Direct services, to assist family members in:
    a. Defining and achieving goals, including meeting obligations of tenancy in order to secure and maintain a lease;
    b. Identifying and accessing community-based resources which improve family functioning;
        i. Services are both planned and responsive to crises related to the Child Welfare case and/or housing need;
        ii. Referrals are documented and tracked in HPP's HENRI database;
    c. Increasing financial security: accessing and maintaining employment, entitlements, and/or benefits;
    d. Development of communication and self-advocacy skills;
2. Groups and activities, including the development of family councils, tenant or program participants' group and other community-building activities;
3. Innovative methods of engaging with family members in an attempt to increase likelihood of participation in improving various aspects of their lives.

For a more detailed overview of the key roles and partners in service delivery, please refer to the Zoom-In HPP Logic Model below.

Families Moving Forward San Francisco: Homeless Prenatal Program Case Management Logic Model



Guiding Principles

Housing stability is a platform and precursor to the well-being of families and children. Safe, stable, and affordable housing serves as a platform for engaging family members with a network of persons: professionals/formal supports and non-professionals/informal supporters. The supportive housing case manager works to develop a network of service providers and interventions which maximize a family's tenure in housing: assistance maintaining household and finances; performing activities of daily living; upholding the terms of their lease; maximizing tenant safety and security within their community; building a sense of community among other families within the supportive housing program and within the family's neighborhood; and preventing avoidable evictions.

Trusting relationships promote positive change and growth in families. An underlying assumption of the role of the family supportive housing case manager, arguably in any such helping relationship, is that building and maintaining a trust-based relationship is essential for working towards positive outcomes. Case managers encourage open communication and cultivate trust with family members. Families should view all services providers as a source of support and assistance, both for routine services as well as in times of crisis. Every interaction with family members is an opportunity for further engagement and alliance building.

Services are non-time limited and voluntary. Given the complexity and persistence of service needs among families, needed interventions have no fixed time limits. There is **no indication that service participation is required or mandatory by the supportive housing program provider**. It is anticipated that after achieving stability and improved outcomes, some families may no longer need as many formal supports or may need and desire less frequent contact with service providers, including the supportive housing case manager. Such decisions should be made based upon mutual agreement between the service providers and the family members. A family's trusting relationship with providers should reinforce a culture of open communication where a family's changing needs can be discussed and addressed.

Service Approach

Team-based. Services are **well-coordinated with other providers.** The safety, stability and well-being needs of family members in supportive housing are complicated, requiring wide ranging practice knowledge and skills. Often individuals representing multiple disciplines and programs or agencies work with families. Practices such as team case conferencing and team clinical supervision allow staff and supervisors to help troubleshoot difficult situations and to reinforce a non-judgmental, supportive and collaborative culture. Family Team meetings which involve family members, in an environment where the family is an integral part of the work and success of the team, can be also used to review the status of family members and for planning. The Family Team Meeting is also an opportunity to identify any issues that are of concern to the parent and the child welfare worker. It's a chance for these concerns to be discussed early, to avoid jeopardizing the progress of the family and their housing stability.

Emphasizes community support and safety. Stress and isolation undermine health and parenting. Supportive housing case managers actively work to build community and a culture of support and interaction among families involved with supportive housing, as well as their non-

supportive housing neighbors. There will be many families who have learned not to trust their neighbors and would rather engage in activities outside the immediate community. Opportunities to connect to other families both in the program and in the community should be offered on an-ongoing basis.

Collaborative relationships. FMF staff work to build rapport between the landlord and the family, to reduce the risk of the family feeling isolated in their new home, and safeguarding against a return to homelessness. Additionally, the relationship fostered between the landlord and FMF allows for direct communication, should any issues arise (i.e., late payment of rent, concerns of domestic violence, or relapse), to ensure any risks are being managed and the family is being supported through these life events.

Flexible. The strength of the supportive housing model is that it provides unique opportunities to work with and directly witness family circumstances in real-time and, at times, on a daily basis. Supportive housing providers deliver services "in vivo" contributing to the ability to attend to the wide range of needs experienced by families with complex needs. The work of an FMF case manager goes beyond their desk and typically does not take place only within the hours of 9-5. **Case managers** are **flexible in arranging meeting times, locations** and services. These forms of assistance and troubleshooting further reinforce families' perception and experience of services as being dependable and a true source of help.

Trauma-informed. Supportive housing practitioners should be aware of the stressors with which many supportive housing families live and the fact that many family members may have been exposed to a range of traumatic experiences: community violence, domestic violence, physical abuse, traumatic grief, child welfare involvement, substance abuse, and mental health issues. Exposure to multiple or prolonged traumatic events, typically beginning in early childhood within the primary caregiving system, produces complex trauma. Providers should have the skills to identify and appropriately respond to trauma symptoms. As well, organizations, including supportive housing settings, have become much more aware of how the physical environment of office spaces and even administrative procedures may elicit negative responses related to a person's experiences with stress and trauma.

Strengthens protective and promotive factors. Traditionally, many social services and interventions for families have focused on identifying and addressing risk. In contrast, a protective and promotive factor approach focuses on what we know about families who are able to be stable and even thrive in the face of risk. By focusing a protective factors approach on both parents and children supportive housing can build the capacity for:

- Children to adapt, heal and thrive
- Parents to provide the nurturing supports that children need
- The whole family to increase stability in internal and external interactions

A Protective Factors approach supports families in building the skills and the capacities they need to deal effectively with stress and challenges when they arise.

Components and Definitions

The work of a family supportive housing case manager is laid out below in Figure 1 which provides a high level illustration of the case management activities. While the presentation here is linear and clear, most often in real-life it is not. Given challenging circumstances and events, families may appear to regress, even after making significant progress. Following a description of the phases, the critical components of the practice in which case managers engage are defined and presented in behavioral terms, with guidance on how case managers and/or supervisors can (self) assess performance.

Organizational Supports

These practices will only succeed if the case managers receive the support and coaching they need to perform effectively. This includes:

The supportive housing program or organization is responsible for supporting case managers in their ongoing practices of engagement, assessment, and teaming with qualified, committed, well-compensated, trained and supported staff. Case managers must have manageable caseloads and workloads in order to dedicate the time needed for each family. The principles and values of the organization should be clearly stated and all efforts made to be infuse them into business practices and daily practices with family and provider partners.
Practice expectations and outcomes should also be clear to all (staff, management, family members) and all must be held accountable for the role they play in helping to achieving those outcomes.

The supportive housing program or organization may have to establish Memoranda of Understanding, agreements or procedures to facilitate the mutual work of the multiple organizations with which supportive housing program staff and participants interact. Families are often engaged across multiple programs and case managers are expected to identify and interact with staff of those programs.

Organizations need to be aligned with best practices in providing trauma informed care. Families served by supportive housing programs may have experienced trauma. Trauma can cause changes in brain neurobiology; social, emotional impairment, and cognitive development; adoption of risky behaviors as coping mechanisms and persistent physical, social and mental health problems. Physically comfortable and safe spaces, caring reliable staff, policies and procedures perceived as fair and clear, all help towards healing people. From the executive to the family member level, understanding the challenges and behaviors exhibited by people who have experienced trauma and possessing skills to address them are needed to help heal family members. These experiences can be provided on a daily basis by all supportive caseworkers who work with families and especially a family supportive housing caseworker who plays a special role in a family's life.

Staff Roles

Program Manager

The FMF Program Manager is responsible for the overall daily operations, supervision, planning, development, and implementation of the FMF Program at HPP. The FMF Program Manager's responsibilities include communicating and collaborating with multiple outside agencies participating in the FMF Program and directly supervising an intensive case management and individual counseling program for families from the San Francisco Child Welfare Program selected to participate in the FMF Program.

Assistant Program Manager

This position is responsible for assisting the Program Manager in the supervision of case managers and applicable contracts, and providing a level of direct service as determined by the Program Manager. The Assistant Program Manager is also responsible for coordinating data and service delivery models between HPP and external project partners.

Outreach Case Specialist

The Outreach Case Specialist will be responsible for facilitating initial contact with families randomized into the Treatment Group, as well as their assigned Child Welfare worker. The Outreach Case Specialist is responsible for obtaining informed consent for participation, and for beginning the assessment process with newly referred families.

Housing Specialist/Bilingual Housing Specialist

The Housing Specialist will work closely with Case Managers and other members of the FMF team to identify housing opportunities suitable for each family in the program; prepare families for a housing voucher program and remove barriers to housing; assist families in securing a specific housing unit and obtaining necessary rental assistance; help families through their housing transitions; and support successfully housed families with any housing-related problems they may be experiencing.

Family Case Manager

The Family Case Manager is responsible for providing guidance, extensive support, and resources to families who are currently dealing with homelessness, substance use, mental health, and domestic violence issues. The Family Case Manager must promote a positive, professional attitude towards families, and is responsible for conducting assessments, family team meetings, face-to- face interviews, and home visits. They will act as a liaison between the PSW and the Family.

Holloway House Family Case Manager

The Holloway House Family Case Manager (HHFCM) is responsible for providing guidance, extensive support, and resources to families who are currently residing at Holloway House, while assisting each family with their housing search. The HHFCM will be responsible for conducting initial and follow-up assessments, family team meetings, housing searches, and home visits. The Family Case Manager will be required to meet with representatives from the Child Welfare System on a regular basis.

Family Team Meeting Facilitator

In the role of Family Team Meeting (FTM) Facilitator, one staff member is responsible for coordinating and conducting FTM encounters between participating families, child welfare workers, and other providers. (See Engagement phase below.) Additionally, the FTM Facilitator provides team support during home visits, offers targeted services to participating fathers, as well as driving connections with JobsNow services through Human Services Agency of San Francisco.

Phase-Specific Key Tasks

Service Phase	Case Manager	Housing Specialist	Child Welfare Worker
General	ï Supports client in all aspects of housing search placement and stabilization	ï Facilitates intensive housing application efforts ï Networks with landlords and housing options ï Consults with team regarding best options for family	ï Provides case management in support of the child's well-being along the court dependency process
Intake	ï Facilitates client's entry into program ï Begins assessment	ï Offers auxiliary support as needed	ï Consults with housing team ï Shares information regarding plan of case
Engagement	ï Completes assessment and Family Action Plan ï Identifies barriers to housing ï Works with housing specialist to determine best options ï Motivates clients to focus on housing search ï Builds relationship with client ï Fosters protective and promotive factors for client ï Accompanies clients on interviews, supports clients with lease signings ï Supports client with transition into apartment	ï Acts as liaison between the family, rental assistance sources, and landlords for expediting the coordination of applying that funding to a specific eligible unit ï Guides the FCM and client in the application process ï Partners with FCM to support client in housing search ï Advocates with PHA when necessary ï Identifies barriers or red flags regarding potential unit ï Builds a network of landlords open to leasing-up FMF families, ï Negotiates with landlords on behalf of clients as necessary.	ï Child welfare casework
Stabilization	ï Provides regular home visits supporting client in building social network and self sufficiency ï Works with client to foster protective and promotive factors ï Provides crisis intervention support and treatment linkage	ï Follows up with client and landlord to ensure the things are going smoothly ï Advocates on behalf of client when necessary regarding problems with unit ï Provides guidance and consultation regarding landlord challenges ï When necessary, supports client with eviction prevention and unit transfer	ï When case is opened, CWW provides child welfare focused case management ï Recommends case for closure when appropriate
Maintenance	ï Does regular home visits ï Provides ongoing support to maintain stability ï Implements crisis intervention strategies (i.e., domestic violence advocacy or relapse support) to ensure maintenance of housing	ï Completes periodic check ins with client and landlord	ï No CWW involvement when case is closed

Part 2: Primary Service Phases

I. Intake (Referral Open)

See FMF Overview and Program Expectations for additional details regarding this process.

Outreach

Upon being randomly assigned to the Treatment Group and subsequently referred to FMF, our Outreach Case Specialist (OCS) will contact the child welfare worker to gather initial information about the family's child welfare case and housing situation. The OCS will attempt to contact the family using the phone number provided with the initial lottery referral, repeating once a week for up to 90 days or until contact is made, at which point a brief overview of the program will be given, and a first meeting will be scheduled at HPP to begin informed consent and their initial assessment.

Initial Meeting with Family

Informed Consent

Upon arriving at HPP for their first meeting with FMF staff, the OCS will support the family with review and completion of the HPP Registration Form, as well as all HIPAA signature pages. The OCS will review the FMF Overview and Program Expectations, and begin the family's initial assessment. Further, the Informed Consent process will continue into the Rapid Team Meeting (RTM), at which time additional Consent Forms will be signed and placed in the client file.

Initial Assessment

HPP case management staff members are trained in administering an amended version of the Adult Needs & Strengths Assessment (ANSA), which will be used to develop a comprehensive biopsychosocial snapshot of the individual functioning of each eligible adult in the family. This assessment will begin at the initial meeting between the OCS and the primary family member, who will complete all items through the Residential Stability section.

At this time, the OCS will also complete the Short-Form Housing Assessment Matrix (Mini-HAM) and consult with the Housing Specialist (HS) to determine a recommendation for housing appropriate to the needs of a particular family.

Moving Toward Engagement

Assigning a Case Manager

Following this initial meeting with the family, the OCS will meet with the Program Manager to assign an FMF Case Manager (CM). The OCS will be responsible for transferring 'ownership' of the client's case in HENRI to the CM assigned.

Rapid Team Meeting (RTM)

The OCS will assist with scheduling the RTM and will be responsible for informing the assigned CM of the RTM date, time, and location. The OCS will also be responsible for attending the RTM and collecting signatures on the following additional consent forms and placing them in the client file:

- Consent to Release Information for Families Moving Forward
    - Data Sharing Consent Form
    - Survey Consent Form
- Authorization to Release Protected Health Information

Before concluding the RTM, the family will coordinate with their assigned FMF Case Manager to schedule their first appointment together. It will be the FMF Case Manager's responsibility to enter that appointment into HENRI.

Intake Phase Summary

Intake Phase Summary of OCS Expectations

1. RTM scheduled within 2 weeks of lottery referral
2. Consents and agreements Signed
3. Initial ANSA started
4. Mini-HAM completed
5. Case Manager assigned

Data Follow-Up

Case Status Change
The OCS will monitor initial CM progress with client, and upon completion of the initial ANSA will change the client's FMF case in HENRI from 'Referral Open' to 'Case Open' status. If unable to engage family over the first 90 days, OCS will close FMF referral in HENRI.

FMF Referrals Entry
The OCS and/or assigned FMF case manager will be expected to document all external referrals given to FMF clients under the FMF Referrals area of the client's FMF case in HENRI.

Housing Events Entry
The OCS will be responsible for communicating the family's housing status at intake directly to the Housing Specialist, who will be expected to enter an initial Housing Event in the family's case.

II. Engagement (Case Open)

During this phase, HENRI will list a client's FMF Case status as "Case Open", indicating that they have entered an intensive phase of FMF case management focused on crisis intervention, biopsychosocial assessment, building of collateral supports, and the development of a supportive relationship. The Case Manager and Housing Specialist will utilize a multidisciplinary approach to identify any motivational or practical barriers to a family's engagement in the housing search process, and will respond using the strategies described below. All participating families will be offered services to support their ability to identify appropriate funding while searching for eligible permanent housing units. In practice, some interventions may primarily target the reduction of barriers to a family engaging in that process; this is intended to enhance, rather than to preclude, the implementation of a Housing First service model. These potential barriers, as well as their associated programmatic responses are discussed below.

The Housing First philosophy holds that homeless individuals require stable housing before they can effectively address other treatment needs such as addiction and mental illness. It is intended to address housing needs from a consumer perspective, rather than requiring treatment programs as a condition for receiving housing. Positive results from Housing First programs demonstrate the value of being stably housed while offered supportive services. While most existing studies focus on single adults, the FMF project will contribute to an understanding of how Housing First models can support families.

Given the current climate of rental markets in San Francisco and the surrounding metro areas, there are a number of larger systemic barriers which can present challenges to the application of a Housing First approach. For example, while a family may have secured sustainable funding and present as highly motivated to engage in the process of identifying a unit, rental prices for available units may remain too elevated for that funding to be applied, or another prospective tenant may offer to pay above market-rate rent in order to secure the unit. With these issues in mind, the role of FMF in implementing a Housing First approach must also necessarily include efforts to sustain the motivation of participating families, in part, by addressing outstanding case management needs as the housing process moves forward.

Engagement in Case Management Services

Within 1 week of completing the RTM, the family will be expected to attend their first meeting with the assigned FMF Case Manager, who will complete the ANSA previously started by the OCS, and begin development of a Family Action Plan (FAP), in which any potential barriers to engagement will be identified This plan will place special emphasis on the family securing permanent housing, and will take into consideration the recommendation previously indicated by the family's Mini-HAM outcome, unless circumstances have changed considerably, in which case the Family Action Plan may be updated immediately with the family.

Ongoing Clinical and Peer Support

The assigned FMF Case Manager will be expected to engage the family in weekly case management meetings to address any crisis intervention needs, provide any appropriate referrals, and discuss temporary housing situation and options, such as with family or friends, emergency shelters, transitional housing programs, or with specific contract referrals such as

STAR Community Home or Holloway House. (See *Bridge Housing Referrals* below for additional details.)

In these weekly meetings, case managers will implement solution-focused strategies informed by a Motivational Interviewing approach, in order to continually identify and address barriers impacting the family's engagement in the housing search process. Issues of motivation will be addressed through person-centered, strengths-based interventions aimed at increasing clients' readiness for change and confidence in their abilities to effectively participate in the process. Through the individualized service relationship, as well as through appropriate referrals, FMF Case Managers will also enhance client engagement by working directly with clients to address any challenges related to literacy, knowledge of technology, access to transportation. Lastly, FMF Case Managers will mitigate the impact of complex biopsychosocial factors (such as diagnosed mental illness, active substance use, or physical disability) by offering continued compassionate interventions, making suitable external referrals, and providing reasonable accommodations to support all participating families in their progress toward housing.

The family's FMF Case Manager will also be available for phone and email consultation with child welfare around risks associated with family functioning, as well as advocacy around the family's needs. The FTM Facilitator (or another FMF staff, depending on availability) will also coordinate with the child welfare worker to schedule at least one monthly *Family Team Meeting* (FTM) held with the family members, the assigned child welfare worker, and any additional service providers.

In our efforts to connect these families to more appropriate immediate supports, we may partner during this phase with service partners that may include residential treatment programs, Family Treatment Court (FTC), and Infant Parent Program (Meghan Spyker, Post-Doctoral Fellow: meghan.spyker@ucsf.edu).

Bridge Housing Referrals

Integrated into our efforts to provide specialized resources to FMF families are two contracts which allow us to provide temporary, semi-structured "Bridge Housing" to eligible FMF families who are actively engaged in efforts to identify and secure an appropriate housing unit within the Housing First framework our program offers. Families are prioritized based upon the lack of alternate options for temporary housing, as well as degree of fit for a particular contracted partner agency described in the sections below.

Holloway House

HPP's Families Moving Forward team has partnered with the Human Services Agency of San Francisco and Hamilton Family Center to provide a limited number of FMF families with a temporary living environment while parents work toward obtaining more stable permanent housing and addressing the broader needs of their family. Each family will continue working with their primary FMF Case Manager while also receiving on-site support at Holloway House, both from the Holloway House Family Case Manager & Coordinator, staffed part-time by HPP, as well as the Residential Counselors, staffed 24/7 by Hamilton Family Center.

The Holloway House program balances a client-centered, harm-reduction model of care with the clear and consistent expectations needed to maintain a safe cooperative living environment for all families, staff, and visitors. Additional details about the philosophy, programming, and expectations of participants can be found in the Holloway House Community Agreement; information about family eligibility and the referral process is located in Holloway House Referral Process.

Star Community Home

We have also partnered with Star Community Home, a project of Catholic Charities which offers single-parent families "a safe place to live, providing nutritious meals and beginning to build the skills necessary for a self-sufficient future." This important resource, which boasts a 97% housing stabilization success rate, has agreed to maintain space for up to two (2) qualifying FMF families on an ongoing basis. Our FMF Case Managers and management maintain regular phone communication with this external program to track the family's progress, as well as any challenges that may arise for the family. The requirements and referral process are briefly outlined below:

Requirements

- Homeless woman with child(ren) under 12 years old
- No substance use or alcohol problems for at least 6 months
- No domestic violence problems for at least 6 months
- Willing to move outside San Francisco
- Willing to participate in money management program
- Participate in weekly community meetings
- Complete chores, which rotate on a weekly basis
- Meet with on-site Case Manager at least once weekly
- Respect all house rules

Referral and Intake Process

1. The FMF Case Manager discusses potential referral family with FMF Program Manager
2. If appropriate, the FMF Program Manager will send an email to Lucia Lopez (Program Manager, llopez@catholiccharitiessf.org) with a brief description of the client, and the family's current contact information.
3. Lucia Lopez will conduct the initial screening
4. If the client is a good candidate for the Star Community Home program, she will be referred to a Case Manager there for a more intensive interview.

Family Action Plan

The family will collaborate with the FMF Case Manager to develop a Family Action Plan (FAP) to clarify the overall goals, divide objectives into individual steps, and better understand who is responsible for associated follow-through. (Depending on the Action Item, the person responsible may be the client, the FMF Case Manager, the FMF Housing Specialist, the family's child welfare worker, or another service partner.) The initial FAP will be developed within 30 days of completing the initial ANSA.

The family's current FAP will be reviewed regularly at case management appointments. Additionally, following each subsequent semi-annual ANSA, (regardless of program phase), the

FMF Case Manager will be expected to review the most current FAP in supervision, to ensure all action items adequately address the family's current needs and strengths. Further, should a particular event (i.e., change in living situation, change in family structure, relapse, etc) indicate an immediate need to update the current FAP prior to re-assessment, the FMF Case Manager may work together with both the client and the Program Manager to do so.

Housing Search, Placement, and Advocacy

The FMF Case Manager will also provide support to the family in identifying, applying to and securing permanent housing that is appropriately matched with the funding source approved for the family. FMF Case Managers are committed to making intensive efforts to support clients in the process; this may be through spending time searching online for units together, reviewing and completing rental application forms, and discussing strategies for interacting with landlords. If necessary, the FMF Case Manager and/or Housing Specialist may be available to accompany the family for viewing a desired apartment to determine whether the unit and the surrounding area will be likely to provide the family with a safe, healthy, and caring community.

The Case Manager or the Housing Specialist may not disclose any personal client information or status with the child welfare system, and will encourage clients to be selective in the details they choose to share with landlords.

In order to advocate for the family as a potential tenant, the FMF Case Manager and/or the Housing Specialist may speak with landlords in general about the FMF program, focusing on the benefits of case management, without disclosing confidential client information.

Once an eligible unit is selected, the FMF Case Manager will work in coordination with the Housing Specialist to ensure all necessary documentation is accurately completed and compiled, prior to the family signing a lease. (See *Housing Specialist Services* below for additional details.) When a unit is secured and funding has been assigned, the FMF Case Manager will be available to provide limited support with the process of moving the family's belongings into the new unit, as well as access to assistance with needed household items. (See *Move-In Support* below for additional details.)

In addition, the FMF Case Manager will continue working with the family in a Supportive Housing Case Management role, in order to support further stabilization through semi-structured monthly home visits, continued child welfare advocacy, and external service referrals. (See *Stabilization* section below for additional details on next phase of services.)

Move-In Support Furniture

& Home Goods

Upon moving into permanent housing, all FMF families eligible for assistance with furniture will receive the same type of items. If the families are not satisfied with the furniture items provided, they have the right to purchase furniture on their own. Below is the list of eligible items.

- One adult queen bed
- One bed for each child, or bunk beds as requested

- One dresser for each family member
- One table with chairs for the family

Funding for furniture for families can come from two potential sources: Season of Sharing (SOS) and FMF One Time. When families apply for move-in assistance from HPP (for deposit and first month's rent), the Housing Specialist will inform the case manager whether the family is expected to have remaining funds available for furniture from SOS. If the family does not have funds available from SOS, then the family will need to use One Time funding. Additional items may be requested from the family's FCS worker. FCS workers should be able to provide a bed and dresser for the family.

The FMF Case Manager will request approval of furniture budget by Program Manager. When budget is approved, the FMF Case Manager will work with the client to order furniture. Although each FMF family is allotted a maximum $1500 for furniture assistance through FMF One Time, this number should not be disclosed to families. Furniture is usually ordered from El Corazon or Today's Furniture. Both agencies, will usually ship furniture directly to client's home.

Procedure for Ordering Furniture:

1. CM will check-in with Housing Specialist to determine funding source
2. CM will request budget approval from Program Manager.
3. Meet with client and order furniture from Today's Furniture or El Corazon
4. Request a promissory note from the Assistant Manager of HPP's Housing Assistance Program for payment
5. Arrange furniture delivery date with furniture company

Beds can also be ordered through the Tufts and Needles Program by going to HPP Resources and filling out a bed request. Case Managers should consult with the Assistant Manager of HPP's Housing Assistance Program to make a request.

Home Goods: Case Managers may request home goods valuing a maximum of $100, on a family's behalf, by submitting the appropriate request in HENRI under the FMF case of the primary family member.

Integration with Family Treatment Court (FTC)

A subset of families referred for FMF may have identified "harm or danger" related to substance abuse, and may be mandated by child welfare to go into residential drug treatment. As FMF is a Housing First program, it does not reject potential tenants because they need treatment. In these cases, Housing Specialists and child welfare workers can work together with the family to obtain appropriate paperwork so that a voucher will be available to the family as soon as they exit treatment.

When risks related to substance use are identified, child welfare will follow their standard procedure in referring families to HPP for engagement and assessment services with FTC. To avoid duplication of case management services and to establish emphasis of initial case management and on-going engagement efforts, the FMF team will outreach and introduce themselves to the family but the FTC team will initiate assessment, treatment placement, and child welfare advocacy.

Procedure

1. Parents identified for FMF **AND** HPP substance use support & engagement services:
    a. The child welfare worker will submit the referral for HPP services.
    b. Parent will be invited to the **Family Service Intake** group by the FTC Outreach Team, where they will be presented with the general information about the dependency and assessment processes.
    c. Child welfare worker will flag the referral as an FMF family, when they are aware of the lottery spot issued.
2. During RTM, team will develop plan for collaboration:
    a. The FMF Case Manager will work on a Housing Action Plan
    b. The FTC CM will assist the client with all treatment related actions.
3. If parent enrolls in FTC:
    a. FTC case management will primarily focus on treatment & parenting issues
    b. FMF Case Managers that have a family participating in FTC services will attend the FTC weekly team meeting to discuss FTC cases. This will take place every Tuesday from 1-1:30 pm.
    c. Both the FMF and the FTC case manager will attend all FTM's
    d. The FMF CM will attend any Team Decision Meeting (TDM) to ensure continued eligibility for FMF services and to assist with housing issues that may arise due to any changes in child placement status.
    e. The FMF CM will check in with child welfare worker to see if the client can start the housing process *after 90 continuous days of treatment* or the housing placement process will be placed on hold until Collaborative Case Review and Housing Plan can be established parallel to the Treatment and Participation plan.

Housing Specialist Services

Prioritizing a Housing First placement requires intensive, targeted focus to assist families in navigating a complex affordable housing landscape and guiding them through processes which can often feel baffling and bureaucratic. The FMF program has designated Housing Specialists on-staff available to support families with navigating the housing search process by helping to identify vacant units, providing transportation, negotiating with landlords, as well as coordinating with both SFHA and other local regional public housing authorities (PHAs). These supports are ultimately aimed at helping families move into eligible housing as fast as possible, and, specifically for families holding Family Unification Program vouchers, expediting the local PHA's lease-up rate.

The primary role of the Housing Specialist in the Engagement Phase is (1) to identify a funding source and provide targeted support with closely following these procedures to maximize a family's opportunities for obtaining permanent housing, (2) to act as liaison between the family, rental assistance sources, and landlords for expediting the coordination of applying that funding to a specific eligible unit, and (3) to facilitate the move-in process by accessing *rental assistance* funds either through HPP or other local agencies. Additionally, the Housing Specialist will work directly with landlords to (a) promote the FMF program, (b) develop key professional relationships to build a network of landlords open to leasing-up FMF families, and (c) negotiate with landlords on behalf of clients as necessary.

Weekly meeting with Housing Specialist

The family will arrange an initial meeting with the Housing Specialist at HPP to further review the steps by which they may obtain access to the funding source indicated by their Mini-HAM results. The Housing Specialist will further help the family to set up an email account for housing search (if needed), create a draft e-mail for communicating with landlords, and provide coaching to families around speaking with landlords by telephone and email.

Families meet with the FMF Case Manager as frequently as possible to search listings and identify possible housing opportunities. In order to advocate for the family as a potential tenant, the FMF Case Manager and/or the Housing Specialist may speak with landlords in general about the FMF program, focusing on the benefits of case management, without disclosing confidential client information.

Housing Search Support

After the family has completed the Mini-HAM, the client will work primarily with their FMF Case Manager to look for an apartment that meets FMF standards, with targeted additional support from the Housing Specialist. The Housing Specialist will support the family in compiling documents for a Landlord Packet, an individualized folder containing copies of important documents to be shared with prospective landlords to facilitate communication and improve landlord confidence. (See “Landlord Packets” section below for additional details.)

Weekly FMF Housing Workshop

Every Monday, the FMF Housing Specialist and FMF Intern facilitate a specialized Housing Workshop in HPP's computer lab. This is a workshop where all FMF clients are referred for opportunities to access one-on-one support from the FMF Housing Specialist and FMF Intern in creating landlord packets, finishing their Section 8 applications, and searching for housing.

Landlord Packets

The individualized Landlord Packet is developed with support from the FMF Housing Specialist or FMF Intern, and will generally contain items such as the family’s (1) current Section 8 voucher, (2) HPP Deep Subsidy Letter (see “Housing Choice Voucher [Section 8]” below for details), (3) recent credit report, (4) blank Intent to Rent form, and (5) blank W9 form.
Additionally, each Landlord Packet will be accompanied by a business card with contact information for the Housing Specialist.

In the FMF Housing Workshop, families will receive targeted support with running a credit report through annualcreditreport.com or National Tenant Network, and writing a self-reference letter. The Housing Specialist will also provide a personalized subsidy letter to the family, along with a copy of their Section 8 voucher, blank W9 form, and a blank Intent to Rent form. For ease of use, a copy of the completed landlord packet will be kept on file by the Housing Specialist, while the client is provided with several copies of their own.

Section 8 Application Support

Some clients may be in the process of completing their Section 8 application, making the Housing Workshop a useful opportunity for staff put in an order for a birth certificate, make a referral to the local DMV for a Reduced-fee ID Card or Social Security card, or call CalWORKs/an employer to request proof of income be sent to HPP via fax. The process of completing the full Section 8 application can take upwards of a full hour on its own, and so is

generally scheduled for a separate meeting with the Housing Specialist. (See “Housing Choice Voucher [Section 8]” below for additional details.)

Housing Search

The FMF Housing Workshop is also utilized as an opportunity to provide clients with new SF Below Market Rate applications, help them set-up and learn how to use e-mail to contact landlords, search with clients on GoSection8.com and craigslist.org and call landlords together. The Housing Specialist may also provide a script of how to talk to, e-mail, and/or leave voicemails for landlords when they are searching on their own time.

In order to provide additional incentive for using this valuable resource, a family will be given a $10 FoodsCo card each week they attend.

HFC Housing Brokers

Our contracted partners at Hamilton Family Center (HFC) are available for additional support with the identification of, and access to potential housing opportunities. Referrals can be made directly by the FMF Case Manager or Housing Specialist.

Rental Funding Sources

The identification of an appropriate funding source is a crucially important step in connecting FMF families to viable housing options for maximum stability, given a family’s particular situation. Over the course of a case, the Housing Specialist and FMF Case Manager will collaborate to remain flexible, acting as a liaison between rental assistance sources and clients while ensuring that a family’s current funding source remains appropriately matched with potentially shifting circumstances. A summary of the processes for accessing each of these funding sources is provided in the subsections below:

Housing Choice Voucher [Section 8]

Under this program, participants lease units from private landlords and pay no more than 30% of their adjusted income for rent, with SFHA paying the remaining balance of the rent.

In order to begin the housing process, FUP-eligible families must have a completed and approved Housing Voucher Application (HVA) Packet on file with the San Francisco Housing Authority (SFHA). Additionally, the Housing Specialist may provide FUP families with an HPP Deep Subsidy Letter, on agency letterhead, offering limited rental assistance funds while waiting for their Housing Choice Voucher (HCV, also known as Section 8 Voucher) to be issued by the SFHA, so that they may begin their housing search.

Families in the FMF project have many challenges and are suffering from complex trauma. All staff working with the family must understand that the issues that brought the family to FMF are also the ones that will make it difficult for them to assemble a housing authority application packet and continue through the complicated process of becoming housed with a public subsidy. In order to house families quickly, Child welfare workers and the Housing Specialist must work hand in hand to assist their clients with applications and obtaining documents.

Housing Voucher Application Packet Checklist
The Case Manager begins collecting the housing packet as soon as the client is assigned. The packet should be filled out completely by the client, without use of white-out or cross-outs. The

Housing Voucher Application Packet should consist of the following items (underlined items should be hyperlinked to forms, some can be found here: http://www.sfha.org/Forms.html)

- □ A birth certificate for **each** household member listed under Household Composition section of the application
- □ A Social Security Card for **each** household member listed under Household Composition section of the application
- □ Declaration of 214 Status Form for **each** household member (including children)
- □ Marriage certificate and/or divorce decree, if applicable (if last name on social security card and birth certificate are not the same, this provides the housing authority with a documented explanation for the name change)
- □ Payment plan for debt or statement of $0 balance/letter of good standing from Housing Authority (if the client lists on p. 2 of the application that he/she has lived in public housing or had Section 8)
- □ Medical documentation in cases of disability requiring reasonable accommodations in the housing unit.
- □ Green Card (if client has come from another country and has a green card).

[Note: If the client is not here legally, they will not be able to produce a green card or their social security card. In this case, please note their immigration status on the packet checklist so that the designated Housing Specialist will know not to look for those items. It is important to note here that if the client is not here legally, if and when the family is issued a voucher, the client will not be considered in the number of bedrooms on the voucher.]

The following items for **each** household member who is **18 years of age or older**:

- □ Signed HUD Authorization for the Release of Information/Privacy Act Notice
- □ Signed Release of Information
- □ Signed SFHA Authorization to Release Information (for background check)
- □ Third Party income Verification for **all income sources**, including child support, DSS, SSI, etc. (no more than 30 days old).
- □ Statement of No Income form (if applicable)
- □ Copy of bank statement, with client's name, account number and bank name, no more than 30 days old (if applicable)

Packet Submission

The Housing Specialist will review application packets and ensure they are complete and legible before moving forward with the packet submission process.

Once the completed packet is complete, the Housing Specialist will send an email to MaryAnn Cerasoli (Social Worker Specialist, maryann.cerasoli@sfgov.org) and Robin Love (Program Manager, robin.love@sfgov.org) at HSA-SF, requesting a digital copy of the "Family Unification Program Referral Letter" (FUP Referral Letter) for that family. We normally receive the FUP Referral Letter from MaryAnn either the day of the request or the day following. This FUP Referral Letter and the application must be sent together, and must both have matching dates.

Upon receiving the FUP Referral Letter from HSA, the Housing Specialist scans it with the completed application packet, submits the scan to Lily Duong (Eligibility Worker, duongl@sfha.org) at SF Housing Authority (SFHA).

Lily at SFHA will review the packet and will inform the Housing Specialist if there is a need for corrections. Although we have not been made aware of a standard wait-time for a response, it generally takes between 5-7 business days for the packet to be processed by SFHA. When the packet has been approved, Eligibility Worker will notify the family by phone, and the Housing

Specialist by email, and an Intake Appointment will be scheduled at SFHA. This Intake Appointment will consist of a document/eligibility review, as well as completing the following forms, as appropriate:

- Personal Declaration Form
- Supplement Form
- General Release of Information
- Debts Owed to PHA and Terminations Form

After approximately 5-7 business days, Lily will attempt to contact the family by phone to schedule a Voucher Pick-Up Appointment. If Lily is not able to speak with the family directly at that time, Lily will then email the Housing Specialist, who will provide the family with Lily's phone number and encourage them to schedule a Voucher Pick-Up Appointment. When that appointment has been scheduled between Lily and the family, Lily sends a confirmation e-mail to the Housing Specialist. The client may attend this appointment on their own, at which they pick up their voucher at the SFHA office, generally from the front desk.

Extension Requests
Vouchers remain valid for 60 days, after which time a Voucher Extension Request must be submitted to SFHA, or other appropriate PHA. A voucher may be renewed up to three times, meaning the total lifespan of the voucher equals 180 days.

At the time of the initial request for extension, the Housing Specialist will assist the family in filling out a Section 8 Housing Extension Request form, along with a Record of Search for Housing, and send both together, via email, to Lily Duong (Eligibility Worker, duongl@sfha.org). At the second and third extension, the Housing Specialist will also send a letter accompanying the extension request; this letter, sent via email to Eligibility Worker (Lily Duong, duongl@sfha.org) will re-state that the family is part of the FMF program, and describe the family's efforts to search for housing.

If a client's voucher reaches its full lifespan (180 days), a client may request a new voucher by completing the application process again -- as long as they are still FMF eligible. This will include providing a new Personal Declaration Form, Authorization to Release Information (for background check), and submitting of up-to-date vital documents (time sensitive documents: income verification, bank statements, and student verification). Housing Specialist will send the new application to Eligibility Worker and a new referral sheet from HSA with the same date.

Denial of Eligibility
Following negotiations with SFHA, we are currently at the Federal minimum for exclusionary criteria regarding eligibility. The remaining potential barriers to eligibility are (1) owing back rent for Public Housing unit(s), (2) being a registered sex offender, or (3) having been involved in the production of methamphetamine on SFHA property. Upon encountering one of these barriers, the FMF Case Manager may choose to write an appeal (such as "Request for Informal Review for Denial of Eligibility" or "Request for Reasonable Accommodation"), which is sent via email to Director of Leased Housing (Sarah Ramler, ramlers@sfha.org). [Additional details pending.]

Securing a Unit for Use with FUP Voucher
HPP establishes that that the landlord will rent to the family, either by verbal or written confirmation (i.e., with Intent to Rent form completed by landlord). At that time, the Housing Specialist, family and landlord fill out a Request for Tenancy Approval (RTA), which the Housing Specialist the emails to Eligibility Worker (Lily Duong, duongl@sfha.org) at the SFHA.

Unit Pre-Inspection

FMF requires that all units occupied by families receiving FMF rental assistance or security deposit assistance meet HUD's Housing Quality Standards (HQS). In order to ensure that the client will be living in a safe and sanitary unit, the potential apartment must pass an HQS inspection completed by a housing inspector from the local Housing Authority (if applicable). HQS inspections are required before the lease is signed and at least annually (if the lease is renewed).

The Housing Specialist uses the Overview of Housing Quality Standards, or other "common fail checklist" to conduct an informal pre-inspection of the family's unit to ensure that the client will be living in a safe and sanitary unit, and to increase the likelihood that the unit will pass the formal HQS inspection carried-out by the PHA.

Any modifications needed should be negotiated with the landlord before the PHA inspection. It is recommended that the Housing Specialist come prepared with batteries and other items that could quickly fix any potential inspection issues on the spot. This builds FMF's reputation among landlords and will help encourage landlords to rent with FMF again.

Housing Authority HQS Inspections

The Housing Specialist is notified of inspection date by SFHA Program Manager II (L'Tanya Allen-Harris, allenl@sfha.org). In some cases, especially in the context of re-inspection, the inspector calls client directly. It is recommended that housing specialist reach out to inspection department to let them know that an FMF client is awaiting inspection. This typically takes approximately 5-7 business days. The Housing Specialist should contact Program Manager II if s/he has not been notified of inspection appointment after 7 days. The Housing Specialist and family attend the inspection with the landlord. If unit does not pass inspection for facility reasons, the Housing Specialist negotiates with landlord to correct the identified issues in the unit and a re-inspection is scheduled. After the unit passes inspection, the Housing Specialist will contact the landlord by phone to review the Payment Standard and negotiate as needed, in order to make a final confirmation that the full rent will be paid and that the landlord is satisfied with the price. Once this has been confirmed, the family may sign the lease.

Portability Requests & Outside PHA Advocacy

The pricing in our current rental market in San Francisco can be prohibitive to many FMF clients; even affordable units may fail to meet SFHA payment standards. As a result, a number of families choose to port their FUP vouchers to other county PHAs, where there is often little knowledge of the FMF project, and thus a potential for delays in the lease-up process for FUP-holding families. The Housing Specialist may provide targeted support to these families by developing relationships with staff at PHAs outside of SF, as well as offering advocacy on the family's behalf in order to reduce delays with processes such as porting and inspections.

In cases where a family elects to live in a community outside of San Francisco City & County, a Portability Request Form must be submitted to Lily Duong at the SFHA after an apartment has been identified and landlord agrees to rent to the family. The Housing Specialist submits this form to Lily via email, noting additional requests for hand-delivery, and for the Housing Specialist to be notified when the processed Portability Request is ready for pick-up. (Note: If

the family's voucher is less than 30 days away from expiring at that time, the Housing Specialist will also submit a Section 8 Housing Extension Request and accompanying Record of Search for Housing, together with the Portability Request.) Upon receiving the request, Lily notifies the Housing Specialist of receipt via email. Lily then reviews the request with her supervisor, Housing Program Manager I (Londell Earls, earlsl@sfha.org), and the request is sent to Senior Eligibility Clerk (Lei Rochelle Johnson, johnsonl@sfha.org) for processing.

SFHA typically processes the portability request in approximately one week. If there is no response from SFHA after 7 days, the Housing Specialist should then check with Lei Rochelle Johnson, or her supervisor, Program Manager II (Charles Akhidenor, akhidenorc@sfha.org).

Once the porting documents are processed and ready, Senior Eligibility Clerk will notify the Housing Specialist via email. The family will need to bring valid ID to the SFHA in order to pick-up the port packet envelope, which **MUST** remain sealed until hand-delivered to the destination Housing Authority. Upon approval of the Portability Request by the destination Housing Authority, the family and the Housing Specialist will attend an intake appointment at their new housing authority, and an initial inspection will be scheduled.

Throughout the porting process, the Housing Specialist will communicate with the landlord while ensuring that Deep Subsidy funding is issued in ½-month increments until the port has completed and the unit has passed inspection. The date on which the unit passes inspection is the date when the lease can be signed.

Deep Subsidy

Eligible FMF participants have access to the SF-HSA/HPP Rental Subsidy Program, which can be used over a 12-24 month period and is designed to help participants secure housing while waiting for their Housing Choice Voucher (HCV, also known as Section 8 Voucher) to be issued by the San Francisco Housing Authority (SFHA) and during the time they are searching for a unit. The use of the subsidy varies between each participant and depends on the safety plan developed by the FMF Case Manager and the participant. This subsidy may be used for client needs including, but not limited to the following:

- Emergency hotel stays
- Rent payments in temporary housing
- Collecting documents and supplies needed for permanent housing
- Rent payments for permanent housing until the HCV is received.

Families enrolled in FMF are eligible if they are on a housing track in which a Section 8 voucher is being pursued. The deep subsidy would most likely not be used with families who have the opportunity to move into a LOSP unit (see below) or those who receive a shallow subsidy.

For additional details about the limitations of this subsidy, please speak to the FMF program manager, or refer to the FMF Subsidy Contract. The SF-HSA requires that tenants pay 50% of their income towards rent; the City paying the remaining balance.

Shallow Subsidy

A shorter-term, *Shallow Subsidy* offers up to $1500 per month, for a period of 1-2 years, to families who will be able to cover their rent and living expenses independently in the near future.

Local Operating Subsidy Program (LOSP)
FMF also utilizes the SF-HSA's *Housing and Homeless Services Local Operating Subsidy* which helps fund the development of permanent supportive housing complexes throughout the city. Some families will have the opportunity to move into these units, but openings are relatively rare. When a unit becomes available, the FMF Case Manager and/or Housing Specialist will support eligible families with the application process.

Move-In Support
If families need help with move-in costs once securing permanent housing they can apply for *rental assistance* through HPP or another agency (CalWORKs, Season of Sharing Fund, First Avenues/Hamilton Family Center, Raphael House, Compass Connecting Point). Housing Specialist meets with family and works with landlord to obtain all documentation needed to acquire HPP funds (and if needed Season of Sharing funds) for first month's rent and deposit. Move in paperwork includes Deposit Return Policy, W9 form, proof of ownership, client vital documents, and FMF subsidy agreement, and any other applicable items listed in Important Housing Information

Engagement Phase Summary

Case Manager Expectations

- Weekly Case Management Meetings (average 15 hours during first month of participation)
- Monthly *Family Team Meeting* (while child welfare case still open)
- Initial ANSA to be completed no more than 2 weeks after RTM
- Initial Family Action Plan developed within 30 days of ANSA
- New ANSA assessment every 6 months
- Family Action Plan updated as needed.

Data Follow-Up

Offsite Visits Entry
While case managers may visit families that have not yet obtained permanent housing (in residential treatment, shelter, doubled up), they are **not required** to do so; these meetings will be entered into HENRI by FMF staff as direct services with the Location field indicating "Offsite".

FMF Referrals Entry
All FMF Case Managers are expected to be documenting all internal and external service referrals provided to FMF clients under the FMF Referrals area of the client's FMF case in HENRI. Additionally, FMF Case Managers are encouraged to follow-up by entering Outcomes whenever possible for referrals already made.

Housing Events Entry
The Housing Specialist is responsible for obtaining information (i.e., from the family, FMF Case Manager, property managers, housing authorities, etc.) and is further expected to enter all Housing Events into the family's FMF case in the HENRI database. These data will reflect any changes to the family's housing status and/or access to specific funding sources.

III. Stabilization

Once a family has successfully moved into leased housing, their FMF case will enter the Stabilization Phase, in which their case manager will provide Supportive Housing Case Management services while the Housing Specialist remains available to address issues related to the unit in which the family is now living.

Supportive Housing Case Management Services

During this time, HENRI will still list a client's FMF Case status as "Case Open", indicating that they will continue receiving intensive FMF case management support, which will now be primarily focused on (a) strengthening of collateral supports, (b) successful closure of the family's child welfare case, (c) maintaining the family's new housing placement, and (d) management of the family's short-term subsidy and/or transition to a Section 8 voucher if eligible, with the overall goal of gradually reducing the family's need for ongoing case management support.

Home Visiting

Within the first 30-days of a family moving into leased housing, the FMF Case Manager will complete an initial semi-structured Home Visit in order to (a) assess the degree to which the family has begun adjusting to their new unit, (b) identify any outstanding issues in regards to the living situation or property management, and (c) update the Family Action Plan to incorporate aspects of the family's progress and ongoing need for case management or external referrals. Particular attention will be paid to safety in the home and life skills related to retaining housing including: budgeting and bill paying, relationship with the landlord and other tenants, cleanliness and household maintenance.

Conceptual Framework

An important part of FMF's integrative approach to stabilizing families is the Home Visit. Working with a client in their home reduces barriers, fosters engagement and supports a comprehensive assessment process. Home visits differ from case management appointments in that they are specifically geared toward the challenges a client is facing in their environment. Homeless Prenatal Program's Clinical Case Managers conduct regularly scheduled home visits matched with level of need.

Tenant meetings in their living environment include the following core elements:

1. **Clinical Support:** *building rapport, continued assessment, identifying risks & strengths;*
2. **Action Planning:** identification of targeted goals and stepwise outcomes;
3. **Linkage:** connecting family to immediate treatment services that support action plan;
4. **Psychoeducation:** coaching around fostering safe environments, healthy attachments;
5. **Skill Building:** development of life skills for problem-solving and navigation of systems.

Policy & Procedures

At the time of the initial Home Visit, the FMF Case Manager will provide the family with a printed copy of the You're Housed! What Now? information sheet. The FMF Case Manager will then review the corresponding page from the FMF Home Visit Follow-Up packet (i.e., "Home Visit #1) with the family, marking any items that may indicate action steps, advocacy, or collateral referrals may be needed. The current Family Action Plan will be updated to reflect the family's new living situation, and to outline strategies for supporting ongoing stability in their unit.

Due to the limited transportation resources available to our program staff, Home Visits will be prioritized for families housed within San Francisco; those families placed in housing beyond San Francisco will be called monthly for a semi-structured phone check-in that covers the same types of information gathered during an in-person Home Visit. These Home Visits or phone calls will continue for a period of at least 6 months before a family is considered for transition to the Maintenance Phase of the program. However, Home Visits may continue beyond the initial 6 month period on an as-needed basis, in order to continue deepening a family's supports for ongoing stabilization.

Following each completed Home Visit, the family's FMF Case Manager will review the related page of the FMF Home Visit Follow-Up packet with her/his supervisor for ongoing support.

Ongoing Case Management Support

The family's assigned FMF Case Manager will continue meeting with the client at least 2-3 times each month, including the monthly Home Visit described above. These meetings for Supportive Housing Case Management services will emphasize goals around family members finding employment and strengthening independent living skills. Additionally, while the family's child welfare case is still open, Family Team Meetings will continue to be held monthly, and may take place in the family's leased housing if appropriate. Following the initial Home Visit, the family's assigned FMF Case Manager will review the current Family Action Plan, either at subsequent Home Visits or at case management meetings, and will work together with families to update the plan as needed.

Supportive Service Referrals

In order to address specific needs identified in the current Family Action Plan, the FMF case management interventions in this stage may also be characterized by targeted referrals through "warm hand-offs" to a growing network of community partners. These referrals may provide support with case management needs including, but not limited to, the following:

Family Need	**Supportive Service Referrals**	**Family Need**	**Supportive Service Referrals**
Independent Living Skills	● Parenting Classes, SafeCare ● Nutritional Services ● Financial/Benefits Counseling	Housing Services	● Tenant Rights ● Utilities Assistance ● Eviction Prevention
Physical Health	● Routine Medical Care ● Health & Wellness Education ● HIV / AIDS Services	Substance Abuse Services	● Relapse Prevention Plan ● Outpatient Treatment ● Methadone Maintenance ● Alcoholics / Narcotics Anonymous
Mental Health	● Individual or Family Psychotherapy ● Child or Parent/Child Psychotherapy ○ Infant Parent Program ○ Child Trauma Research Project ● Group Therapy / Support Groups ● Psychiatry, Medication Management	Employment Services	● JobsNow Referrals ● Job Readiness Training ○ Resume Development ○ Interview Skills ● Continuing Education ● Volunteer Opportunities

Housing Specialist Services

During the Stabilization Phase of a family's participation in the FMF program, the Housing Specialist will continue to provide housing retention services as needed in order to support continued housing stability as case managers focus on home visiting, Family Action Plans, and supportive service referrals.

Services offered by Housing Specialists during this phase may include, but are not limited to:

- resolving landlord-tenant issues around maintenance, repairs, or lease compliance;
- satisfying unpaid rent through arrangement of payment plans with tenant and/or one-time financial assistance through the program;
- navigating administrative issues that may arise periodically between landlord, family, and the PHA.

Stabilization Phase Summary

Summary of Case Manager Expectations

- Family Action Plan updated within 30 days of move-in, and then updated as needed
- Initial Home Visit within 30 days of move-in
- Monthly Home Visits or phone follow-ups for at least 6 months after move-in
- At least 2-3 meetings per month with FMF Case Manager
- Monthly *Family Team Meeting* (while child welfare case still open)
- New ANSA assessment every 6 months

Data Follow-Up

Home Visits Entry

Home visits are required only for families that have obtained permanent housing, and will be entered into the HENRI database by FMF staff as direct services with the Location field indicating "Client Home". While case managers may visit families that have not yet obtained permanent housing (in residential treatment, shelter, doubled up), they are **not required** to do so; these meetings will be entered into HENRI by FMF staff as direct services with the Location field indicating "Offsite".

FMF Referrals Entry

All FMF Case Managers are expected to be documenting all internal and external service referrals provided to FMF clients under the FMF Referrals area of the client's FMF case in HENRI. Additionally, FMF Case Managers are encouraged to follow-up by entering Outcomes whenever possible for referrals already made.

Housing Events Entry

The Housing Specialist is responsible for obtaining information (i.e., from the family, FMF Case Manager, property managers, housing authorities, etc.) and is further expected to enter all Housing Events into the family's FMF case in the HENRI database. These data will reflect any changes to the family's housing status and/or access to specific funding sources.

IV. Maintenance (Check-In)

After at least six months of continued progress in the Stabilization Phase, the family may reach the decision, in discussion with their FMF Case Manager, that they are ready for a reduced level of program involvement. Regardless of when the most recent ANSA was completed, the case manager will complete an updated ANSA, which will need to demonstrate **all three of the following** in order for the family to be considered for the Maintenance (or "Check-In") phase of the program:

1. The family has signed a lease of subsidized housing and has a successful track record of paying their portion of the rent independently,
2. All child welfare cases have been successfully closed, and
3. The family has no outstanding case management needs, as demonstrated by ratings of **either 0 or 1** on all ANSA items.

Additionally, the FMF Case Manager will work with the family to complete an updated Family Action Plan, which should reflect the family's current stability and collateral supports, as well as strategies for responding to potential challenges that may arise, given the family's case history.

The FMF Case Manager will review both this newest ANSA and the updated Family Action Plan in supervision with the Program Manager, who will determine whether the family is eligible to move to the Maintenance Phase of the program. If the family is approved for this change, the Program Manager will add the "Check-In" sub-status to the client's FMF case in HENRI.

Supportive Housing Case Management Services

This phase involves at least 6 months of regular case management check-ins, either in the form of in-person meetings, or phone contact, between qualifying families and their FMF Case Manager. Interventions in this phase are intended to connect families to needed resources that will support their family's ability to maintain the stability they have achieved, even after their FMF case is closed. This includes an emphasis on external referrals, as well as auxiliary services offered at HPP on an ongoing basis.

As in previous program phases, the FMF Case Manager will continue to complete a new ANSA assessment every 6 months, and will update the Family Action Plan as needed, until the family is eligible for Graduation. Home visits will also continue as needed to bolster the family's independence as FMF services are reduced.

Housing Specialist Services

As families settle in to their housing, the Housing Specialist role shifts toward supports that emphasize housing retention. For some families with complex histories, the housing retention efforts focus on basic housing/living skill building; interaction with landlords, neighbors and property managers, maintaining current reported income and adjusting rent as necessary, maintaining the unit, and so on.

Housing Retention

During the Maintenance Phase of a family's participation in the FMF program, the Housing Specialist will continue to provide auxiliary housing support services on an as-needed basis.

Services offered by Housing Specialists during this phase may include, but are not limited to:

- resolving landlord-tenant issues around maintenance, repairs, or lease compliance;
- satisfying unpaid rent through arrangement of payment plans with tenant and/or one-time financial assistance through the program;
- navigating administrative issues that may arise periodically between landlord, family, and the PHA.

Maintenance Phase Summary

Summary of Case Manager Expectations

- At least 1-2 case management meetings monthly, or more as needed
- New ANSA assessments continue every 6 months
- Family Action Plan reviewed and updated as needed
- Home Visits continue as needed

Data Follow-Up

Home Visits Entry
Home visits during the Maintenance Phase will continue to be entered into the HENRI database by FMF staff as direct services with the Location field indicating “Client Home”.

FMF Referrals Entry
All FMF Case Managers are expected to be documenting all internal and external service referrals provided to FMF clients under the FMF Referrals area of the client’s FMF case in HENRI. Additionally, FMF Case Managers are encouraged to follow-up by entering Outcomes whenever possible for referrals already made.

Housing Events Entry
Should a family’s living situation change during the Maintenance Phase, the Housing Specialist is responsible for entering any subsequent Housing Events into the family’s FMF case in the HENRI database. These data will reflect any changes to the family’s housing status and/or access to specific funding sources.

V. Graduation

- Exit Criteria: See Engagement Flow Chart
- Closing ANSA (all ratings either 0 or 1)
- Case Review with FMF Program Manager
- Exit Interview See "FMF exit interview" PDF

CM/Client Expectations Dependent on Case Status & Sub-status

- Inactive: *(i.e., has enrolled, still eligible, but no current engagement)*
  - monthly check-in attempts for 6 months
- Case Closure
  - Complete Urban Institute "Family Exit Form"
  - Yelena to upload